Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Appendices

MEETING
29 March 2023 14:00

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Contents

Agenda item ICB 29-03-069

Approval of the Redesign of Musculoskeletal Pathway

GIRFT High Volume Low Complexity (HVLC) ICB on site visit held on 25th January 2023

Dear Shropshire, Telford, and Wrekin colleagues

Re: HVLC GIRFT Visit – Shropshire, Telford, and Wrekin ICB

It was a pleasure to have a face-to-face meeting with colleagues across the Shropshire, Telford and Wrekin ICB following our last virtual visit in March 2022. The level of engagement, and positive contribution from the team was greatly appreciated, particularly considering the difficult times acute trusts are experiencing. It is evident from the attendance and engagement at the meeting, that you are building strong working relationships between the clinical and operational staff on all three sites.

The SaTH CEO kindly set out the vision for the long-term plan, with a focus on the importance of achieving the HTP (which has gone to public consultation), and the need to put patients first. Colleagues acknowledged that a new strategy for Orthopaedics is required to serve the local population and recognised that collaborative working within the ICB is essential to meet this need.

Increasing Daycase (DC) Surgery rates is a core objective of the HVLC programme to ensure we make the best possible use of our available bed base. As a system, your DC rates for the BADS (British Association of Day Surgery) group of procedures reduced from 82% to 79% since we last met, therefore, we would hope to see you regain the levels you have previously achieved. I was therefore surprised as to the lack of Daycase facilities available at SaTH, and I'd ask that this be reviewed as it is clearly key to maximising your overall bed base and patient flows.

I was encouraged to hear about the implementation of the day case improvement working group at RJAH, and the learning from this programme should be shared across the ICB with opportunities to scale up across all specialties.

Theatre productivity is another major focus of the HVLC programme. Given the constraints particularly around workforce, it is essential we maximise the usage of the sessions that we do run, and consistently achieve 85% of capped utilisation as well as ensure we maximise cases per list. I would like to congratulate you on achieving 85% capped theatre utilisation at RJAH, however there were concerns raised regarding theatre utilisation and efficiency at SaTH which you acknowledged and are actively reviewing. I observed some of the theatre utilisation challenges on the Telford site during our walkaround whereby all the lists I reviewed were significantly underutilised. It is imperative that this is addressed. We have established the National Theatre Programme to support providers with their improvement work and will be sharing guidance, best practice, and offering 'hands on' support as required.

As with many systems, you outlined workforce issues and UEC pressures that are providing some constraints to service provision. I was encouraged to hear you have an anaesthesia fellow and a cross site ODP apprenticeship programme in place and a clear desire to look at new roles and ways of working. However, your constraints have led to an extremely limited Orthopaedic elective service at SaTH with virtually no inpatient elective care for several years. Considering the current challenges faced; we discussed the importance of streamlining services to provide ring fenced elective Orthopaedic care. The consensus was for trauma to be based at the Shrewsbury (RSH) site. We agreed that elective day case will be delivered at the Telford (PRH) site with elective inpatient care to be based at RJAH, this includes those patients requiring Enhanced Care as RJAH has a unit that caters for most surgical patients who have complex medical issues.

It was agreed that elective orthopaedic patients who were clinically complex due to comorbidities but deemed suitable for surgery on the understanding ICU facilities were available, would be treated at SaTH but this would be expected to be a small number of patients.

There was a commitment to work differently and an acknowledgement that surgeon's skills are being impacted in relation to elective in-patient orthopaedic surgery. In response to this, as a system, you recognise the need for a single consultant workforce model. It was good to hear that you have already started this journey by issuing joint consultant contracts, however we would like to see an active increase in this initiative across PRH and RJAH sites for all consultants. This initiative will help to reduce waiting times for patients and ensure surgeons are able to maintain skills accordingly. To further facilitate this, there was an appetite in the room for a single PTL which would help provide equity of patient treatment within the region.

At RJAH, you identified some areas of good practice with the commencement of the enhanced recovery programme, and undertaking prehab, joint school, and rapid rehab work. I look forward to seeing the progress in reducing length of stay with this programme and it would be good to see the system working collaboratively in this area.

In order to support reduction of 78-week patient waits to zero by the end of March, you informed me that for Orthopaedics, you have plans for a single MSK triage service across STW to go live on 13th February 2023. RJAH also agreed to review the outstanding orthopaedic patients from SaTH for mutual aid and re-review the current undated patients. You discussed continued use of mutual aid including London, Kettering, and Birmingham, and talked of collaborative work with Alderhey for the paediatric and adult spinal patients. In addition to this, we discussed the need to increase capacity within Gynaecology to reduce the 78 week backlog to zero by the end of March 23, this can be supported by increasing the insourcing efforts to support further weekend working and utilising mutual aid opportunities across the Region. As discussed, my GIRFT team can offer 'hands on' support with mutual aid efforts including providing scripts to support the patient acceptance rate for transfer.

We discussed the work GIRFT are leading regarding elective Hub development & accreditation, as part of the TIF process. I want to reiterate the importance therefore of achieving the hub standards across all elective hub facilities.

To summarise, I'd like to thank you again for facilitating what was a very positive face to face meeting. It's fantastic to see the levels of commitment from everyone in the room and on the call to enable and maintain excellent care for our patients. As ever, if there is any further support you need from myself or my team, please don't hesitate to get in touch.

Yours Sincerely

Professor Tim Briggs
National Director for Clinical Improvement and Elective Recovery, NHSE
Chair of the GIRFT Programme

Key Actions Summary, and supporting resources:

Day Case	• Achieve 85% Day Case rates for BADS procedures
Theatre utilisation	• Theatre utilisation low at SaTH • Learning to take place from Glen Burnley at South Warwickshire around maintaining the elective care pathways during emergency pressures
Orthopaedics	• Single PTL for RJAH and SaTH – Regional and National GIRFT team support offered to achieve this • Elective in-patient care at RJAH (HDU support from SaTH for medically complex patients). • Ring fenced - Elective day case work to be delivered at PRH and community provision (includes procedure rooms) • Trauma to move to RSH • Paediatric trauma surgery to be Consultant delivered with a view to reviewing the value of a Paediatric Trauma Orthopaedic Consultant • Single consultant workforce model across all 3 sites. • Maximise theatre utilisation at RJAH as part of TIF bid agreement • RJAH to undertake a further review of the current SATH 52ww and 78ww patients to scope provide mutual aid opportunities • Achieve 4 joints per list or the equivalent of in all Orthopaedic elective lists • Reduction in Arthroplasty length of stay for inpatients ○ Good Practice model (link) SWAT (South Warwickshire accelerate Transfer) Programme • Adoption of day case arthroplasty pathways e.g Exeter Nightingale
General Surgery	• Review the Clinical Lead ask for Theatre space at Telford to enable the surgeons to undertake more HVLC cases • Further improvements to be made across LoS <2 days for emergency appendicectomy currently 22% across the ICB against a benchmark of 36.2%
Gynaecology	• Improvements required in minimal access rates for hysterectomy • Gynaecology Consultants being given additional capacity every weekend (currently alternate weeks) to recover the 78-week backlog
ENT	• Review potential coding issues with adult tonsillectomy • Improvements required in ENT daycase tonsillectomy rates as currently performance as an ICB is the lowest in the country
Ophthalmology	• Look to improve cases per list even further and therefore, achieve the GIRFT recommendations of 10 cataracts in a non-training list
Urology	• Improvements needed in Daycase rates for TURBT • Continue efforts to reduce 78 week wait backlog including seeking mutual aid support via regional systems • UAN to be strengthened with UHNM
Notable good practice	• Exemplar theatre utilisation rates at RJAH lessons to be shared across the system • In collaboration with the Midlands Regional team there has been the implementation of DC pathway protocol for vaginal hysterectomy which will see a step change in the LoS <2 days for vaginal hysterectomy for benign condition • Cataract suite at Shrewsbury set up and running at 8 or more cataracts on the dedicated HVLC lists

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Final RJAH MSK Integration Engagement 03.23 v2

29.03.2023


thevaluecircle
MSK integration for Shropshire, Telford and Wrekin ICS

Statement of case

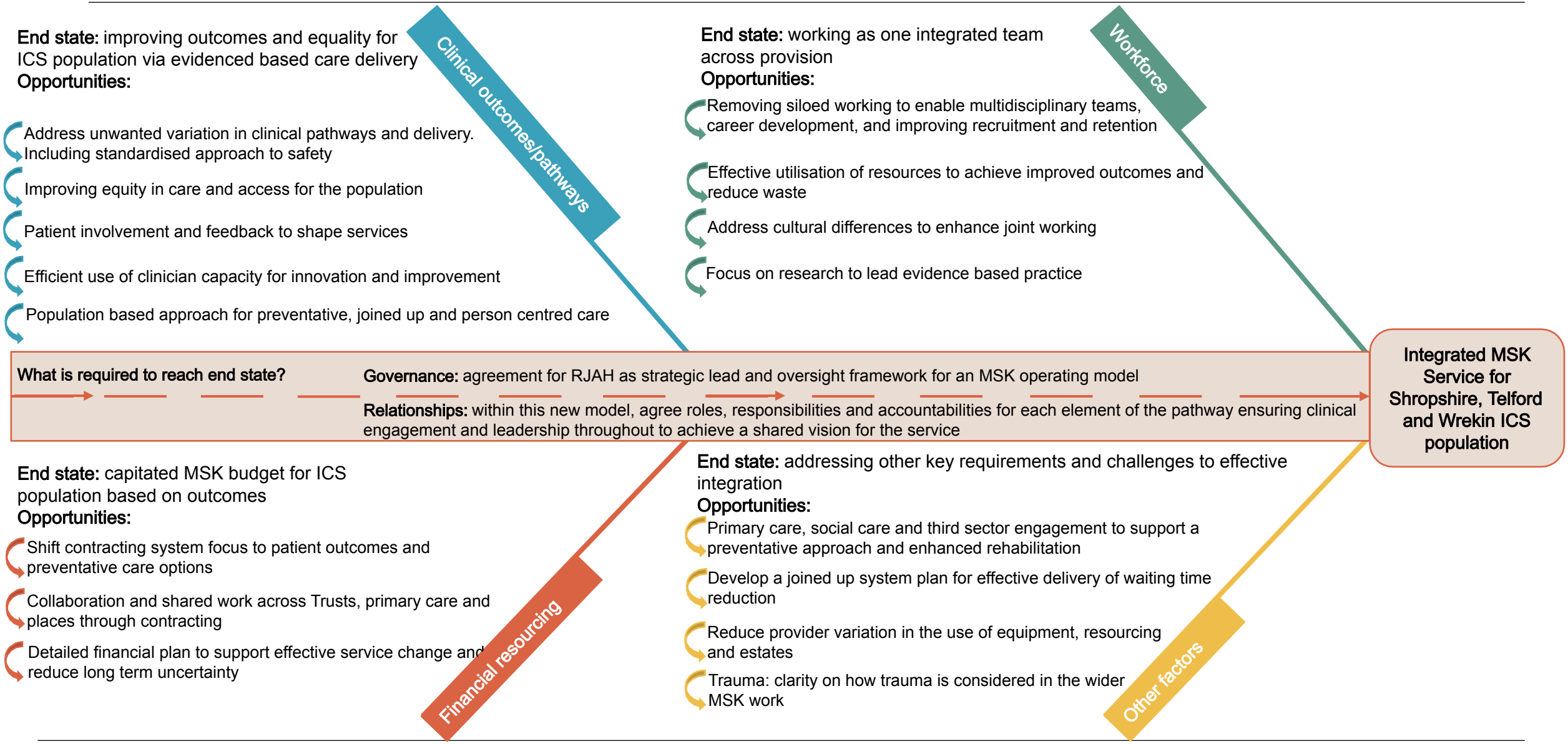
- The integrated care system in Shropshire, Telford and Wrekin (STW) have ambitions to improve safety and quality, integrate services, tackle health inequalities and access to care, and create a great place for staff to work. The ICS recognise there is an opportunity to demonstrate an efficient and sustainable way to fulfil these ambitions by taking a population-based approach to meet the needs of patients facing musculoskeletal (MSK) concerns.

- We have identified a number of system wide inefficiencies and operational challenges around utilisation of resources to drive better value, reduce variation in clinical outcomes including equity in access to care. Within the provision and commissioning of MSK services in STW, there is an understanding that addressing the current challenges to achieve the long-term ambitions will require the current system functions to be fundamentally redesigned along with work on relationships.

- This transformation would also consider a whole pathway approach which will enable a preventative care, thereby reducing the need for acute intervention.

- The ICS have reached a stage where they are now ready to allow delegation of functions, commonality of assurance, and a system wide method for governance processes which will enable the MSK transformation to be implemented and embedded.

Requirements for taking a population based approach to MSK



Roadmap to MSK integration for Shropshire, Telford and Wrekin ICS: creating a discipline for our system

Phase 1 (Jan 23-Mar 23): Proposition development

Activities:
- Identification of underlying challenges in current system and the key changes that need to be made to reach 'end state'

Maturity gateway 1: Mar 23

Agree framework to be used including RJAH as the strategic lead. Agree a set of principles for working

Phase 2.0 (Feb 23-Apr 23): Clinical engagement

Activities:
- Engagement of senior clinicians and relevant Trust and primary care leads across the ICS
- Sense check framework

Outputs
- Identification of clinical leads
- Final driver framework
- Risk assessment (inc. financial)

Maturity gateway 2: Apr 23

Sign off driver framework actions and agree business and clinical leads for each element

Phase 2.1 (Mar 23-Jul 23): Underlying enablers

Activities:
- Agreeing governance model, defining roles and responsibilities to support an integrated culture
- Developing a new contracting and commissioning model
- Utilise best practice (GIRFT, RightCare, NICE)
- ICS consider any consultation requirements/align with national planning guidance

Outputs
- Begin development of MSK operational model
- Job portfolio development
- Engagement and embedding cultural narrative

Maturity gateway 3: Jul 23

Sign off roles, responsibilities and oversight of pathways, including new contracting and commissioning methodology through agreed governance process

Phase 3 (Jul 23-Oct 23): operational and financial plans

Activities:
- Finalise detailed operational model and outcomes with clinicians and patients
- Develop detailed integrated MSK workforce and financial plans

Outputs
- Operational model and outcomes
- Workforce and financial plans

Maturity gateway 4: Oct 23

Sign off operational model and workforce and financial plans through agreed governance process

Phase 4 (Oct 23-Jan 24): Transition planning

Activities:
- Wider socialisation of plans and beginning implementation processes
- Develop transition plan aligning with national planning guidance- current to future state including agreed metrics to monitor effectiveness of care, alongside an accountability framework

Outputs
- Transition plan

Maturity gateway 5: Jan 24

Sign off transition plan through agreed governance process

Phase 5 (Jan 24- Mar 24): Transition period

Activities:
- Implementing transition plan from current to future state

Outputs
- Risk assessment of initial implementation
- Monitoring, identifying and implementing continuous improvement linked to feedback and evidence based research

Maturity gateway 6: Mar 24

Sign off final implementation plan for new MSK model

Shadow form

Key principles for successful integration

- Whilst RJAH will function as the strategic lead, all other Trusts will be needed to collaborate and participate by supporting their partner organisations to continually achieve consistent outcomes that align with the agreed standard of care and use of resources. This will be formalised through an overarching accountability framework and standards set for delivering safe, effective, equitable services with good experience for the population. Individual Trust boards will be responsible for delivering these standards within the services that they provide.

- The consultant body working within the STW MSK service will operate as one integrated team, working to the standards set for MSK services. Accreditation specific to Nursing and AHP staff groups will be required to ensure standardisation of delivery of MSK care.

- Clinical pathways will be designed by clinicians and coproduced with experts by experience. These pathways will enable the provision of evidence based effective care.

- Whist resources for MSK will be combined for the population, work will be undertaken to understand the financial strategy for the new model of care. This work will include a plan to avoid financial disruption or destabilisation to individual Trusts as the model is implemented.

Requirements to take this forward

- To ensure collective ownership and accountability, it will be important to engage all parts of the system in the development plans which will be underpinned by a new joint culture for MSK service delivery.
- The formal structures and process will be implemented across the system and upheld by a set of shared values that are driven by agreed behaviours, strong relationships rooted in effective communication and trust.
- To support this, a reconstituted MSK Transformation Board will be established. The Board will comprise of two subgroups: the first being the existing tier 1 and 2 work, and the second to oversee all activities related to the orthopaedics and trauma elements.

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Thank you

Agenda item ICB 29-03-070

ICB CEO Report

1st OPA wait times

Specialty	number of weeks until 1st OPA		Specialty	number of weeks until 1st OPA
Breast	2		Hand Wrist & Elbow	3
Colorectal	57		Shoulder	3
Gastroenterology	30		Foot & Ankle	2
Hepatology	9		Hip/Knee	2
Upper GI	12		Soft Tissue	2
Urology	79		Ophthalmology	37
Vascular	17		Glaucoma	68
Diabetes	52		Vitreo-retinal	53
Endocrine	56		General - Oph	51
Renal	7		Diabetic - Oph	47
Cardiology routine	64		Plastics - Oph	45
Cardiology urgent	32		Corneal	35
RACPAC	12		Medical Retina	21
Respiratory routine	69		Cataract	18
Respiratory urgent	8 to 10		Paediatrics - Oph	16
Dermatology routine	26		General Gynae PRH	52
Dermatology urgent	6 to 8		General Gynae RSH	52
Stroke	14		General Paeds PRH	22
General Medicine PRH/Falls	28		General Paeds RSH	23
General Medicine RSH/Falls	27		ENT Adults	44
Movement Disorder PRH	4		ENT Paeds	57
Movement Disorder RSH	3		Max Fax	32
			Orthodontics	31

Data Source: SaTH centres

Treatment times

Service	Number of weeks to treatment
Breast Surgery Service	9
Cardiology Service	32
Clinical Oncology Service	16
Colorectal Surgery Service	27
Dermatology Service	28
Diabetes Service	73
Dietetics Service	1
Ear Nose and Throat Service	30
Elderly Medicine Service	4
Endocrinology Service	10
Gastroenterology Service	23
General Internal Medicine Service	42
General Surgery Service	9
Gynaecological Oncology Service	21
Gynaecology Service	37
Hepatology Service	15
Maxillofacial Surgery Service	37
Medical Psychotherapy Service	26
Occupational Therapy Service	8
Ophthalmology Service	22
Oral Surgery Service	32
Orthoptics Service	34
Orthotics	1
Paediatric Gastroenterology Service	15
Paediatric Ophthalmology Service	30
Paediatric Service	43
Pain Management Service	21
Physiotherapy Services	32
Respiratory Medicine Service	8
Trauma and Orthopaedic Service	60
Upper Gastrointestinal Surgery Service	46
Urology Service	31
Vascular Surgery Service	35

Data Source: Weekly National Waiting List Submission for Inpatient RTT Clock Stops from Week - Ending 5th Feb 2023 , 12th Feb 2023, 19th Feb 2023 for SATH

Commissioner / Provider Collaborative Business Case

Author:	Shameem Akhtar	**Paper Date:**	March 2023
IDC Member Sponsor:	Gareth Robinson	**Paper Category:**	
Paper Reviewed by:	Gareth Robinson Simon Whitehouse	**Paper FOIA Status:**	

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

1. Purpose of Paper

To seek a mandate via the development of a business case to address the nine challenges identified in the Moorhouse report and consider how tactical commissioning is best deployed for the STW population.

2. Introduction

In October 2021 NHSE/I consulted on how best to devolve commissioning to Provider Collaboratives in respect of the mental health sector, STW system responded by confirming they wanted to explore the development of a local Provider / Commissioner collaborative.

This paper seeks a mandate to engage more formally with all stakeholders with the aim of developing a phased business case. This exploration will include the scope of the business case, the degree of delegated responsibility from the ICB, the relationship with Places and Communities, and the formulisation of the strategic ambitions in relation to Mental Health services in STW.

3. Recommendations

The committee approves the initiation of the proposed business case development work.

Contents

1. Introduction

The 2022 Health and Care Act, formalised ICSs as legal entities with statutory powers and responsibilities. Statutory ICSs comprise two key components: Integrated Care Boards *(ICBs)* statutory bodies that are responsible for planning and funding most NHS services in the area. ICBs have also taken on some commissioning responsibilities from NHS England.

The legislation has also changed procurement and competition requirements, removing the requirement for mandatory competitive retendering. This is all part of a shift towards strategic commissioning and a more collaborative approach to planning and improving services. The role of commissioners has required an increase in closer working with key partners across the system to understand population needs, determine key priorities and design, plan and resource services to meet those needs. While distinct commissioning and provision responsibilities still formally sit in the ICB, in practice the division is becoming increasingly blurred, including within the Shropshire Telford and Wrekin *(STW)* system, with the ICB and STW Care Group increasingly working more collaboratively.

Within this changed landscape NHS providers are increasingly being expected to look beyond their organisational priorities to focus on system-wide objectives and improving outcomes and reducing inequalities for the communities they serve. Increasingly the vehicle chosen to deliver system objectives is via the Provider Collaborative route, building upon learning and greater collaboration during the COVID-19 pandemic.

1.1 Background

The national direction of travel is that commissioners and providers should increasingly be working hand in hand to plan care for their populations. While distinct commissioning and provision responsibilities still formally sit within the ICB, there is an expectation that providers are part of the Integrated Care System *(ICS)* and as such they are being asked to take on wider responsibilities for the performance and delivery of the whole system.

There is evidence to suggest having a collaborative care model can lead to improved access to Mental Health care on a large scale. This includes delivery of integrated care either through a joint delivery model or through population-health principles *(Ramanuj, P., & Pincus, H. 2019),* which includes a system of communication and coordination between a team of providers and commissioners working in concert to address all of the health care needs of each patient *(fully integrated care*). *(Unützer, J., Carlo, A. D., & Collins, P. Y. 2020).*

There are significant opportunities in working collaboratively to benefit patients and service users.

1.2 Current position

STW Care Group services a large footprint, serving a diverse population with a complex geography; Shropshire is a mostly rural county with 35% of the population living in villages, hamlets and dispersed dwellings; a relatively affluent county masking pockets of deprivation, growing food poverty, and rural isolation. Telford & Wrekin is predominantly urban with more than a quarter living in the 20% most deprived nationally and some living in the most deprived areas.

STW Mental Health Service are among the poorest funded in England, calculated to receive the second lowest funding levels per head based on population size *(Moorhouse 2021).*

Moorhouse were commissioned to look at Mental Health Services across the STW footprint, through stakeholder interviews, workshops and detailed desktop review a range of challenges have been identified and grouped into nine themes *(table 1).* This report will consider if and to what extent each option addresses these challenges, alongside NHSE expectations around collaboration.

1.3 Purpose of report

To seek a mandate via the development of a business case to address the nine challenges identified in the Moorhouse report and consider how tactical commissioning is best deployed for the STW population. In October 2021 NHSE/I consulted on how best to devolve commissioning to Provider Collaboratives in respect of the mental health sector *(Appendix 3)*, STW system responded by confirming they wanted to explore the development of a local Provider Collaborative for mental health investment standards *(MHIS related commissioning)*. Subsequent to this the ICB and MPFT developed a joint post – Programme Director Provider Collaborative to lead the exploration of this with stakeholders.

This paper seeks a mandate for this post holder to engage more formally with all stakeholders with the aim of developing a phased business case. This exploration will include the scope of the business case, the degree of delegated responsibility from the ICB, the relationship with Places and Communities, and the formulisation of the strategic ambitions in relation to Mental Health services in STW. The exploration will seek to identify benefits and the necessary governance arrangements in relation to any new ways of working which will be key to the proposed case for change.

1.4 Challenges across Mental Health Services *(table 1)*

Challenges	Description
1.System funding	• Shropshire, Telford & Wrekin mental health services receive the second lowest levels of funding by population of any ICS across England, equating to approximately £135 spend per head compared to an average of £173 nationally (Mind/NHS Digital, 2018-19). • This low level of funding results in a number of services only able to provide the statutory levels of service with limited ability to go above this baseline in some areas.
2.Joint working across the system	• Whilst the senior leaders across mental health services are well connected and work collaboratively, there is a disconnect between teams on the front line, working in siloes. • Front lines teams do not experience the same level of collaboration evidenced within the ICS leadership, this can result in patients bouncing between services. • There is limited involvement of Primary Care following patient referrals, meaning opportunities are missed to take a holistic approach to a patient's physical and mental health care.
3.Number of services with significant demand and capacity challenges	• Mental health services across England are currently seeing unprecedented levels of demand. This increased demand is reflected across STW. • Low levels of funding across the system have an impact on the service provision, quality of services and quantity of services available to the population. • An example of the impact that this has can be seen in the volume of out of area bed days used, which averages 392 per month across FY 2020/21.
4.Complex patients are occasionally being treated through IAPT	• There are examples of patients with complex care needs being treated in settings that do not reflect the level of care required, such as severe PTSD patients being treated through IAPT. • Additionally, the IAPT access rate across STW is at 4.31% which is below average across England likely meaning fewer people are accessing services than need support.
5. Long term service commissioning	• A number of service providers face challenges recruiting and retaining staff due to the short term nature of existing commissioning contracts. • Short term commissioning and contracting for key services results in challenges on the ground in the delivery of services resulting in inconsistent and disjointed service offering in the community.
6.Leadership at place can be inconsistent and unclear	• There is collaborative leadership across the ICS, however the local nuances between Shropshire and Telford & Wrekin result in differing approaches and minimal coordination at an ICS level leading to inconsistencies of service offerings and scope. • Place level mental health leadership is not always clear to operational staff and service managers, resulting in confusion and limited coordination of service delivery.
7.Communication at the grassroots level is challenged	• Communication between operational teams has been highlighted as an issue in many areas, with limited communication particularly between mental health teams and primary care teams resulting in limited coordination in the delivery of patient care.

	• In a recent GP survey of mental health services, communication was highlighted as the most common issue within adult mental health services and crisis services, additionally 86% of GPs wanted more information on mental health services and pathways. Better communication would facilitate more joined up and collaborative patient care, supporting improved patient outcomes.
8.Information and data sharing	• There are multiple patient record and patient management systems in use across the system, combined with IG challenges prevent information from being quickly and easily shared across organisations resulting in staff not being able to access the full picture when diagnosing and treating patients. • Patient records and discharge notes are not always shared in a timely manner. • 72% of GPs feel they do not get enough information once a patients has been referred.
9.Resourcing and recruitment challenges	• Mental health services have been under unprecedented demand induced pressure, this is causing challenges across the system, with services often unable to keep up with demand, resulting in longer internal waits for treatment, resulting in increased complexity of user condition. Unfortunately a number of mental health providers across STW are unable to hire adequately trained staff to reach the staffing levels that are required to resolve this issue. • Currently high staff turnover within mental health services with 20.25% of STW mental health staff leaving within their first year of service.

2. Proposed direction of travel

Development of a Provider Collaborative - full integration model

The business case will consider the development of a local Provider Collaborative *(LPC)* under an integrated model which would see delegation of functions to the Provider Collaborative from the ICB, pooled budgets for areas agreed by the collaborative as being within the scope of the Provider Collaborative.

Definition of a Provider Collaborative (NHSE)

Provider Collaboratives are partnership arrangements involving at least two Trusts working at scale across multiple places, with a shared purpose and effective decision-making arrangements to:

- Reduce unwarranted variation and inequality in health outcomes, access to services and experience.
- Improve resilience by, for example, providing mutual aid.
- Ensure that specialisation and consolidation occur where this will provide better outcomes and value.

Introduction to Provider Collaboratives

Provider Collaboratives, are a key component in system level delivery of ICSs, enabling them to deliver their core purpose and meet the triple aim of better health for everyone, better care for all and efficient use of NHS resources.

Effective collaboratives can help streamline delivery and functions and foster better relationships between ICSs, providers and wider partners to integrate care and respond to needs of local communities

Expectations of a Provider Collaborative

Expectations for Provider Collaboratives, including reducing unwarranted variation in patient outcomes, access, and experience, and building greater resilience for services by sharing capacity and resources.

NHS England has set out a number of guiding principles that should underpin a Provider Collaborative arrangement. These include:

- A shared vision and commitment to collaborate
- Strong accountability mechanisms for members
- Building on existing successful governance arrangements
- Efficient decision-making
- Embedding clinical and community voices
- Streamlining ways of working.

Regional Picture *(Midlands)*

It is understood that all 11 systems in the Midlands region *(East and West)* intend to proceed to a Provider Collaborative arrangement. All 11 systems are in different states of development, with the Backcountry being the only one to have achieved NHSE authorisation.

Form

The form of the Provider Collaborative will require discussion, consultation and agreement by all partners for purposes of this paper it is assumed that the Lead Provider Collaborative model is most likely to be preferred as there is currently only one main NHS Mental Health provider in the STW geographical region *(MPFT).*

Provider Collaboratives have 3 Broad Types *(NHSE/I Toolkit Jan 2022),* however, Provider Collaborative models are not mutually exclusive and can be combined or evolve into another; they can all be implemented within current legislative framework *(NHSE 2021).*

1. Provider Leadership Board

- Groups of acute Trusts or mixed groups part of a system.
- Common delegated responsibilities from respective boards in line with scheme of delegation.
- Use committees in common approach.

2. Shared Leadership

- Usually involve 2 - 3 Trusts; specific aims to improve quality or sustainability of one or more of Trusts.
- Same person fills CEO posts at Trust's involved in the Collaborative this may include chair / Exec posts.
- Each Trust Board remains separately accountable for decisions made.

3. Lead Provider

- A single Trust takes contractual responsibility for an agreed set of services on behalf of the Provider Collaborative; sub-contracts to other providers as required.
- Alongside the contract the NHS LP enters into a partnership agreement with other members who contribute to the shared delivery of services.
- Model established as part of the NHS-Led Provider Collaborative programme for specialist MH & LDA services.

Membership

The membership of the Provider Collaborative will require discussion, consultation and agreement by all partners for purposes of this paper it is assumed that the core membership will initially consist of the organisations listed below with the understanding that the membership will expand to include the voluntary community social enterprise sector *(VCSE),* people with lived experience, patients and carers, and any other stakeholder groups as deemed appropriate.

Core Members

- STW ICB
- MPFT
- Shropshire Local Authority
- Telford & Wrekin Authority

Scope

The scope of the Provider Collaborative will require discussion, consultation and agreement by all partners for purposes of this paper it is assumed this will form part of the development of a business case proposal that will require board sign off by the core membership.

Appendix 2 details ICB commissioning expenditure on Mental Health services for the period 2022 to 2023 which will assist in giving an initial baseline for detailed discussion.

Commissioning

The adoption of a Lead Provider *(LP)* Model will require the exploration and development of a delegated commissioning function that sits within the Provider Collaborative, to plan, procure and quality assure service delivery. Consideration will be given traditional ways of working, hybrid working and devolved statutory responsibilities.

National guidance on Provider Collaboratives, sets out an expectation that lead providers have a clear separation of duties between commissioning and provision / delivery. This is key to avoid conflict of interest and will need to be included in the formation of any future Provider Collaborative irrespective of what form the Provider Collaborative takes.

Other integrated functions

Consideration will need to be given into other functions that could be better placed to sit within a LPC, these may include:

- Quality Assurance
- Finance
- BI / Performance
- Contracting
- Communications and Engagement
- Corporate Functions

Design Principles

Development of a business case for a LPC should incorporate the design principles detailed below, that are based on national guidance.

1. Joint working
2. Population focused
3. Engagement led
4. Data driven
5. Cross place
6. Efficient and sustainable
7. Learning organisation

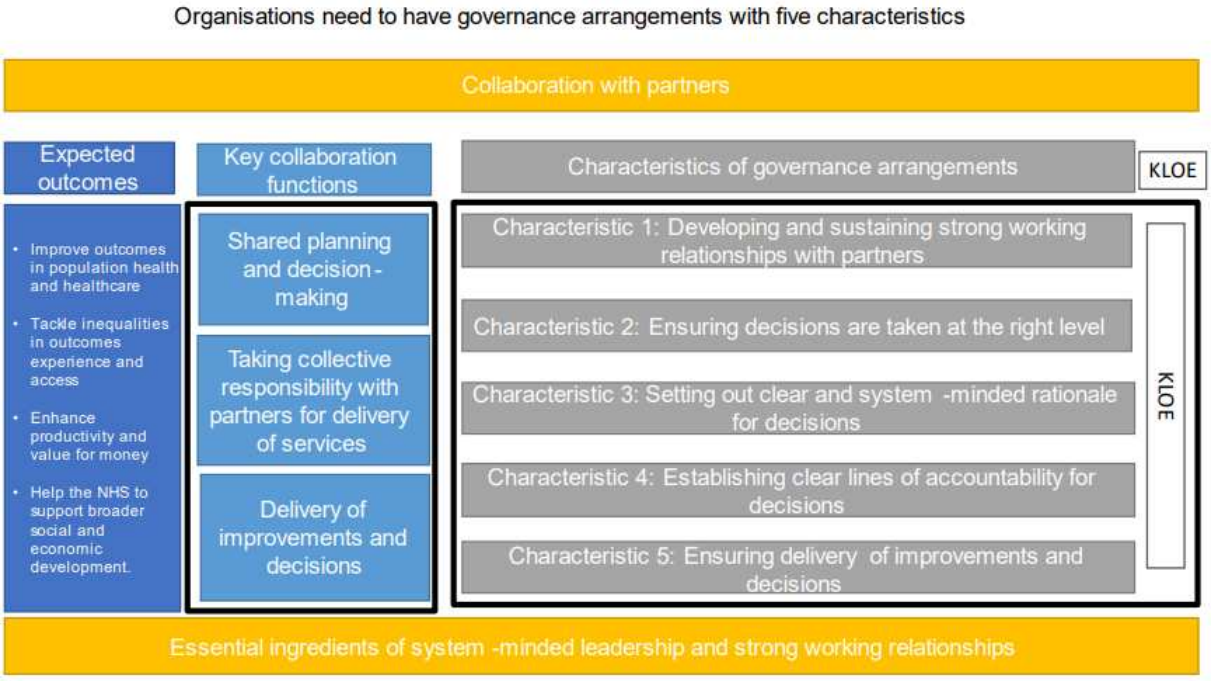
Resourcing

A range of support will be required to explore and develop the business case input from the following areas:

- Options development (PC Program Director)
- Project Management support (PMO)
- Secretarial Support
- Finance
- Commissioning
- Contracting
- Business Intelligence
- Data Collection
- Communications and Engagement
- Legal advice
- Stakeholder engagement
- Membership of a working groups

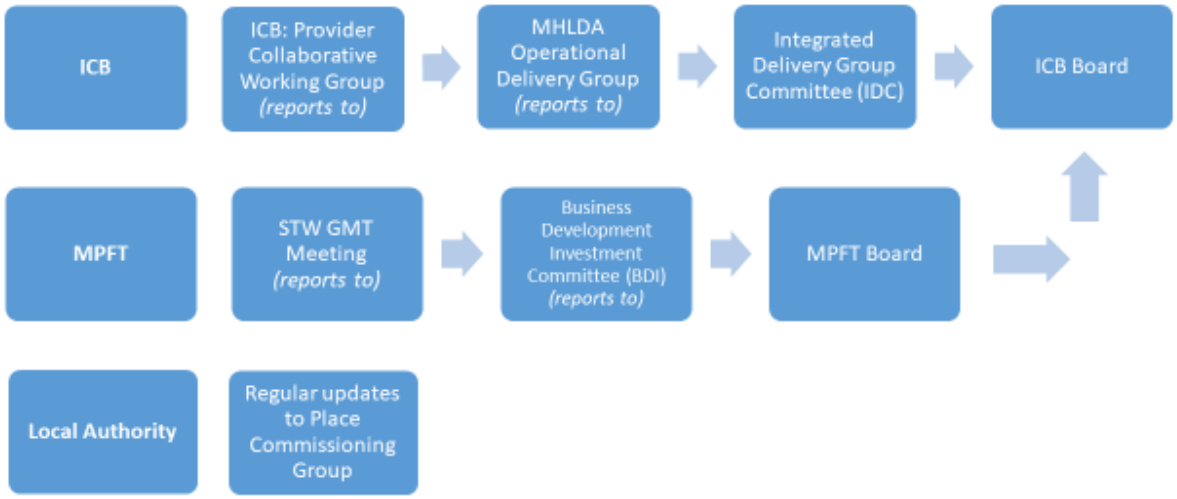
Oversight and Assurance *(table 2)*

To facilitate effective collaboration it is acknowledged that we must get the oversight and assurance mechanisms correct. NHSE guidance on good governance and collaboration will be adopted *(table 2).*



Reporting Arrangements *(figure 1)*

The expectation is that stakeholder boards will receive quarterly updates *(figure 1),* with ultimate decision making forum based on ICB recommendation.



Recommendation

The board approves the initiation of the proposed business case development work.

3. Appendix 1 – Summary reading and information sources

Moorhouse Review (2021) STW mental health Portfolio Review & system Design

NHSproviders.org. (n.d.). *NHS Providers*. [online] Available at: https://NHSproviders.org.

PAR562 Draft Guidance on good governance and collaboration (2022) Draft Guidance on good governance and collaboration (england.nhs.uk)

PAR642 Integrated Care systems: Design Framework. (2021). https://www.england.nhs.uk/wp-content/uploads/2021/06/B0642-ics-design-framework-june-2021.pdf

PAR754 Working together at scale: guidance on Provider Collaboratives. (2021). https://www.england.nhs.uk/wp-content/uploads/2021/06/B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf

PR1560 Arrangements for delegation and joint exercise of statutory functions Guidance for integrated care boards, NHS trusts and foundation trusts (2022)

Ramanuj, P., & Pincus, H. (2019). Collaborative care: Enough of the why; what about the how? The British Journal of Psychiatry, 215(4), 573-576. doi:10.1192/bjp.2019.99

The National Health Service (Joint Working and Delegation Arrangements) (England) Regulations 2022.

Unützer, J., Carlo, A. D., & Collins, P. Y. (2020). Leveraging collaborative care to improve access to mental health care on a global scale. World psychiatry: official journal of the World Psychiatric Association (WPA), 19(1), 36–37. https://doi.org/10.1002/wps.20696

Wickens, C. (2022, April 21). *Provider Collaboratives: explaining their role in System working*. The King's Fund. https://www.kingsfund.org.uk/publications/provider-collaboratives

Appendix 2 – Financial Information 2022/2023

Title	Document
MHIS split	 MHIS split for costing paper Oct 2
Shropshire, Telford & Wrekin LD&A summary	 LD&A Funding Update 300123.xlsx
Out of area report	 Copy of Out of Area report 30.12.2
CCG Finance Feedback	 CYP SIT Report - CCG Finance Feedb

Appendix 3 - STW response on the consultation to devolve Mental Health Commissioning to Provider Collaboratives *(October 2021)*

Shropshire, Telford & Wrekin
Integrated Care System

Colleagues,

Response from Shropshire, Telford & Wrekin ICS on the Consultation Document: Devolving Mental Health Commissioning to Provider Collaboratives

The consultation document has been shared with the membership of the Mental Health, Learning Difficulties & Autism (MH,LD&A) Operational Delivery Group and the Chief Executives Group (to which the Operational Delivery Group reports).This is a collation of the responses received.

The system has had a MH, LD & A group for several years, which first operated informally as a network and has evolved with the formation of STPs through to ICS with a formal governance structure in place. This has been working to deliver the related long-term commitments of the ICS, and to deliver transformation at scale and drive up quality. The system agrees that approach 2 is the natural evolution of what is already successfully in place.

We support the Mental Health Programme recommending that the MHIS-related commissioning budget is **devolved to a local provider collaborative in line with Approach 2,** and consider that this would be best placed to address the needs of our local population, and to work closely at PLACE.

In terms of the support that the system would need in moving this forwards:

1) In response to the consultation we wish to highlight the legacy baseline deficit in investment in mental health in Shropshire, Telford & Wrekin that cannot be addressed through MHIS growth alone. The ICS is a financially challenged system in Level 4 of NHSE system support so addressing this internally is particularly challenging, and we ask for transitional support to be considered, so that health inequalities and parity of esteem issues can be addressed.
2) It would be helpful to receive practical guidance on the next steps, particularly in relation to strengthening the relationship between the local provider collaborative and PLACE and VCSE (the cultural change required to work effectively with VCSE) and how MHIS funding can be applied to wider local provider collaboratives which include partners like VCSE and social care, and to also receive learning from other areas who have been early implementers.
3) Specialised mental health collaboratives are described in the consultation document but we would wish to highlight that progress with the Children & Young People provider collaborative appears limited with no benefits identified in Shropshire, Telford & Wrekin as yet. This is significant because of the section 31 related issues at the acute trust and the lack of availability of tier 4 beds.

Yours sincerely,

Cathy Riley
SRO for MH, LD & A Operational Delivery

Staff Survey 2022
The results of the 2022 NHS Staff Survey were published on 9th March 2023. In this ICS, the staff survey is currently carried out in our provider Trusts – SaTH, SCHT and RJAH. Each organisation has a detailed report examining each question, services or teams of more than 11 people and free text comments. This report provides a high-level summary only.

The staff survey is aligned with the NHS People Plan, and the People Promise. The data has been measured against each of the seven elements of the People Promise, plus two further themes – staff engagement and morale. Each organisation is benchmarked against its peers – RJAH against Specialist Trusts, SaTH against Acute Trusts and SCHT against Community Trusts.

Nationally, the context for the NHS and Social Care has been challenging over the past 3 years and many of our services have experienced significant increased demand, increased acuity and complexity in presentation of patients/service users and a number of significant workforce challenges.

Response Rates
Response rates give us an indication of individual engagement with their employer. Across the Midlands response rates have fallen between 2021 & 2022. In 2022, Derby & Derbyshire had the highest response rate at 54.3%, with STW ICS is the middle of the pack at 50.2%. The lowest response rate was Coventry & Warwick at 40.1%. We have seen a fall relative to our ICS position in 2020, when our ICS average response rates were 52.1%.

	MPFT	RJAH	SaTH	SCHT
Response Rate	55%	52%	49%	50%
People Responding	5005	837	3392	777

Organisational Summaries
The easiest way to compare the organisations is to look at their People Promise results graphically. Nationally, the overall results for 2022 show improvements in two of the Promise's seven elements – "We are a team" and "We are always learning" - with a greater proportion of staff feeling supported by their line manager and having opportunities to develop in their careers. Scores for a further four of the elements and the staff engagement theme have remained more constant.

MPFT have scored near the top of the benchmark group for all People Promise themes. They are particularly proud their staff have identified the Trust's positive commitments to compassionate culture, specifically highlighting equality, diversity & inclusion, feeling safe to speak up at work, being able to make suggestions to shape new initiatives and innovations, recognizing the work of colleagues, supporting learning and development, helping achieve a balance between home and work life and receiving the respect they deserve from colleagues at work.

RJAH scores have remained broadly the same as last year in relation to the People Promise themes, and they are particularly proud that their staff have reported they feel more supported by their immediate line manager, with those scores moving from being below average to above average for their benchmark group, with improvements of 4-5% in many of the questions linked to that theme – a statistically significant change.

SaTH have continued to score below average for all 9 of the People Promise results & themes. However, in their own context and journey, they are particularly proud that their staff have reported significant improvements in being treated compassionately & inclusively, being safe & healthy, always learning, working flexibly and being part of a team.

SCHT scores have remained broadly the same as last year in relation to the People Promise themes, and the Trust is below the benchmark group average for all these themes. SCHT are proud of

improvements in the themes of ‘We work flexibly,’ and ‘We are a team’ – with the most improvement in four areas - ‘appraisals left me feeling the organisation values my work and helped me agree clear objectives for my work’, ‘relationships at work are unstrained’, ‘I have opportunities to improve my knowledge and skills’ and ‘In the last 12 months I have not felt unwell due to work related stress’.

Our provider Trusts each have their own relative context and journey within this national picture. Against the People Promise themes, compared to 2021, the Staff Survey Coordination Centre has identified the following changes in scoring:

People Promise Theme	MPFT	RJAH	SaTH	SCHT
We are compassionate & inclusive	Significantly higher	No significant change	Significantly higher	No significant change
We are Recruitment & rewarded	No significant change	No significant change	No significant change	No significant change
We each have a voice that counts	No significant change	No significant change	No significant change	No significant change
We are safe & healthy	Significantly higher	No significant change	Significantly higher	No significant change
We are always learning	Significantly higher	No significant change	Significantly higher	No significant change
We work flexibly	Significantly higher	No significant change	Significantly higher	No significant change
We are a team	Significantly higher	No significant change	Significantly higher	No significant change
Staff engagement	Significantly higher	No significant change	No significant change	No significant change
Morale	No significant change	No significant change	Significantly higher	No significant change

Please note: When determining the above a “rounding” approach is taken, which is one factor that can impact why figures that look the same to 1 decimal place (dp) may be significant while those that look different to 1dp are sometimes not significant. Each score is rounded to 1dp which means that figures can appear more similar or more different than they actually are.

The test also considers the sample size (larger sample sizes are more likely to result in changes being statistically significant) and the actual values (a 0.1 movement on a very high or low score is more significant than a similar movement on a mid-range score).

The results of the significance testing are provided as a guide to help data users see where there may have been ‘real’ changes in the scores year on year, and where changes are too small to be statistically significant. It is always advised these tests are used for guidance only and that actions are based on the comparison with benchmark scores, the longer-term trends, and the context in which the survey took place.

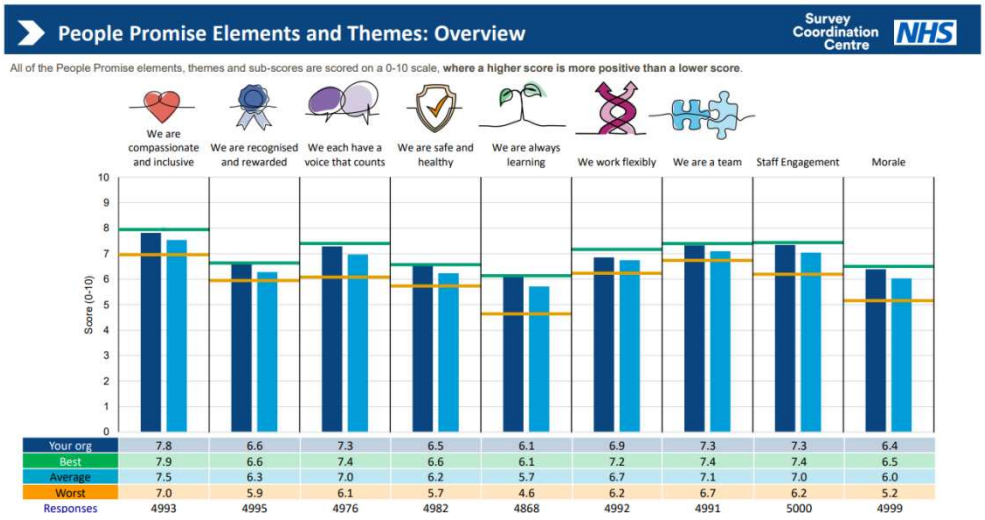
Our Less Positive Themes

Reporting incidents & raising concerns	•MPFT - Less people report they are confident about **incident reporting and feedback** •RJAH - Less people report feeling confident that if the organisation would **address concerns raised** with it •SaTH - Less people feel able to **raise a concern** compared to last year •SCHT - Less people report feeling confident that the organisation would **address concerns about unsafe clinical practice**.
Health & Wellbeing	•RJAH - More people report **feeling mentally and physically exhausted** after every shift. •SCHT - Less people report feeling confident that the organisation takes **positive action on health and wellbeing**
Pay	•RJAH - Less people report feeling **satisfied with level of pay.** •SCHT - Less people report feeling **satisfied with level of pay.**
Patient care	•MPFT -Less people report **confidence around patient care**
Good Work	•RJAH - More people report feeling **under more pressure** than previously
Recognition	•RJAH - More people report **working harder than ever** while **not being appreciated** for doing so
Compassion and Inclusivity	•SaTH - Rank the lowest of their benchmark group for being **compassionate and inclusive.**
Advocacy	•SaTH - Rank bottom in the Midlands (and fifth from bottom in England) for **advocacy**

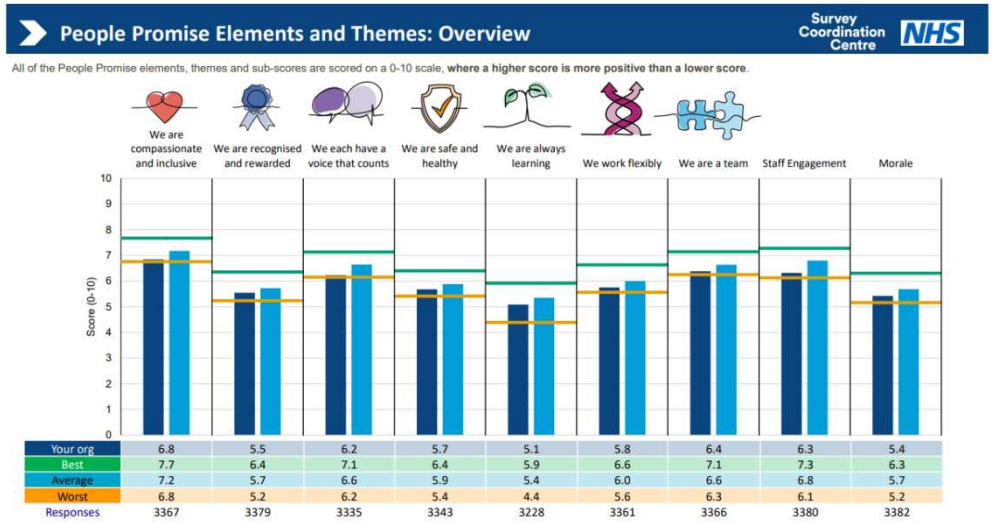
The following themes have been identified by our provider organisations for focused attention in 2023.

Reporting incidents & raising concerns	•MPFT - Ensuring that **staff feel heard and receive timely feedback about their concerns** •RJAH - Embedding recent changes to the **Freedom To Speak Up process** •SCHT - Building a **culture of civility, respect and speaking up**
Health & Wellbeing	•MPFT - A continued focus on **staff well-being** •SCHT - **Health & Wellbeing**
Pay & Recognition	•MPFT - A focus on **how we recognise achievements** and make **appropriate change**s to improve morale •RJAH - Support with the **cost of living.** •SCHT - **Reward & Recognition**
Culture & Leadership	•RJAH - Supporting **strong leadership** through the launch of the RJAH Leadership Programme •SaTH - Continue **cultural & leadership journey**
Good Work	•MPFT - A focus on **how we listen and work alongside our staff** to **recognise their context** •RJAH - More people report feeling **under more pressure** than previously
Retention	•MPFT - A focus on **looking after and retaining the current workforce** •RJAH - Investing effort in staff **retention**
Compassion and Inclusivity	•MPFT - A focus on a **compassionate and inclusive culture** •SaTH - Work to improve all **EDI** metrics •SCHT - **Equality, Diversity and Inclusion** (EDI)
Filling Vacancies	•RJAH - Working hard to **recruit** more staff
Careers	•SCHT - Career development
Collaboration	•SaTH - **Partnering & collaboration across the ICS** on work such as education & workforce planning are the keys to recruitment success

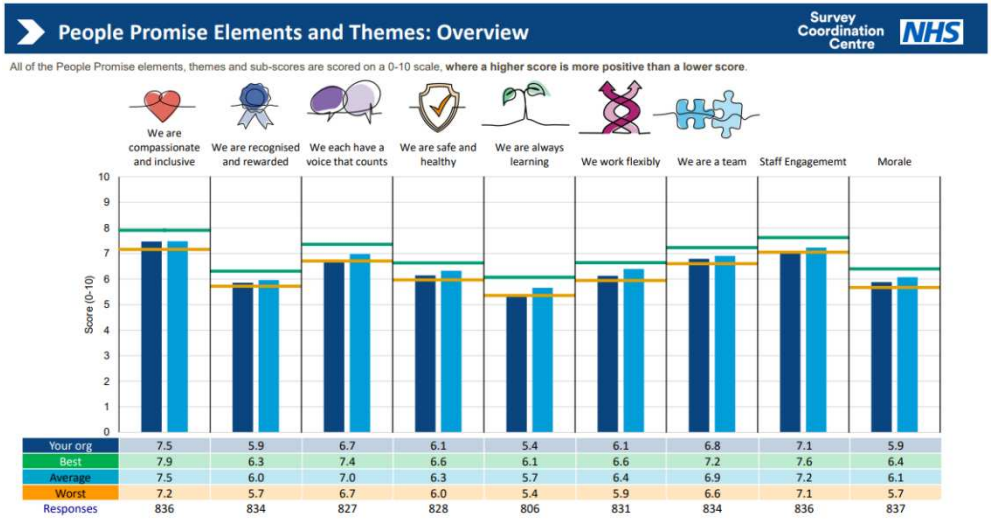
MPFT



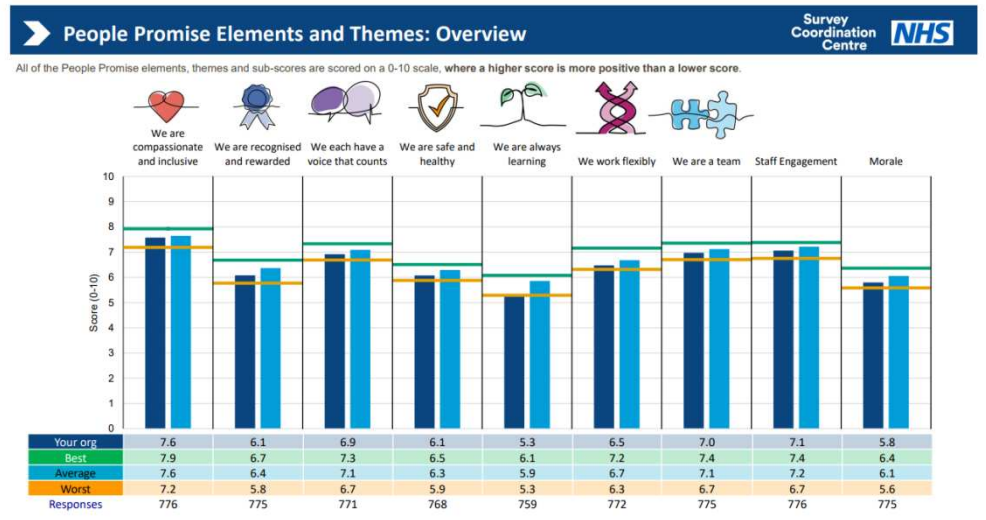
SaTH



RJAH



SCHT



To:
- ICB chief executives

cc.
- Regional:
  - directors
  - directors of finance
  - directors of system transformation

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

2 March 2023

Dear colleagues

ICB running cost allowances: efficiency requirements

Thank you for the extraordinary effort that you, your teams and your partner organisations in systems are making to keep services operating safely and effectively over the winter period.

Our letter of 24 January confirmed arrangements for delegation of commissioning responsibilities for pharmaceutical, general ophthalmic and dental (POD) services, including the impact of those transfers on ICB Running Cost Allowance (RCA) in 2023/24. We are now able to confirm the longer-term expectations on RCA.

The financial context for the NHS means that we need to review overall spending on management costs. In NHS England this has involved implementation of changes to significantly reduce the size of regional teams and national programmes, and to transfer staff and functions from regional teams to ICBs. We also need to ensure that ICBs are operating at their optimal size to deliver their strategic functions and to prioritise resources for front line care.

We know that many ICBs are already planning changes to their structures to reflect new statutory responsibilities following establishment in July 2022. We are therefore confirming changes to the RCA for the next three years to give maximum certainty.

In determining these changes we have listened to the views of ICB leaders and have set these in the context of the future funding settlement for the NHS. We believe that the level of reduction required is significant but deliverable. Setting the central requirement in terms of the overall RCA (which is based on population) for each ICB gives maximum flexibility to determine locally how to configure teams, what functions to outsource, and where to work across multiple geographies. There is no intention to drive changes to ICS footprints through this work but rather to ensure that collaboration is strengthened to enable efficiency requirements to be delivered.

Changes to RCA

Baseline Running Cost Allowances for ICBs have already been held flat in cash terms in 2023/24. This has been published through the annual operational planning guidance and the supporting publication of allocations for 2023/24 to 2024/25.

RCA will then be subject to a 30% real terms reduction per ICB by 2025/26, with at least 20% to be delivered in 2024/25. This provides time for ICBs to reorganise and gives some flexibility on funding change, with scope for ICBs to go further and faster where possible, enabling resources to be recycled into front line care. No increases to the RCA to allow for inflation in this period are anticipated. We are now updating the published future year RCA with three-year allocations for each ICB that reflect this 30% reduction. Adjustments for delegated POD functions will then be made separately.

At our regular joint meeting on 28 February we committed to setting up a session for ICB Chief Executives to work through the requirements and the resources available to support. We will aim to get this in the diary with you in the week commencing 6 March 2023. In addition, regional teams will work with ICBs to support implementation of these changes and will be able to provide access to benchmarking information and examples of good practice in organising or sharing functions as the work progresses. The development of provider collaboratives presents an important opportunity to streamline roles and action across systems and we expect that system partners will agree what resource should sit with provider collaboratives to support service transformation.

Thank you again for your all your ongoing efforts to deliver against the continuing operational challenges and for all the work with your partners on improving population health outcomes for people in England.

Yours faithfully

Mark Cubbon
Chief Delivery Officer
NHS England

Sir David Sloman
Chief Operating Officer
NHS England

Julian Kelly
Chief Financial Officer
NHS England

Agenda item ICB 29-03-072

People Programme Annual Report 2022/23 & ICS People Strategy 2023 - 2027

Integrated Care System

Shropshire, Telford and Wrekin

People Strategy

A collaborative approach by NHS, Local Authority, Social Care & Primary Care employers with support from further & higher education providers.

2023 - 2027

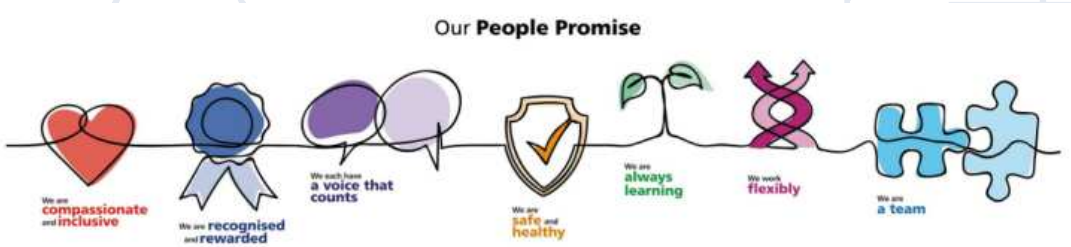
Draft Version 5 7th March 2023

Foreword by Catriona McMahon, Chair of our System People Committee & Tracy Hill, Interim System Chief People Officer

We are pleased to introduce this, our first single system People Strategy for the health & care workforce of Shropshire, Telford & Wrekin.

This People Strategy has been developed collaboratively by members and stakeholders of the Integrated Care System People Committee and represents a positive step towards working together with a shared strategic direction underpinned by consistent & aligned organisational delivery plans.

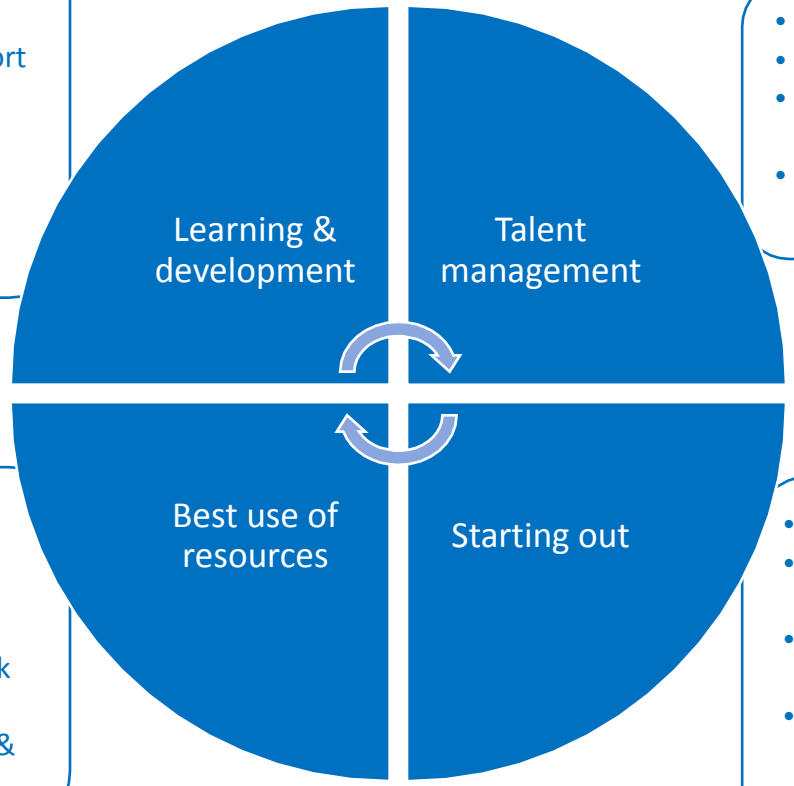
Our People Strategy sets out our ambition for the next 5 years for the circa 23,000 people who work with us, and is structured around the four core pillars of the NHS People Plan, underpinned by the NHS People Promise and the ambitions set out in the 2021 report The Future of NHS Human Resources & Organisational Development. Each ambition describes what we want to do and our shared prioritised plans for delivery – and can be flexible to accommodate changing demands.



Growing for the future

We aspire to have engaged, motivated, skilled people who want to start & progress their career & broaden their experiences with us. We will…

- Have one system education, learning & development offer for all
- Offer professional development opportunities to support career development & professional registration needs
- Ensure all our people have equal access to simulated learning environments to enable them to develop & maintain their skills



- Provide development opportunities & stretch assignments
- Have a proactive approach to talent
- Celebrate the expertise of our people in the context of rural health & care
- Value the expertise of all our age groups & enable generational skills & experience to be shared

- Centrally manage our apprenticeship, learning, development & education funding
- Ensure all our people have equal access to development funding
- Use less agency workers & at the right price – I don't think this fits here
- Use our workforce plans to centrally commission further & higher education & development for our people

- Have one front door for new entrants to join us
- Have a planned & coordinated approach to apprenticeships & graduate entrants
- Have an exciting range of work experience & school relationships
- Work in partnership with local Colleges & Universities to support people living, learning & working locally, engaging our local population in roles & careers we can offer
- Have a continuous programme to ensure pre–registration student placement meets demand for growth

Prioritised Programmes & year of start…

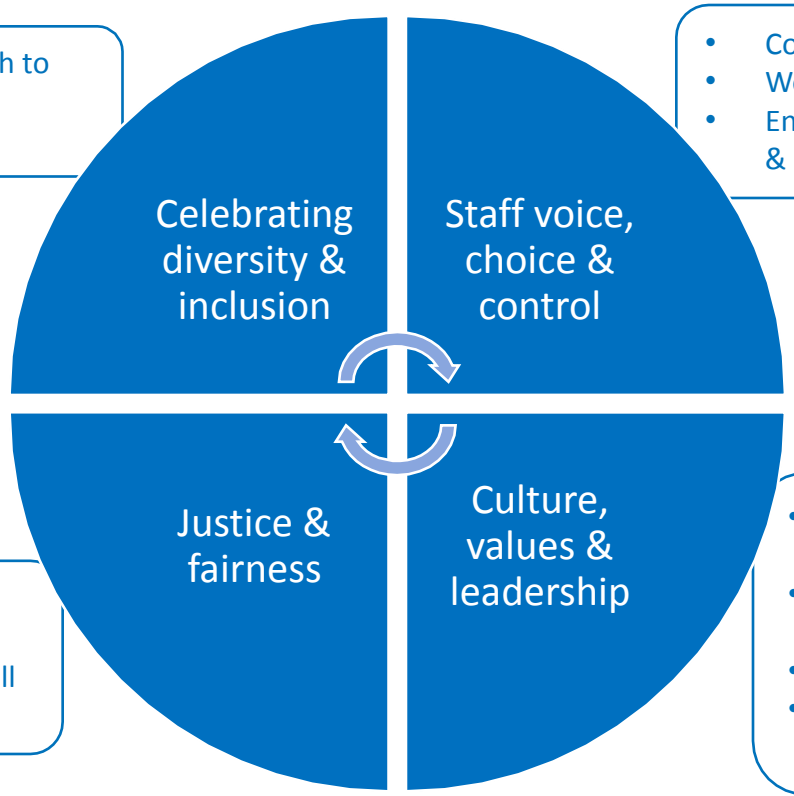
Priority 1 Priority 2 Priority 3

Programmes or Projects	Year 1	Year 2	Year 3-5
Co-ordinating our approach to apprenticeship programmes	X		
Implementing a single learning management system across all employers in STW			X
Implementing Legacy Mentors – our experienced people mentoring our new people	X		
Enabling digital mentors for the less digitally confident		X	
Implementing centralised CPD/apprenticeship/development funds & their stewardship	X		
Coordinating development opportunities/stretch roles, starting with High Potential Scheme	X	X	
Commencing a system wide development programme for those who aspire to very senior roles	X		
Building our 'Next Generation' marketing strategy with local schools & colleges	X		
Implement a pre-employment programme including numeracy & literacy, to support people to access employment opportunities	X		
Working in partnership with colleges & providers to coordinate T-level student placements	X		
Implementing a system approach to careers programmes	X		
Increase our pre-registration student placements and develop a sense of belonging to STW from onset of placement	X		
Delivering a centralised model of delivery of non-medical education including utilisation of simulated learning environments & mobile training unit across the system	X		

Belonging in STW

We aspire to have a shared compassionate & inclusive culture that enables our people to thrive at work. We will…

- Have a shared strategy, understanding & approach to inclusion & diversity
- Have inclusive working practices for our people.



- Connect our communities & networks.
- Work in partnership with our Trade Union colleagues
- Enable our people to have the opportunity to engage & contribute, & get their ideas heard

- Have one shared set of employment policies & processes for all our people
- Ensure the Just Culture principles run throughout all our people management policies and practice

- Commit to one vision and one set of values & embed them in how we lead & work together
- Respect all our professional groups & organisations & work together to build a new shared future
- Ensure our leaders are visible to all our people
- Have a shared, agreed approach to OD for development & transformation of our services & our people

Prioritised Programmes & year of start…

Priority 1 Priority 2 Priority 3

Programmes or Projects	Year 1	Year 2	Year 3-5
Ensure our approach to inclusion is for everyone, not just our people with protected characteristics	X		
Use shared system-wide people management processes & policies	X		
Embed Just Culture principles in people management	X		
Ensure everyone – in health and social care - can contribute to a staff survey providing feedback on their experiences	X		
Ensure we have a system wide Trade Union/Partnership forum	X		
Creating System-wide Vision & values	X		
Implementing a single point of entry for STW for job opportunities (job/recruitment bureau)		X	
Creating a workforce strategy specifically for our older (legacy) workforce		X	
Attract – working together to develop marketing & branding for all STW health & care employers	X		

Looking after our people

We aspire that our people will feel valued, nurtured & cared for & will recommend us as a great place to work. We will…

- Have a shared approach to enabling our people to be physically, mentally & emotionally healthy
- Have a shared approach to supporting our people when they become unwell
- Ensure all occupational health services provide consistent, high-quality support

- Understand & value all roles & professions that make up our workforce
- Have equity of pay & roles for our total workforce
- Reward the workforce equitably

- Have clear career pathways/roadmaps for all our staff groups
- Understand how career needs & aspirations can be met
- Have one approach to buddying, mentoring, pastoral support & care for our people

- Ensure flexible working practices becomes the norm
- Value the skills & experience of our workforce
- Be a great place to work

Prioritised Programmes & year of start…

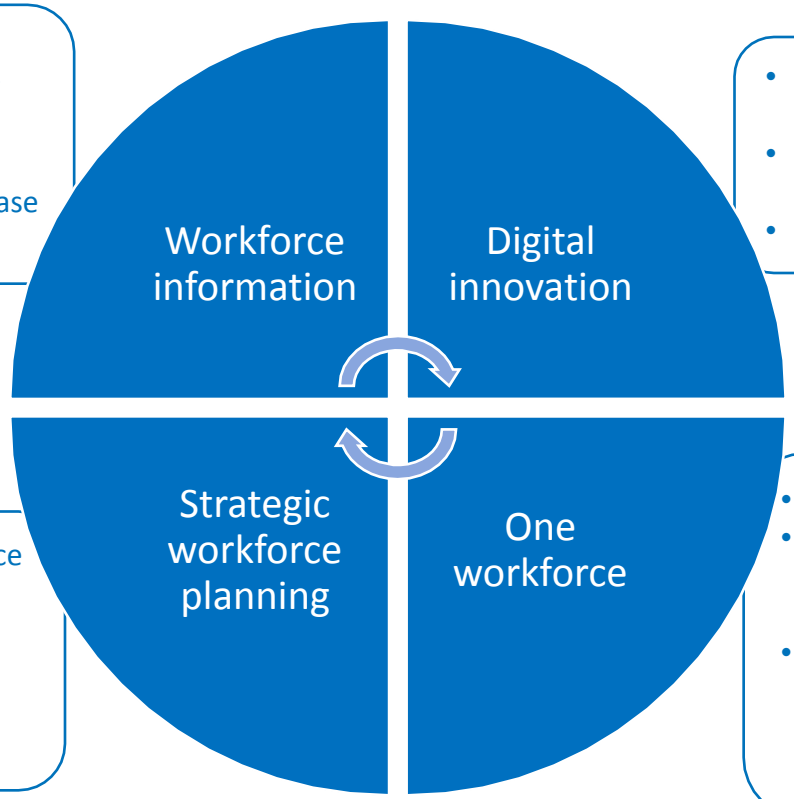
Priority 1 Priority 2 Priority 3

Programmes or Projects	Year 1	Year 2	Year 3-5
A single system approach to our people's wellbeing	X		
A single approach to inclusive Leadership (HPS)	X		
Mapping all our key career pathways (retention)		X	
Attract/Retain - Day in the life type marketing material		X	
System-wide collaborative coaching & mentoring pool	X		
Equal pay banding & job content for equivalent roles across NHS employers			X
Harmonised terms & conditions & pay for Bank Workers (Just NHS/NHS & Primary Care/NHS, Primary & Social Care)		X	
Key worker housing			
Raising the profile of flexible working platforms	X	X	
Time in our daily work to learn & develop			X
Provision of elder care or childcare		X	

New ways of working & strategic workforce planning

We aspire to be one workforce, supporting the delivery of high quality care to our communities. We will…

- Have a shared approach to the provision of timely & high quality information about our whole workforce
- Have a shared approach to providing & managing our Electronic Staff Record database in NHS employers



- Use digital innovation including Artificial Intelligence & Robotic Process Automation in our people management processes
- Work seamlessly with digital colleagues to enable our people to develop the right digital skills for their work
- Enable flexible working, enabling this with digital technology

- Have a shared approach to strategic workforce planning to enable service transformation
- Engage our leaders, professionals, clinicians, finance & activity colleagues in workforce planning

- Act maturely & collaboratively together on people matters
- Enable our workforce to flow freely between organisations in support of patient care, development needs, mutual aid & widening experiences
- Reimagine our people services & functions (e.g. HR, Recruitment, Staff Records, Temporary Staffing, Occupational Health, Organisational Development, Business Partnering) to support the One Workforce concept

Prioritised Programmes & year of start…

Priority 1 Priority 2 Priority 3

Programmes or Projects	Year 1	Year 2	Year 3-5
Implement a system bank using a single digital solution & managed by a single organisation on behalf of all system employers		X	
Begin using a common & shared set of key workforce metrics for all system employers	X		
Create one workforce information & ESR function across NHS employers	X		
Create one system workforce planning & transformation team (including HR, OD, Education & Learning expertise) across all system employers	X		
Implement AI & RPI consistently in people management processes			X
Operational workforce sharing between NHS system employers	X		
Create one system recruitment function providing recruitment services for all system employers & enabling provision of the single point of entry for STW for job opportunities (job/recruitment bureau)	X		
Create one system HR Advisory & Business Partnering function providing recruitment services for all system employers			X
Create one system Organisational Development function providing recruitment services for all system employers		X	
Develop a consistent and shared approach to the provision of high quality Occupational Health services			X
Operationalise the One Workforce principle (System first) in all our key work programmes	X		
Create & use a single workforce plan for all our System workforce	X		

Agenda item ICB 29-03-073

Integrated Care System Performance Report

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Integrated Performance Report

Appendix A - Data Pack

29th March 2023

Content

UEC Core Metrics

Service	Measure
Pre-Hospital	Response times for ambulances
	Reducing avoidable trips (conveyance rates) to Emergency Departments by 999 ambulances
	Proportion of contacts via NHS 111 that receive clinical input
A&E	Percentage of Ambulance Handovers within 15 minutes
	Time to Initial Assessment - percentage within 15 minutes
	Average (mean) time in Department - non-admitted patients
Hospital	Average (mean) time in Department - admitted patients
	Clinically Ready to Proceed
Whole System	Patients spending more than 12 hours in A&E
	Critical Time Standards

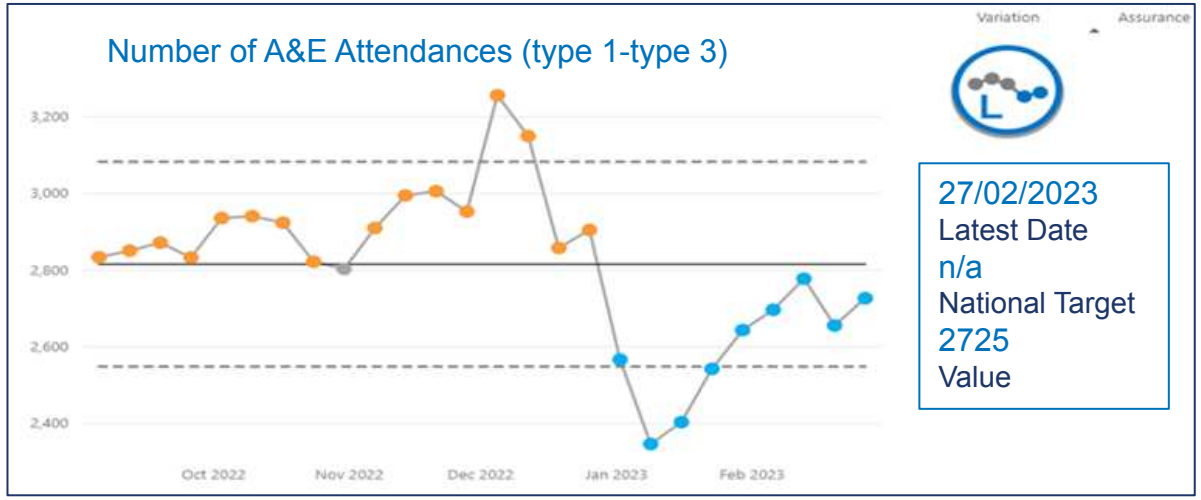
8 of these measures and other supporting metrics to assist achievement of the Core metrics bundle are captured within the UEC dashboard reported via the UEC Operational Group by exception to the system UEC board.

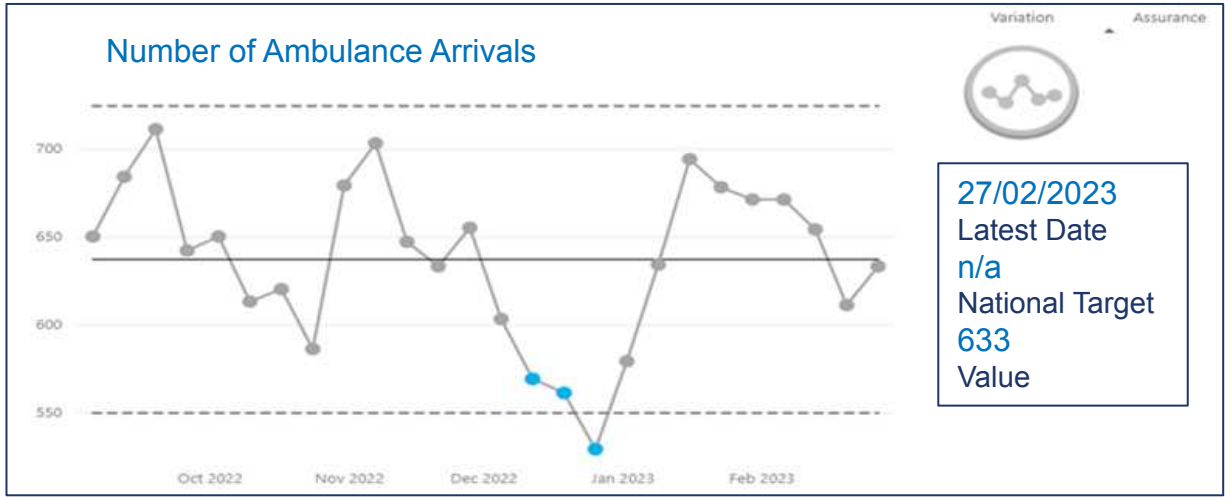
The 2 RED highlighted metrics are not currently captured. Clinically Ready to Proceed will be captured once the new Patient Administration System (PAS) is implemented at SaTH. Critical Time Standards criteria have not yet been set nationally.

Urgent and Emergency care data

The following UEC slides contain the latest monthly update (February performance) against the national core UEC measures. The charts provided include trajectories for improvement and benchmarking against regional and STW pre-covid (19/20) performance where available.

Setting the scene: Demand data



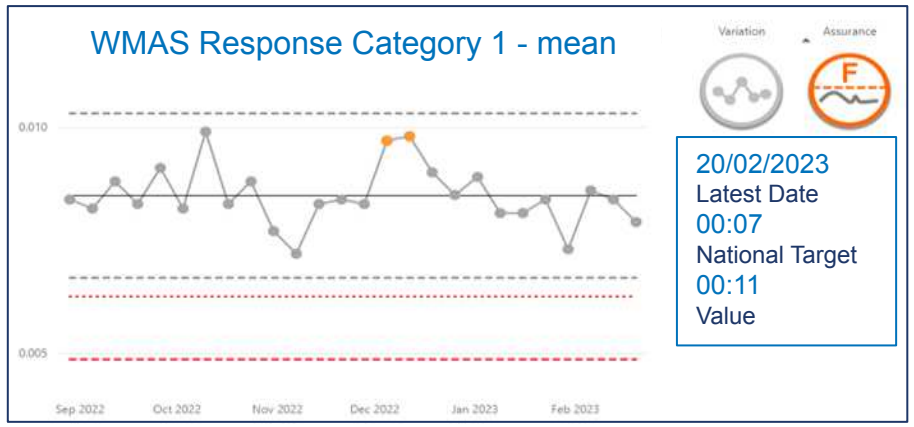


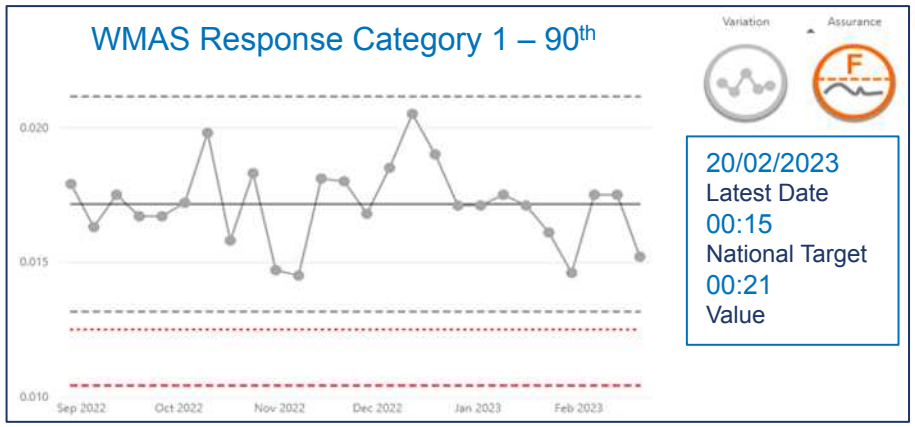
A&E attendances increased during February; although not to the highs previously reported, the impact was a decrease in performance during February. However, improvements can still be seen from January onwards based on interim changes implemented.

As previously reported, the coding reported behind the Emergency Care Data Set (ECDS) data has prevented in-depth review of ECDS data. Data quality will still remain challenged until the move to the new PAS in October '23.

Ambulance arrivals have again started to decrease following a sharp rise in January. Arrivals have been between 678 on the week of 23rd January falling to 613 on the week of 20 February.

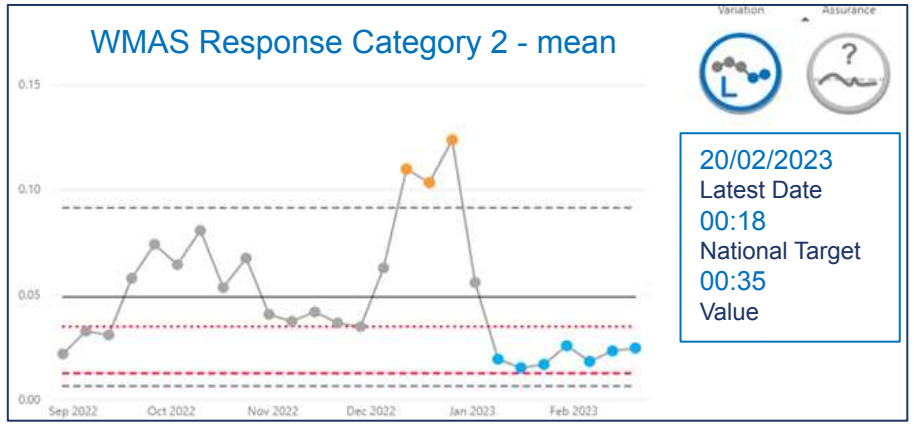
UEC Dashboard Latest – Core Metrics
Ambulance response times

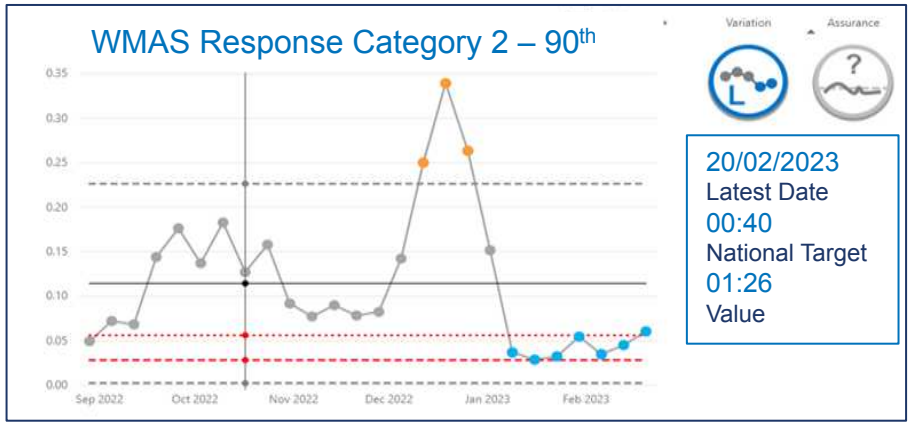




Key: Mean line (average) | Upper and Lower control limits | Localised improvement target | National Target

Cat 1 response times report very little variance or improvement. The latest week captured does show an improved time of 21 minutes for the 90th percentile. National target remains at 15 minutes.



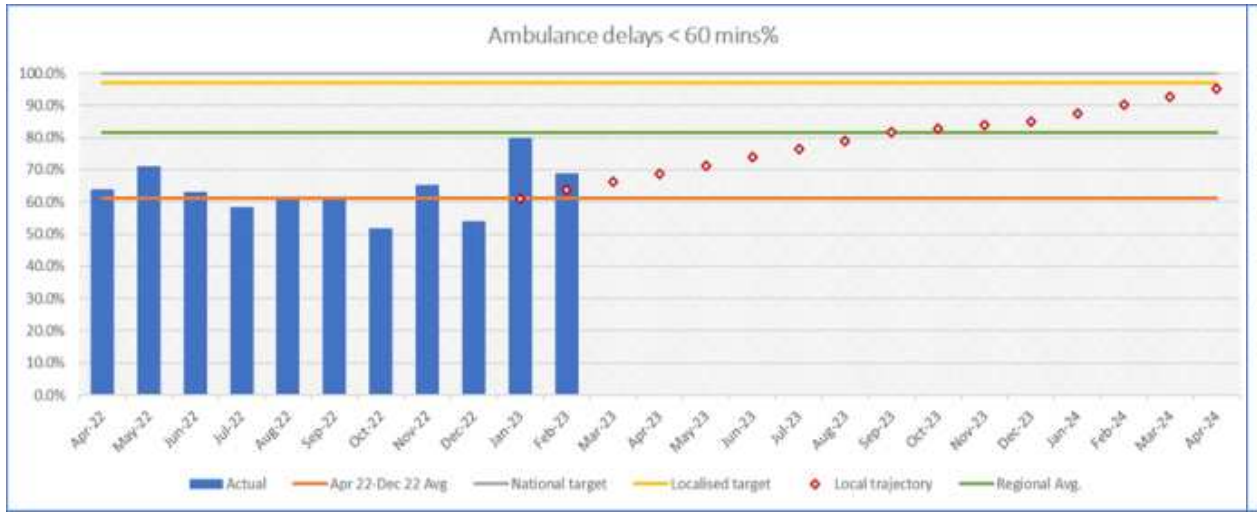


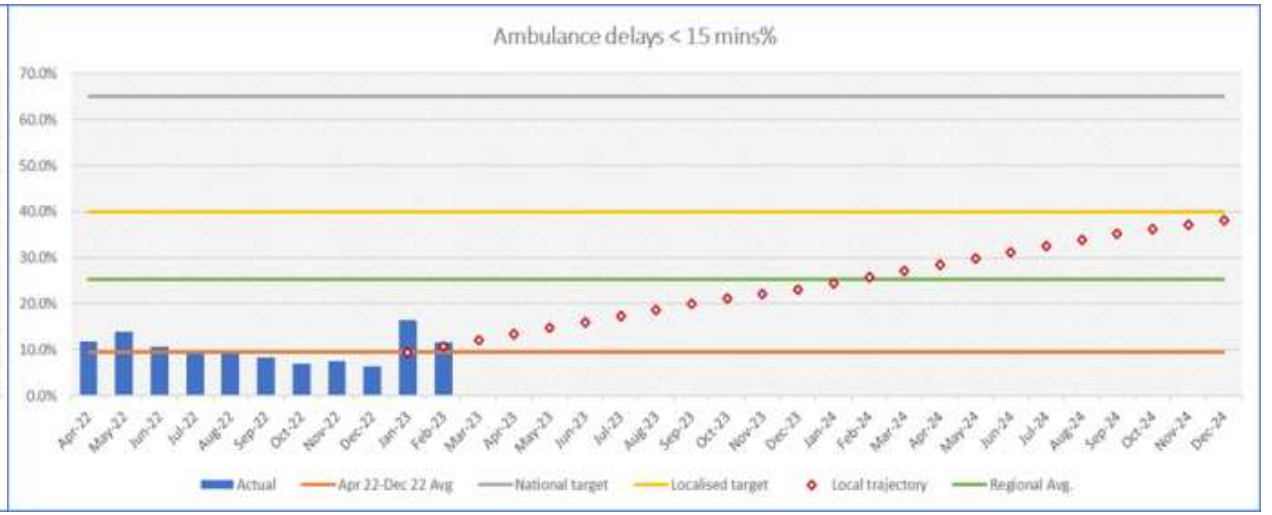
Category 2 times remain much improved and have been ahead of localised improvement target and close to the national target. Cat 2 conveyance activity remains consistent.

UEC Dashboard Narrative:

STW along with Shropdoc and Shropcom partners now have twice daily stack review calls of Cat 3 and 4 with WMAS. Shropdoc are leading on this on behalf of the system. Initial analysis shows that the Stack Review calls are having a positive impact in identifying alternative pathways other than ED. These calls take place 7 days a week.

UEC Dashboard Latest – Core Metrics continued
Ambulance Handover delays





Ambulance Delays of less than 60 minutes

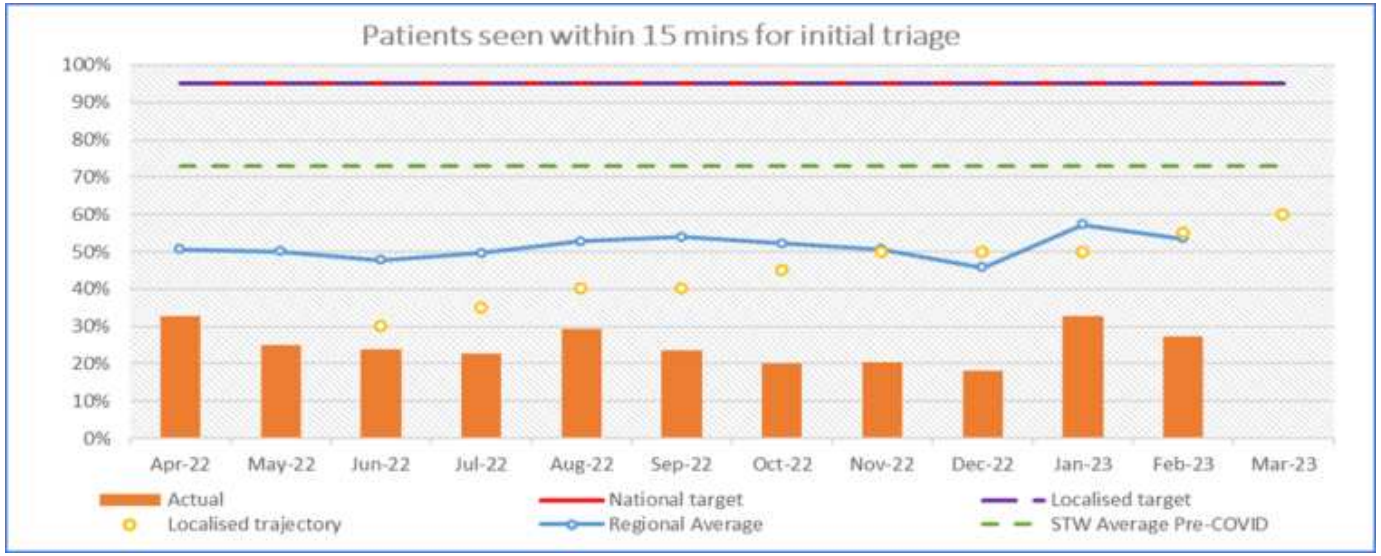
February handovers to PRH and RSH are reporting a reduction in performance of 69%, down from 80% in January. Despite the reduction, performance figures still met the new trajectory.

The latest figure for the region is 89.6%; STW therefore reported a variance of 23% to the regional average.

Ambulance Delays of less than 15 minutes

Again, 15-minute performance reduced during February, reporting 11.6%. However, STW still reported achievement of trajectory.

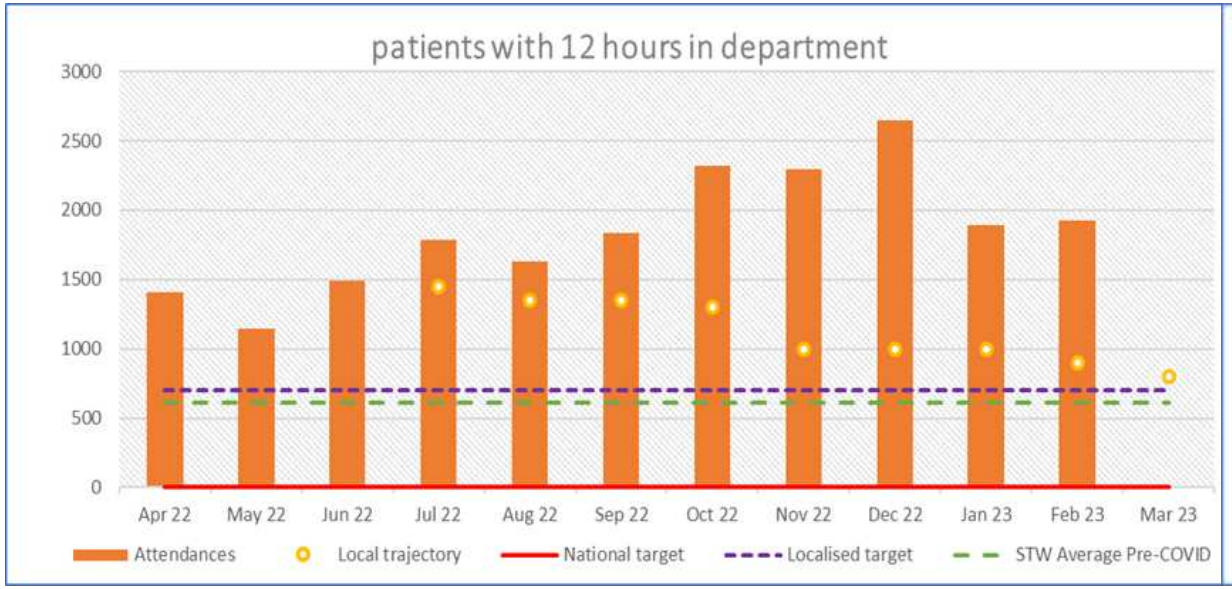
UEC Dashboard Latest – 15 min initial assessment

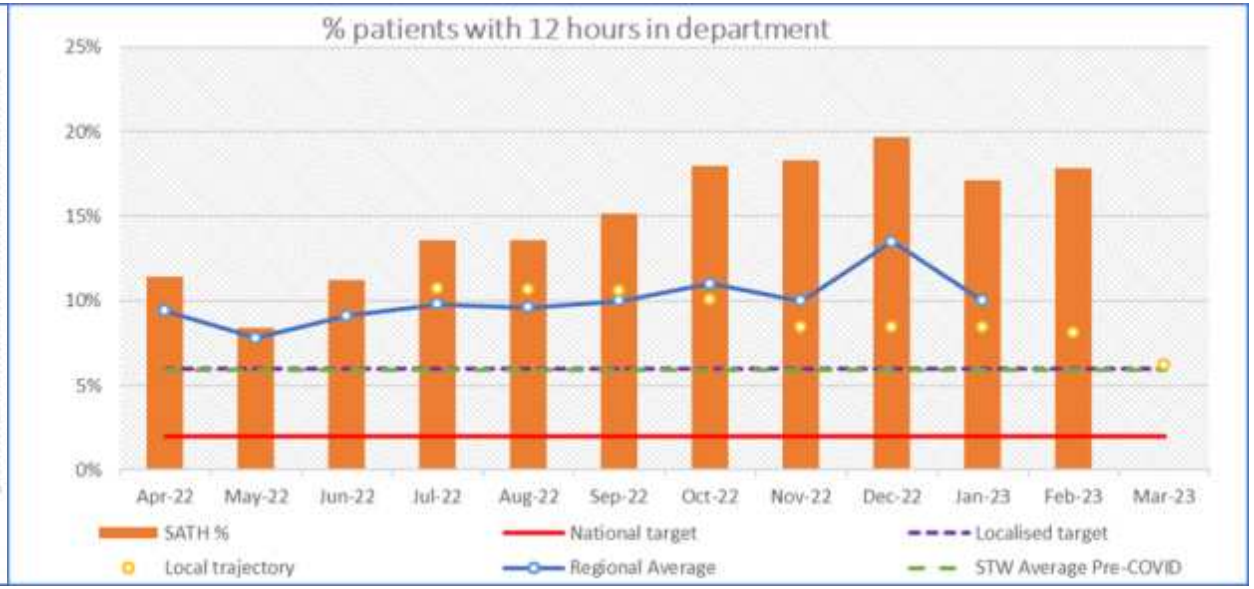


During February, 27% of people were seen within 15 minutes for initial assessment. STW continue to follow the regional performance trend pattern; the increasing demand reported during February (compared to January) being the key factor for the performance change.

There has been some sustained improved performance around initial assessment during January, however performance dipped slightly in February but remains way short of local recovery trajectory and regional average.

UEC Dashboard Latest – 12 hour patient



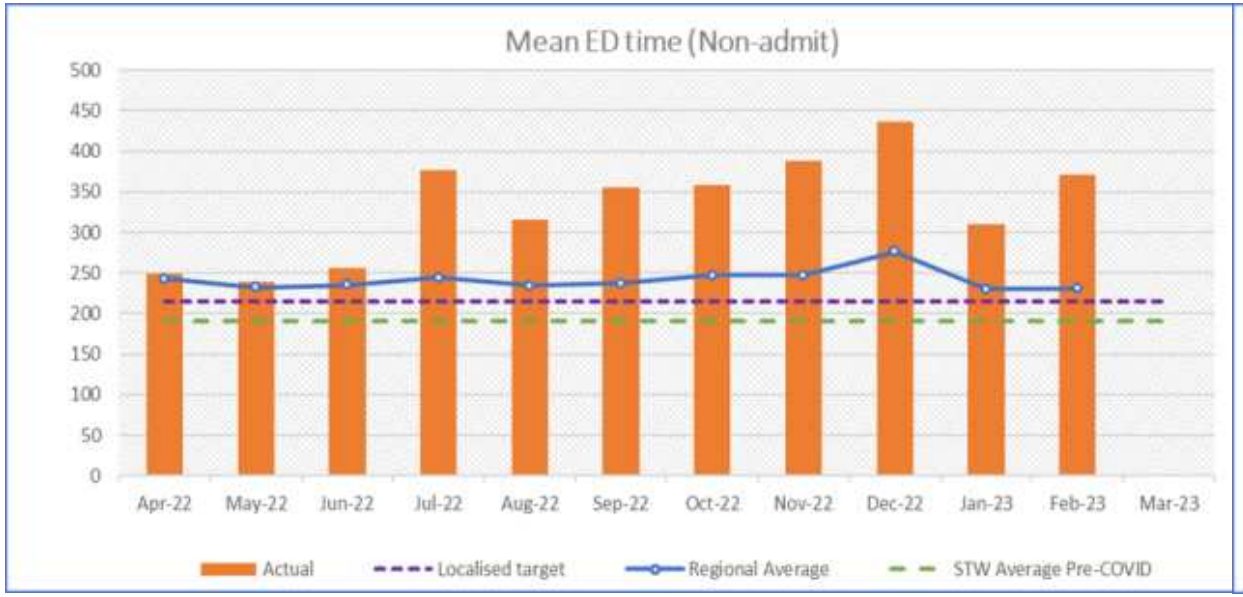


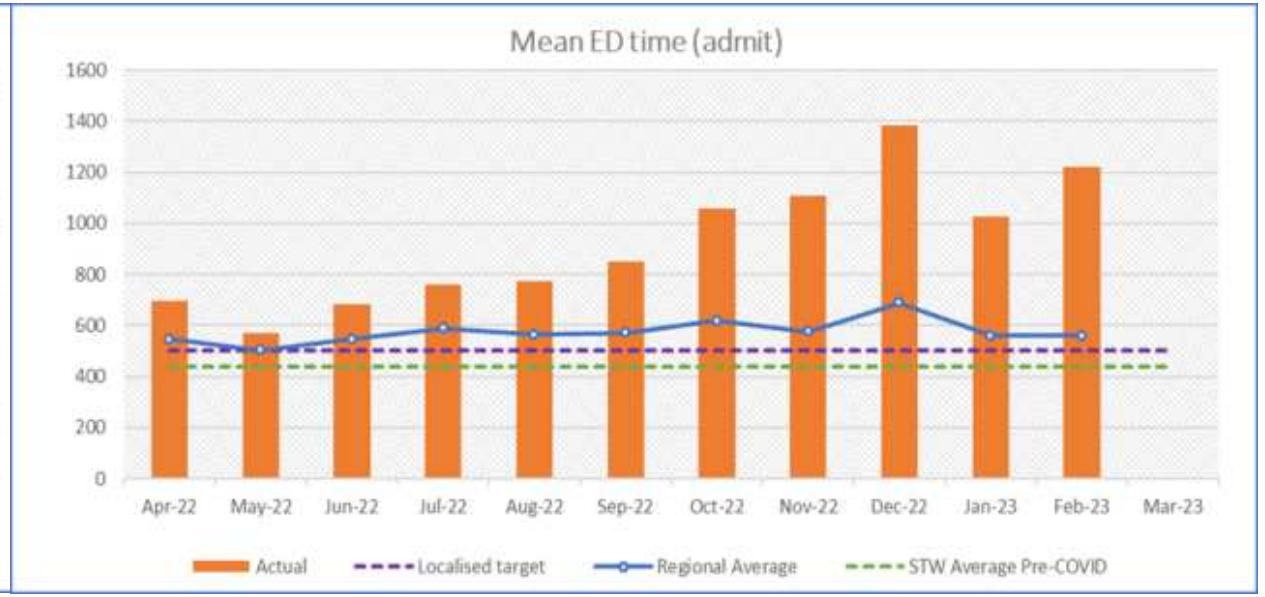
February reported a slightly worsened position with 17.9% of total attendances incurring 12+ hours in ED; this equates to a total of 1926 cases incurring 12 hours+ in department (+35 compared to Jan '23).

Immediate regional systems' data now available monthly: January reported 10%.
In early January there was a reduction in the number of patients spending more than 12 hours in ED to levels experienced in August 2022. Improvement work includes the acute floor reconfiguration and validation around non-admitted patients. Discharge improvement work is ongoing to support increased capacity that will reduce time spent in ED.

UEC Dashboard Latest – Core Metrics continued

Mean time in ED





Non-Admitted

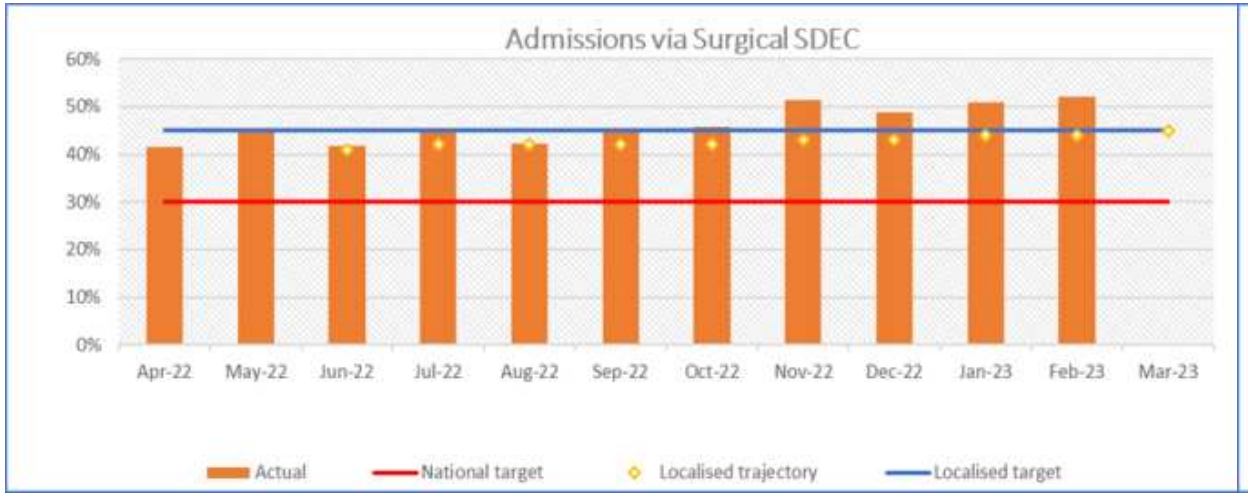
During February, STW reported a average of 371 mins for Non-admitted attendances. Mean time in ED for non-admitted patients reduced through the beginning of January as flow through the department improved, enabling patients to be seen and treated more quickly. The marginal increase in attendances during February had an impact on time in ED.

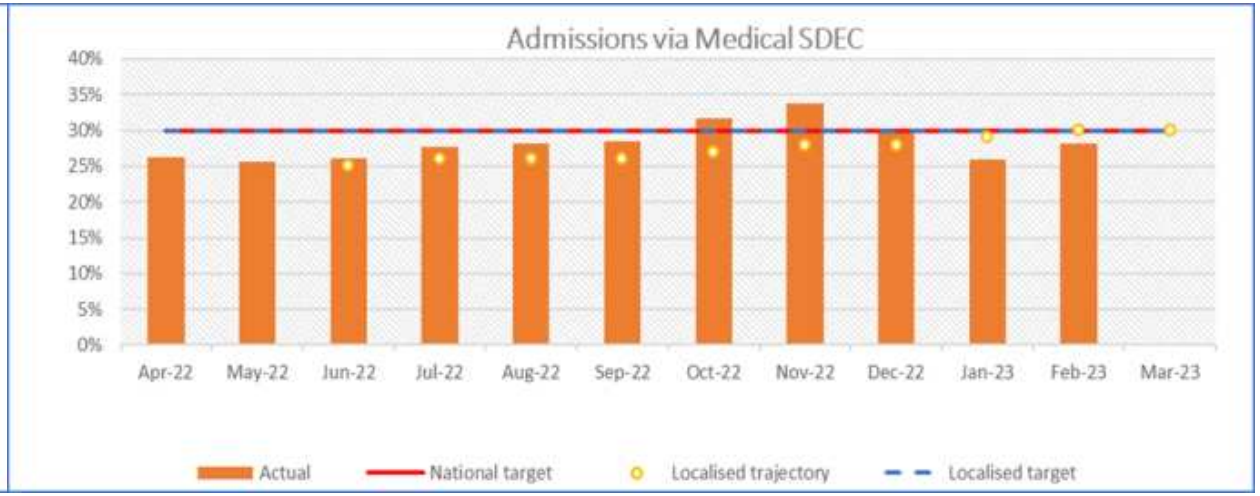
Admitted

The average increased significantly during February to 1220 mins. The localised target is set at 500 mins, with regional average reporting 560 during January.

UEC Dashboard – additional supporting metrics

The system has other Key Metrics that are not part of the national core bundle;
these have been selected as essential to monitoring the overall UEC improvement.



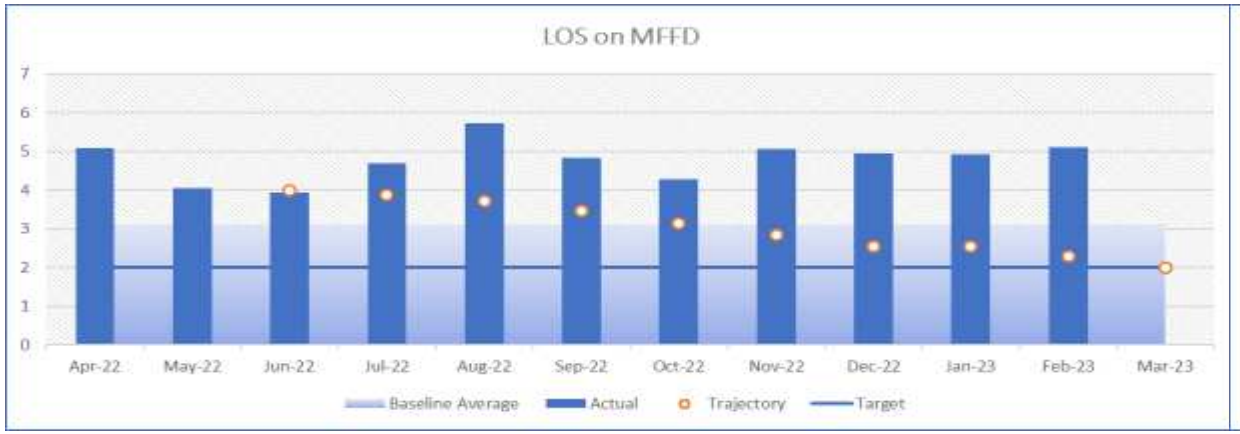


The surgical SDEC continues to report achievement of our local stretch target during February, reporting 52%.

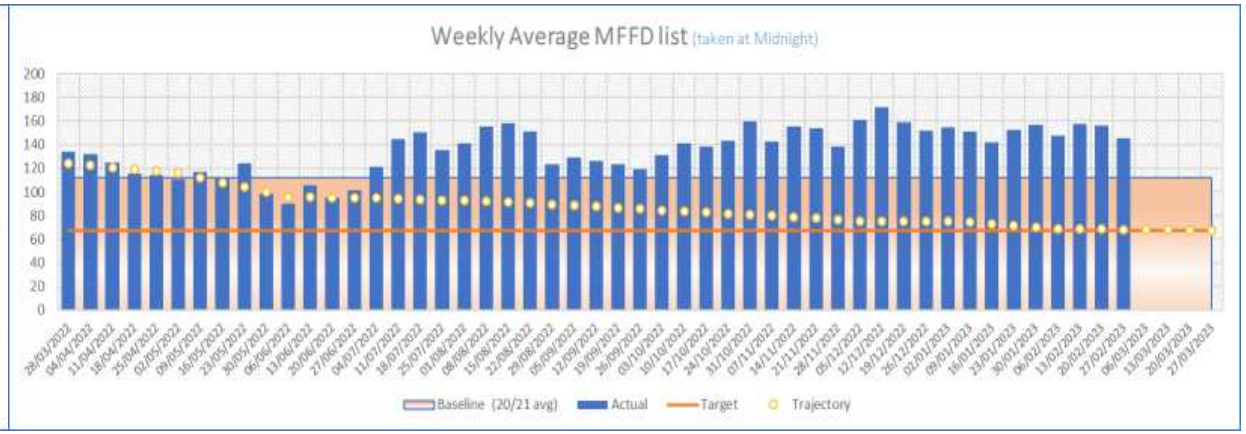
The Medical SDEC has improved during February reporting 28%, although still a little under target.

The acute floor opened in mid December. Patients are now being admitted via AMA rather than SDEC therefore we may continue to see performance in this metric reduce due to the pathway changes but is an improved pathway for the patients. There was an increase in weekly performance in February (seen in the Weekly UEC Dashboard) and this coincides with the flow out of the acute floor being more constrained and therefore more patients being held back in ED.

UEC Dashboard – MFFD



February figures increase to 5.1 days average length of stay as Medically fit for discharge (MFFD).



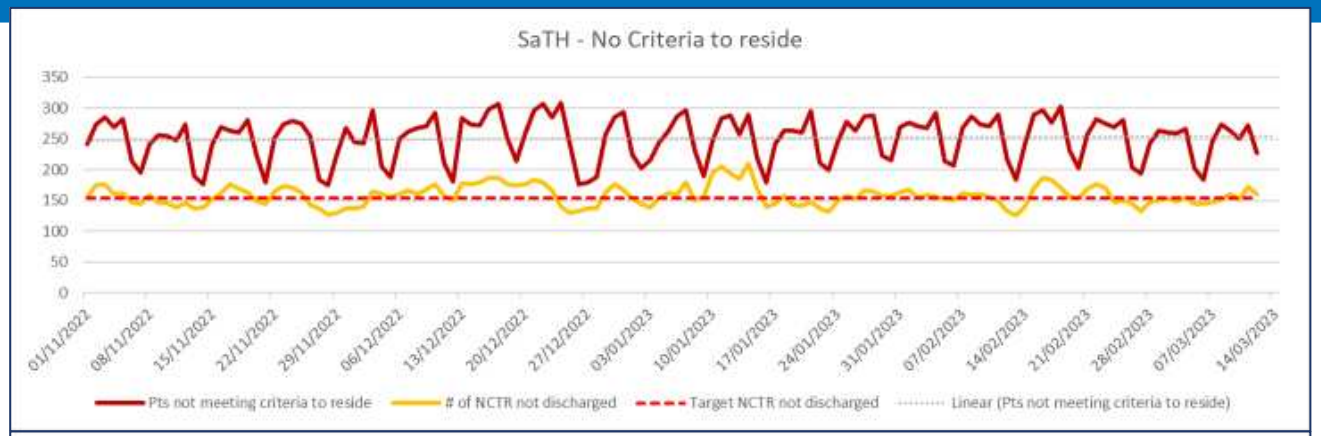
The latest weekly average discharge, 27/02/22, is reporting an average of 146 patients per day on the MFFD list.

First capture of No Criteria to Reside reporting for SaTH - on next slide.

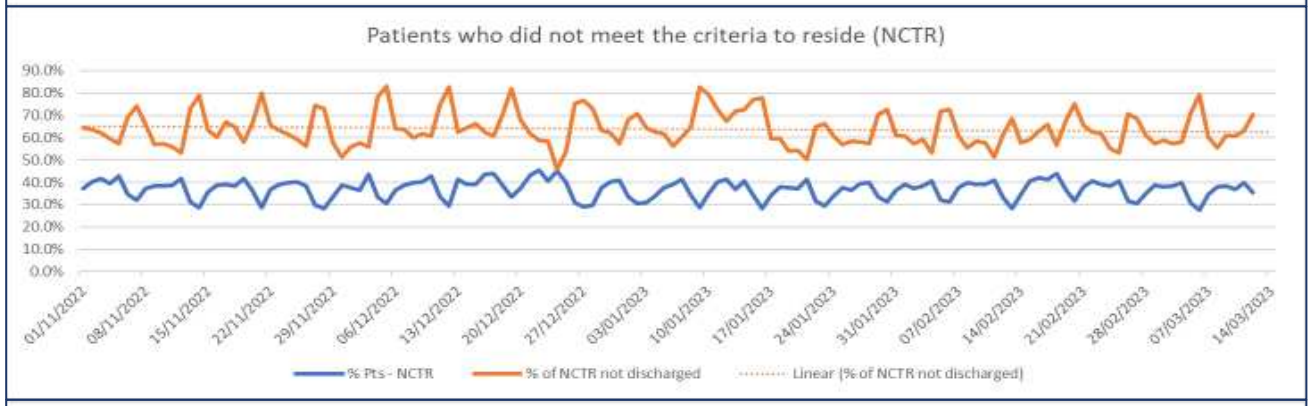
Key criteria/definitions understood to align with SaTH reporting/capture:

- MFFD – Based on a combination of clinical review and treatment completed where a fit for discharge date has been input and aligned to complex discharge patients only and at the point in time reported, e.g., 4pm
- Ready for Discharge (RFD) – of those patients at point in time recorded as MFFD, the RFD patients are not awaiting anything further that might prevent discharge - e.g. meds, community equipment
- No Criteria to reside (NCTR) – with the current PAS, SaTH are not able to capture this as per national criteria. The current NCTR figures reported are based on the daily sitrep as reported to the national team for use in the Foundry platform. The methodology for SaTH to report is based on persons captured "Yesterday". The remaining MFFD list (Complex patients) at midnight + the number of patients discharged before midnight.
  This does not capture simple discharges that were not completed.

Inpatients with No Criteria to Reside

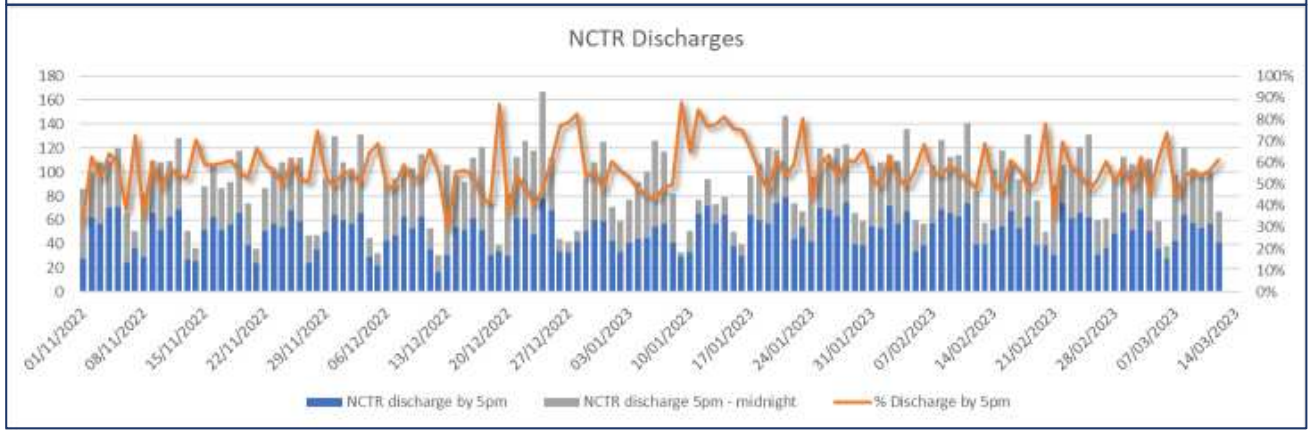


Daily info flow as captured in SaTH Discharge sitreps. A target is yet to be provided for the total number of patients reported as NCTR (No Criteria to Reside) or Not Discharged NCTR; the target line shown is based on Nov '22 average only as an indicator.



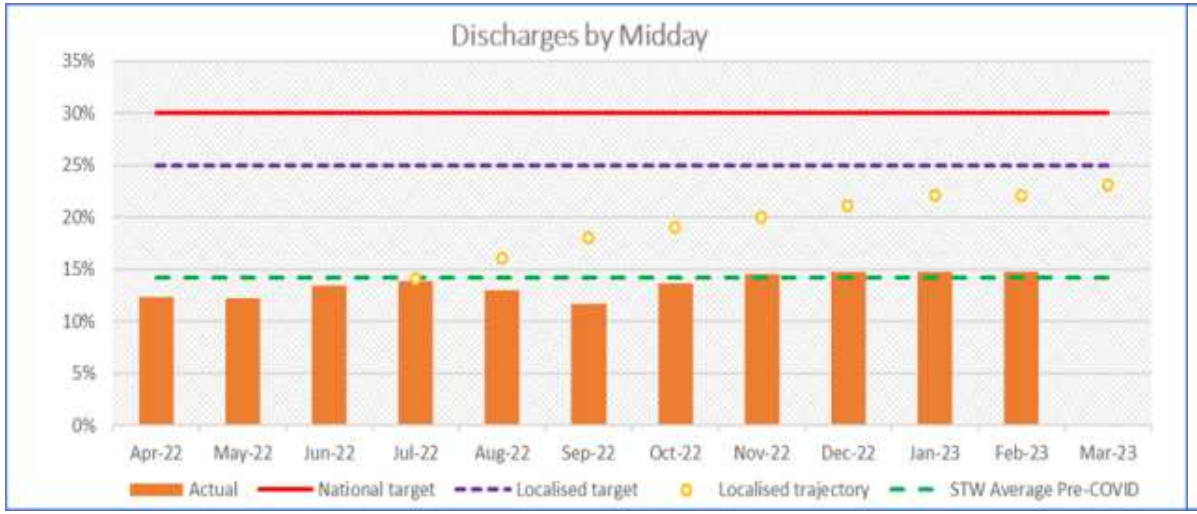
A slight decrease in the proportion of NCTR patients who have not been discharged.

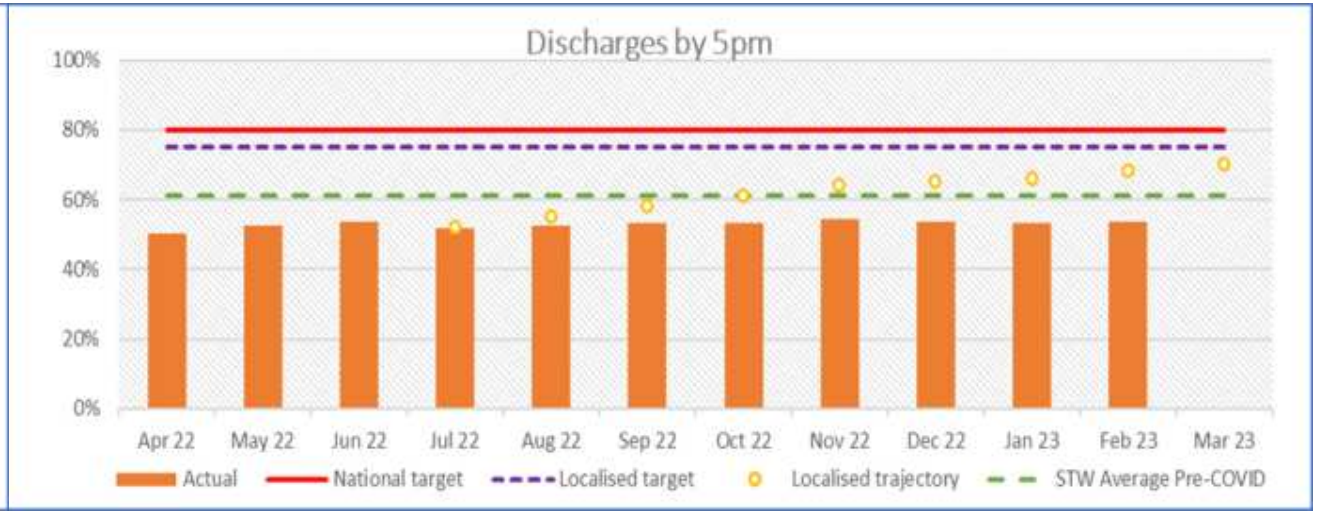
The total % of NCTR patients remains consistent with weekly trend patterns reported. The lows align with figures reported for Mondays.



This chart show the NCTR patients discharged before and after 5pm. Since Nov '22 an average of 57% were discharged by 5pm, although this peaked during Christmas week and again mid January at 87-89%
Jan '23 = 62%
Feb '23 = 55%

UEC Dashboard – Discharges





Review of Discharge data has been captured for midday and 5pm achievement.

Midday performance for February remained at 14.7%; trajectory was set for 22%.

5pm discharges are reporting a broadly flat position for February of 53.6%. STW pre-covid achievement was 61%.

Discharge improvement work is ongoing to identify morning discharges and a trial with EZEC transport to test a model for very early discharges. The Next Patient model is also supporting the early identification of patients for discharge lounge and pre-planning discharge the day before with the aim of improving morning discharges.

Elective Recovery – long waits

Key Data

104 week waits

Organisation	End of 104ww+ February Confirmed Position	Forecasted end of 104ww+ March Cohort	Forecasted end of 104ww+ April Cohort
SaTH	1	0	0
RJAH	13	2	0
Total	**14**	**2**	**0**

104+ww - March- System Plan was 0, currently forecasting 2

- RJAH – Forecast 2 patients -1 impacted by the JD Industrial Action (5 were at risk) – complex and unable to redate in month. 1 patient requires injection ahead of surgery, a three-week gap between injection and procedure is clinically essential.
- SaTH – Plan to meet 0 at the end of March.

78 week waits

Organisation	Original Planning submission 78+ ww at March 2023	78+ ww (March 2023 cohort) Reported 30.01.23	End of March 78+ ww Forecast (March 2023 cohort)	Current Forecast (April 23) 78+ ww
SaTH	211	512	102	0
RJAH	247	222	114	90
Total	**458**	**734**	**216**	**90**

Both SaTH and RJAH are on target to achieve better than the operating plan submission at the end of March however challenges remain with meeting the 0 target for April 23.

Summary

Key Issues / risks to delivery 104 ww & 78 ww

- Workforce challenges and critical incidents declared at SaTH
- High volume of Spinal disorder patients at RJAH (Including Specialist adult and paediatrics scoliosis)
- Low volume of patients willing to transfer out of the region or other providers
- Lack of mutual aid within the region for specialist procedures such as spinal disorders
- Impact of industrial strike action on local services

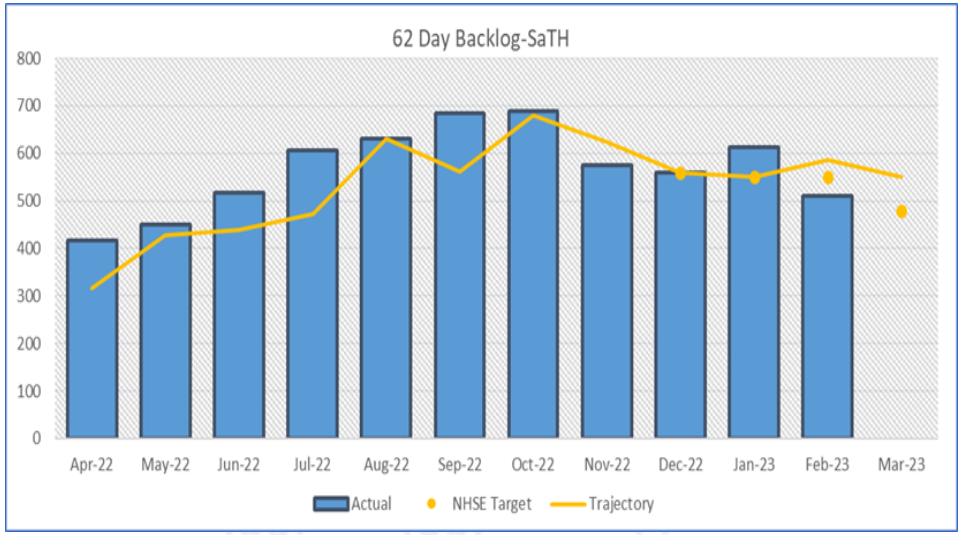
Key Actions for recovery 104 ww & 78 ww

- Ongoing work with Royal Orthopaedic Hospital and Walton Centre
- Focus on Independent Sector Utilisation
- Both Trusts focussed on delivering 78ww trajectory and reducing 104ww as low as possible, with complex spinal disorders the main risk to delivery, system still planning for zero 104ww year end
- In conjunction with above, Diagnostic patients being sent to radiology to plot capacity in advance
- Technical, clinical and administrative validation processes in place.

Cancer Recovery

Key Data

SATH current position (as at 13/03/23):
430 patients waiting 63-104 days
180 patients waiting over 104 days.



Summary

There has been a big improvement in 62-day performance; SaTH is now below the overall backlog trajectory by 23 patients. The majority of those on the backlog are urology patients – see next slide.

For 28-day faster diagnosis, performance is challenged due to delays on skin as the biggest pathway. Capacity has been addressed for this and should translate into improved performance. For the other high-volume pathways, breast achieved 89.1% in January and colorectal is utilising straight to test so both will support overall improved performance.

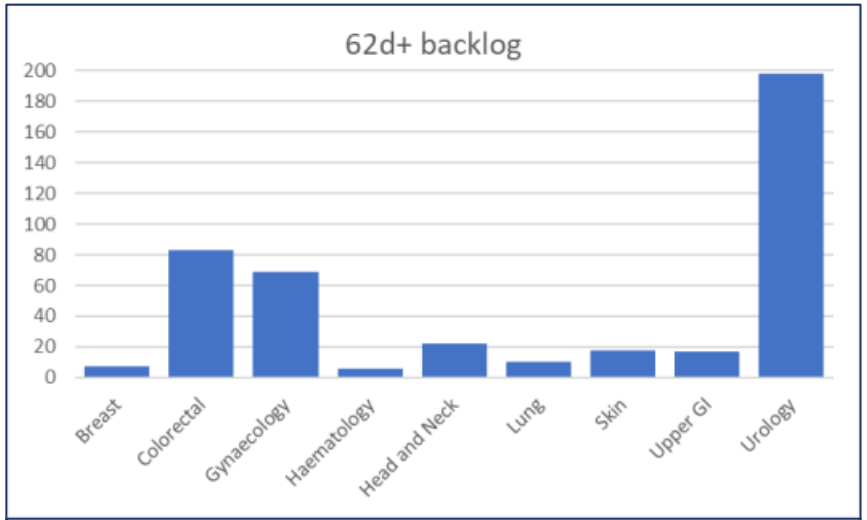
What have we done/ next steps

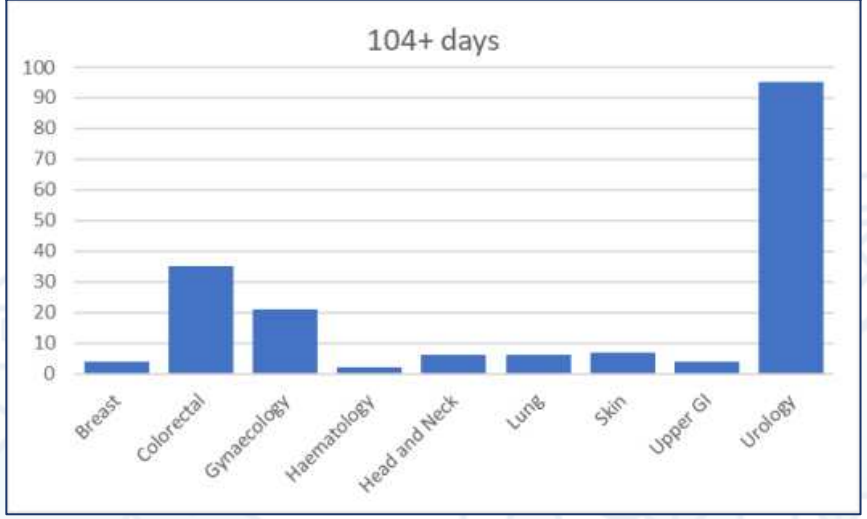
- Continue to utilise radiology insourcing services, with further capacity expected when the current intake of overseas staff are fully trained and the Community Diagnostic Hub comes online – these will help reduce the 62 day backlog & increase the 28 day FDS performance
- All challenged cancer pathways (urology, lower GI, gynaecology and skin) have recovery plans in place and are monitored on a weekly basis. For gynaecology, a straight to scan pathway is now in place and 2-week wait appointments for US and post-menopausal bleeding (PMB) now booking within target. Theatre capacity planned to return to pre-covid levels in April 23.
- For colorectal, a new FIT pathway service provider begins delivering services from April. In addition, there is increased uptake of use of FIT by GPs as a diagnostic tool (33% of referrals accompanied by a FIT result in first week of March).
- Teledermatology pilot until end of April in one locality to help reduce pressure on the skin cancer pathway; full roll-out expected to follow.
- Additional urology biopsy procedures funded by the West Midlands Cancer Alliance (WMCA)

Cancer - challenged pathway

Key Data

SATH current backlog (week ending 05/03/2023)





Summary

The urology pathway is now the most challenged, with 198 patients waiting over 62 days of which, 95 patients have waited over 104 days.

What have we done and next steps

Actions to address the backlog in urology:

Local Anaesthetic Transperineal Prostate Biopsy (LATP) capacity - diagnostics secured for 120 procedures.
1st session, 9 new cancers, 53% pickup rate. 2nd session has taken place awaiting results - in place.

Implementing Best Practice Tariff Payment (BPTP) - Work has commenced with Improvement team to implement standards of care in MDT and streamline patient pathways. WLIs in place for additional clinics for results and treatment planning. Ongoing improvement work in Radiology as current timelines do not enable BPTP to be met - end of Q1.

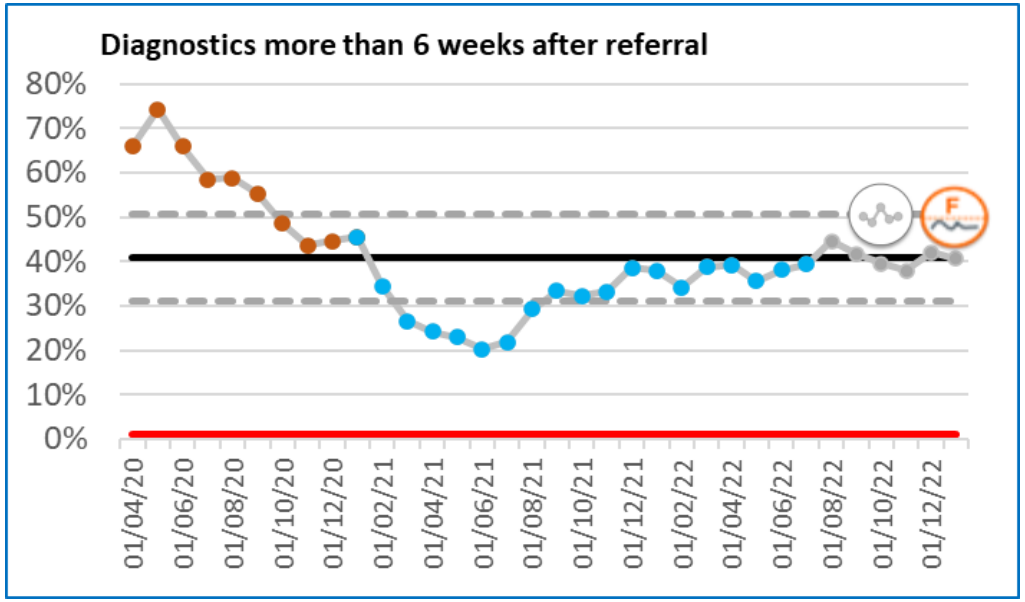
Insufficient Cancer Nurse Specialist (CNS) workforce to implement LATP & nurse-led triage - Recruitment completed but candidate has since withdrawn.
To recommence recruitment process - end of Q1.

Service reliant on Locums support - work continues to recruit Agency and NHS Locums in place. Implementation of robotic surgical procedures may attract new candidates – ongoing.

Demand exceeding capacity - Continuing to utilise outsourcing to support other elements of the service - in place.

Surgical capacity - Working with WMCA/NHSE to identify mutual aid – ongoing.

Diagnostics Recovery



Summary

The overall 6 weeks standard for diagnostics was not achieved for both SaTH and RJAH, however there continues to be improvement month on month. January position is 40.6%, a slight reduction from December (42%). February's unvaldated data shows further improvement.

Non-obstetric ultrasound has the largest number of long waiters, but the second highest MRI is continuing to show a small but steady decrease in waiters.

Colonoscopy: a second outsourced imaging provider for reporting at SaTH commenced in December 2022 which is reducing waits for cancer patients and starting to reduce pressure on services generally.

STW activity is above 100% of the 2019/20 baseline and 100% or more of the 2022/23 Operational Plan except for flexi-sigmoidoscopy where pathway changes due to Faecal Immunochemical Testing (FIT) have reduced demand.

	Nov-22		Dec-22		Jan-23	
Diagnostic	22/23 Actual % of 19/20 Baseline - Working Day Adjusted	22/23 Actual % of 22/23 Operational Plan	22/23 Actual % of 19/20 Baseline - Working Day Adjusted	22/23 Actual % of 22/23 Operational Plan	22/23 Actual % of 19/20 Baseline - Working Day Adjusted	22/23 Actual % of 22/23 Operational Plan
Cardiology - Echocardiography	113%	116%	94%	103%	110%	118%
Colonoscopy	128%	100%	116%	99%	119%	90%
Computed Tomography	124%	123%	117%	106%	121%	103%
Magnetic Resonance Imaging	129%	131%	114%	109%	122%	111%
Non-Obstetric Ultrasound	105%	124%	95%	99%	116%	116%
Flexi-sigmoidoscopy	32%	79%	42%	109%	49%	97%

What have we done and next steps

- Insourcing of radiology support, increasing capacity by using mobile scanners, enhanced payments and WLIs and Business Case submitted for scanning and reporting.
- RJAH – radiologists being onboarded and new capacity coming online for MRI in early summer.
- SATH
  - 3 new rooms and funding for staffing in Endoscopy and further activity throughput via insourcing providers.
  - Insourced ultrasound capacity.
- Community diagnostic hub to open late summer

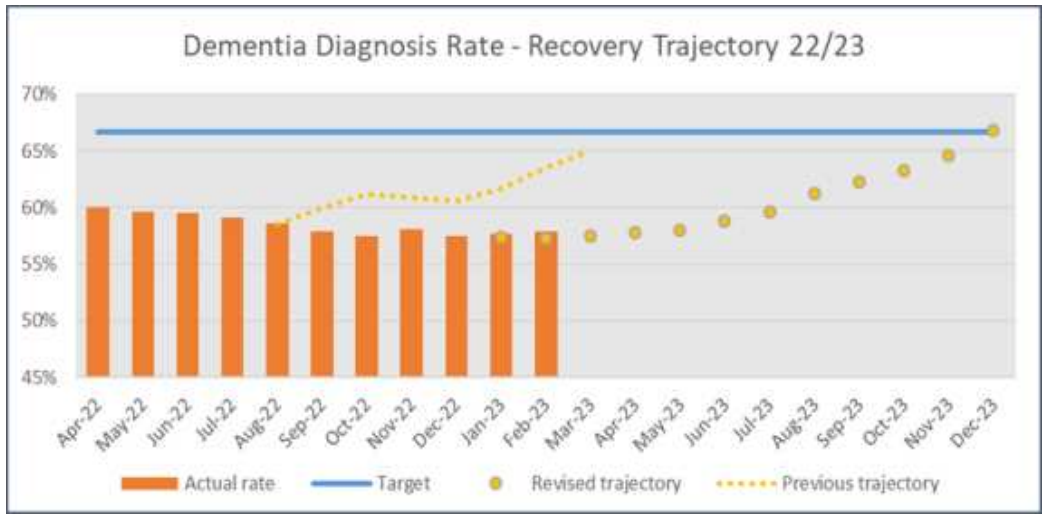
Mental Health Indicators

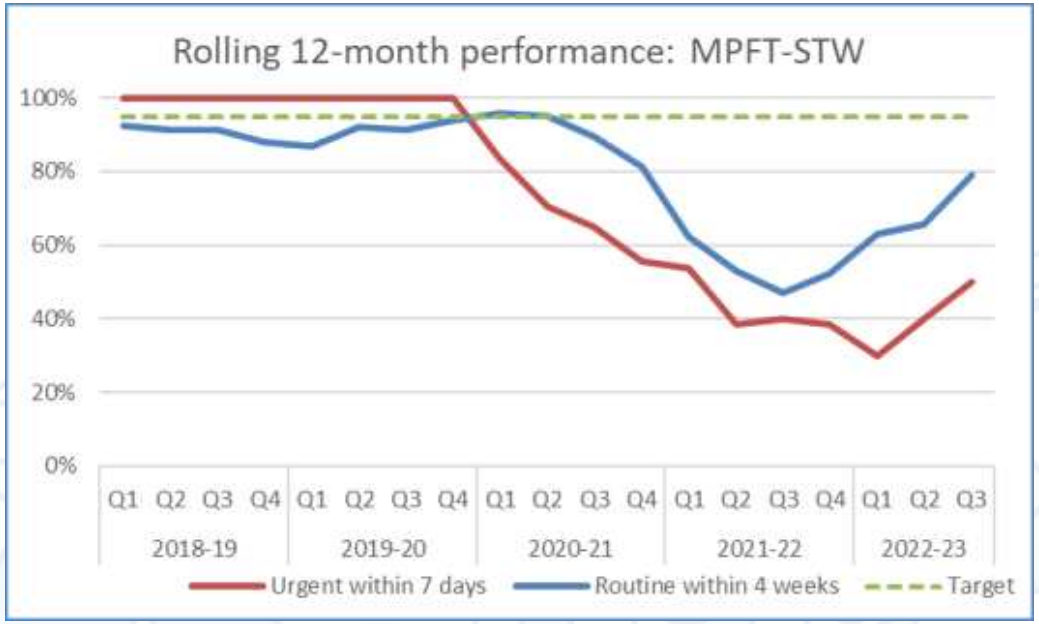
KPI	Latest month	Measure	Target	Assurance	Variation	Mean	Lower process limit	Upper process limit
Dementia Diagnosis rate (STW)	Jan 23	58%	67%	F	L	63%	62%	64%
Dementia Diagnosis rate (England)	Sep 22	62%	67%	F	L	64%	63%	65%
Talking Therapies (IAPT) Recovery Rate (MPFT)	Jan 23	46%	50%	?		52%	42%	62%
Finished Talking Therapy first seen <6 weeks (MPFT)	Jan 23	91%	75%	P	L	96%	92%	100%
Finished Talking Therapy first seen <18 weeks (MPFT)	Jan 23	95%	95%	P	L	100%	98%	101%
Talking Therapy treatment started <18 weeks (MPFT)	Jan 23	99%	95%	P		99%	95%	103%
Wait for second Talking Therapy appointment <90 days (MPFT)	Jan 23	79%	90%	?		82%	72%	92%
SMI patients with Health Checks (in-month figure)	Jan 23	118	186	F	H	58	8	108
Early Intervention in Psychosis <2 weeks	Jan 23	100%	60%	?		89%	42%	136%

Summary

- National published figures show that dementia diagnosis rates have been declining since the start of the pandemic, dipping below 60% for STW since May 2022 and below the National average of 62% (but official figures availability is currently paused, last available is for September 2022).
- Unvalidated Talking Therapy figures from MPFT show that recovery rates and waiting times for follow-up appointments are below target but have been prone to fluctuation, whilst response times targets for starting treatment are being met.
- Physical Health checks for SMI registered patients show a slight improvement from December, but continue to be considerably short of target. The impact of the pandemic was that activity dropped across all regions, and performance has been starting to improve slowly over the last 12-18 months.

Mental Health: Dementia Diagnosis Rate, CYP ED Waits, CYP access





Dementia Diagnosis Rate

Whilst official data reporting has been paused, the proxy figure for STW shows a stabilised position which is meeting the revised trajectory and recent month's performance is showing small improvements; however, it is not expected to reach the target of 66.67% until later in 2023.

Progress against the recovery plan had been hampered by high levels of sickness and vacancies within the assessment and diagnosis team, and acute pressures. The number of patients on the assessment waiting list have been increasing; in addition to an increase in the number of referrals.

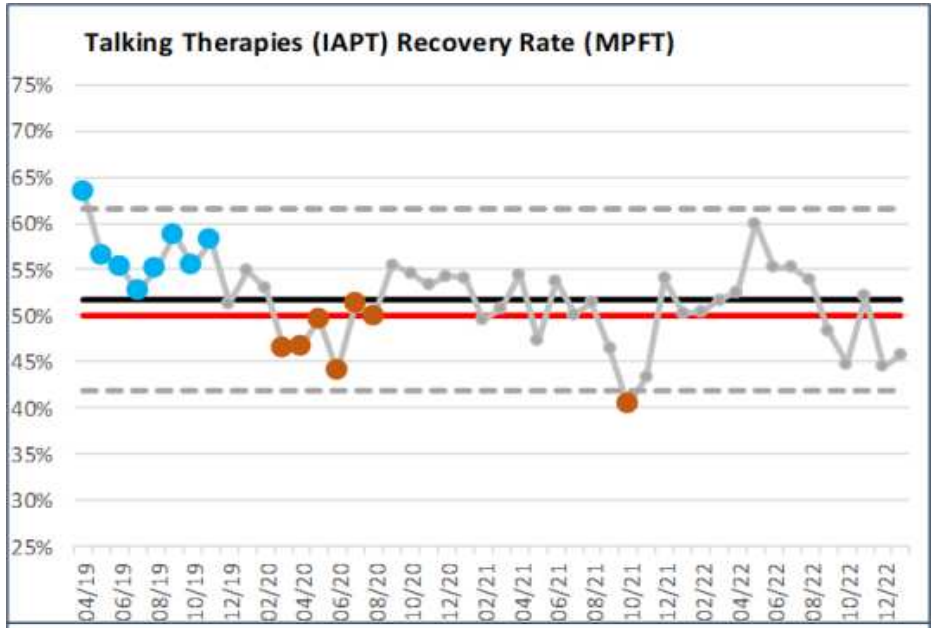
There is a modest increase in the rate evident from January, which is expected to continue. There are plans for a waiting list initiative to be held for the assessment pathway; the provider is going out to external procurement currently.

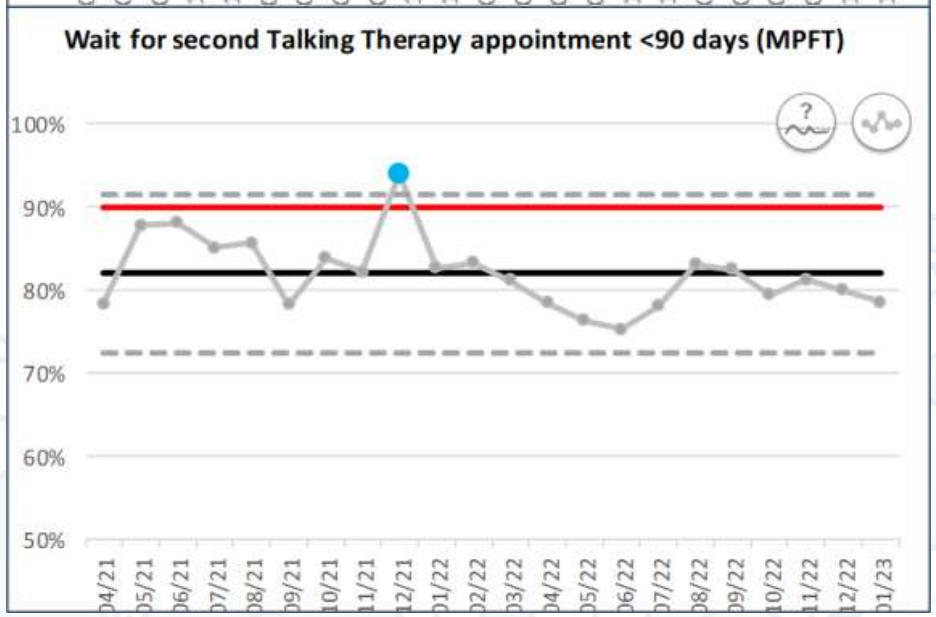
CYP Eating Disorder Waits

Children and Young People (CYP) referred with a suspected Eating Disorders (ED) have been deteriorating since January 2021. Difficulties with recruiting and retaining skilled staff being the main cause, as well as the impact of the pandemic on children.

A recovery plan was put in place late 2022 & increased staffing now in place following several recruitment attempts. Performance has improved from Quarter 1 to the current quarter. Focussed work continues to improve the waiting times towards 95% targets.

Mental Health: Talking Therapies (IAPT)





Summary

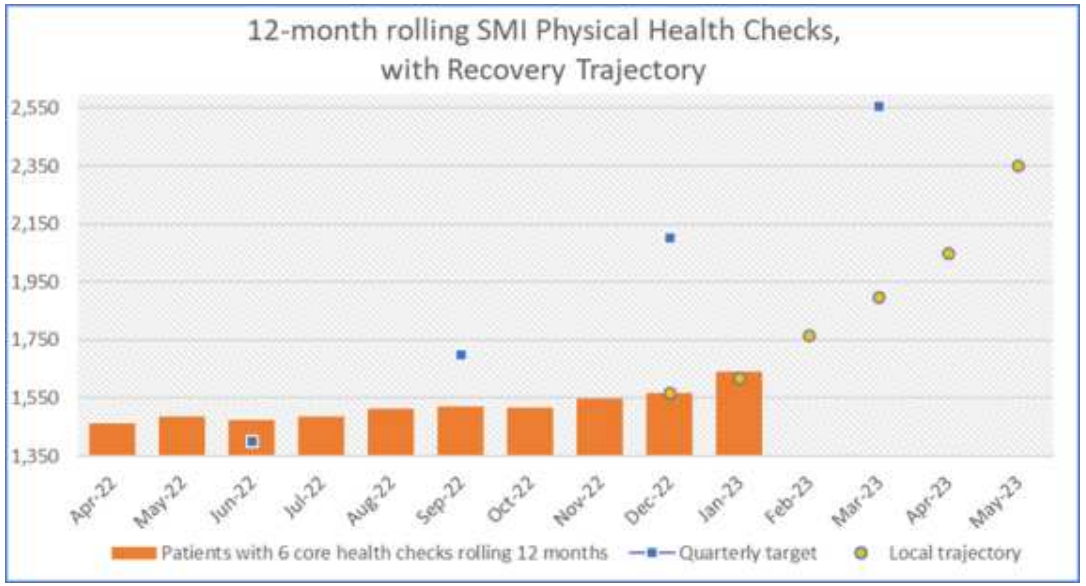
Figures from MPFT (unvalidated) show that recovery rates and waiting times for follow-up appointments have been prone to fluctuation due to the clinical discharge of people who have been inappropriately entered into the Talking Therapies service whose mental health needs are more complex. Performance has been close to the 50% target every month and January is 45.7%.

Access to treatment has been below target all year for both first contact and in-treatment waits, as the commissioned level was insufficient for the nationally set targets in 2022/23. A demand & capacity review has been concluded, alongside a review of funding and workforce. Two services are on track to merge into one across Shropshire, Telford and Wrekin. Workforce and trainee programme numbers are regularly reviewed with HEE and NHSE leads.

Performance of waits from 1st to 2nd appointment had been deteriorating since December 2021. The expectation to reach target of 90% waiting less than 90 days by April 2023 is unlikely given that performance has reduced to just below 80% in January although some improvement is being seen for February.

A waiting list initiative is in place since December aimed to reduce 50-70% of more complex waits over the next six to nine months. This has so far delivered a reduction of around 50% (exact figures are awaited).

Mental Health: SMI Health Checks, OoA Placements



Serious Mental Illness Physical Health Checks

Patients with a Serious Mental Illness (SMI) should receive as a minimum a physical health check within 12 months. There is evidence that having regular checks achieves improved awareness of physical health and choices for service users, earlier detection of serious conditions to enable earlier treatment options, avoid admissions to acute hospital and improved health outcomes.

Performance remains below target. There are some protracted IT issues which have delayed recovery of performance. IT leads engaged to resolve the issues. A review has highlighted that the current way of working between MPFT and GP practices is impacting on early recovery. Commissioners are leading a detailed review of the services in collaboration with primary care and MPFT. Performance is slowly improving in line with the planned trajectory, and early indications from February unofficial data show a continued increase.

Out of Area Placements

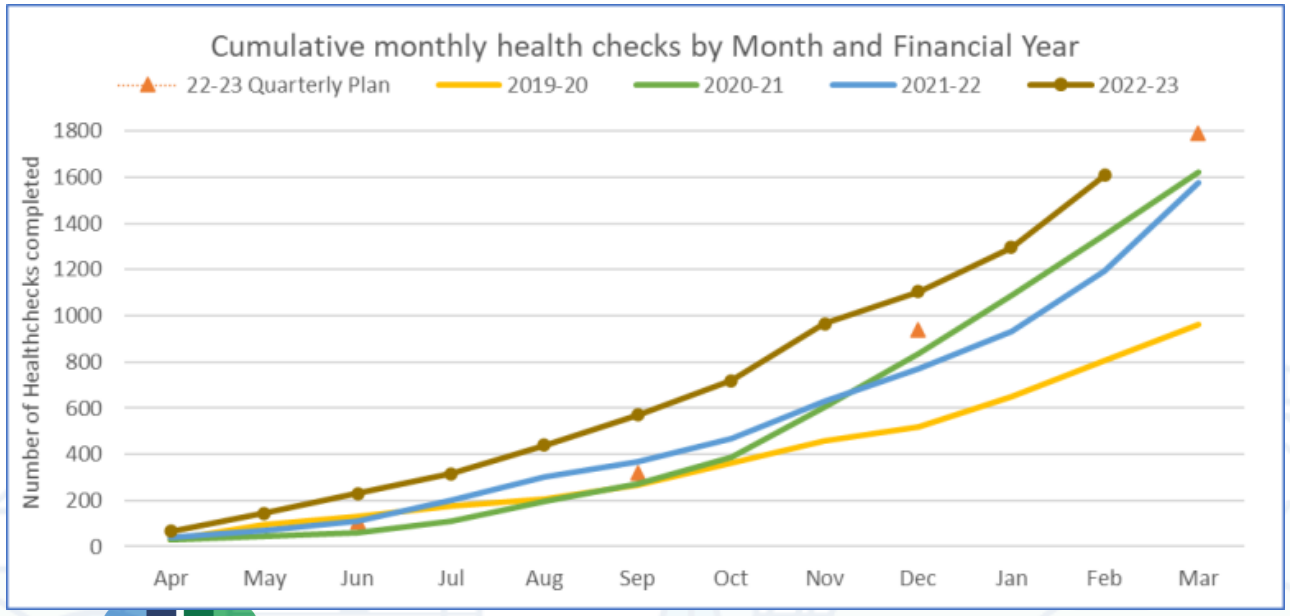
At the end of January there were 3 service users in inappropriate Out of Area placements over and above the Acute and PICU bed capacity. The number is prone to need arising at the time, and recently has been as high as 8 or 9 patients. Current demand for acute and PICU beds remains high and does fluctuate, mirroring the national picture. Issues remain in regard to care packages and limited care home availability, causing delays.

Mitigating actions include a system group review of length of stay and delayed discharges to reduce occupied bed days. Multi Agency Discharge Events (MADE) continue to support and challenge discharge planning. These are held quarterly with the next one due in April 2023.

Learning Disabilities – Inpatients and Annual Health checks

Current Inpatients position – February 2023

	ADULT TOTAL			ICB ADULT			PROVIDER COLLABORATIVE (SECURE)			CHILDREN UNDER 18		
	Actual	Trajectory	Var (+/-)	Actual	Trajectory	Var (+/-)	Actual	Trajectory	Var (+/-)	Actual	Trajectory	Var (+/-)
Dec-22	20	17	3	11	6	5	9	11	-2	2	1	1
Jan-23	22	15	7	14	5	9	8	10	-2	2	1	1
Feb-23	21	15	6	13	5	8	8	10	-2	2	1	1



Inpatients

Adults are over plan by 6 as at February, due to new admissions as well as the plan in Quarter 4 reducing. By the end of March, plan is to have a maximum of 15 adults (ICB and Provider collaborative for Secure beds). Urgent work being undertaken to assess whether some adults can be safely discharged back to community, involving system partners and support from NHSE.

Children also over plan by 1, although there is a planned discharge during March.

Annual Health Checks

The national standard is that at least 75% of all people registered with either a Learning Disability and/or Autistic is offered a physical health check annually as a minimum.

Activity has historically been weighted towards the final two quarters of the year, as the graph opposite shows. Performance to February 2023 is 1,608 health checks completed which is equivalent to 63.2%, On target to achieve the 75% (1,789 checks) by the end of March 2023, based on previous years levels in March.

Finance - M10 position

Key Data

- £54.7m YTD deficit at M10
- £33.7m adverse to plan YTD at M10
- £46.7m adverse to plan FOT at M10 following amendment to the FOT as part of the FOT change protocol discussed with NHSE Previously reported risk now factored into the current forecast position.
- £5.2m COVID expenditure above plan at M10
- £17.3m above agency expenditure cap at M10

	M10 YTD			FULL YEAR		
Organisation	Plan Surplus/ (Deficit) £000	Actual Surplus/ (Deficit) £000	Variance to Plan £000	Plan Surplus/ (Deficit) £000	Forecast Surplus/ (Deficit) £000	Variance to Plan £000
Commissioners						
NHS Shropshire, Telford and Wrekin	(10,682)	(18,590)	(7,908)	(11,743)	(21,795)	(10,052)
System Affordability Gap	9,291	0	(9,291)	13,934	0	(13,934)
Total Commissioners	**(1,391)**	**(18,590)**	**(17,199)**	**2,191**	**(21,795)**	**(23,986)**
Providers						
The Shrewsbury and Telford Hospital NHS Trust (SaTH)	(17,253)	(38,559)	(21,306)	(19,135)	(47,506)	(28,371)
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT (RJAH)	(1,510)	1,342	2,852	(772)	2,431	3,203
Shropshire Community Healthcare NHS Trust (SCHT)	(853)	1,147	2,000	(1,330)	1,102	2,432
Total Providers	**(19,616)**	**(36,070)**	**(16,454)**	**(21,237)**	**(43,973)**	**(22,736)**
TOTAL SYSTEM Performance Financial Position Surplus/(Deficit)	**(21,007)**	**(54,660)**	**(33,653)**	**(19,046)**	**(65,768)**	**(46,722)**

The main drivers continue to be:

- Increases to agency/bank expenditure driven by open escalation areas, staff sickness, extremely high levels of NRTR (No Right to Reside) patients and insufficient discharge capacity
- Expenditure with Local Authorities on additional discharge support in excess of resources available.
- Increases to independent sector ophthalmology activity driven through patient choice and long waiting times at our main provider.
- Increases in capital charges due to the need for capital improvements to support service improvement. Relative to other systems, this is a large sum for STW ICS.
- Increased package prices in Individual Commissioning due to inflationary pressures.
- Prescribing- inflationary pressures in Cat M and NCSO pricing.
- Non delivery of the system stretch efficiency target.

Finance- M10 position

Summary

- A number of operational pressures are impacting on our system and the financial impact of these is manifesting in our expenditure run rate.
- Since September the system has indicated that it would need to amend its forecast position to show a significant deterioration from plan. In November, NHSE issued a FOT change protocol to be followed. The system has therefore been in regular dialogue with NHSE colleagues regarding the projected forecast based on run rate and known mitigations. The system has also been in discussions with national colleagues with meetings taking place in October, December and February.
- The FOT protocol guidance requires the system overall and each organisation to:
  - complete a variance analysis regarding the overspend and underlying causes,
  - complete a detailed review of uncommitted expenditure,
  - complete a recovery plan showing the steps taken to reduce expenditure including detail of difficult choices made,
  - show detail of any shortcomings identified from the HFMA financial sustainability review,
  - evidence of sign off by the board including execs and non execs of the change of forecast
- The system sought Board approval for the amendment to be formally reported in the Month 10 position. Due to the timing of the discussions with NHSE and the month end submissions, this was enacted through emergency decision making with approval from both the ICB/System Chair and CEO and engagement with both the system finance committee and system audit committee chairs. Provider organisations have all taken the FOT change through their internal governance processes.
- There are a number of key drivers of the deterioration from plan and the system is taking action wherever possible to mitigate the impact of these. It is crucial that we are able to see how and when the benefits from these actions will manifest in the financial position as this level of granularity of information is being used to inform the 23/24 financial plan

What have we done; next steps

STW its material underlying deficit and local challenges, including those associated with geography, configuration of estate and availability of substantive workforce. We are committed to delivering our plans at a time when we are also battling heavy demand in urgent care.

Medium to long term financial plan development underway for refresh in Q4, includes detailed mapping of underlying position as part of above exercise

Updates to 'triple lock' process underway to include scrutiny of substantial non recurrent investment.

Winter summit took place in December to understand drivers of increased MFFD and LOS and to explore potential actions and impact on escalation costs

Efficiency and transformation plan development (see efficiency slide)

Financial sustainability self assessments completed and have now been through an internal audit process

Detailed analysis of run rate and regular monthly enhanced reporting actioned around COVID, Agency, ERF and efficiency trajectories.

ICB Finance- M10 position

Summary

- At month 10 the ICB has an adverse YTD position against plan of £7.9m YTD. The overspend continues to be driven by four main areas of concern:
  - Independent sector NCA ophthalmology activity which has significantly increased due to patient choice and expanded capacity
  - Continued community discharge expenditure, for the rest of the year this will now be funded through the Social Care Fund. A winter summit took place across the system to understand the drivers of increased MFFD and LOS and potential actions and impact on escalation costs.
  - Increased pricing of packages in Individual Commissioning. This has been offset in year with prior year benefits but this presents an underlying pressure.
  - Prescribing - there is a national issue around NCSO and Cat M pricing and we understand that some national funding may be available to regional teams but that it is unlikely to flow to us as a system
- Primary care prior year benefits and Individual Commissioning balance sheet flexibility are helping to offset the above in year pressures.
- The reported FOT at M10 is an adverse variance to plan of £10.1m due to the continued pressure outlined in the areas above.

Key Risks and Pressures

- The reported FOT now includes the risk areas previously highlighted.
- There remains approximately £1.0m of gross risk regarding further Prescribing pressures between now and the end of the year. This has arisen due to national pressures on NCSO and Cat M pricing of drugs. It is however felt that this could be mitigated in this financial year if the costs arose so the unmitigated risk position is now nil.

What have we done and next steps

- Further review of all SDF and expenditure forecast for M11-12 by all budget holders
- Negotiated system wide contracts with Welsh provider to enable system bottom line improvement
- Winter summit took place in December across the system to better understand drivers of increased MFFD/LOS and community/discharge costs. Potential actions discussed and impact on escalation costs being quantified.

Financial Performance by Organisation

NHS Shropshire, Telford and Wrekin

At month 10 adverse position against plan of £7.9m YTD. The overspend continues to be due to independent sector NCA ophthalmology activity, a small COVID overspend and continued community discharge expenditure offset with primary care prior year benefits. Forecast adverse variance against plan of £10.1m and assumes significant mitigations to overspending areas.

Shrewsbury and Telford Hospitals NHS Trust

At Month 10 adverse position against plan of £21.3m YTD. This variance is mainly due to escalation areas remaining open due to COVID and staffing cost increases due to higher tier agency staff, offset by reduced elective activity due to COVID levels. Significant risk remains with regards to bringing the COVID spend back in line with plan. The forecast position is based on the unrecoverable YTD COVID position and escalation areas remaining open.

Robert Jones and Agnes Hunt

Month 10 position £2.8m favourable to plan. YTD £1.3m surplus. Income improvement due to recognition of Welsh block income and specialised commissioning income, offsetting adverse driven by variable clinical income and private patient activity shortfalls. Expenditure reduced by partial release of annual leave accrual and marginal cost savings, offsetting continued workforce cost pressures due to high agency usage over cap. FOT revised in light of in month changes and now £2.4m surplus, £3.2m favourable to plan.

Shropshire Community Health Trust

At Month 10 a favourable position against plan of £2m YTD. Covid vaccination activity is below plan YTD resulting in lower income and cost. Favourable variance to plan YTD is due mainly to high levels of vacancies with net leavers over 2% of clinical staff in post at 31 March 2022. Activity is impacted by vacancies, particularly in Community nursing, partly offset by increased activity in other areas. Plan is to grow workforce, including further international recruitment of nursing staff.

Risk

Risk Summary	SATH	RJAH	SCHT	ICB	System	Total System Gross risk	Potential Mitigation	Total System Net risk
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Elective Recovery - risk 75% income not realised but costs in place	0	(310)		0		(310)	310	0
Other income risks (eg spec comm contract)	0	(150)				(150)	150	0
Inflation/Energy	0	0	(300)			(300)	300	0
High cost drugs	0			(1,000)		(1,000)	1,000	0
Impact of continued COVID expenditure	0	(125)	0			(125)	125	0
Efficiency Programme	0	(158)	0	0		(158)	158	0
Workforce Recruitment		(200)	0			(200)	200	0
	0	**(943)**	**(300)**	**(1,000)**	**0**	**(2,243)**	**2,243**	**0**

The level of risk in the system remains high at £76.2m, and £45.1m after potential mitigations.

Key issues remain around:

- The level of mitigation built into the reported forecast position without any firm plans to deliver – FOT change protocol being discussed with NHSE
- Escalation areas remaining open
- Delivery of efficiency programmes
- Overall inflation levels
- Prescribing pricing issues

CEOs have nominated leads to work through a rapid financial improvement planning process aimed at significantly improving the scale of the savings plan.

The Integrated Delivery Committee is supporting and overseeing financial recovery planning.

£5.3m of key system cost pressures and investments (£13.2m FYE) that were not included in the plan remain unfunded which presents a number of operational, quality and safety risks if left unaddressed in the longer term (see over page).

Finance – Capital

Key Data

- Capital programme underspending by £10.8m YTD at M10
- The forecast remains at an underspend of £2.7m. This is because there has been an opportunity to bid for theatre improvement work through TIF2 national funding rather than funding through the BAU capital allocation.

Summary

- SATH YTD slippage relates to the estates programme and the off site renal unit at Hollinswood House.
- The forecast outturn position at RJAH has been updated following the regional capital meeting at the end of October. The driver for the forecast underspend is due to the TIF2 bid that has now been submitted to the region for approval.
- ICB capital plans relate to primary care – GP IT and primary care improvement grants
- There are a number of business cases and bids that have been submitted to the regional and national teams for additional capital funding including, the Community Diagnostic Centre at Telford and system wide digital programmes.

What have we done and next steps

- There is a detailed 2022/23 forecast outturn for the capital programme across all providers which is monitored monthly at the Capital Prioritisation and Oversight Group.
- A compliant tow year capital plan will be submitted in the planning return following a prioritisation exercise.
- Over the coming months, a detailed 24 month, 5 year and 10 year capital plan will be developed across the system.
- Capital Prioritisation and Oversight Group to oversee longer term capital plan to run alongside revenue plan

CAPITAL PROGRAMME	M10 YTD			FULL YEAR		
Organisation	Plan £000	Actual £000	Variance £000	Plan £000	Forecast £000	Variance to £000
NHS Shropshire, Telford and Wrekin	(133)	(133)	0	(1,103)	(1,103)	0
The Shrewsbury and Telford Hospital NHS Trust (SaTH)	(15,846)	(7,852)	7,994	(19,822)	(19,822)	0
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT (RJAH)	(6,955)	(4,205)	2,750	(11,659)	(14,403)	(2,744)
Shropshire Community Healthcare NHS Trust (SCHT)	(1,173)	(1,196)	(23)	(2,500)	(2,500)	0
TOTAL SYSTEM	(24,107)	(13,386)	10,721	(35,084)	(37,828)	(2,744)

ICS Workforce Dashboard – M11 Summary

Shropshire, Telford & Wrekin
Integrated Care System

Summary - Feb 23

22,715

WTE

5.9%

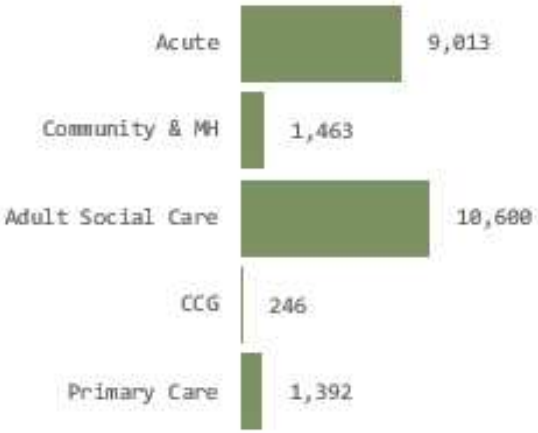
Vacancy

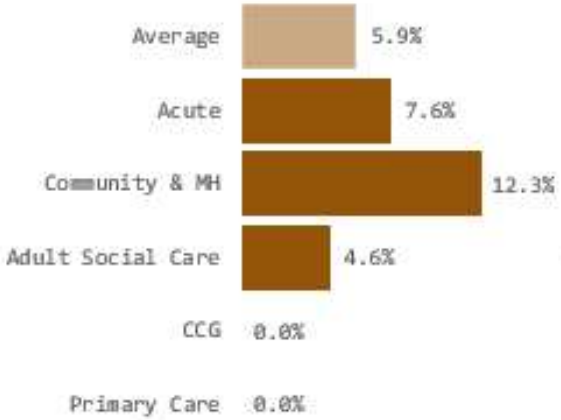
22.0%

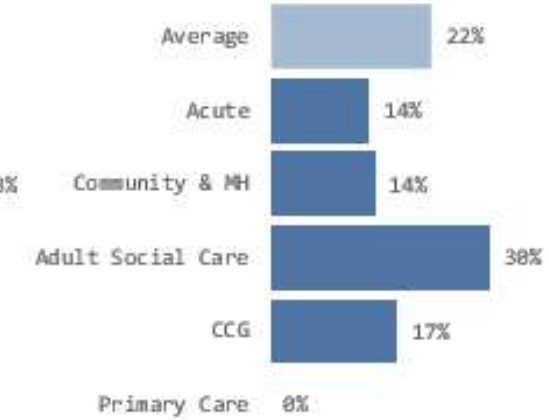
Turnover

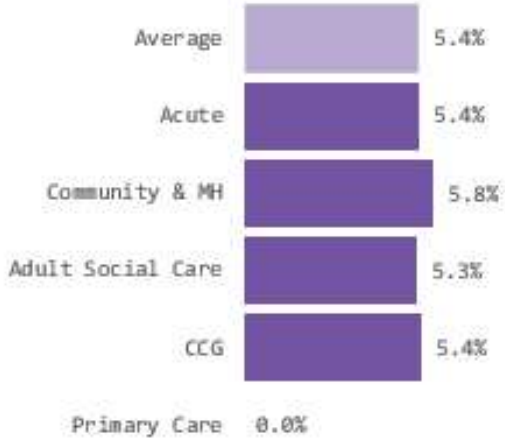
5.4%

Sickness









81%

AfC Appraisals

87%

Medical Appr.

91%

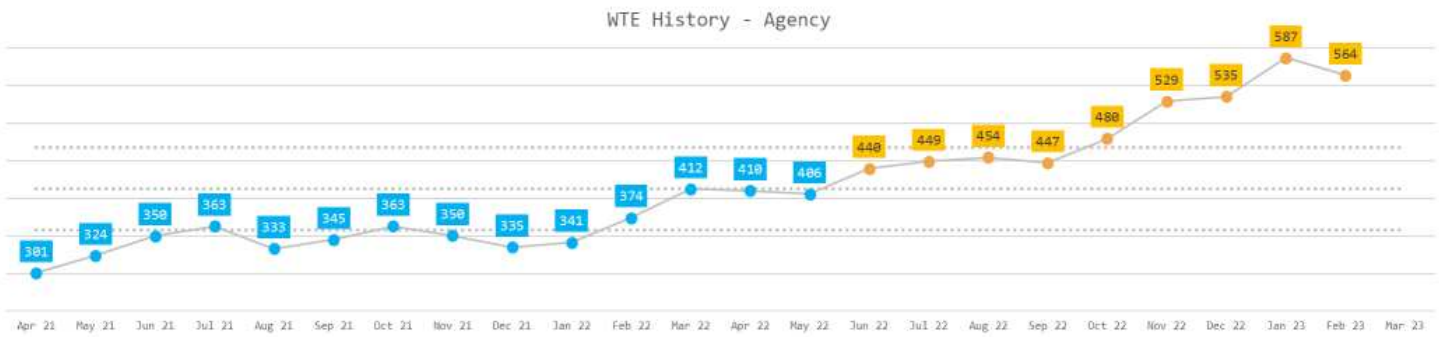
Mand. Training

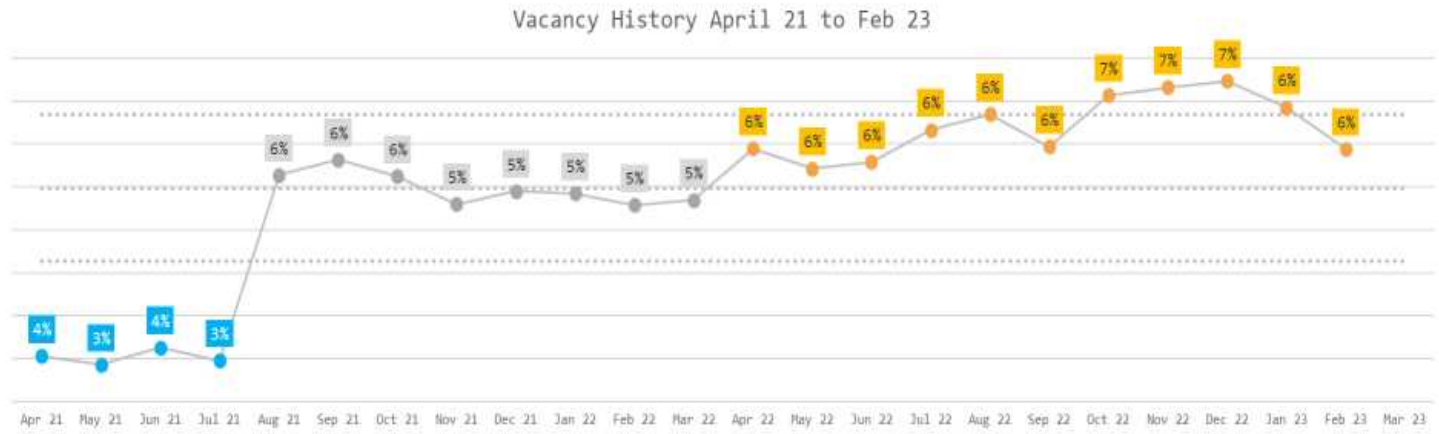
Data Sources:
NHS Trust Monthly Provider Workforce Returns
Skills for Care Sept 2019 and March 2020
Primary Care NHS Digital

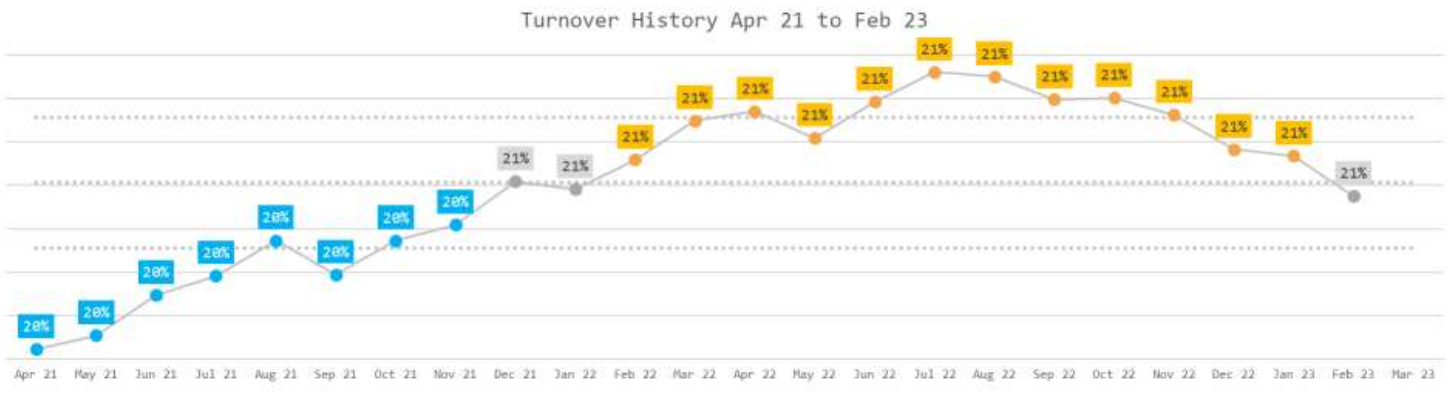
ICS Workforce Dashboard - M11 – February 2023 (NHS Only)

Measure	Dimension	Data Source	Data Period	System	SaTH	RJAH	SCHT
Sickness Absence	Monthly Sickness Absence Rate	PWC	February 2023	5.4%	5.6%	4.2%	5.8%
Substantive (WTE)	Total	PWC	February 2023	9,206	6,468	1,417	1,321
	Registered Nursing & Midwifery	PWC	February 2023	2,558	1,820	271	467
	HCSW	PWC	February 2023	1,239	903	182	154
	Infrastructure	PWC	February 2023	1,893	1,020	544	328
	Allied Health Professionals	PWC	February 2023	674	371	157	146
	Pharmacy	PWC	February 2023	135	97	17	21
	Other STT	PWC	February 2023	286	228	24	34
	GP, Medical and Dental	PWC	February 2023	901	738	140	23
Vacancies (WTE)	Total	PWC	February 2023	837	504	149	185
	Registered Nursing & Midwifery	PWC	February 2023	238	126	51	60
	HCSW	PWC	February 2023	175	146	15	14
	Infrastructure	PWC	February 2023	102	24	32	45
	Allied Health Professionals	PWC	February 2023	83	44	18	21
	GP, Medical and Dental	PWC	February 2023	109	86	18	5
Vacancy Rate %	Total	PWC	February 2023	8.3%	7.2%	9.5%	12.3%
	Registered Nursing & Midwifery	PWC	February 2023	8.5%	6.5%	16.0%	11.4%
	HCSW	PWC	February 2023	12.4%	13.9%	7.7%	8.1%
	Infrastructure	PWC	February 2023	5.1%	2.3%	5.6%	12.1%
	Allied Health Professionals	PWC	February 2023	11.0%	10.5%	10.4%	12.7%
	GP, Medical and Dental	PWC	February 2023	10.8%	10.4%	11.5%	17.1%
Temporary Staffing	Bank WTE	PWC	February 2023	707	574	63	70
	Agency WTE	PWC	February 2023	564	457	34	73
	Bank WTE %	PWC	February 2023	6.7%	7.7%	4.2%	4.8%
	Agency WTE %	PWC	February 2023	5.4%	6.1%	2.2%	5.0%
Turnover	In-month leavers rate	PWC	February 2023	13.7%	13.9%	12.7%	14.3%
	Leavers - All	PWC	February 2023	1,266	897	180	189

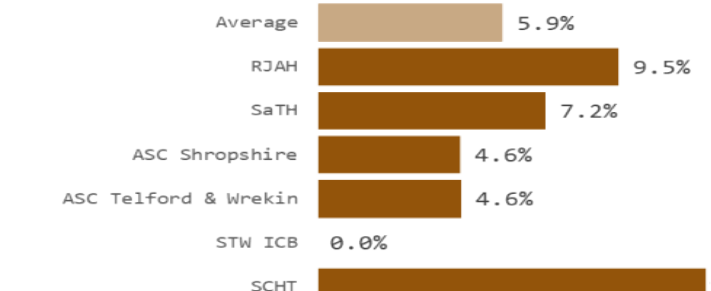
ICS Workforce (NHS) Dashboard – M11 February 2023

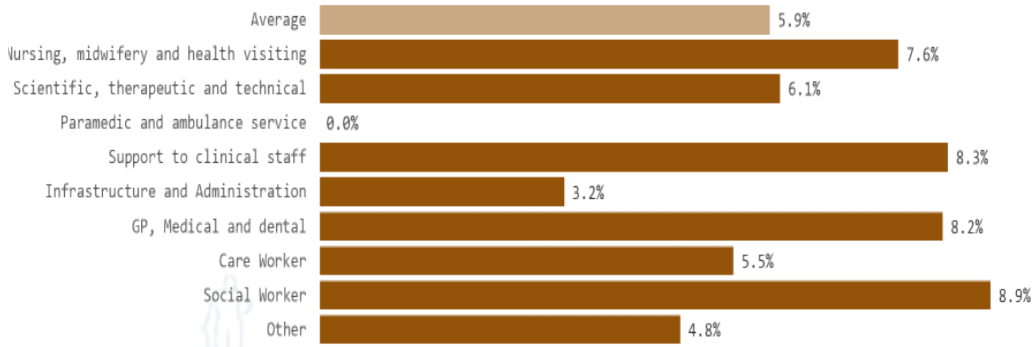


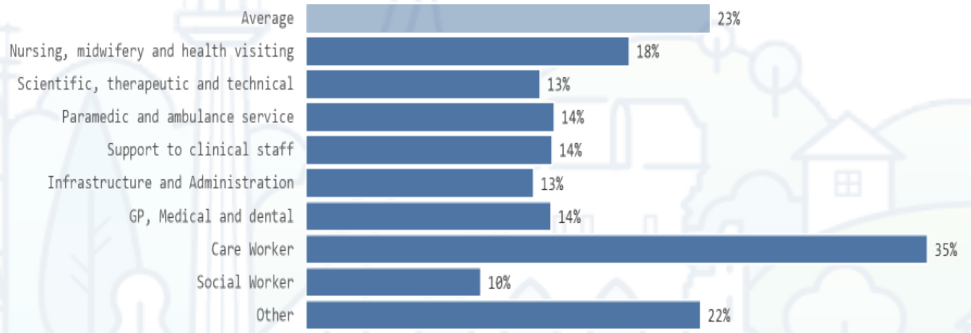




Vacancy Rates







Agenda item ICB 29-03-074

System Risk Appetite and Board Assurance Framework (BAF)

Integrated Care Board

Agenda item no.	ICB 29-03-074
Meeting date:	29th March 2023
Paper title	System Risk Appetite and Board Assurance Framework (BAF) - APPENDICES

Appendix 1

Risk appetite by risk domain	
Population health and wellbeing and inequalities	We have a MEDIUM appetite for risks that impact the health and wellbeing of our population. To address inequalities and improve outcomes for specific priority populations we are prepared to take decisions that risk an adverse or differential impact on other population segments. We will target our resources to ensure equity of outcome even when this means investing differentially or disinvesting in existing services. We believe that sustainably addressing a wide range of inequalities requires us to concentrate on addressing the broader determinants of health and investing in primary prevention. This requires a long-term approach that may result in adverse impacts in the short to medium term as we target resources accordingly. We will look for opportunities to pool resources to address the broader determinants of health. We prefer options where we know we can establish robust methods for monitoring and measuring impact on outcomes.
Engagement and Partnership working	We have a HIGH appetite for risks that impact our relationships and engagement with partners and stakeholders. We will promote potentially controversial ideas and innovations and make difficult decisions if we believe these could result in benefits, even if this risks considerable scrutiny and media attention. We will seek to manage any risks through proactive communication and engagement and involving all our stakeholders in our decisions.
Quality of services	We have a MEDIUM appetite for risks that impact the quality of our services and will accept some well controlled quality risks if there is the potential for delivering increased benefit for example by targeting inequalities in quality outcomes, accelerating quality improvement or exceeding quality standards. We believe that quality can be improved by addressing inequities in access to care and early interventions and will prioritise those approaches that ensure we are able to address people's needs early. We will seek to minimise quality risk by putting in place robust quality monitoring and building an evidence base for quality improvement. For example, we may make a decision that could have some impact on some service users' experience if we believe it will result in significant improvements in safety health or outcomes. In these circumstances we will actively manage risk and prioritise meeting patient safety and regulatory standards.
Workforce	We have a MEDIUM appetite for risks that impact the sustainability of our workforce. In some circumstances we are prepared to adopt innovative ways of working particularly where this may increase efficiency, productivity and value for money. For example, we may change existing employment practices to support multi-disciplinary and cross organisation working. We will seek to minimise risks by creating sustainable ways of recruiting, training and retaining staff across organisations and sectors and aligning our workforce to services that better meet population needs and address inequalities.
Finance	We have a MEDIUM appetite for financial risk. We would seek to minimise these risks by operating robust financial controls, harnessing the benefits of joint working and looking at improving utilisation of assets and resources across the system. We are prepared to accept some financial risk when this is associated with actions that could improve productivity and value for money and/or capitalise on opportunities to accelerate or increase benefits. We are willing to invest differentially to target initiatives and reduce inequalities and we understand that implementation of innovations needs to be adequately resourced. We also understand that adequate time needs to be allowed before assessing the implementation as there may be a lag between the implementation and the desired results. We are willing to address difficult conversations about finances openly and directly, engaging with implications and risks connected to finances in an integrated way. We are looking for joined up system financial management, which takes account of the differing financial requirements and constraints of system partners.
Regulation, Governance and Probity	We have a MEDIUM appetite for risks that impact on regulation, governance and probity. We will always seek to reduce the risk by acting in an open and transparent way and with integrity.

	We recognise that delivering our objectives may occasionally require us to challenge orthodoxies around regulatory requirements in the interests of "doing the right thing." We expect to have very clear and proactive communication with regulators to secure their support. • We will ensure we put in place the culture, systems and processes that enable us to take an innovative approach whilst meeting regulatory and governance standards and delivering our statutory duties.

APPENDIX 2
Strategic system risks, mapped against:

- ICS aims (x4)
- STW ICS pledges (x10)

1. System strategic risks by ICS aim

Key:
Aim 1 = Improving outcomes
Aim 2 = Reducing inequalities
Aim 3 = Increasing productivity and value for money
Aim 4 = Contributing socio-economic benefit to the community

Ref	Enabler	Strategic Risk	Aim 1	Aim 2	Aim 3	Aim 4
1	Focus	Lack of focus on targeted initiative in the light of competing priorities	✓	✓	✓	✓
2	Collaboration	Unable to develop and sustain a culture of collaboration and partnership working	✓	✓	✓	✓
3	Resources	Inefficient and ineffective use of budgets and resources, including workforce, estate, etc	✓	✓	✓	✓
4	Capacity	Lack of capacity to meet increased winter demands	✓	✓	✓	
5	Workforce	Inability to develop, recruit, train and retain an integrated health, care and wellbeing workforce	✓	✓	✓	
6	Digital	Unable to develop and use digital and data systems	✓	✓	✓	
7	Socio-economic environment	Challenging political and economic environment, rising cost of living and slow economic growth	✓	✓		
8		Ineffective contribution to social/ economic development and the green agenda	✓	✓	✓	✓
9	Policy	Uncertainty regarding adult social care reform and funding	✓	✓	✓	

2. System strategic risks by STW ICS pledges

Key:
1 = Improving safety and quality
2 = Integrating services at place and neighbourhood level
3 = Tackling the problems of ill health, health inequalities and access to health care
4 = Delivering improvements in Mental Health and Learning Disability/Autism provision
5 = Economic regeneration
6 = Climate change
7 = Leadership and governance
8 = Enhanced engagement and accountability
9 = Creating system sustainability
10 = Workforce

Ref	System strategic risk	1	2	3	4	5	6	7	8	9	10
1	Lack of focus on targeted initiative in the light of competing priorities	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
2	Unable to develop and sustain a culture of collaboration and partnership working	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
3	Inefficient and ineffective use of budgets and resources, including workforce, estate, etc	✓	✓	✓	✓	✓	✓			✓	✓
4	Lack of capacity to meet increased winter demands	✓		✓	✓					✓	✓
5	Inability to develop, recruit, train and retain an integrated health, care and wellbeing workforce	✓	✓	✓	✓	✓				✓	✓
6	Unable to develop and use digital and data systems	✓	✓	✓	✓			✓	✓	✓	✓
7	Challenging political and economic environment, rising cost of living and slow economic growth	✓		✓	✓	✓	✓			✓	✓
8	Ineffective contribution to social/ economic development and the green agenda	✓		✓	✓	✓	✓			✓	✓
9	Uncertainty regarding adult social care reform and funding	✓	✓	✓	✓			✓	✓	✓	✓

APPENDIX 3

Detailed System Board Assurance Framework Descriptions – DRAFT

Strategic Aim: ALL		Risk score 16 4x4
Strategic Risk No.1: Unable to develop and sustain a culture of collaboration and partnership working and secure system focus on targeting initiatives		
If we are unable to develop and sustain a culture of collaborative working and build effective partnerships	*Then* we will not be able to achieve our aims, focus on our priorities or deliver our objectives.	*Resulting in* poor outcomes for our population, adverse impacts on our partner organisations and increased scrutiny of our effectiveness

	Impact	Likelihood	Score	Risk Trend
Current				
Target				

Risk Lead	ICB Chief Executive Officer	Assurance committee	ICB Board

System Controls	Assurances reported to ICB Board and committees
Strategies and Plans • ICB Constitution • ICP Terms of Reference • Governance Handbook / Functions and Decisions Map • System Development Plan • Better Care Fund Plans • Primary Care Strategy • Clinical and Professional Leadership Programme • Integrated Care Strategy Partnerships and Services • Integrated Care Partnership • ICS Chief Executive Group • ShIPP • TWIP Governance & Engagement Structures • Integrated Care Partnership; Board of the Integrated Care Board and Integrated Delivert Committee	First Line of Assurance • Monitoring and oversight at ICB Executive Group and ICS Chief Executive Group Second Line of Assurance • Population Health Board Third Line of Assurance • Integrated Care Partnership oversight • National Health Service England Integrated Care Board Establishment Assessment and Establishment Order
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
• Joint 5 year forward plan • Independent assessment (NHSE, CQC)	• Develop 5 year forward plan by March 2023 • Complete self-assessment against NHSE/CQC regulatory framework

Current Performance – Highlights
• xxx

Associated Risks on the ICB Corporate Risk Register		
Risk no.	Description	Current score
x	X	X

Relevant risks on system partners risk registers
Description
xxx

Strategic Aim: ALL		Risk score 25 5x5
Strategic Risk No.2: Inefficient and ineffective use of budgets and resources, including workforce, estate, etc		
If we are unable to adopt integrated planning practices as rapidly as we need to	*Then* we will be unable to use our budgets and wider resources more effectively and efficiently and share risks and benefits	*Resulting in* challenges in service delivery for our population, poor health outcomes, and increased scrutiny of our effectiveness

	Impact	Likelihood	Score	Risk Trend
Current				
Target				

Risk Lead	ICB Chief Finance Officer	Assurance committee	ICB Finance Committee

System Controls	Assurances reported to ICB Board and committees

Strategies and Plans
• System Financial Strategy, incorporating:
  ○ Healthcare Financial Management Association (HFMA) Financial sustainability checklist
  ○ Triple Aim framework
  ○ Value based decision making approach
• Financial Revenue Plan
• Financial Capital Plan
• Efficiency and Transformation Plans
• General Practice Estate Programme
 	
Partnerships and Services
• ShIPP
• TWIPP
• Digital Board
• Estates Board
• People Board
• Planned Care Board
• UEC Delivery Board
 	
Governance & Engagement Structures
• Finance Committee
• Investment Panel
• Integrated Delivery Committee
• Audit Committee
	First Line
	• Monitoring delivery of System Financial Strategy and Financial Plan by CFO group
	• Standing Orders, Standing Financial Instructions and Delegated Financial Limits
	• Financial Accounting Performance Metrics
	• HFMA Financial Sustainability Checklist
	• Better Payment Practice Code
	• Productivity review informed by:
	  ○ Getting It Right First Time (GIRFT)
	  ○ Model Health System
	  ○ ICS Patient Level Information and Costing Systems (PLICS) dashboard
	  ○ Health Expenditure benchmarking tool (HEB)
	
	Second Line
	• Finance Report to Finance Committee
	• Integrated Performance and Finance Report to the Board
	
	Third Line
	• Monthly Integrated (Care System) Finance Return and Provider Finance Returns reporting to NHSE
	• Quarterly NHSE Financial Stocktake
	• NHSE Annual planning process (and triangulation of Finance, Activity and workforce planning)

Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
• Joint 5 year forward plan • Joint financial plan across ICS partners • Independent assessment (NHSE, CQC)	• Develop 5 year forward plan by March 2023 • Develop financial sustainability plan by March 2023 • Complete self-assessment against NHSE/CQC regulatory framework

Current Performance – Highlights
• xxx

Associated Risks on the ICB Corporate Risk Register		
Risk no.	Description	Current score
x	X	X

Relevant risks on system partners risk registers
Description

Strategic Aim: ALL		Risk score 25 5x5
Strategic Risk No.3: Lack of capacity to tackle health inequalities and to meet the health and wellbeing needs of the growing and ageing population, including meeting quality, safety and experience objectives		
If we are unable to find sufficient staffing or other resources	*Then* we will not be able to meet increased demands on our services	*Resulting in* poorer outcomes for our population, adverse impacts on our partner organisations and increased scrutiny of our effectiveness

	Impact	Likelihood	Score	Risk Trend
Current				
Target				

Risk Lead	ICB Chief Nursing Officer	Assurance committee	Quality and Performance Committee

System Controls	Assurances reported to ICB Board and committees
Strategies and Plans • System Development Plan • Primary Care Winter Plan • Integrated Care Strategy Partnerships and Services • CEO Group • Urgent and Emergency Care Board • Finance Advisory Board • ShIPP • TWIPP • Mental Health Delivery Board • Emergency Preparedness Resilience and Response Framework • System People Board • Local Maternity and Neonatal System • Primary Care Networks • System Quality Group Governance & Engagement Structures • Integrated Care System CEO Group • ICB Board • ICB Finance Committee • ICB Quality and Performance Committee • ICB Integrated Delivery Committee • ICB System People Committee • ICB Strategy Committee	First Line of Assurance • Routine Quality Monitoring and Triangulation by Quality Team • General Practice Appointment Data Monitoring • Performance Dashboard • Monthly Key Lines of Enquiry for areas of underperformance / concern • Monthly Oversight System Review Meetings • Monitoring and oversight by command structure Second Line of Assurance • Cancer and Planned Care Report to ICB Quality Safety and Performance Committee • Urgent and Emergency Care Report to ICB Quality and Performance Committee • Integrated Performance Report to ICB Quality and Performance Committee • Learning Disability and Autism Assurance Report to ICB Quality and Performance Committee • Performance Report to ICB Quality and Performance Committee • Annual Operating Plans to Finance Committee • Local Maternity and Neonatal System Report to ICB Quality and Performance Committee • Primary Care Quality reporting to Primary Care Commissioning Committee • Integrated Provider Report to ICB Quality and Performance Committee Third Line of Assurance • National System Oversight Framework • NHSE Quarterly System Review Meetings
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
• Joint 5 year forward plan • Independent assessment (NHSE, CQC)	• Develop 5 year forward plan by March 2023 • Develop Integrated Care Strategy by June 2023 • Complete self-assessment against NHSE/CQC regulatory framework

Current Performance – Highlights
• xxx

Associated Risks on the ICB Corporate Risk Register		
Risk no.	Description	Current score
x	X	X

Relevant risks on system partners risk registers
Description
xxx

Strategic Aim: ALL			Risk score 25 5x5
Strategic Risk No.4: Inability to develop, recruit, train and retain an integrated health, care and wellbeing workforce			
If we are unable to recruit, retain and develop our workforce across the entirety of the integrated care pathway	*Then* we will not be able to provide properly integrated health, care and wellbeing services across our system	*Resulting in* poorer outcomes for our population, adverse impacts on our partner organisations and increased scrutiny of our effectiveness	

	Impact	Likelihood	Score	Risk Trend
Current				
Target				

Risk Lead	ICB Chief People Officer	Assurance committee	System People Committee

System Controls	Assurances reported to ICB Board and committees
Strategies and Plans • One People Plan Recommendations and Insights Report Partnerships and Services • People Board • Chief People Officer Group Governance & Engagement Structures • People Committee	First Line of Assurance • Workforce dashboard Second Line of Assurance • People Plan Progress Report to the People Committee of the Integrated Care Board
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
• Joint 5 year forward plan • ICP People Plan • Independent assessment (NHSE, CQC)	• Develop 5 year forward plan by March 2023 • Develop ICP People Plan by March 2023 • Complete self-assessment against NHSE/CQC regulatory framework

Current Performance – Highlights
• xxx

Associated Risks on the ICB Corporate Risk Register		
Risk no.	Description	Current score
x	X	X

Relevant risks on system partners risk registers
Description
xxx

Strategic Aim: ALL			Risk score 15 5x3
Strategic Risk No.5: Lack of capacity and strategy to develop and use digital and data systems to enable efficient and effective care across the ICS			
If we are unable to develop and use our digital and data systems	*Then* we will not be able to make informed decisions, develop integrated services that are digitally enabled and monitor their effectiveness against our aims	*Resulting in* challenges in service provision, staff dissatisfaction, and poorer health and care outcomes for our local population	

	Impact	Likelihood	Score	Risk Trend
Current				
Target				

Risk Lead	ICB Chief Medical Officer	Assurance committee	ICB Strategy Committee

System Controls	Assurances reported to ICB Board and committees
Strategies and Plans • Integrated Care Strategy • Population Health Roadmap • Joint Strategic Needs Assessments Partnerships and Services • Population Health Management Board • Digital Transformation Board • TWIPP • ShIPP Governance & Engagement Structures • Integrated Delivery Committee • Strategy Committee	First Line of Assurance • Routine progress reports from key workstreams • Regular Population Health Management Workstream Update to the Population Health Board • Regular Inequalities Workstream Update to the Population Board Second Line of Assurance • Population Health Report to Integrated Delivery Committee
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
• Joint 5 year forward plan • Joint information and data strategy across ICP • Independent assessment (NHSE, CQC)	• Develop 5 year forward plan by June 2023 • Develop information and data strategy across ICP • Complete self-assessment against NHSE/CQC regulatory framework

Current Performance – Highlights
• xxx

Associated Risks on the ICB Corporate Risk Register		
Risk no.	Description	Current score
x	X	X

Relevant risks on system partners risk registers
Description
xxx

Strategic Aim: ALL		Risk score 25 5x5
Strategic Risk No.6: Inability to respond strategically to an increasingly challenging political and economic environment, the rising cost of living and slowing economic growth		
If we are unable to respond collectively to the economic challenges facing our local area	*Then* we will not be able to make a difference to living standards locally or wider economic growth	*Resulting in* poorer outcomes for our population, including increased use of food banks and inequity in access and outcomes with further pressure on health and care services, particularly in relation to mental health

	Impact	Likelihood	Score	Risk Trend
Current				
Target				

Risk Lead	LA Chief Executive Officers	Assurance committee	ICB Board

System Controls	Assurances reported to ICB Board and committees
Strategies and Plans • Integrated Care Strategy • Population Health Roadmap • Health and Wellbeing Strategies • Local Authority Strategies Partnerships and Services • Integrated Care Partnership • Population Health Board • ShIPP • TWIPP • Primary Care Networks Governance & Engagement Structures • Integrated Care Partnership • Health and Wellbeing Boards	First Line of Assurance • Ongoing involvement with Healthwatch as well as the Voluntary Community and Social Enterprise • Joint Strategic Needs Assessments Second Line of Assurance • Population Health Board Report to ICB Integrated Delivery Committee
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
• Joint 5 year forward plan • Independent assessment (NHSE, CQC)	• Develop 5 year forward plan by June 2023 • Complete self-assessment against NHSE/CQC regulatory framework

Current Performance – Highlights
• xxx

Associated Risks on the ICB Corporate Risk Register		
Risk no.	Description	Current score
x	X	X

Relevant risks on system partners risk registers
Description
xxx

Strategic Aim: ALL			Risk score 12 4x3
Strategic Risk No.7: Inability to contribute effectively as a system to social and economic development and the green agenda			
If we are unable to respond collectively to the social and economic challenges facing our local area, and particularly the green agenda	*Then* we will not be able to make a difference to wider economic growth across our system or reducing negative environmental impacts of service provision	*Resulting in* poorer longer-term outcomes for our local population both in relation to health and wellbeing and the environment in which they live	

	Impact	Likelihood	Score	Risk Trend
Current				
Target				

Risk Lead	ICB Chief Executive Officer	Assurance committee	ICB Board

System Controls	Assurances reported to ICB Board and committees
Strategies and Plans • Integrated Care Strategy • ICP and ICB development programme • ICS Green Plan and individual Trust Green Plans Partnerships and Services • TWIPP • ShIPP • Provider Collaboratives • ICS Chief Executives Group • Networks Governance & Engagement Structures • Integrated Care Partnership and Integrated Care Board and associated committees • ICB – agreed values and behaviours	First Line of Assurance • Sustainability reports • Joint Strategic Needs Assessments • Workforce mapping Second Line of Assurance • Population Health Board report to ICB Integrated Delivery Committee
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
• Joint 5 year forward plan • Independent assessment (NHSE, CQC)	• Develop 5 year forward plan by June 2023 • Complete self-assessment against NHSE/CQC regulatory framework

Current Performance – Highlights
• xxx

Associated Risks on the ICB Corporate Risk Register		
Risk no.	Description	Current score
x	X	X

Relevant risks on system partners risk registers
Description
xxx

Strategic Aim: ALL			Risk score 16 4x4
Strategic Risk No.8: Inability to respond to the uncertainty regarding adult social care reform and funding levels			
If we are unable to develop a robust local plan to respond to the uncertainties regarding adult social care reform and funding levels	*Then* we will not be able to attract and retain social care workforce nor ensure sustainable provision of adult social care services across our local area	*Resulting in* poorer health and care outcomes for our population, and increased pressure on hospital and mental health services locally	

	Impact	Likelihood	Score	Risk Trend
Current				
Target				

Risk Lead	Lead Local Authority Director of Adult Social Care	Assurance committee	ICB Integrated Delivery Committee

System Controls	Assurances reported to ICB Board and committees
Strategies and Plans • Integrated Care Strategy Partnerships and Services • Care Collaboratives • Provider Collaboratives • ICS Chief Executive group • Networks Governance & Engagement Structures • Integrated Care Partnership and Integrated Care Board and associated committees • ICB – agreed values and behaviours	• NHSE Establishment assessment • Establishment Order • ICB Constitution • ICB governance handbook • Functions and decisions map
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
• Joint 5 year forward plan • Independent assessment (NHSE, CQC)	• Develop 5 year forward plan by June 2023 • Complete self-assessment against NHSE/CQC regulatory framework

Current Performance – Highlights
• xxx

Associated Risks on the ICB Corporate Risk Register		
Risk no.	Description	Current score
x	X	X

Relevant risks on system partners risk registers
Description
xxx

Agenda item ICB 29-03-075

Delegation of Pharmacy, Optometry and Primary and Secondary Care Dental services (PODs) commissioning functions from NHSE to ICBs and the associated governance arrangements, required from April 2023.

Dated 2023

(1) **NHS ENGLAND**

- and -

(2) **NHS BIRMINGHAM AND SOLIHULL INTEGRATED CARE BOARD**

- and -

(3) **NHS BLACK COUNTRY INTEGRATED CARE BOARD**

- and -

(4) **NHS HEREFORDSHIRE & WORCESTERSHIRE INTEGRATED CARE BOARD**

- and -

(5) **NHS COVENTRY & WARWICKSHIRE INTEGRATED CARE BOARD**

- and -

(6) **NHS SHROPSHIRE, TELFORD & WREKIN INTEGRATED CARE BOARD**

- and -

(7) **NHS STAFFORDSHIRE & STOKE-ON-TRENT INTEGRATED CARE BOARD**

Agreement in relation to the establishment and operation of joint working arrangements

Table of contents

Clause heading and number — Page number

THIS AGREEMENT is made on the_____ day of _____2023

BETWEEN[1]**:**

(1) **NHS England** of Quarry House, Quarry Hill, Leeds LS2 7UE (acting under the name NHS England) ("**NHS England"**); and

(2) **NHS Birmingham & Solihull Integrated Care Board** of First Floor, Wesleyan, Colmore Circus, Birmingham, B4 6AR ("**Birmingham & Solihull ICB"**); and

(3) **NHS Black Country Integrated Care Board** of Civic Centre, St Peters Square, Wolverhampton WV1 1SD ("**Black Country ICB"**); and

(4) **NHS Herefordshire & Worcestershire Integrated Care Board** of Kirkham House, John Comyn Drive, Perdiswell, Worcester, WR3 7NS ("**Herefordshire & Worcestershire ICB"**); and

(5) **NHS Coventry & Warwickshire Integrated Care Board** of Westgate House, Market St, Warwick CV34 4DE NN3 6BF ("**Coventry & Warwickshire ICB"**); and

(6) **NHS Shropshire, Telford & Wrekin Integrated Care Board** of Halesfield 6, Halesfield, Telford, TF7 4BF ("**Shropshire, Telford & Wrekin ICB"**); and

(7) **NHS Staffordshire & Stoke-on-Trent Integrated Care Board** of Winton House, Stoke Road, Stoke-on-Trent ST4 2RW ("**Staffordshire & Stoke-on-Trent ICB"**).

each a "Partner" and together the “Partners”.

Birmingham & Solihull ICB, **Black Country ICB, Herefordshire & Worcestershire ICB, Coventry & Warwickshire ICB, Shropshire, Telford & Wrekin ICB** and **Staffordshire & Stoke-on-Trent ICB** are together referred to in this Agreement as the **“ICBs”,** and **“ICB”** shall mean any of them.

BACKGROUND

(A) NHS England has statutory functions to make arrangements for the provision of prescribed services for the purposes of the NHS.

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

(C) Pursuant to section 65Z5 of the NHS Act, NHS England and the ICBs are able to establish and maintain joint arrangements in respect of the discharge of their commissioning functions.

(D) NHS England and the ICBs agree to jointly exercise the Joint Functions through the decisions of the Joint Committee under section 65Z5 of the NHS Act and as set out in this Agreement and the Terms of Reference.

(E) NHS England and the ICBs acknowledge and agree that making arrangements to involve the ICBs in the exercise of NHS England’s Commissioning Functions is likely to lead to an improvement in the way the Commissioning Functions of all Partners are exercised.

(F) This Agreement sets out the arrangements that will apply between NHS England and the ICBs in relation to the joint commissioning of Specialised Services for the ICBs’ Populations. These arrangements are intended to give the ICBs greater involvement in the commissioning of Specialised Services to better align and transform pathways of care around the needs of local populations.

[1] Complete Partners' names as appropriate.

(G) NHS England and the ICBs have entered into this Agreement to define their arrangements for joint working. To avoid doubt, none of the Partners are delegating the exercise of any of their Commissioning Functions or any other functions to any other Partner under this Agreement.

(H) This Agreement is intended for use in the 2023/24 financial year, to govern what are envisaged to be transitional joint working arrangements prior to the delegation of specialised commissioning functions from NHS England to ICBs, effective from 2024.

NOW IT IS HEREBY AGREED as follows:

1. **COMMENCEMENT AND DURATION**

1.1 This Agreement has effect from the date of this Agreement and will remain in force for the Initial Term unless terminated in accordance with Clause 20 (Leaving the Joint Committee) below.

1.2 The Partners may extend this Agreement beyond the Initial Term for a further period, by written agreement prior to the expiry of the Initial Term.

2. **PRINCIPLES AND AIMS**

2.1 The Partners acknowledge that, in exercising their obligations under this Agreement, each Partner must comply with the statutory duties set out in the NHS Act and must:

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

2.1.2 consider how, in performing its obligations, it can address health inequalities;

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

2.1.4 act at all times in good faith towards each other.

2.2 The Partners agree:

2.2.1 that successfully implementing this Agreement will require strong relationships and an environment based on trust and collaboration;

2.2.2 to seek to continually improve whole pathways of care including Specialised Services and to design and implement effective and efficient integration;

2.2.3 to act in a timely manner;

2.2.4 to share information and best practice, and work collaboratively to identify solutions, eliminate duplication of effort, mitigate risks and reduce cost;

2.2.5 to act at all times in accordance with the scope of their statutory powers; and

2.2.6 to have regard to each other's needs and views, irrespective of the relative contributions of the Partners to the commissioning of any Specialised Services and, as far as is reasonably practicable, take such needs and views into account.

2.3 The Partners' primary aim is to maximise the benefits to patients of integrating the Joint Functions with the ICBs' Commissioning Functions through designing and commissioning the Joint Specialised Services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim.

3. SCOPE OF JOINT WORKING ARRANGEMENTS

3.1 This Agreement sets out the arrangements through which the Partners will work together to exercise the Joint Functions as set out in Schedule 4, including:

3.1.1 the establishment of a Joint Committee;

3.1.2 the participation by all Partners in the work of the Joint Committee;

3.1.3 the development of leadership and expertise in respect of the Joint Specialised Services;

collectively referred to as the "Joint Working Arrangements".

4. JOINT COMMITTEE

4.1 NHS England shall together with the ICBs establish a Joint Committee which will operate in accordance with the Terms of Reference set out in Schedule 2 (Joint Committee – Terms of Reference). The Joint Committee (and each member of the Joint Committee) will act at all times in accordance with the Terms of Reference.

4.2 The Partners shall nominate Authorised Officers to the Joint Committee in accordance with Schedule 2.

4.3 Subject to Clauses 4.4 and 8.1 and the terms of the Schedules, NHS England shall exercise the Joint Functions collaboratively with the ICBs in accordance with this Agreement and must reach decisions in relation to the Joint Functions through discussion and agreement. Where in exceptional cases consensus cannot be reached between the members of the Joint Committee in respect of matters under consideration, the voting arrangements set out in the Terms of Reference will apply.

4.4 NHS England may at any time exercise the Joint Functions outside of the Joint Working Arrangements where, in its view, that is necessary for reasons of urgency, and in such circumstances it shall inform the Partners of such action at the earliest reasonable opportunity.

4.5 The Partners may establish sub-groups or sub-committees of the Joint Committee with such terms of reference as may be agreed between them from time to time. Any such sub-groups or sub-committees that are in place at the commencement of this Agreement may be documented in the Local Terms (Schedule 9).

4.6 The ICBs shall ensure that their Authorised Officers have appropriate delegated authority, in accordance with each ICB's internal governance arrangements, to represent the interests of each ICB in the Joint Committee and any other sub-groups or sub-committees established by the Joint Committee.

4.7 The Partners recognise the need to ensure that any potential conflicts of interest on the part of any Partner, including its representatives, in respect of this Agreement and the establishment or operation of the Joint Committee and any sub-group or sub-committee of the Joint Committee must be appropriately identified, recorded and managed.

5. JOINT FUNCTIONS

5.1 This Agreement shall include such Joint Functions as identified in Schedule 4 in respect of the Joint Specialised Services.

5.2 The Joint Committee must establish effective, safe, efficient and economic arrangements for the discharge of the Joint Functions.

5.3 The Joint Committee must exercise the Joint Functions in accordance with:

5.3.1 the terms of this Agreement;

5.3.2 all applicable Law;

5.3.3 Guidance;

5.3.4 the Terms of Reference; and

5.3.5 Good Practice.

5.4 In exercising the Joint Functions, the Joint Committee must comply with the Mandated Guidance set out in Schedule 8, or otherwise referred to in this Agreement, and such further Mandated Guidance as may be issued by NHS England from time to time, including on the NHS England or FutureNHS websites.

5.5 The Joint Committee must perform the Joint Functions:

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

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

6. THE RESERVED FUNCTIONS

6.1 NHS England will exercise the Reserved Functions, including but not limited to those set out in Schedules 5 (Retained Services) and 6 (Reserved Functions).

6.2 The Reserved Functions include all of NHS England's Specialised Commissioning Functions other than the Joint Functions.

6.3 The Partners acknowledge that NHS England may ask the ICBs to provide certain administrative and management services to NHS England in relation to Reserved Functions.

7. FURTHER COLLABORATIVE WORKING

7.1 An ICB may, at its discretion, table for discussion at any Joint Committee meeting an item relating to any ICB Function, where such ICB Function relates to Specialised Commissioning Functions, in order to facilitate engagement and promote integration and collaborative working. Decision-making in respect of such discussions will remain with the relevant ICB. For the avoidance of doubt, the Joint Committee will not have any authority to take decisions in respect of ICB Functions.

7.2 NHS England may, at its discretion, table for discussion at any Joint Committee meeting an item relating to a Reserved Function (including but not limited to the Part A Retained Services) or any such other of NHS England's Functions that it considers appropriate in order to facilitate engagement and promote integration and collaborative working. For the avoidance of doubt, the Joint Committee will only have authority to take decisions in respect of the Joint Functions. The decision-making will remain with NHS England for all other NHS England Functions.

8. **FINANCE**

8.1 For the Initial Term, NHS England shall hold the Specialised Commissioning Budget and shall be responsible for paying for the Joint Specialised Services from the Specialised Commissioning Budget pursuant to the Specialised Services Contracts. NHS England will establish and maintain the financial and administrative support necessary to meet any auditing regulations applicable to NHS England. The Joint Committee shall ensure full compliance with the Finance Guidance and any other relevant Mandated Guidance.

8.2 For the avoidance of doubt, in the Initial Term, the ICBs are not required to financially contribute to the Specialised Commissioning Budget and the Partners do not intend to create a pooled fund or joint budget for the purpose of this Agreement. The NHS England Standing Financial Instructions shall apply in respect to the commissioning of all Joint Specialised Services.

8.3 Each Partner shall bear its own costs as they are incurred, unless expressly provided otherwise in this Agreement or otherwise agreed in advance in writing by the Partners. Such costs may include, but will not be limited to, costs of attendance at Joint Committee meetings and costs in complying with each Partner's relevant obligations in this Agreement.

8.4 Prior to the end of the first year of the Term, the Partners will review the financial arrangements described in this Clause 8 (Finance) and consider whether alternative arrangements should be put in place for any extended Term. Any changes to this Agreement to effect such new arrangements will be made in accordance with Clause 10 (Variations).

9. **STAFFING**

9.1 During the Initial Term the Specialised Services Staff shall be employed by NHS England.

9.2 The Partners must comply with any Mandated Guidance issued by NHS England from time to time in relation to any NHS England Staff.

10. **VARIATIONS**

10.1 The Partners acknowledge that the scope of the Joint Working Arrangements, including the scope of the Joint Functions, may be reviewed and amended from time to time.

10.2 This Agreement may be varied by the agreement of the Partners at any time in writing in accordance with the Partners' internal decision-making processes.

11. **DATA PROTECTION**

11.1 The Partners must ensure that all Personal Data processed by or on behalf of them in the course of carrying out the Joint Working Arrangements is processed in accordance with the relevant Partner's obligations under Data Protection Legislation and Data Guidance, and the Partners must assist each other as necessary to enable each other to comply with these obligations.

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

11.2.1 becomes aware of any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted or unusable; or

11.2.2 becomes aware of any security breach,

in respect of the Relevant Information it shall promptly notify the Joint Committee and NHS England. The Partners shall fully cooperate with one another to remedy the issue as soon as reasonably practicable.

11.3 In processing any Relevant Information further to this Agreement, each Partner shall at all times comply with all NHS England policies and guidance on the handling of data.

11.4 Any information governance breach must be responded to in accordance with Data Security and the Protection Incident Reporting tool. If any Partner is required under Data Protection Legislation to notify the Information Commissioner's Office or a Data Subject of an information governance breach, then, as soon as reasonably practical and in any event on or before the first such notification is made, the relevant Partner must fully inform NHS England and the Joint Committee of the information governance breach. This clause does not require the relevant Partner to provide information which identifies any individual affected by the information governance breach where doing so would breach Data Protection Legislation.

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

11.6 The Partners will share information to enable joint service planning, commissioning, and financial management subject to the requirements of law, including in particular the Data Protection Legislation in respect of any Personal Data.

11.7 Other than in compliance with judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise required by any Law, no information will be shared with any other Partners save as agreed by the Partners in writing.

11.8 Schedule 7 makes further provision about information sharing and information governance.

12. IT INTER-OPERABILITY

12.1 The Partners will work together to ensure that all relevant IT systems operated by the Partners in respect of the Joint Functions are inter-operable and that data may be transferred between systems securely, easily and efficiently.

12.2 The Partners will use their respective reasonable endeavours to help develop initiatives to further this aim.

13. FURTHER ARRANGEMENTS

13.1 The Partners must give due consideration to whether any of the Joint Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under section 65Z5 and section 75 of the NHS Act. The Partners must comply with any Guidance around the commissioning of Joint Specialised Services by means of arrangements under section 65Z5 or 75 of the NHS Act.

14. FREEDOM OF INFORMATION

14.1 Each Partner acknowledges that the others are a public authority for the purposes of the Freedom of Information Act 2000 (**"FOIA"**) and the Environmental Information Regulations 2004 (**"EIR"**).

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

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

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

14.2.3 each Partner acknowledges that the final decision as to the form or content of the response to any request is a matter for the Partner to whom the request is addressed.

14.3 NHS England may, from time to time, issue a FOIA or EIR protocol or update a protocol previously issued relating to the dealing with and responding to of FOIA or EIR requests in relation to the Joint Working Arrangements. The Joint Committee and each Partner shall comply with such FOIA or EIR protocols.

15. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY

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

15.2 Without prejudice to the general obligations set out in Clause 5 (Joint Functions), each ICB must maintain a register of interests in respect of all persons involved in decisions concerning the Joint Functions. This register must be publicly available. For the purposes of this clause, an ICB may rely on an existing register of interests rather than creating a further register.

15.3 Where any member of the Joint Committee has an actual or potential conflict of interest in relation to any matter under consideration by the Joint Committee, that member must not participate in meetings (or parts of meetings) in which the relevant matter is discussed or make a recommendation in relation to the relevant matter. The relevant appointing body may send an alternative representative to take the place of the conflicted member in relation to that matter.

16. CONFIDENTIALITY

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

16.2 Subject to Clause 16.3, the receiving Partner agrees:

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

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

16.2.3 to maintain the confidentiality of the disclosing Partner's Confidential Information.

16.3 The receiving Partner may disclose the disclosing Partner's Confidential Information:

16.3.1 in connection with any Dispute Resolution Procedure;

16.3.2 to comply with the Law;

16.3.3 to any appropriate Regulatory or Supervisory Body;

16.3.4 to its staff, who in respect of that Confidential Information will be under a duty no less onerous than the Receiving Partner's duty under Clause 16.2;

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

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

16.4 The obligations in Clause 16 will not apply to any Confidential Information which:

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

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

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

16.5 This Clause 16 does not prevent NHS England making use of or disclosing any Confidential Information disclosed by an ICB where necessary for the purposes of exercising its functions in relation to that ICB.

16.6 This Clause 16 will survive the termination of this Agreement for any reason for a period of 5 years.

16.7 This Clause 16 will not limit the application of the Public Interest Disclosure Act 1998 in any way whatsoever.

17. LIABILITIES

17.1 Nothing in this Agreement shall affect:

17.1.1 the liability of NHS England to any person in respect of NHS England's Commissioning Functions; or

17.1.2 the liability of any of the ICBs to any person in respect of that ICB's Commissioning Functions.

17.2 NHS England shall be responsible for and shall retain the conduct of any Claim in relation to the Joint Functions and Reserved Functions.

17.3 Each ICB must:

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

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

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

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

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

18. DISPUTE RESOLUTION

18.1 Where any dispute arises within the Joint Committee in connection with this Agreement, the Partners must use their best endeavours to resolve that dispute within the Joint Committee in accordance with the Terms of Reference.

18.2 Where any dispute is not resolved under Clause 18.1 on an informal basis, any Authorised Officer may convene a special meeting of the Joint Committee to attempt to resolve the dispute.

19. BREACHES OF THE JOINT WORKING AGREEMENT

19.1 If any Partner does not comply with the terms of this Agreement, then NHS England may:

19.1.1 exercise its rights under this Agreement; and

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

19.2 Without prejudice to Clause 19.1, if any Partner does not comply with the terms of this Agreement (including if the Joint Committee or any Partner exceeds its authority under this Agreement), NHS England may (at its sole discretion):

19.2.1 waive its rights in relation to such non-compliance in accordance with Clause 19.3;

19.2.2 ratify any decision;

19.2.3 terminate this Agreement in accordance with Clause 20 (Leaving the Joint Committee*)* below;

19.2.4 exercise the dispute resolution procedure in accordance with Clause 18 *(Dispute Resolution Procedure)*; and/or

19.2.5 exercise its rights under common law.

19.3 NHS England may waive any non-compliance by a Partner with the terms of this Agreement provided that the Partner provides a written report to the Joint Committee as required by Clause 19.4 and, after considering the Partner's written report, NHS England is satisfied that the waiver is justified.

19.4 If:

19.4.1 a Partner does not comply with this Agreement; or

19.4.2 NHS England notifies a Partner that it considers the Partner has not complied, or may not be able to comply with, this Agreement;

then that Partner must provide a written report to the NHS England within ten (10) Operational Days of the non-compliance (or the date on which the relevant Partner considers that it may not be able to comply with this Agreement) or such notification pursuant to Clause 25 setting out:

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

19.4.4 if the non-compliance is capable of remedy, a plan for how the Partner proposes to remedy the non-compliance.

20. LEAVING THE JOINT COMMITTEE

20.1 If an ICB wishes to exit the Joint Committee and end its participation in this Agreement, the relevant ICB must provide at least six (6) months' notice to NHS England of its intention to exit the Joint Committee and end its participation in this Agreement. Such notification shall only take effect from the end of 31 March in any calendar year.

20.2 NHS England and the ICBs will work together to ensure that there are suitable alternative arrangements in place in relation to the exercise of the Joint Functions.

20.3 The ICB(s) acknowledge that the exercise of the Joint Functions remains the responsibility of NHS England.

20.4 NHS England may terminate this Agreement forthwith where it considers it necessary or expedient to terminate the Joint Working Arrangements, but in reserving this power NHS England anticipates that this will only be used in exceptional circumstances and that in all instances it will use its reasonable endeavours to seek an orderly termination of the Joint Working Arrangements.

21. CONSEQUENCES OF TERMINATION

21.1 Upon termination of this Agreement (in whole or in part), for any reason whatsoever, the following shall apply:

21.1.1 the Partners agree that they will work together and co-operate to ensure that the winding down of these arrangements is carried out smoothly and with as little disruption as possible to patients, employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so;

21.1.2 termination of this Agreement shall have no effect on the liability of any rights or remedies of any Partner already accrued, prior to the date upon which such termination takes effect.

21.2 The provisions of Clauses 11 (Data Protection), 14 (Freedom of Information), 16 (Confidentiality), 17 (Liabilities) and 21 (Consequences of Termination) shall survive termination or expiry of this Agreement.

22. PUBLICITY

22.1 The Partners shall use reasonable endeavours to consult one another before making any public announcements concerning the subject matter of this Agreement.

23. EXCLUSION OF PARTNERSHIP OR AGENCY

23.1 Nothing in this Agreement shall create or be deemed to create a legal partnership under the Partnership Act 1890 or the relationship of employer and employee between the Partners, or render any Partner directly liable to any third party for the debts, liabilities or obligations of any Partner.

23.2 Save as specifically authorised under the terms of this Agreement, no Partner shall hold itself out as the agent of any other Partner.

24. THIRD PARTY RIGHTS

24.1 The Contracts (Rights of Third Parties) Act 1999 shall not apply to this Agreement and accordingly the Partners to this Agreement do not intend that any third party should have any rights in respect of this Agreement by virtue of that Act.

25. NOTICES

25.1 Any notices given under this Agreement must be sent by e-mail to the relevant Authorised Officers or their nominated deputies.

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

26. ASSIGNMENT AND SUBCONTRACTING

26.1 This Agreement, and any right and conditions contained in it, may not be assigned or transferred by a Partner, without the prior written consent of the other Partners, except to any statutory successor to the relevant function.

27. SEVERABILITY

27.1 If any term, condition or provision contained in this Agreement shall be held to be invalid, unlawful or unenforceable to any extent, such term, condition or provision shall not affect the validity, legality or enforceability of the remaining parts of this Agreement.

28. WAIVER

28.1 No failure or delay by a Partner to exercise any right or remedy provided under this Agreement or by law shall constitute a waiver of that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy. No single or partial exercise of such right or remedy shall prevent or restrict the further exercise of that or any other right or remedy.

29. STATUS

29.1 The Partners acknowledge that they are health service bodies for the purposes of section 9 of the NHS Act. Accordingly, this Agreement shall be treated as an NHS contract and shall not be legally enforceable.

30. **ENTIRE AGREEMENT**

30.1 This Agreement constitutes the entire agreement and understanding of the Partners and supersedes any previous agreement between the Partners relating to the subject matter of this Agreement.

31. **GOVERNING LAW AND JURISDICTION**

31.1 Subject to the provisions of Clause 18 (Dispute Resolution) and Clause 29 (Status), this Agreement shall be governed by and construed in accordance with English Law, and the Partners irrevocably agree that the courts of England shall have exclusive jurisdiction to settle any dispute or claim that arises out of or in connection with this Agreement.

32. **FAIR DEALINGS**

32.1 The Partners recognise that it is impracticable to make provision for every contingency which may arise during the life of this Agreement and they declare it to be their intention that this Agreement shall operate between them with fairness and without detriment to the interests of either of them and that, if in the course of the performance of this Agreement, unfairness to either of them does or may result, then the other shall use its reasonable endeavours to agree upon such action as may be necessary to remove the cause or causes of such unfairness.

33. **COMPLAINTS**

33.1 Any complaints received by the Partners shall be dealt with in accordance with the statutory complaints procedure of the Partner to whose Commissioning Function(s) the complaint relates. For the avoidance of doubt, NHS England shall manage all complaints in respect of the Joint Specialised Services and Retained Services.

34. **COUNTERPARTS**

34.1 This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

This Agreement has been entered into on the date stated at the beginning of it.

SIGNED by Dale Bywater .....

for and on behalf of NHS England (Signature)

.....

(Date)

SIGNED by David Melbourne .....

for and on behalf of NHS Birmingham and Solihull Integrated Care Board (Signature)

.....

(Date)

SIGNED by Mark Axcell .....

for and on behalf of NHS Black Country Integrated Care Board (Signature)

.....

(Date)

SIGNED by Simon Trickett .....

for and on behalf of NHS Herefordshire & Worcestershire Integrated Care Board (Signature)

.....

(Date)

SIGNED by Philip Johns .....

for and on behalf of NHS Coventry & Warwickshire Integrated Care Board (Signature)

.....

(Date)

SIGNED by Simon Whitehouse .....

for and on behalf of NHS Shropshire, Telford, and Wrekin Integrated Care Board (Signature)

.....

(Date)

SIGNED by Peter Axon .....

for and on behalf of NHS Staffordshire and Stoke-on-TrentIntegrated Care Board (Signature)

.....

(Date)

SCHEDULE 1: DEFINITIONS AND INTERPRETATIONS

DEFINITIONS AND INTERPRETATION

1. In this Agreement, unless the context otherwise requires, the following words and expressions shall have the following meanings:

“Agreement"	this agreement between the Partners comprising these terms and conditions together with all schedules attached to it;
“Area”	means the geographical area covered by the ICBs;
“Assurance Processes”	has the meaning in Paragraph 8 of Schedule 4 (Oversight and Assurance);
"Authorised Officer"	the individual(s) appointed as Authorised Officer in accordance with Schedule 2 (Terms of Reference);
"Change in Law"	a change in Law that is relevant to the arrangements made under this Agreement, which comes into force after the Commencement Date;
“Claim”	means for or in relation to the Joint Functions and Reserved Functions (a) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal or the Secretary of State, any governmental, regulatory or similar body, or any department, board or agency or (b) any dispute with, or any investigation, inquiry or enforcement proceedings by any governmental, regulatory or similar body or agency;
“Clinical Commissioning Policies”	a nationally determined clinical policy sets out the commissioning position on a particular clinical treatment issue and defines accessibility (including a not for routine commissioning position) of a medicine, medical device, diagnostic technique, surgical procedure or intervention for patients with a condition requiring a specialised service;
“Clinical Reference Groups”	means a group consisting of clinicians, commissioners, public health experts, patient and public voice representatives and professional associations, which offers specific knowledge and expertise on the best ways that Specialised Services should be provided;
“Collaborative Commissioning Agreement”	means an agreement under which NHS Commissioners set out collaboration arrangements in respect of commissioning Specialised Services Contracts;
"Commencement Date"	means 1 April 2023
"Commissioning Functions"	the respective statutory functions of the Partners in arranging for the provision of services as part of the health service;
"Confidential Information"	means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement or arrangements made pursuant to it and: (a) which comprises Personal Data or which relates to any patient or his treatment or medical history;

(b) the release of which is likely to prejudice the commercial interests of a Partner; or

(c) which is a trade secret;

"Contracting Standard Operating Procedure"	means the Contracting Standard Operating Procedure produced by NHS England in respect of the Joint Specialised Services;
"Core Membership"	means the voting membership of the Joint Committee as set out in the Terms of Reference;
"Data Controller"	shall have the same meaning as set out in the Data Protection Legislation;
"Data Processor"	shall have the same meaning as set out in the Data Protection Legislation;
"Data Guidance"	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement regarding information governance, confidentiality, privacy or compliance with Data Protection Legislation to the extent published and publicly available or their existence or contents have been notified to the ICB by NHS England and/or any relevant Regulatory or Supervisory Body. This includes but is not limited to guidance issued by NHS Digital, the National Data Guardian for Health & Care, the Department of Health and Social Care, NHS England, the Health Research Authority, the UK Health Security Agency and the Information Commissioner;
"Data Protection Legislation"	means the UK General Data Protection Regulation, the Data Protection Act 2018, the Regulation of Investigatory Powers Act 2000, the Telecommunications (Lawful Business Practice) (Interception of Communications) Regulations 2000 (SI 2000/2699), the Privacy and Electronic Communications (EC Directive) Regulations 2003 (SI 2426/2003), the common law duty of confidentiality and all applicable laws and regulations relating to the processing of personal data and privacy, including where applicable the guidance and codes of practice issued by the Information Commissioner;
"Data Protection Officer"	shall have the same meaning as set out in the Data Protection Legislation;
"Data Security and Protection Incident Reporting tool"	the incident reporting tool for data security and protection incidents, which forms part of the Data Security and Protection Toolkit available at https://www.dsptoolkit.nhs.uk/;
"**Delegated Commissioning Group**" **"DCG"**	means a group hosted by NHS England whose terms shall include providing an assurance role in compliance with the Assurance Processes;
"Dispute Resolution Procedure"	the procedure set out in Clause 18 (Dispute Resolution);
"Finance Guidance"	guidance, rules and operating procedures produced by NHS England that relate to these Joint Working Arrangements, including but not limited to the following:

- Commissioning Change Management Business Rules;

- Contracting Standard Operating Procedure;
- Cashflow Standard Operating Procedure;
- Finance and Accounting Standard Operating Procedure;
- Service Level Framework Guidance;

"FOIA"	the Freedom of Information Act 2000 and any subordinate legislation made under it from time to time, together with any guidance or codes of practice issued by the Information Commissioner or relevant government department concerning this legislation;
“Guidance”	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the Partners have a duty to have regard (and whether specifically mentioned in this Agreement or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified by any relevant Regulatory or Supervisory Body;
“High Cost Drugs”	Means medicines not reimbursed though national prices and identified on the NHS England high cost drugs list;
“ICB Functions”	the Commissioning Functions of the ICB;
"Information"	has the meaning given under section 84 of FOIA;
“Indemnity Arrangement”	mean either: (i) a policy of insurance; (ii) an arrangement made for the purposes of indemnifying a person or organisation; or (iii) a combination of (i) and (ii);
"Information Sharing Agreement"	any information sharing agreement entered into in accordance with Schedule 7 (Further Information Governance and Sharing Provisions);
“Indemnity Arrangement”	means either: (i) a policy of insurance; (ii) an arrangement made for the purposes of indemnifying a person or organisation; or (iii) a combination of (i) and (ii);
“Initial Term”	the period of one year from 1 April 2023;
“Joint Committee”	means the joint committee of NHS England and the ICBs, established under this Agreement on the terms set out in the Terms of Reference;
“Joint Working Arrangements”	means the arrangements for joint working as set out in Clause 3 (Scope of Joint Working Arrangements);
“Joint Functions”	those aspects of the NHS England Specialised Commissioning Functions, as set out in Schedule 4, that shall be jointly exercised by NHS England and the ICBs through the decisions of the Joint Committee in accordance with the Terms of Reference;
“Joint Specialised Services”	means those Specialised Services listed in Schedule 3 (Joint Specialised Services);
"Law"	means:

(a) any statute or proclamation or any delegated or subordinate legislation;

(b) any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and

(c) any judgment of a relevant court of law which is a binding precedent in England;

"Mandated Guidance" means any protocol, policy, guidance, guidelines, framework or manual relating to the exercise of the Joint Functions and issued by NHS England from time to time as mandatory in respect of the Joint Working Arrangements. At the Commencement Date the Mandated Guidance in respect of the Joint Functions shall be as set out in Schedule 8;

"National Standards" means the service standards for each Specialised Service, as set by NHS England and included in Clinical Commissioning Policies or National Specifications;

"National Specifications" the service specifications published by NHS England in respect of Specialised Services;

"Need to Know" has the meaning set out in Schedule 7;

"NHS Act" the National Health Service Act 2006;

"NHS England Functions" NHS England's statutory functions exercisable under or by virtue of the NHS Act;

"Non-Personal Data" means data which is not Personal Data;

"**Oversight Framework**" means the NHS Oversight Framework, as may be amended or replaced from time to time, and any relevant associated Guidance published by NHS England;

"Part A Retained Services" means those services listed in Part A of Schedule 5;

"Part B Retained Services" means those services listed in Part B of Schedule 5;

"Partners" the parties to this Agreement;

"Personal Data" has the meaning set out in the Data Protection Legislation;

"Population" means the population for which an ICB or all of the ICBs have the responsibility for commissioning health services;

"Provider Collaborative" a group of Specialised Service Providers who have agreed to work together to improve the care pathway for one or more Specialised Services;

"Provider Collaborative Arrangements"	Means the contracting arrangements entered into in respect of a Provider Collaborative;
"Provider Collaborative Guidance"	Means the guidance published by NHS England in respect of Provider Collaboratives;
"Regional Quality Group"	A group set up to act as a strategic forum at which regional partners from across health and social care can share, identify and mitigate wider regional quality risks and concerns as well as share learning so that quality improvement and best practice can be replicated;
"Regulatory or Supervisory Body"	means any statutory or other body having authority to issue guidance, standards or recommendations with which the relevant Party and/or Staff must comply or to which it or they must have regard, including: (i) CQC; (ii) NHS England; (iii) the Department of Health and Social Care; (iv) NICE; (v) Healthwatch England and Local Healthwatch; (vi) the General Medical Council; (vii) the General Dental Council; (viii) the General Optical Council; (ix) the General Pharmaceutical Council; (x) the Healthcare Safety Investigation Branch; and (xi) the Information Commissioner;
"Relevant Information"	means the Personal Data and Non-Personal Data processed under this Agreement, and includes, where appropriate, "confidential patient information" (as defined under section 251 of the NHS Act), and "patient confidential information" as defined in the 2013 Report, The Information Governance Review – "*To Share or Not to Share?"*);
"Request for Information"	has the meaning set out in the FOIA;
"Reserved Functions"	those aspects of the Specialised Commissioning Functions that are not Joint Functions, including but not limited to those set out in Schedule 6;
"**Relevant Clinical Networks"**	means those clinical networks identified by NHS England as required to support the commissioning of Specialised Services for the Population;
"Retained Services"	means those Specialised Services for which NHS England shall retain commissioning responsibility, as set out in Schedule 5 and being the Part A Retained Services and the Part B Retained Services;

"Shared Care Arrangements"	these arrangements support patients receiving elements of their care closer to home, whilst still ensuring that they have access to the expertise of a specialised centre and that care is delivered in line with the expectation of the relevant National Specification;
"Single Point of Contact"	the member of Staff appointed by each relevant Partner in accordance with Paragraph 14 of Schedule 7;
"Special Category Personal Data"	has the meaning set out in the Data Protection Legislation;
"Specialised Commissioning Budget"	means the budget identified by NHS England for the purpose of exercising the Joint Functions;
"Specialised Commissioning Functions"	means the statutory functions conferred on NHS England under Section 3B of the NHS Act 2006 and Regulation 11 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996 (as amended or replaced);
"Specified Purpose"	means the purpose for which the Relevant Information is shared and processed to facilitate the exercise of the Joint Functions and Reserved Functions as specified in Schedule 7 *(Further Information Governance and Sharing Provisions)* to this Agreement;
"Specialised Services"	means the services commissioned in exercise of the Specialised Commissioning Functions;
"Specialised Services Contract"	a contract for the provision of Specialised Services entered into in the exercise of the Specialised Commissioning Functions;
"Specialised Services Provider"	a provider party to a Specialised Services Contract;
"Specialised Services Staff"	means the Staff carrying out the Joint Specialised Services Functions immediately prior to the date of this Agreement;
"Staff"	means the Partners' employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of any Partner (whether or not the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors' and their sub-contractors' personnel;
"System quality group"	means a group set up to identify and manage concerns across the local system. The system quality group shall act as a strategic forum at which partners from across the local health and social care footprint can share issues and risk information to inform response and management, identify and mitigate quality risks and concerns as well as share learning and best practice;
"Term"	the Initial Term, as may be varied by: (a) any extensions to this Agreement that are agreed under Clause 1.1 (Commencement and Duration); or

(b) the earlier termination of this Agreement in accordance with its terms;

"Terms of Reference"	means the Terms of Reference for the Joint Committee agreed between NHS England and the ICBs at the first meeting of the Joint Committee, a draft of which is included at Schedule 2 (Joint Committee – Terms of Reference);
"Triple Aim"	the duty on each of the Partners in making decisions about the exercise of their functions, to have regard to all likely effects of the decision in relation to: (a) the health and well-being of the people of England; (b) the quality of services provided to individuals by the NHS; (c) efficiency and sustainability in relation to the use of resources by the NHS;
"UK GDPR"	means Regulation (EU) 2016/679 of the European Parliament and of the Council of 27th April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018;
"Working Day"	any day other than Saturday, Sunday, a public or bank holiday in England.

2. References to statutory provisions shall be construed as references to those provisions as respectively amended or re-enacted (whether before or after the Commencement Date) from time to time.

3. The headings of the Clauses in this Agreement are for reference purposes only and shall not be construed as part of this Agreement or deemed to indicate the meaning of the relevant Clauses to which they relate. Reference to Clauses are Clauses in this Agreement.

4. References to Schedules are references to the schedules to this Agreement and a reference to a Paragraph is a reference to the paragraph in the Schedule containing such reference.

5. References to a person or body shall not be restricted to natural persons and shall include a company, corporation or organisation.

6. Words importing the singular number only shall include the plural.

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

8. Where anything in this Agreement requires the mutual agreement of the Partners, then unless the context otherwise provides, such agreement must be in writing.

9. Any reference to the Partners shall include their respective statutory successors, employees and agents.

10. In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

11. Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

SCHEDULE 2: JOINT COMMITTEE – TERMS OF REFERENCE

Note: The Terms of Reference will be agreed at the first meeting of the joint committee.

Document name:		West Midlands ICB Joint Committee Terms of Reference	
Senior Responsible Owner (SRO):		[Insert]	
Lead:		[Insert]	
Version	[Insert]	**Date:**	[Publish Date]

Document management

Revision history

Version	Date	Summary of changes

Approved by

This document must be approved by the following people:

Name	Signature	Title	Date	Version

Related documents

Title	Owner	Location

Introduction and purpose	The Joint Committee has been established by the ICBs as listed: **Integrated Care Board** of **NHS Derby and Derbyshire ("ICB"**); **Integrated Care Board** of **NHS Leicester, Leicestershire and Rutland** ("{LLR} **ICB"**); **Integrated Care Board** of **NHS Lincolnshire** ("{●} **ICB"**). **Integrated Care Board** of **NHS Northamptonshire** ("{●} **ICB"**). **Integrated Care Board** of **NHS Nottingham and Nottinghamshire** ("{●} **ICB"**). **And** **NHS England** In order to jointly discharge commissioning responsibilities covering the EAST Midlands geographical footprint defined in Schedule 4 of the Joint Working Agreement between the parties. This includes:- • Responsibilities for which the ICBs and NHSE are jointly responsible for commissioning. [PART A of the meeting]. • Responsibilities for which the ICBs are responsible for (including those delegated to them by NHSE England). [PART B of the meeting]. • The Joint Committee will collaboratively make decisions on the strategic planning and delivery, including resource allocation, oversight and assurance, to improve health and care outcomes and reduce health inequalities. • Subject to Clauses 6.1 and 6.2 of the Joint Working Agreement (Further Collaborative Working), the Partners may, to such extent that they consider it desirable, table an item at the Joint Committee relating to any other of their functions that is not a Joint Function to facilitate engagement, promote integration and collaborative working. The Partners may establish sub-groups or sub-committees of the Joint Committee, with such Terms of Reference as may be agreed between them. Any such arrangements that are in place at the commencement of the Joint Working Agreement may be documented in the Local Terms (Schedule 7).

The Terms of Reference	These Terms of Reference support effective collaboration between all Partners acting through this Joint Committee. They set out the role, responsibilities, membership, decision-making powers and reporting arrangements of the Joint Committee in accordance with the Joint Working Agreement between the ICBs, and ICBs & NHSE. The Joint Committee will operate as the decision-making forum for exercising the agreed Joint Functions in accordance with the Joint Working Agreement. By agreement, the Partners may use an alternative title for the Joint Committee that reflects local arrangements, for example, 'Commissioning Committee.'
Statutory Framework	The Partners have arranged to exercise the Relevant Functions jointly pursuant to section 65Z5 of the NHS Act 2006. The Joint Committee is established pursuant to section 65Z6 of the NHS Act 2006. Apart from as set out in the Agreement, the Joint Committee does not affect, and must act in accordance with, the statutory responsibilities and accountabilities of the Partners.
Role of the Joint Committee	The role of the Joint Committee for Part A and Part B is to provide strategic decision-making, leadership and oversight for the Joint Working and Joint Commissioning services and any associated activities. The Joint Committee and aligned subsidiary arrangements will safely, effectively, efficiently and economically discharge the Joint Functions and deliver these services through the following key responsibilities:- • Making relevant joint decisions in relation to the planning and commissioning of the services, and any associated commissioning or statutory functions, for the population, for example, through undertaking population needs assessments; • Making recommendations on population-based services financial allocation and financial plans; • Identifying and setting strategic priorities and undertaking ongoing assessment and review of services within the remit of the Joint Committee and aligned subsidiary arrangements, including tackling unequal outcomes and access; • Supporting the development of partnership and integration arrangements with other health and care bodies that facilitate population health management and providing a forum that enables collaboration to integrate service pathways, improve population health and services and reduce health inequalities. This includes establishing links and working effectively with Provider Collaboratives and cancer alliances, and working closely with other ICBs, Joint Committees and NHSE where there are cross-border patient flows to providers; • Will provide strategic quality leadership and oversight for services outlined in Schedule 4 • Determining the appropriate structure of subsidiary arrangements to enable:- o Oversight and assurance of the services in relation to quality, operational and financial performance, including co-ordinating risk / issue management or escalation; and developing the approach to intervention with Specialised Services Providers where there are

	quality or contractual issues; ○ Effective engagement with stakeholders, including patients and the public, and involving them in decision-making; ○ The input of appropriate clinical advice and leadership, including through Clinical Reference Groups and Relevant Clinical Networks; • Otherwise ensuring that the roles and responsibilities set out in the Agreement between the Partners are discharged in compliance with all statutory duties, guidance and good practice, including ensuring that the Joint Committee and aligned subsidiary arrangements have sufficient independent scrutiny of its decision-making and processes. PART A – NHSE & ICB NHS England will be a Partner for the commissioning of Specialised Services defined under a separate Joint Working Agreement. ICB and NHSE under that agreement will make joint decisions for the benefit of the population PART B – ICB Only ICBs defined in the Tier One Joint Committee of the East Midlands will make decisions regarding all services outlined in Schedule 4 and will act as a forum for discussion and make recommendations to ICBs on issues where further joint action or working between ICBs would be of benefit outside the arrangements delegated to it. This might include but would not be limited to:- ○ Joint Policy development ○ Links to other regional structures such as Academic Health Science Networks and Clinical networks.
Accountability and reporting	PART A The Joint Committee will be formally accountable to the Boards of the ICBs and the Board of NHSE through the relevant NHSE regional governance structure for the functions delegated to the Joint Committee through the Schemes of Reservation and Delegation (SORDs). Individual votes for each ICB organisation coupled with NHS England right to substitute an alternative decision: each organisation that is a Core Partners of the Joint Committee has a single vote. However, NHS England can substitute an alternative decision if it considers it is in the best interests of the health service. The reasons for substituting a decision should be documented. Partners also have a right to refer the decision to the regional director for review. PART B The Joint Committee will be formally accountable to the Boards of the ICBs for the functions delegated to the Joint Committee through the Schemes of Reservation and Delegation (SORDs).

	Where an ICB Board requests that the Joint Committee provides information or reports on its proceedings or decisions, the Partners must comply with that request within a reasonable timescale.
Membership	Core Membership The following individuals will be the core members of the Joint Committee:- • An Authorised Officer (the CEO) from each ICB • An Authorised Officer from NHSE [PART A of the meeting only] Each of the Core Members may nominate a named substitute to attend meetings if they are unavailable or unable to attend or because they are conflicted. Each of the Partners must ensure that the members nominated on their behalf (and any named substitutes) are of a suitable level of seniority and duly authorised to act on its behalf and to agree to be bound by the final position or decision taken at any meeting of the Joint Committee. One of the authorised officers from a single ICB will act as the Executive Lead for the Joint Committee, it is expected therefore that the Chair of the Joint Committee be nominated from another ICB. Discretionary Membership Each of the Partners may be represented at meetings by representatives (who may be officers or, in the case of an ICB, Non-Executive Members / Directors of the ICB) who may observe proceedings and contribute to the deliberations as required, but these will not have the right to vote. The Partners may also identify individuals or representatives of other organisations that may be invited to observe proceedings and contribute to the Joint Committee's deliberations as required. These representatives will not have the right to vote. Term of Membership Members (and any substitutes appointed) will hold their appointment until the partner they represent nominates an alternative member or they cease to hold their substantive role with the relevant partner. Membership Lists The Chair (or in the absence of a Chair, the Partners themselves) shall ensure that there is prepared (and updated from time to time) a list of the members and that this list is made available to the Partners.

Chair	At the first meeting of the Joint Committee, the Core Membership shall select a Chair, or joint Chairs, from among the membership. A Chair will be selected for PART A (NHSE having the casting cote) and PART B of the meeting (these may be the same person or a different person). The Chair(s) shall hold office for a period of two years and be eligible for re-appointment for one further term. At the first scheduled meeting after the expiry of the Chair's term of office, the Core Membership will select a Chair, or joint Chairs, who will assume office at that meeting and for the ensuing term. If the Chair(s) is / are not in attendance at a meeting, the Core Membership will select one of the members to take the chair for that meeting.
Meetings	The Joint Committee shall meet at least quarterly. At its first meeting (and at the first meeting following each subsequent anniversary of that meeting) the Joint Committee shall prepare a schedule of meetings for the forthcoming year ("the Schedule"). The Chair(s), or in the absence of a Chair, the Partners themselves, shall see that the Schedule is notified to the members. Any of the Partners may call for a special meeting outside of the Schedule as they see fit, by giving notice of their request to the Chair. The Chair(s) may, following consultation with the Partners, confirm the date on which the special meeting is to be held and then issue a notice giving not less than four weeks' notice of the special meeting.
Quorum	A Joint Committee meeting is quorate if the following are in attendance: • the Authorised Officer (or substitute) nominated by NHSE [PART A only]; • at least one representative member (or substitute) from each ICB. Attendance at meetings by telephone/video conferencing will count towards the quorum.
Decisions and veto.	The Committee must seek to make decisions relating to the exercise of the Joint Functions on a consensus basis. The Partners must ensure that matters requiring a decision are anticipated and that sufficient time is allowed prior to Joint Committee meetings for discussions and negotiations between Partners to take place. Where it has not been possible, despite the best efforts of the Core Membership, to come to a consensus decision on any matter before the Joint Committee, the Chair for Part A (NHSE) and Chair of Part B (s) may require the decision to be put to a vote in accordance with the following provisions:- • For decisions in PART A of the meeting each core member shall have a single vote with a decision made by a simple majority of those present and voting, with the NHSE having a second and casting vote in the event of a tie. Decisions made under this provision will be subject to NHSE having a right to substitute an alternative decision if it considers it is in the best interests of the health service. The reasons for substituting a decision should be documented. Core Members also have a right to refer the decision to the Regional Director for review. • For decisions in PART B of the meeting, each ICB will have one vote with decisions being made by a simple majority of those voting. Any

	disputes will be resolved using the dispute resolution process outline in sections 17 of the joint working agreement. Decisions of the Joint Committee will be binding on the Partners (subject to the right of NHSE [PART A only] to substitute alternative decisions in line with the provision above).
Conduct and conflicts of interest	Members will be expected to act consistently with existing statutory guidance, NHS Standards of Business Conduct and relevant organisational policies. The NHS Standards of Business Conduct policy is available from: https://www.england.nhs.uk/publication/standards-of-business-conduct-policy/ Members should act in accordance with the Nolan Principles (the Seven Principles of Public Life): https://www.gov.uk/government/publications/the-7-principles-of-public-life Members should refer to and act consistently with the NHSE guidance: *Managing Conflicts of Interest in the NHS: Guidance for staff and organisations*. See: https://www.england.nhs.uk/ourwork/coi/ Where any member has an actual or potential conflict of interest in relation to any matter under consideration, the Chair (with appropriate advice) will determine the appropriate action to be taken in line with the principles of proportionality and preserving the spirit of collaborative decision making. Such action could include the member not participating in meetings (or parts of meetings) in which the relevant matter is discussed, or from the decision making and/or voting on the relevant item. A Partner whose Authorised Officer is conflicted in this way may secure . that their named substitute attends the meeting (or part of meeting) in the place of that member. A record of how the conflict has been managed will be recorded in the minutes.
Confidentiality of proceedings	The Committee is not subject to the Public Bodies (Admissions to Meetings) Act 1960. Admission to meetings is at the discretion of the Partners. All members in attendance are required to give due consideration to the possibility that the material presented to the meeting, and the content of any discussions, may be confidential or commercially sensitive, and to not disclose information or the content of deliberations outside of the meeting's membership, without the prior agreement of the Partners.
Publication of notices, minutes and papers	The Partners shall provide sufficient resources, administration and secretarial support to ensure the proper organisation and functioning of the Committee. The Chair(s), or in the absence of a Chair, the Partners themselves, shall see that notices of meetings, together with an agenda listing the business to be conducted and supporting documentation, is issued to the Partners one working week (or, in the case of a special meeting, three calendar days prior to the date of the meeting). The proceedings and decisions taken shall be recorded in minutes, and those minutes circulated in draft form within one week of the date of the meeting. The Committee shall confirm those minutes at its next meeting.

Review of the Terms of Reference	These terms of reference will be reviewed within twelve months of the committee's establishment and then at least annually thereafter. Any changes to the committee's decision-making membership or core functions must be approved by the partners. Other changes to the terms of reference may be agreed by the committee and reported to the Partners for assurance.
Date of Approval of Terms of Reference	TBC

SCHEDULE 3: JOINT SPECIALISED SERVICES

The following are the Specialised Services that NHS England has determined as being suitable and ready for greater ICB involvement:

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
2	Adult congenital heart disease services	13X	Adult congenital heart disease services (non-surgical)
		13Y	Adult congenital heart disease services (surgical)
3	Adult specialist pain management services	31Z	Adult specialist pain management services
4	Adult specialist respiratory services	29M	Interstitial lung disease
		29S	Severe asthma
5	Adult specialist rheumatology services	26Z	Adult specialist rheumatology services
7	Adult Specialist Cardiac Services	13A	Complex device therapy
		13B	Cardiac electrophysiology & ablation
		13C	Inherited cardiac conditions
		13E	Cardiac surgery (inpatient)
		13F	PPCI for ST- elevation myocardial infarction
		13H	Cardiac magnetic resonance imaging
		13T	Transcatheter Aortic Valve Replacement (TAVI)
		13Z	Cardiac surgery (outpatient)
9	Adult specialist endocrinology services	27E	Adrenal Cancer
		27Z	Adult specialist endocrinology services
11	Adult specialist neurosciences services	08E	Neurosurgery - Low Volume Procedures (National)
		08F	Neurosurgery - Low Volume Procedures (Regional)
		08G	Neurosurgery - Low Volume Procedures (Neuroscience Centres)
		08O	Neurology
		08P	Neurophysiology
		08R	Neuroradiology
		08S	Neurosurgery
		08T	Mechanical Thrombectomy
12	Adult specialist ophthalmology services	37C	Artificial Eye Service
		37Z	Adult specialist ophthalmology services
13	Adult specialist orthopaedic services	34A	Orthopaedic surgery
		34R	Orthopaedic revision
15	Adult specialist renal services	11B	Renal dialysis
		11C	Access for renal dialysis
16	Adult specialist services for people living with HIV	14A	Adult specialised services for people living with HIV
17	Adult specialist vascular services	30Z	Adult specialist vascular services
18	Adult thoracic surgery services	29B	Complex thoracic surgery
		29Z	Adult thoracic surgery services: outpatients
30	Bone conduction hearing implant services (adults and children)	32B	Bone anchored hearing aids service
		32D	Middle ear implantable hearing aids service
35	Cleft lip and palate services (adults and children)	15Z	Cleft lip and palate services
36	Cochlear implantation services (adults and children)	32A	Cochlear implantation services
40	Complex spinal surgery services (adults and children)	06Z	Complex spinal surgery services
54	Fetal medicine services (adults and adolescents)	04C	Fetal medicine services

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
58	Specialist adult gynaecological surgery and urinary surgery services for females	04A	Severe Endometriosis
		04D	Complex urinary incontinence and genital prolapse
58A	Specialist adult urological surgery services for men	41P	Penile implants
		41S	Surgical sperm removal
		41U	Urethral reconstruction
59	Specialist allergy services (adults and children)	17Z	Specialist allergy services
61	Specialist dermatology services (adults and children)	24Z	Specialist dermatology services
62	Specialist metabolic disorder services (adults and children)	36Z	Specialist metabolic disorder services
63	Specialist pain management services for children	23Y	Specialist pain management services for children
64	Specialist palliative care services for children and young adults	E23	Specialist palliative care services for children and young adults
65	Specialist services for adults with infectious diseases	18A	Specialist services for adults with infectious diseases
		18E	Specialist Bone and Joint Infection
72	Major trauma services (adults and children)	34T	Major trauma services
78	Neuropsychiatry services (adults and children)	08Y	Neuropsychiatry services
83	Paediatric cardiac services	23B	Paediatric cardiac services
94	Radiotherapy services (adults and children)	01R	Radiotherapy services (Adults)
		51R	Radiotherapy services (Children)
		01S	Stereotactic Radiosurgery / radiotherapy
105	Specialist cancer services (adults)	01C	Chemotherapy
		01J	Anal cancer
		01K	Malignant mesothelioma
		01M	Head and neck cancer
		01N	Kidney, bladder and prostate cancer
		01Q	Rare brain and CNS cancer
		01U	Oesophageal and gastric cancer
		01V	Biliary tract cancer
		01W	Liver cancer
		01Y	Cancer Outpatients
		01Z	Testicular cancer
		04F	Gynaecological cancer
		19V	Pancreatic cancer
		24Y	Skin cancer
106	Specialist cancer services for children and young adults	01T	Teenage and young adult cancer
		23A	Children's cancer
106A	Specialist colorectal surgery services (adults)	33A	Complex surgery for faecal incontinence
		33B	Complex inflammatory bowel disease
		33C	Transanal endoscopic microsurgery
		33D	Distal sacrectomy for advanced and recurrent rectal cancer
107	Specialist dentistry services for children	23P	Specialist dentistry services for children
108	Specialist ear, nose and throat services for children	23D	Specialist ear, nose and throat services for children
109	Specialist endocrinology services for children	23E	Specialist endocrinology and diabetes services for children
110	Specialist gastroenterology, hepatology and nutritional support services for children	23F	Specialist gastroenterology, hepatology and nutritional support services for children
112	Specialist gynaecology services for children	23X(b)	Specialist paediatric surgery services - Gynaecology
113	Specialist haematology services for children	23H	Specialist haematology services for children

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

SCHEDULE 4: JOINT FUNCTIONS

1. Introduction

1.1 This Schedule sets out in further detail the functions which are to be exercised jointly by the Partners, being, in summary:

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

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

1.1.3 undertaking reviews of Joint Specialised Services in respect of the Population;

1.1.4 supporting the management of the Specialised Commissioning Budget;

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

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

2. General Obligations

2.1 The Partners are jointly responsible for planning the commissioning of the Joint Specialised Services in accordance with this Agreement, the Finance Guidance and the Mandated Guidance.

2.2 The role of the Joint Committee shall include:

2.2.1 planning the commissioning of the Joint Specialised Services;

2.2.2 assurance and oversight of the Joint Specialised Services, including compliance with the National Specifications and relevant Clinical Commissioning Policies;

2.2.3 identifying and setting strategic priorities for the Joint Specialised Services;

2.2.4 development of local commissioning expertise and advice structures.

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

Specific Obligations

3. Procurement and Contract Management

3.1 The Joint Committee will make procurement decisions and support NHS England to carry out any procurement processes in accordance with the Contracting Standard Operating Procedure.

3.2 In discharging these responsibilities, the Joint Committee must comply at all times with Law and any relevant Guidance including but not limited to Mandated Guidance; any

applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services.

3.3 When the Joint Committee makes decisions in connection with the awarding of Specialised Services Contracts, it should ensure that it is able to demonstrate compliance with requirements for the award of such Contracts, including that the decision was:

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

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

3.3.3 made transparently; and

3.3.4 compliant with relevant Guidance and Legislation.

3.4 The Joint Committee shall be consulted on contracting decisions relevant to the exercise of the Joint Commissioning Functions and shall ensure the performance of the following general obligations:

3.4.1 oversee the management of the Specialised Services Contracts and, except in relation to payment, performance of the obligations of the commissioner in accordance with the relevant terms;

3.4.2 support the active management of the performance of the Specialised Services Providers in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services, including, as appropriate, by ensuring that timely action is taken to enforce contractual breaches, serve notices or work with Specialised Services Providers to address any issues;

3.4.3 review expenditure and collectively discuss how to obtain value for money in order to obtain value for money on behalf of NHS England;

3.4.4 where required, support NHS England to undertake any investigations relating (among other things) to whistleblowing claims, infection control and patient complaints;

3.4.5 collectively assess quality and outcomes including but not limited to clinical effectiveness, clinical governance, patient safety and the patient safety incident response framework, risk management, patient experience, and addressing health inequalities;

3.4.6 consider any necessary variations (to be managed by NHS England) to the relevant Specialised Services Contract or services in accordance with Clinical Commissioning Policies, National Specifications, service user needs and clinical developments, including, where necessary, developing and implementing a service development improvement plan with Specialised Service Providers where they are not in position to meet any new National Standard or amendment to a National Specification or Clinical Commissioning Policy that is published in the future;

3.4.7 agree information and reporting requirements to support NHS England to manage information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);

3.4.8 conduct review meetings and support NHS England to undertake contract management, including the issuing of contract queries and agreeing any remedial action plan or related contract management processes.

3.5 Where NHS England considers that it is necessary for the effective commissioning of the Joint Specialised Services, it may take any such decision that it considers necessary and appropriate and shall report such decision to the next Joint Committee.

4. Finance

4.1 Without prejudice to Clause 8 (Finance) of this Agreement, the Joint Committee must support NHS England to manage each of the relevant Specialised Services Contracts, including by:

4.1.1 ensuring proper financial management and governance for Joint Specialised Services in accordance with the Finance Guidance;

4.1.2 supporting the move towards management of population-based budgets for Joint Specialised Services; and

4.1.3 considering and inputting into local price agreements, managing agreements or proposals for local variations and local modifications to be implemented by NHS England.

5. Service Planning and Strategic Priorities

5.1 The Joint Committee is responsible for setting local commissioning strategy, policy and priorities and planning for and carrying out needs assessments for the Joint Specialised Services.

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

5.3 The Joint Committee must ensure that the Partners work with Specialised Service Providers and Provider Collaboratives to translate local strategic priorities into operational outputs for Joint Specialised Services.

5.4 The Joint Committee shall provide input into any consideration by NHS England as to whether the commissioning responsibility in respect of any of the Part A Retained Services should be delegated the Joint Committee or ICB.

6. Commissioning of High Cost Drugs

6.1 The Joint Committee must support the effective and efficient commissioning of High Cost Drugs for Joint Specialised Services.

6.2 The Joint Committee must develop and implement Shared Care Arrangements across the Area of the Joint Committee.

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

6.4 The Joint Committee must ensure:

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

6.4.2 effective introduction of new medicines;

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

6.4.4 consistency of prescribing and unwarranted prescribing variation are addressed.

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

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

6.7 The Joint Committee must provide support to prescribing networks and forums, including but not limited to: immunoglobulin assessment panels, HIV prescribing networks and high cost drugs pharmacy networks.

7. Innovation and New Treatment

7.1 The Joint Committee shall support local implementation of innovative treatments for Joint Specialised Services.

8. Oversight and Assurance

8.1 The Joint Committee must at all times operate in accordance with:

8.1.1 the Oversight Framework published by NHS England;

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

8.1.3 any other relevant NHS oversight and assurance guidance;

collectively known as the “Assurance Processes”.

8.2 The Joint Committee must develop and operate in accordance with mutually agreed ways of working in line with the Assurance Processes.

8.3 The Partners must provide any information and comply with specific actions in relation to the Joint Specialised Services, as required by NHS England, including metrics and detailed reporting in accordance with the Terms of Reference.

9. Mental Health, Learning Disabilities and Autism NHS-led Provider Collaboratives

9.1 The Joint Committee shall co-operate fully with NHS England in the development, management and operation of mental health, learning disability and autism NHS-led Provider Collaboratives including, where requested by NHS England, to consider the Provider Collaborative Arrangements where tabled by NHS England as an item for discussion under Clause 7.2.

10. Service Standards, National Specifications and Clinical Commissioning Policies

10.1 The Joint Committee shall support the development of clinical leadership and expertise at a local level in respect of Specialised Services.

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

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

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

10.5 The Joint Committee must have appropriate mechanisms in place to ensure National Standards and National Specifications are being adhered to.

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

11. Networks

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

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

11.3 The Joint Committee shall support NHS England in the management of Relevant Clinical Networks.

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

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

11.6 The Joint Committee shall ensure that network reports are considered where relevant as part of exercising the Joint Functions.

12. Transformation

12.1 The Joint Committee must provide such support as may be requested by NHS England with transformational programmes which encompass the Joint Specialised Services.

12.2 The Joint Committee shall identify the pathways and services that are priorities for transformation according to the needs of their Population.

12.3 The Joint Committee shall oversee local implementation of transformation programmes in respect of the Joint Specialised Services for the Population.

13. Quality

13.1 The Joint Committee must ensure that appropriate arrangements for quality oversight are in place. This must include the implementation of the Patient Safety Incident Response Framework for the management of incidents and serious events, appropriate reporting of any incidents, undertaking any appropriate patient safety incident investigation and obtaining support as required.

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

13.3 The Joint Committee must ensure that the oversight of the quality of the Specialised Services is integrated with wider quality governance in the local system and aligns with NHS England quality escalation processes.

13.4 The Joint Committee must ensure that there is a System Quality Group to identify and manage concerns across the local system.

13.5 The Joint Committee must ensure that there is appropriate representation at any Regional Quality Groups or their equivalent.

13.6 The Joint Committee must have in place all appropriate arrangements in respect of child and adult safeguarding and comply with all relevant Guidance.

14. Individual Funding Requests

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

15. Data Management and Analytics

15.1 The Joint Committee shall:

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

15.1.2 lead on the provision of data and analytical service to support commissioning of Joint Specialised Services;

15.1.3 ensure collaborative working across the Partners on agreed programmes of work focusing on provision of pathway analytics.

15.2 The Partners shall:

15.2.1 share expertise, and, existing reporting tools, and shall ensure interpretation of data is made available to Joint Committees and other Partners to support the commissioning of the Joint Specialised Services;

15.2.2 work collaboratively with subject matter experts to ensure Partners are able to access data sources available to support the commissioning of the Joint Specialised Services.

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

16. **Incident Response**

16.1 The Joint Committee shall:

16.1.1 support local incident management for Joint Specialised Services as appropriate to stated incident level; and

16.1.2 support national and regional incident management relating to Joint Specialised Services.

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

17. **Freedom of Information and Parliamentary Correspondence**

17.1 The Partners shall provide timely support in relation to the handling, management and response to all freedom of information and parliamentary correspondence relating to Joint Specialised Services.

SCHEDULE 5: RETAINED SERVICES

Part A Retained Services

The following are Retained Services that NHS England has determined are suitable but not yet ready for greater ICS leadership:

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
4	Adult specialist respiratory services	29E	Management of central airway obstruction
		29V	Complex home ventilation
15	Adult specialist renal services	11T	Renal transplantation
29	Haematopoietic stem cell transplantation services (adults and children)	02Z	Blood and marrow transplantation services
		ECP	Extracorporeal photopheresis service
45	Cystic fibrosis services (adults and children)	10Z	Cystic fibrosis services
55	Gender dysphoria services (children and adolescents)	22A	Gender identity development service for children and adolescents
56	Gender dysphoria services (adults)	22Z	Gender identity services
		42A	Gender dysphoria: genital surgery (trans feminine)
		42B	Gender dysphoria - genital surgery (trans masculine)
		42C	Gender dysphoria: chest surgery (trans masculine)
		42D	Gender dysphoria - non-surgical services
		42E	Gender dysphoria: other surgical services
58	Specialist adult gynaecological surgery and urinary surgery services for females	04K	Specialised services for women with complications of mesh inserted for urinary incontinence and vaginal prolapse (16 years and above)
		04L	Reconstructive surgery and congenital anomalies of the female genital tract
65	Specialist services for adults with infectious diseases	18T	Tropical Disease
82	Paediatric and perinatal post mortem services	F23	Paediatric and perinatal post mortem services
87	Positron emission tomography-computed tomography services (adults and children)	01P	Positron emission tomography-computed tomography services (PETCT)
89	Primary malignant bone tumours service (adults and adolescents)	01O	Primary malignant bone tumours service (adults and adolescents)
101	Severe intestinal failure service (adults)	12Z	Severe intestinal failure service
103A	Specialist adult haematology services	03C	Castleman disease
105	Specialist cancer services (adults)	01L	Soft tissue sarcoma
		01X	Penile cancer
111	Clinical genomic services (adults and children)	20G	Genomic laboratory testing services
		20H	Pre-Implantation genetic diagnosis and associated in-vitro fertilisation services
		20Z	Specialist clinical genomics services
		MOL	Molecular diagnostic service
114	Specialist haemoglobinopathy services (adults and children)	38S (DPC)	Sickle cell anaemia -direct patient care
		38T (DPC)	Thalassemia - direct patient care
		38X (HCC)	Haemoglobinopathies coordinating centres (HCCs)
		38X (SHT)	Specialist Haemoglobinopathies Teams (SHTs)
115	Specialist immunology services for adults with deficient immune systems	16X	Specialist immunology services for adults with deficient immune systems
115A	Specialist immunology services for children with deficient immune systems	16Y	Specialist immunology services for children with deficient immune systems

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
134	Specialist services to support patients with complex physical disabilities (excluding wheelchair services) (adults and children)	05C	Specialist augmentative and alternative communication aids
		05E	Specialist environmental controls
137	Spinal cord injury services (adults and children)	06A	Spinal cord injury services (adults and children)
6	Adult secure mental health services	22S(a)	Secure and specialised mental health services (adult) (Medium and low) -including LD / ASD / WEMS / ABI / DEAF
		22S(b)	Secure and specialised mental health services (adult) (Medium and low) - Excluding LD / ASD / WEMS / ABI / DEAF
		22S(c)	Secure and specialised mental health services (adult) (Medium and low) - ASD
		22S(d)	Secure and specialised mental health services (adult) (Medium and low) - LD
		22S(e)	Secure and specialised mental health services (adult) Medium Secure Female WEMS
		22S(f)	Secure and specialised mental health services (adult) (Medium and low) - ABI
		22S(g)	Secure and specialised mental health services (adult) (Medium and low) - DEAF
		YYY	Specialised mental health services exceptional packages of care
8	Adult specialist eating disorder services	22E	Adult specialist eating disorder services
32	Children and young people's inpatient mental health service	22C	Tier 4 CAMHS (MSU)
		24E	Tier 4 CAMHS (children's service)
		23K	Tier 4 CAMHS (general adolescent inc eating disorders)
		23L	Tier 4 CAMHS (low secure)
		23O	Tier 4 CAMHS (PICU)
		23U	Tier 4 CAMHS (LD)
		23V	Tier 4 CAMHS (ASD)
98	Specialist secure forensic mental health services for young people	24C	FCAMHS
102	Severe obsessive compulsive disorder and body dysmorphic disorder service (adults and adolescents)	22F	Severe obsessive compulsive disorder and body dysmorphic disorder service
116	Specialist mental health services for Deaf adults	22D	Specialist mental health services for Deaf adults
124	Specialist perinatal mental health services (adults and adolescents)	22P	Specialist perinatal mental health services
133	Specialist services for severe personality disorder in adults	22T	Specialist services for severe personality disorder in adults

Part B Retained Services

The following are Retained Services that NHS England has determined will remain nationally commissioned:

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
1	Adult ataxia telangiectasia services	23G	Adult ataxia telangiectasia services
2A	Adult oesophageal gastric services in the form of gastro-electrical stimulation for patients with intractable gastroparesis	39A	Gastro-electrical stimulation for patients with intractable gastroparesis
4	Adult specialist respiratory services	29G	Primary ciliary dyskinesia management (adult)
11	Adult specialist neurosciences services	08U	Transcranial magnetic resonance guided focused ultrasound (TcMRgFUS)
		43A	Inherited white matter disorders diagnostic and management service for adults
12	Adult specialist ophthalmology services	37D	Retinal Gene Therapy
		37E	Limbal Cell Treatment (Holoclar)
14	Adult specialist pulmonary hypertension services	13G	Adult specialist pulmonary hypertension services
15	Adult specialist renal services	36E	Cystinosis
19	Alkaptonuria service (adults)	20A	Alkaptonuria service (adults)
19A	Alpha 1 antitrypsin services (adults)	29H	Alpha 1 antitrypsin services
20	Alström syndrome service (adults and children)	H23	Alström syndrome service (adults and children)
21	Ataxia telangiectasia service for children	23J	Ataxia telangiectasia service for children
21A	Atypical haemolytic uraemic syndrome services (adults and children)	11A	Atypical haemolytic uraemic syndrome services (adults and children)
22	Autoimmune paediatric gut syndromes service	16A	Autoimmune paediatric gut syndromes service
23	Autologous intestinal reconstruction service for adults	12A	Autologous intestinal reconstruction service for adults
24	Bardet-Biedl syndrome service (adults and children)	20B	Bardet-Biedl syndrome service (adults and children)
25	Barth syndrome service (adults and children)	36A	Barth syndrome service (male adults and children)
26	Beckwith-Wiedemann syndrome with macroglossia service (children)	36B	Beckwith-Wiedemann syndrome with macroglossia service (children)
27	Behçet's syndrome service (adults and adolescents)	16B	Behçet's syndrome service (adults and adolescents)
28	Bladder exstrophy service (children)	D23	Bladder exstrophy service (children)
31	Pain-related complex cancer late effects rehabilitation service (adults)	01A	Breast radiotherapy injury rehabilitation service
33	Choriocarcinoma service (adults and adolescents)	01I	Choriocarcinoma service (adults and adolescents)
34	Chronic pulmonary aspergillosis service (adults)	29Q	Chronic pulmonary aspergillosis service (adults)
37	Complex childhood osteogenesis imperfecta service	K23	Complex childhood osteogenesis imperfecta service
38	Complex Ehlers Danlos syndrome service (adults and children)	M23	Complex Ehlers Danlos syndrome service (adults and children)
39	Complex neurofibromatosis type 1 service (adults and children)	08A	Complex neurofibromatosis type 1 service (adults and children)
41	Complex tracheal disease service (children)	B23	Complex tracheal disease service (children)
42	Congenital hyperinsulinism service (children)	N23	Congenital hyperinsulinism service (children)
43	Craniofacial service (adults and children)	15A	Craniofacial service (adults and children)
44	Cryopyrin associated periodic syndrome service (adults and children)	02A	Cryopyrin associated periodic syndrome service (adults and children)
46	Diagnostic service for amyloidosis (adults and children)	02B	Diagnostic service for amyloidosis (adults and children)
47	Diagnostic service for primary ciliary dyskinesia (adults and children)	29D	Diagnostic service for primary ciliary dyskinesia (adults and children)

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
48	Diagnostic service for rare neuromuscular disorders (adults and children)	08B	Diagnostic service for rare neuromuscular disorders (adults and children)
49	Encapsulating peritoneal sclerosis treatment service (adults)	11D	Encapsulating peritoneal sclerosis treatment service (adults)
50	Epidermolysis bullosa service (adults and children)	24A	Epidermolysis bullosa service (adults and children)
51	Extra corporeal membrane oxygenation service for adults with respiratory failure	29F	Extra corporeal membrane oxygenation service for adults with respiratory failure
52	Extra corporeal membrane oxygenation service for neonates, infants and children with respiratory failure	R23	Extra corporeal membrane oxygenation service for neonates, infants and children with respiratory failure
53	Ex-vivo partial nephrectomy service (adults)	01D	Ex-vivo partial nephrectomy service (adults)
56A	Hand and upper limb transplantation service (adults)	40A	Hand and upper limb transplantation service (adults)
56ZA	Ovarian and testicular tissue cryopreservation for patients receiving gonadotoxic treatment who are at high risk of infertility and cannot store mature eggs or sperm	44A	Gonadal tissue cryopreservation services for children and young people at high risk of gonadal failure due to treatment or disease
57	Heart and lung transplantation service (including mechanical circulatory support) (adults and children)	13N	Heart and lung transplantation
		13V	Ventricular Assist Devices
58	Specialist adult gynaecological surgery and urinary surgery services for females	04J	Urinary Fistula
61	Specialist dermatology services (adults and children)	43S	Stevens-Johnson syndrome and toxic epidermal necrolysis (SJS-TEN)
62	Specialist metabolic disorder services (adults and children)	36F	CLN2 Disease
65	Specialist services for adults with infectious diseases	18D	Human T- Cell Lymphotropic Virus Type 1 and 2
		18J	Adult high consequence infectious airborne disease service
		18L	Adult high consequence infectious contact disease service
		18U	Infectious disease isolation units
66	Hyperbaric oxygen treatment services (adults and children)	28Z	Hyperbaric oxygen treatment services (adults and children)
67	Insulin-resistant diabetes service (adults and children)	27A	Insulin-resistant diabetes service (adults and children)
68	Islet transplantation service (adults)	27B	Islet transplantation service (adults)
69	Liver transplantation service (adults and children)	19T	Liver transplantation service (adults and children)
70	Lymphangioleiomyomatosis service (adults)	29C	Lymphangioleiomyomatosis service (adults)
71	Lysosomal storage disorder service (adults and children)	36C	Lysosomal storage disorder service (adults and children)
73	McArdle's disease service (adults)	26A	McArdle's disease service (adults)
75	Mitochondrial donation service	20D	Mitochondrial donation service
76	NF2-schwannomatosis service (adults and children)	08C	Neurofibromatosis type 2 service (adults and children)
77	Neuromyelitis optica service (adults and adolescents)	08D	Neuromyelitis optica service (adults and adolescents)
79	Ocular oncology service (adults)	01H	Ocular oncology service (adults)
80	Ophthalmic pathology service (adults and children)	37A	Ophthalmic pathology service (adults and children)
81	Osteo-odonto-keratoprosthesis service for corneal blindness (adults)	37B	Osteo-odonto-keratoprosthesis service for corneal blindness (adults)
84	Paediatric intestinal pseudo-obstructive disorders service	12B	Paediatric intestinal pseudo-obstructive disorders service
85	Pancreas transplantation service (adults)	27C	Pancreas transplantation service (adults)
86	Paroxysmal nocturnal haemoglobinuria service (adults and adolescents)	03A	Paroxysmal nocturnal haemoglobinuria service (adults and adolescents)

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
88	Primary ciliary dyskinesia management service (adults and children)	29P	Primary ciliary dyskinesia management service (adults and children)
90	Proton beam therapy service (adults and children)	01B	Proton beam therapy service (adults and children)
91	Pseudomyxoma peritonei service (adults)	01F	Pseudomyxoma peritonei service (adults)
92	Pulmonary hypertension service for children	13J	Pulmonary hypertension service for children
93	Pulmonary thromboendarterectomy service (adults and adolescents)	13M	Pulmonary thromboendarterectomy service (adults and adolescents)
95	Rare mitochondrial disorders service (adults and children)	36D	Rare mitochondrial disorders service (adults and children)
97	Retinoblastoma service (children)	01G	Retinoblastoma service (children)
99	Severe acute porphyria service (adults and children)	27D	Severe acute porphyria service (adults and children)
100	Severe combined immunodeficiency and related disorders service (children)	16C	Severe combined immunodeficiency and related disorders service (children)
103	Small bowel transplantation service (adults and children)	12D	Small bowel transplantation service (adults and children)
103A	Specialist adult haematology services	03T	Thrombotic thrombocytopenic purpura (TTP)
104	Specialist burn care services (adults and children)	09A	Specialist burn care services (adults)
		09C	Specialist burn care services (children)
106A	Specialist colorectal surgery services (adults)	33E	Cytoreductive surgery and hyperthermic intraperitoneal chemotherapy for colorectal cancer
108	Specialist ear, nose and throat services for children	32E	Auditory brainstem implants for children
114	Specialist haemoglobinopathy services (adults and children)	38S (NHP)	National haemoglobinopathy panel (NHP)
119	Specialist neuroscience services for children	08M	Spinal muscular atrophy: gene therapy
		43C	Inherited white matter disorders diagnostic and management service for children
		73M	Children's Epilepsy Surgery Service
		T23	Multiple Sclerosis Management service for children
		U23	Open Fetal surgery to treat fetuses with open spina bifida
123	Specialist paediatric liver disease service	C23	Specialist paediatric liver disease service
130	Specialist services for children with infectious diseases	14C	Specialist services for children with infectious diseases: HIV
		18K	High consequence infectious airborne disease services for children
		18M	High consequence infectious contact disease services for children
131	Specialist services for complex liver, biliary and pancreatic diseases in adults	19A	Total pancreatectomy with islet auto transplant
138	Stem cell transplantation service for juvenile idiopathic arthritis and related connective tissue disorders (children)	P23	Stem cell transplantation service for juvenile idiopathic arthritis and related connective tissue disorders (children)
139	Stickler syndrome service (adults and children)	20C	Stickler syndrome diagnostic service (adults and children)
139B	Uterine transplantation services (adults)	04U	Uterine transplantation services
140	Vein of Galen malformation service (adults and children)	A23	Vein of Galen malformation service (adults and children)
142	Wolfram syndrome service (adults and children)	Q23	Wolfram syndrome service (adults and children)
143	DNA Nucleotide Excision Repair Disorders Service (adults and children)	24D	DNA Nucleotide Excision Repair Disorders Service
6	Adult secure mental health services	22O	Offender personality disorder
		22U(a)	Secure and specialised mental health service (adult) (High) - Excluding LD
		22U(b)	Secure and specialised mental health service (adult) (High) - LD
74	Mental health service for deaf children & adolescents	22B	Mental health service for deaf children & adolescents

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
91A	Psychological medicine inpatient services for severe and complex presentations of medically unexplained physical symptoms (adults)	22V	Psychological medicine inpatient services for severe and complex presentations of medically unexplained physical symptoms
141	Integrated veterans' mental health and wellbeing service	22G	Veterans' mental health complex treatment service
		05V	Veterans' prosthetic service

SCHEDULE 6: RESERVED FUNCTIONS

1. Introduction

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

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

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

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

2. Retained Services

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

3. Reserved Specialised Service Functions

3.1 In addition to the commissioning of Retained Services set out in Schedule 5, NHS England shall also carry out the functions set out in this Schedule 6 in respect of the Joint Specialised Services.

4. Oversight and Assurance

4.1 NHS England shall be responsible for developing national oversight and assurance guidance on joint working arrangements for Specialised Services.

4.2 NHS England shall be responsible for assuring the Joint Working Arrangements. Such assurance shall be undertaken in accordance with the Assurance Processes.

4.3 NHS England shall host a Delegated Commissioning Group that will undertake an assurance role in compliance with the Assurance Processes. This assurance role shall include monitoring and suggesting solutions to mitigate systemic risk to Joint Specialised Service provision.

5. Clinical Leadership and Clinical Reference Groups

5.1 NHS England shall be responsible for the following:

5.1.1 providing clinical leadership, advice and guidance to the Joint Committee in relation to the Joint Specialised Services;

5.1.2 supporting ICB Partners to develop clinical leadership for Joint Specialised Services; and

5.1.3 providing clinical and public health leadership for Specialised Services.

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

5.2.1 Clinical Commissioning Policies;

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

6. Clinical Networks

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

6.2 NHS England shall be responsible for the following in respect of the Relevant Clinical Networks:

6.2.1 developing national policy for the Relevant Clinical Networks;

6.2.2 developing and approving the national specifications for the Relevant Clinical Networks;

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

6.2.4 convening or supporting national networks of the Relevant Clinical Networks;

6.2.5 agreeing the annual plan for each Relevant Clinical Network with the involvement of the Joint Committee and Relevant Clinical Network, ensuring these reflect national and regional priorities;

6.2.6 managing Relevant Clinical Networks jointly with the Joint Committee; and

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

7. Complaints

7.1 NHS England shall manage all complaints in respect of the Joint Specialised Services and Reserved Services.

8. Procurement

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

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

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

8.1.3 running provider selection and procurement processes for Specialised Services.

9. Contracting

9.1 NHS England shall retain the following obligations in relation to contracting:

9.1.1 except where 9.1.2 applies, entering into Specialised Commissioning Contracts with Specialised Service Providers as Co-ordinating Commissioner including negotiation of the Specialised Services Contracts and creating all contract documents (including indicative activity plans) and

schedules for inclusion in the Specialised Services Contracts, including the process of negotiation;

9.1.2 where NHS England in its absolute discretion agrees to enter into Specialised Commissioning Contracts with Specialised Service Providers as Associate Commissioner and perform all contracting duties required of an associate as well as ensure oversight of the relevant Specialised Commissioning Contracts through the Joint Committee;

9.1.3 setting, publishing or making otherwise available the Contracting Standard Operating Procedure and other Mandated Guidance detailing contracting strategy and policy for Specialised Services; and

9.1.4 providing and distributing contracting support tools and templates to the Partners.

9.2 NHS England shall keep a record of all of the Specialised Services Contracts setting out the following details in relation to each Specialised Services Contract

9.2.1 name of the Specialised Services Provider;

9.2.2 the name by which the Specialised Services Provider is known;

9.2.3 commissioner name;

9.2.4 Specialised Services Contract start date and end date;

9.2.5 description of Specialised Services;

9.2.6 location of provision of services; and

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

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

10.1 NHS England shall commission and design Provider Collaborative Arrangements for mental health, learning disabilities and autism services. Where it considers appropriate, NHS England shall seek the input of the Joint Committee in relation to relevant Provider Collaborative Arrangements.

11. Finance

11.1 NHS England shall be responsible for:

11.1.1 Performing all necessary financial transactions associated with Specialised Services unless expressly agreed and set out in Local Terms;

11.1.2 Setting financial policy and frameworks and developing the support tools necessary to enable commissioners to plan and deliver against a population-based allocation;

11.1.3 Setting financial allocations for Specialised Services, including the move from historic actual to population-based allocations and including growth, inflation and efficiency targets;

11.1.4 Consolidating and reporting plans and in-year financial delivery against the Specialised Services Budget;

11.1.5 Developing financial impact assessments for National Specifications;

11.1.6 Overseeing dispute escalation and resolution where there are material changes to out-of-area cross-border flows;

11.1.7 Supporting the Joint Committee to ensure the financial delivery of the Joint Specialised Services according to financial business rules and financial frameworks including but not limited to:

11.1.7.1 financial planning;

11.1.7.2 investment and commissioning decision-making;

11.1.7.3 budgetary control and delivery of efficiency targets;

11.1.7.4 financial reporting and accounting;

11.1.7.5 system financial oversight.

12. Individual Funding Requests (IFRs)

12.1 NHS England shall be responsible for the following:

12.1.1 Leading on IFR policy, supporting IFR governance and managing the IFR process; and

12.1.2 Providing pharmacy activity input and public health medicines expertise into IFR decisions.

13. Data Management and Analytics

13.1 NHS England shall:

13.1.1 Lead on data collection, data acquisition and reporting;

13.1.2 Provide leadership of data management and analytics to support the Partners, including professional network development, workforce development and information dissemination;

13.1.3 Set Specialised Services data strategy and ensure alignment with broader NHS England, Department of Health and Social Care and government data strategies;

13.1.4 Secure appropriate resource to support a national service for data processing and analytics for Specialised Services;

13.1.5 Oversee standardised collection, processing and sharing of data used to support Specialised Services commissioning across the Partners, in line with national data strategy;

13.1.6 Work collaboratively with all Partners to drive continual improvement of the quality and coverage of data used to support commissioning of Specialised Services; and

13.1.7 Support ICB data and analytic functions and wider data and analytic networks to develop, deploy locally and utilise business intelligence tools.

14. Pharmacy and Optimisation of High Cost Drugs

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

14.1.1 support the Joint Committee on strategy for access to medicines, minimising barriers to health inequalities;

14.1.2 provide financial management of High Cost Drugs spend, including prescribing analysis, to identify, scope, engage, deliver and record better value medicines strategy and initiatives;

14.1.3 commission High Cost Drugs for Retained Services and of High Cost Drugs for Joint Specialised Services working jointly with Joint Committee;

14.1.4 ensure consistency of prescribing in line with Clinical Commissioning Policies, introduction of new medicines, and addressing unwarranted prescribing variation;

14.1.5 set medicines commissioning policy and criteria for access to certain medicines commissioned by Specialised Services including developing any necessary support tools;

14.1.6 provide expert medicines advice and input into all Specialised Services activities; and

14.1.7 provide direction and support to medicines leads at ICB level to support discharge of duties and delivery of strategic objectives and National Standards.

15. Quality

15.1 In respect of quality, NHS England shall:

15.1.1 work with the Joint Committee to ensure oversight of Specialised Services through quality oversight and risk management;

15.1.2 ensure that quality and safety issues and risks are managed effectively and escalated to the National Specialised Commissioning Quality and Governance Group, or other appropriate forums, as necessary;

15.1.3 ensure that the Joint Specialised Services are aligned and integrated with broader clinical quality governance and processes;

15.1.4 when quality issues relating to Specialised Services are identified, facilitate improvement through programme support, and mobilise intensive support when required on specific quality issues;

15.1.5 facilitate review of Specialised Services where concerns arise, utilising peer reviews or clinical assessment, as appropriate;

15.1.6 ensure all relevant intelligence is shared appropriately for quality and safety monitoring, including between organisations and at system quality groups or appropriate alternative forums;

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

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

15.1.9 support Joint Committees to identify key themes and trends across their Area and utilise data and intelligence to respond and monitor as necessary; and

15.1.10 facilitate and support the national quality governance infrastructure (Specialised Commissioning Quality and Governance Group).

16. Service standards

16.1 NHS England shall carry out the following:

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

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

16.1.3 maintenance and publication of the 'Manual' of prescribed Specialised Services and engagement with the Department of Health and Social Care on policy matters.

17. Transformation

17.1 NHS England shall be responsible for:

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

17.1.2 co-production and co-design of transformation programmes with the Joint Committee and wider stakeholders; and

17.1.3 supporting Joint Committees in co-ordinating and enabling Specialised Services transformation programmes for Joint Specialised Services where necessary.

18. Incident Response

18.1 NHS England shall, lead on incident management for Specialised Services.

18.2 NHS England shall lead on monitoring, planning and support for service and operational resilience and provide support to the Joint Committee to develop its oversight of these arrangements.

18.3 NHS England shall respond to specific service interruptions; for example. supplier, workforce challenges and provide support to the Joint Committee in any response to interruptions.

19. Innovation and New Treatment

19.1 NHS England shall ensure the implementation of innovative treatments for Joint Specialised Services and Retained Services such as Advanced Medicinal Therapy Products (ATMPs), recommended by NICE technology appraisals within statutory requirements.

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

SCHEDULE 7: FURTHER INFORMATION GOVERNANCE AND SHARING PROVISIONS

1. Introduction

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

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

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

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

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

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

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

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

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

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

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

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

2. Purpose

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

2.2. Each Partner must ensure that they have in place appropriate Data Sharing Agreements to enable data to be received from any third party organisations from which the Partners must obtain data in order to achieve the Specified Purpose. Where necessary specific and detailed purposes must be set out in a Data Sharing Agreement that complies with all relevant Legislation and Guidance.

3. Benefits of information sharing

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

4. Lawful basis for sharing

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

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

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

5. Restrictions on use of the Shared Information

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

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

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

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

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

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

6. Ensuring fairness to the Data Subject

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

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

6.1.2. amendment of respective privacy notices and policies to reflect the processing of data carried out further to this Agreement, including covering

the requirements of articles 13 and 14 UK GDPR and providing these (or making them available to) Data Subjects;

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

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

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

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

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

7. Governance: Staff

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

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

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

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

7.4. The Partners shall ensure that:

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

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

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

8. Governance: Protection of Personal Data

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

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

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

8.4. If any Partner

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

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

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

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

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

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

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

8.6. The Partners shall act generally in accordance with Data Protection Legislation requirements. This includes implementing, maintaining and keeping under review appropriate technical and organisational measures to ensure and demonstrate that the processing of Personal Data is undertaken in accordance with Data Protection Legislation, and in particular to protected the Personal Data (and Special Category Personal Data) against unauthorised or unlawful processing, and against accidental loss, destruction, damage, alteration or disclosure. These measures shall:

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

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

8.7. In particular, teach Partner shall:

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

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

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

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

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

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

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

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

9. Governance: Transmission of Information between the Partners

9.1. This paragraph supplements paragraph 8 of this Schedule.

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

9.3. Wherever possible, Personal Data should be transmitted and held in pseudonymised form, with only reference to the NHS number in 'clear' transmissions. Where there are significant consequences for the care of the patient, then additional data items, such as the postcode, date of birth and/or other identifiers should also be transmitted, in accordance with good information governance and clinical safety practice, so as to ensure that the correct patient record / data is identified.

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

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

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

10. Governance: Quality of Information

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

11. Governance: Retention and Disposal of Shared Information

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

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

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

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

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

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

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

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

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

12. Governance: Complaints and Access to Personal Data

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

12.2. Complaints about information sharing shall be reported to the Single Points of Contact and the Joint Committee. Complaints about information sharing shall be routed through each Partners' own complaints procedure unless otherwise provided for in the Joint Working Arrangements or determined by the Joint Committee.

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

12.4. Basic details of the Agreement shall be included in the appropriate log under each Partner's Publication Scheme.

13. Governance: Single Points of Contact

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

14. Monitoring and review

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

SCHEDULE 8: MANDATED GUIDANCE

Generally applicable Mandated Guidance

- National Guidance on System Quality Groups.
- Managing Conflicts of Interest in the NHS.
- Arrangements for Delegation and Joint Exercise of Statutory Functions.
- Guidance relating to procurement and provider selection.
- IG Guidance relating to serious incidents.
- All other applicable IG and Data Protection Guidance.
- Any applicable Freedom of Information protocols.
- Any applicable guidance on Counter Fraud, including from The NHS Counter Fraud Authority.
- Any applicable guidance relating to the use of data and data sets for reporting.

Workforce

- Guidance on the Employment Commitment.

Finance

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

Specialised Services Mandated Guidance

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

SCHEDULE 9: LOCAL TERMS

General

Where there is a dispute as to the content of this Schedule, the Partners should follow the Disputes Resolution procedure set out at Clause 18.

Following signature of the Agreement, this Schedule can be amended by the Partners using the Variations procedure at Clause 10.

Part 1 – Further Governance Arrangements

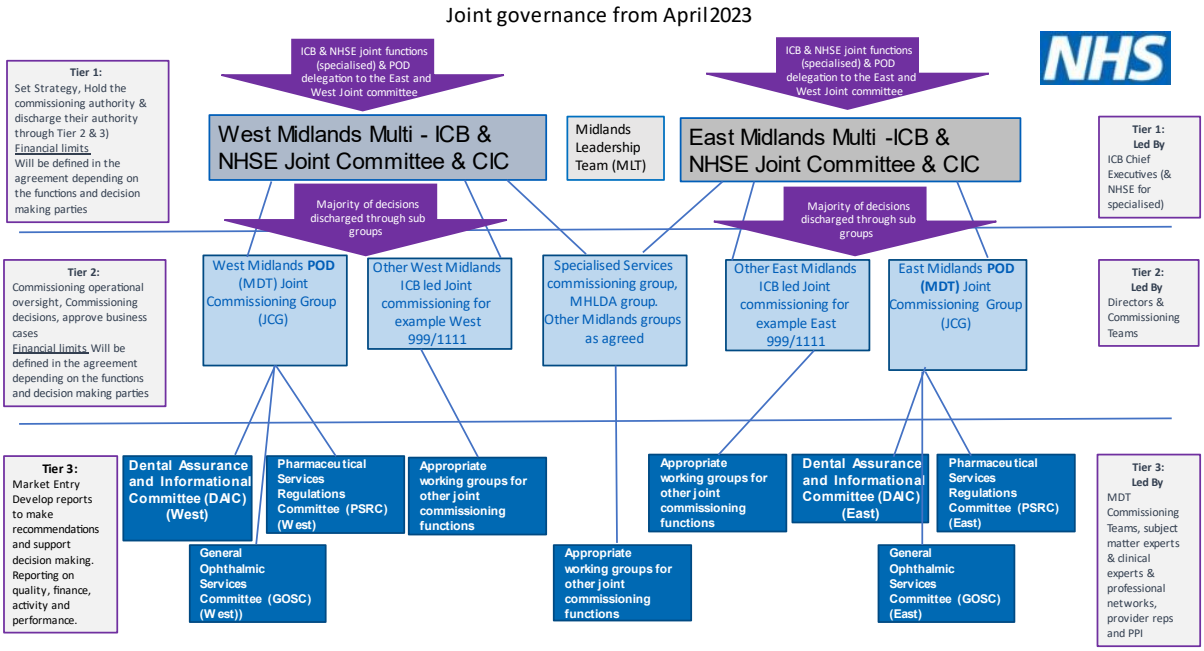
1.1 The Joint Committee wil operate in 2 parts, these being,

- Part 1: Functions of NHSE that are not yet delegated to ICB's which are designated for formal joint working.
- Part 2: Functions and services delegated to it from the individual ICBs.

1.2 All delegated decisions will be made at the Joint Committee in line with the scheme of delegation outlined below.

1.3 Figure 1 below illustrates the decision-making Tiers, with Tier 1 forming the Joint Committee.

1.4 The Terms of Reference for any sub groups operating on behalf of the Joint Committee must be formally approved by Partners



DRAFT Schemes of Financial Delegation

TIER ONE - Function, Decision or Purpose	Value	Who Transacts
JOINT COMMITTEES – East & West		
To jointly discharge joint working (pre-delegation) and joint commissioning (once delegated) responsibilities through an East & West Joint Committees decision-making structure; including scope to receive	23/24 will be as per NHSE SFIs ceilings (as with Midlands Commissioning Group now, but with ICB input) until Spec	

future delegations (either further from NHSE, or from ICBs to each other, to work together for services they wish to collaborate on)	Comm is part-delegated April-24, then the Joint Committee will be empowered to commit resources to the ceilings determined by the decision to be taken.
Part A and Part B to provide strategic decision-making, leadership and oversight for the Joint Working / Joint Commissioning of services and any associated activities. PART A – NHSE & ICBs: NHSE will be a Partner for the commissioning of Specialised Services defined under this Joint Working Agreement. ICBs and NHSE under this agreement will make joint decisions for the benefit of the population. PART B – ICBs Only: ICBs defined in the Tier One Joint Committee of the East Midlands will make decisions regarding all services outlined in Schedule 4 of a separate joint working agreement between ICBs and will act as a forum for discussion and make recommendations to ICBs on issues where further joint action or working between ICBs would be of benefit outside the arrangements delegated to it. This might include but would not be limited to: - Joint Policy development / Links to other regional structures such as Academic Health Science Networks and Clinical networks and Joint Commissioning between ICBs on POD services as delegated from NHSE by 1st April 2023 (see Tiers 2 & 3 below)]	

TIER TWO - Function, Decision or Purpose	Value	Who Transacts
JOINT COMMISSIONING SUB-GROUPS – East & West for Specialised Services		
Midlands Acute Specialised Commissioning Group	23/24 will be as per NHSE SFIs ceilings (as with Midlands Commissioning Group now, but with ICB input) until Spec Comm is part-delegated April-24, then the Joint Committee will be empowered to commit resources to the ceilings determined by the decision to be taken.	
JOINT COMMISSIONING SUB-GROUPS – East & West for Quality and Finance		
DETAILS TBC		
JOINT COMMISSIONING SUB-GROUPS – East & West for POD Services		
Details contained within separate joint working agreement for POD and other services which ICB wish to joint work on.		

TIER THREE - Function, Decision or Purpose	Value	Who Transacts
To be confirmed through Midlands Acute Specialised Commissioning Group		

Part 2 – Workforce Arrangements

In 2023/24, NHS England will retain the relevant specialised commissioning workforce which will support the arrangements described in this Agreement. During 2023/24, NHSE will make arrangements to transfer the specialised commissioning workforce to a host ICB on 01/04/2024 to coincide with the delegation of specialised services.

Dated 2023

West Midlands Integrated Care Boards

NHS Birmingham and Solihull Integrated Care Board

NHS Black Country Integrated Care Board

NHS Coventry and Warwickshire Integrated Care Board

NHS Herefordshire and Worcestershire Integrated Care Board

NHS Shropshire, Telford and Wrekin Integrated Care Board

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Agreement in relation to the establishment and operation of joint working arrangements –

“Tier One”: Joint Committee West Midlands

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Clause heading and number — Page number

THIS AGREEMENT is made on the_____ day of _____2023

BETWEEN[1]:

(1) NHS Birmingham and Solihull Integrated Care Board

(2) NHS Black Country Integrated Care Board

(3) NHS Coventry and Warwickshire Integrated Care Board

(4) NHS Herefordshire and Worcestershire Integrated Care Board

(5) NHS Shropshire, Telford and Wrekin Integrated Care Board

And

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

each a "Partner" and together the “Partners”.

{●} **ICB**, {●} **ICB** and {●} **ICB** are together referred to in this Agreement as the **“ICBs”,** and **“ICB”** shall mean any of them.

BACKGROUND

(A) The ICBs have statutory functions to make arrangements for the provision of services for the purposes of the NHS in their areas, apart from those commissioned by NHSE.

(B) Pursuant to section 65Z5 of the NHS Act, NHSE and the ICBs are able to establish and maintain joint arrangements in respect of the discharge of their commissioning functions.

(C) ICBs agree to exercise decisions of the Joint Committee(s) under section 65Z5 of the NHS Act and as set out in this Agreement and the Terms of Reference.

(D) ICBs acknowledge and agree that making joint arrangements to exercise ICB Commissioning Functions is likely to lead to an improvement in the way the Commissioning Functions of all Partners are exercised.

(E) This Agreement sets out the arrangements that will apply the ICBs in relation to the joint exercising of the Joint Working / Joint Commissioning Functions for the ICBs’ populations. These arrangements are intended to better align and transform pathways of care around the needs of local populations.

(F) ICBs have entered into this Agreement to define their arrangements for joint working. To avoid doubt, none of the Partners are delegating the exercise of any of their Commissioning Functions or any other functions to any other Partner under this Agreement.

(G) This Agreement is intended for use in the 2023/24 financial year, to govern defined Services; ICBs will:

(A) Govern the joint working between ICBs in relation to the commissioning functions delegated to the Joint Committee by the ICBs and as defined in Schedule 4 of this agreement. The Joint Committee will discharge the delegated functions through its subgroups and in accordance with the Scheme of Reservation and Delegation defined by the joint committee

NOW IT IS HEREBY AGREED as follows:

1. **COMMENCEMENT AND DURATION**

1.1 This Agreement has effect from the date of this Agreement and will remain in force for the Initial Term unless terminated in accordance with Clause 19 (Leaving the Joint Committee) below.

1.2 The Partners may extend this Agreement beyond the Initial Term for a further period, by written agreement prior to the expiry of the Initial Term.

2. **PRINCIPLES AND AIMS**

2.1 The Partners acknowledge that, in exercising their obligations under this Agreement, each Partner must comply with the statutory duties set out in the NHS Act and must:

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

2.1.2 consider how, in performing its obligations, it can address health inequalities;

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

2.1.4 act at all times in good faith towards each other.

2.2 The Partners agree:

2.2.1 that successfully implementing this Agreement will require strong relationships and an environment based on trust and collaboration;

2.2.2 to seek to continually improve whole pathways of care pertinent to the Joint Working / Joint Commissioning services and to design and implement effective and efficient integration;

2.2.3 to act in a timely manner;

2.2.4 to share information and best practice, and work collaboratively to identify solutions, eliminate duplication of effort, mitigate risks and reduce cost;

2.2.5 to act at all times in accordance with the scope of their statutory powers; and

2.2.6 to have regard to each other's needs and views, irrespective of the relative contributions of the Partners to the commissioning of any Joint Working and Joint Commissioning services and, as far as is reasonably practicable, take such needs and views into account.

2.3 The Partners' primary aim is to maximise the benefits to patients of integrating the Joint Functions with the ICBs' Commissioning Functions through designing and commissioning the Joint Working / Joint Commissioning services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim.

3. SCOPE OF JOINT WORKING ARRANGEMENTS

3.1 This Agreement sets out the arrangements through which the Partners will work together to exercise the Joint Functions as set out in Schedule 4, including:

3.1.1 the establishment of a Joint Committee;

3.1.2 the participation by all Partners in the work of the Joint Committee;

3.1.3 the development of leadership and expertise in respect of the Joint Working / Joint Commissioning services, collectively referred to as the "Joint Working Arrangements".

4. JOINT COMMITTEE

4.1 The Partner ICBs shall together establish a Joint Committee which will operate in accordance with the Terms of Reference set out in Schedule 3.

4.2 The Joint Committee may establish sub-groups or sub-committees of the Joint Committee, which will operate in accordance with the relevant Terms of Reference agreed by the Joint Committee.

4.3 The Partners shall nominate Authorised Officers to the Joint Committee in accordance with Schedule 3.

4.4 Subject to Clauses **Error! Reference source not found.** to 17.4 and the terms of the Schedules, ICBs in accordance with this Agreement must reach decisions in relation to the Joint Functions through discussion and agreement. Where in exceptional cases consensus cannot be reached between the members of the Joint Committee in respect of matters under consideration, any voting arrangements set out in the Terms of Reference will apply.

4.5 The ICBs shall ensure that their Authorised Officers have appropriate delegated authority, in accordance with each ICB's internal governance arrangements, to represent the interests of each ICB in the Joint Committee and any other sub-groups or sub-committees established by it.

4.6 The Partners recognise the need to ensure that any potential conflicts of interest on the part of any Partner, including its representatives, in respect of this Agreement and the establishment or operation of the Joint Committee and any sub-group or sub-committee of it must be appropriately identified, recorded and managed.

5. JOINT FUNCTIONS

5.1 This Agreement shall include functions that the ICBs delegate to it as outlined in Schedule 4 in respect of the Joint Working / Joint Commissioning services.

5.2 The Partners must establish effective, safe, efficient and economic arrangements for the discharge of the Joint Functions.

5.3 Partners must exercise the Joint Functions outline in the Joint Committee in accordance with:

5.3.1 the terms of this Agreement;

5.3.2 all applicable Law;

5.3.3 Guidance;

5.3.4 the Terms of Reference; and

5.3.5 Good Practice.

5.4 In exercising the Joint Functions, the Joint Committee must comply with the Mandated Guidance set out in Schedule 6, or otherwise referred to in this Agreement, and such further Mandated Guidance as may be issued by NHSE from time to time, including on NHSE or FutureNHS websites.

5.5 The Joint Committee must perform the Joint Functions:

5.5.1 in such a manner as to ensure ICBs compliance with its statutory duties in respect of the Joint Functions;

5.5.2 having regard to NHSE's accountability to the Secretary of State and Parliament in respect of any NHSE delegated Functions.

6. FURTHER COLLABORATIVE WORKING

6.1 An ICB may, at its discretion, table for discussion at any Joint Committee meeting an item relating to any ICB Function, in order to facilitate engagement and promote integration and collaborative working. Decision-making in respect of such discussions will remain with the relevant ICB. For the avoidance of doubt, the Joint Committee will not have any authority to take decisions in respect of ICB Functions, outside of services defined in Schedule 4

6.2 NHSE may table for discussion at any Joint Committee meeting an item relating to NHSE's accountability to the Secretary of State and Parliament in respect of any NHSE delegated Functions or any such other of NHSE's Functions that it considers appropriate in order to facilitate engagement and promote integration and collaborative working.

7. FINANCE

7.1 The Joint Committee shall ensure full compliance with Finance Guidance and any other relevant Mandated Guidance.

7.2 Each Partner shall bear its own costs as they are incurred, unless expressly provided otherwise in this Agreement or otherwise agreed in advance in writing by the Partners. Such costs may include, but will not be limited to, costs of attendance at Joint Committee meetings and costs in complying with each Partner's relevant obligations in this Agreement.

7.3 Prior to the end of the first year of the Term, the Partners will review the financial arrangements described for the joint commissioning of services outlined in Schedule 4 and consider whether alternative arrangements should be put in place for any extended Term. Any changes to this Agreement to effect such new arrangements will be made in accordance with Clause 9 (Variations).

7.4 Any costs relating to the operation of the Joint Committee shall be shared equally by each Partner

7.5 Financial arrangements for costs associated with the joint commissioning of Services in Schedule 4 will be defined in the relevant Hosting agreement for the services

8. STAFFING

8.1 Staff employed to carry out the functions for commissioning and its associated functions for all services outlined in Schedule 4 and for the management for the Joint Committee will be defined in the relevant hosting agreement for the services

8.2 Any costs associated with the staffing for the Joint Commissioning of services will be met equally by each partner

9. VARIATIONS

9.1 The Partners acknowledge that the scope of the Joint Working Arrangements, including the scope of the Joint Functions, may be reviewed and amended from time to time.

9.2 This Agreement may be varied by the agreement of the Partners at any time in writing in accordance with the Partners' internal decision-making processes.

10. DATA PROTECTION

10.1 The Partners must ensure that all Personal Data processed by or on behalf of them in the course of carrying out the Joint Working Arrangements is processed in accordance with the relevant Partner's obligations under Data Protection Legislation and Data Guidance, and the Partners must assist each other as necessary to enable each other to comply with these obligations.

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

10.2.1 becomes aware of any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted or unusable; or

10.2.2 becomes aware of any security breach,

in respect of the Relevant Information it shall promptly notify the Joint Committee. The Partners shall fully co-operate with one another to remedy the issue as soon as reasonably practicable.

10.3 In processing any Relevant Information further to this Agreement, each Partner shall at all times comply with all NHSE policies and guidance on the handling of data.

10.4 Any information governance breach must be responded to in accordance with Data Security and the Protection Incident Reporting tool. If any Partner is required under Data Protection Legislation to notify the Information Commissioner's Office or a Data Subject of an information governance breach, then, as soon as reasonably practical and in any event on or before the first such notification is made, the relevant Partner must fully inform the Joint Committee of the breach. This clause does not require the relevant Partner to provide information which identifies any individual affected by the breach where doing so would breach Data Protection Legislation.

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

10.6 The Partners will share information to enable joint service planning, commissioning, and financial management subject to the requirements of law, including in particular the Data Protection Legislation in respect of any Personal Data.

10.7 Other than in compliance with judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise required by any Law, no information will be shared with any other Partners save as agreed by the Partners in writing.

10.8 Schedule 5 makes further provision about information sharing and information governance.

11. IT INTER-OPERABILITY

11.1 The Partners will work together to ensure that all relevant IT systems operated by the Partners in respect of the Joint Functions are inter-operable and that data may be transferred between systems securely, easily and efficiently.

11.2 The Partners will use their respective reasonable endeavours to help develop initiatives to further this aim.

12. FURTHER ARRANGEMENTS

12.1 The Partners must give due consideration to whether any of the Joint Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under section 65Z5 and section 75 of the NHS Act. The Partners must comply with any Guidance around the commissioning of Joint Specialised Services by means of arrangements under section 65Z5 or 75 of the NHS Act.

13. FREEDOM OF INFORMATION

13.1 Each Partner acknowledges that the others are a 'Public Authority' for the purposes of the Freedom of Information Act 2000 (**"FOIA"**) and the Environmental Information Regulations 2004 (**"EIR"**).

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

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

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

13.2.3 each Partner acknowledges that the final decision as to the form or content of the response to any request is a matter for the Partner to whom the request is addressed.

13.3 NHS England may, from time to time, issue a FOIA or EIR protocol or update a protocol previously issued relating to the dealing with and responding to of FOIA or EIR requests in relation to the Joint Working Arrangements. The Joint Committee and each Partner shall comply with such FOIA or EIR protocols.

14. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY

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

14.2 Without prejudice to the general obligations set out in Clause 5 (Joint Functions), each ICB must maintain a register of interests in respect of all persons involved in decisions concerning the Joint Functions. This register must be publicly available. For the purposes of this clause, an ICB may rely on an existing register of interests rather than creating a further register.

14.3 Where any member of the Joint Committee has an actual or potential conflict of interest in relation to any matter under consideration by the Joint Committee, that member must not

participate in meetings (or parts of meetings) in which the relevant matter is discussed or make a recommendation in relation to the relevant matter. The relevant appointing body may send an alternative representative to take the place of the conflicted member in relation to that matter.

15. CONFIDENTIALITY

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

15.2 Subject to Clause 15.3, the receiving Partner agrees:

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

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

15.2.3 to maintain the confidentiality of the disclosing Partner's Confidential Information.

15.3 The receiving Partner may disclose the disclosing Partner's Confidential Information:

15.3.1 in connection with any Dispute Resolution Procedure;

15.3.2 to comply with the Law;

15.3.3 to any appropriate Regulatory or Supervisory Body;

15.3.4 to its staff, who in respect of that Confidential Information will be under a duty no less onerous than the Receiving Partner's duty under Clause 15.2;

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

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

15.4 The obligations in Clause 15 will not apply to any Confidential Information which:

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

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

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

15.5 This Clause 15 does not prevent an ICB making use of or disclosing any Confidential Information disclosed any other ICB where necessary for the purposes of exercising its functions in relation to that ICB.

15.6 This Clause 15 will survive the termination of this Agreement for any reason for a period of 5 years.

15.7 This Clause 15 will not limit the application of the Public Interest Disclosure Act 1998 in any way whatsoever.

16. LIABILITIES

16.1 Nothing in this Agreement shall affect:

16.1.1 the liability of any of the ICBs to any person in respect of that ICB's Commissioning Functions.

16.2 Partner ICBs shall be responsible for and shall retain the conduct of any Claim in relation to the Joint Functions.

16.3 Each ICB must:

16.3.1 comply with any agreed policy issued by Partners from time to time in relation to the conduct of or avoidance of Claims or the pro-active management of Claims;

16.3.2 if it receives any correspondence, issue of proceedings, claim document or other document concerning any Claim or potential Claim, immediately notify the Joint Committee and send to them all copies of such correspondence;

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

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

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

17. DISPUTE RESOLUTION

17.1 Where any dispute arises within the Joint Committee in connection with this Agreement, the Partners must use their best endeavours to resolve that dispute within the Joint Committee in accordance with the Terms of Reference.

17.2 Where any dispute is not resolved under Clause 17.1 on an informal basis, any Authorised Officer may convene a special meeting of the Joint Committee to attempt to resolve the dispute

17.3 Where any dispute is not resolved under Clause 17.1 or 18.2 the Joint Committee can appoint an independent mediator to attempt to resolve the dispute. The cost of mediation will be borne in equal shares between parties involved in the dispute.

17.4 Where any dispute is remains resolved The Joint Committee will commissioning an independent review. The Joint Committee will abide by the independent review findings. The cost will be borne in equal shares between parties involved in the dispute.

18. BREACHES OF JOINT WORKING

18.1 If any Partner does not comply with the terms of this agreement in relation to services delegated by ICBs then Patners may:

18.1.1 exercise its rights under this Agreement; and

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

18.2 Without prejudice to Clause 18.1, if any Partner does not comply with the terms of this Agreement (including if the Joint Committee or any Partner exceeds its authority under this Agreement), Partners may (at their discretion):

18.2.1 waive its rights in relation to such non-compliance in accordance with Clause 18.3;

18.2.2 ratify any decision;

18.2.3 terminate this Agreement in accordance with Clause 19 (Leaving the Joint Committee*)* below;

18.2.4 exercise the dispute resolution procedure in accordance with Clause 17 *(Dispute Resolution Procedure)*; and/or

18.2.5 exercise its rights under common law.

18.3 Partner may waive any non-compliance by another Partner with the terms of this Agreement provided that the Partner provides a written report to the Joint Committee as required by Clause 18.4 and, after considering the Partner's written report, Partner is satisfied that the waiver is justified.

18.4 If:

18.4.1 a Partner does not comply with this Agreement; or

18.4.2 Partners notifies a Partner that it considers the Partner has not complied, or may not be able to comply with, this Agreement;

then that Partner must provide a written report to Partners within ten (10) Operational Days of the non-compliance (or the date on which the relevant Partner considers that it may not be able to comply with this Agreement) or such notification pursuant to Clause 24 setting out:

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

18.4.4 if the non-compliance is capable of remedy, a plan for how the Partner proposes to remedy the non-compliance.

19. LEAVING THE JOINT COMMITTEE

19.1 If any Partner wishes to exit the Joint Committee and end its participation in this Agreement, the relevant ICB must provide at least six (6) months notification to the Joint Committee of its intention to exit the Joint Committee and end its participation in this Agreement. Such notification shall only take effect from the end of 31 March in any calendar year.

19.2 Partners will work together to ensure that there are suitable alternative arrangements in place in relation to the exercise of the Joint Functions.

19.3 The exercise of the Joint Functions does not alter accountability any partner

20. CONSEQUENCES OF TERMINATION

20.1 Upon termination of this Agreement (in whole or in part), for any reason whatsoever, the following shall apply:

20.1.1 the Partners agree that they will work together and co-operate to ensure that the winding down of these arrangements is carried out smoothly and with as little disruption as possible to patients, employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so;

20.1.2 termination of this Agreement shall have no effect on the liability of any rights or remedies of any Partner already accrued, prior to the date upon which such termination takes effect.

20.2 The provisions of Clauses 10 (Data Protection), 13 (Freedom of Information), 15 (Confidentiality), 16 (Liabilities) and 20 (Consequences of Termination) shall survive termination or expiry of this Agreement.

21. PUBLICITY

21.1 The Partners shall use reasonable endeavours to consult one another before making any public announcements concerning the subject matter of this Agreement.

22. EXCLUSION OF PARTNERSHIP OR AGENCY

22.1 Nothing in this Agreement shall create or be deemed to create a legal partnership under the Partnership Act 1890 or the relationship of employer and employee between the Partners, or render any Partner directly liable to any third party for the debts, liabilities or obligations of any Partner.

22.2 Save as specifically authorised under the terms of this Agreement, no Partner shall hold itself out as the agent of any other Partner.

23. THIRD PARTY RIGHTS

23.1 The Contracts (Rights of Third Parties) Act 1999 shall not apply to this Agreement and accordingly the Partners to this Agreement do not intend that any third party should have any rights in respect of this Agreement by virtue of that Act.

24. NOTICES

24.1 Any notices given under this Agreement must be sent by e-mail to the relevant Authorised Officers or their nominated deputies.

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

25. ASSIGNMENT AND SUBCONTRACTING

25.1 This Agreement, and any right and conditions contained in it, may not be assigned or transferred by a Partner, without the prior written consent of the other Partners, except to any statutory successor to the relevant function.

26. SEVERABILITY

26.1 If any term, condition or provision contained in this Agreement shall be held to be invalid, unlawful or unenforceable to any extent, such term, condition or provision shall not affect the validity, legality or enforceability of the remaining parts of this Agreement.

27. WAIVER

27.1 No failure or delay by a Partner to exercise any right or remedy provided under this Agreement or by law shall constitute a waiver of that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy. No single or

partial exercise of such right or remedy shall prevent or restrict the further exercise of that or any other right or remedy.

28. **STATUS**

28.1 The Partners acknowledge that they are health service bodies for the purposes of section 9 of the NHS Act. Accordingly, this Agreement shall be treated as an NHS contract and shall not be legally enforceable.

29. **ENTIRE AGREEMENT**

29.1 This Agreement constitutes the entire agreement and understanding of the Partners and supersedes any previous agreement between the Partners relating to the subject matter of this Agreement.

30. **GOVERNING LAW AND JURISDICTION**

30.1 Subject to the provisions of Clause 17 (Dispute Resolution) and Clause 28 (Status), this Agreement shall be governed by and construed in accordance with English Law, and the Partners irrevocably agree that the courts of England shall have exclusive jurisdiction to settle any dispute or claim that arises out of or in connection with this Agreement.

31. **FAIR DEALINGS**

31.1 The Partners recognise that it is impracticable to make provision for every contingency which may arise during the life of this Agreement and they declare it to be their intention that this Agreement shall operate between them with fairness and without detriment to the interests of either of them and that, if in the course of the performance of this Agreement, unfairness to either of them does or may result, then the other shall use its reasonable endeavours to agree upon such action as may be necessary to remove the cause or causes of such unfairness.

32. **COMPLAINTS**

32.1 Any complaints received by the Partners shall be dealt with in accordance with the statutory complaints procedure of the Partner to whose Commissioning Function(s) the complaint relates. For the avoidance of doubt, Partners shall manage all complaints in respect of the Service in Schedule 4.

33. **COUNTERPARTS**

33.1 This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

This Agreement has been entered into on the date stated at the beginning of it.

SIGNED by ....

for and on behalf of **Integrated Care Board** of **NHS Birmingham and Solihull ("ICB"**); (Signature)

.....

(Date)

SIGNED by ....

for and on behalf of **Integrated Care Board** of **NHS Black Country ("ICB"**); (Signature)

.....

(Date)

SIGNED by ....

for and on behalf of **Integrated Care Board** of **NHS Coventry and Warwickshire** ("{●} **ICB"**). (Signature)

.....

(Date)

SIGNED by ....

for and on behalf of **Integrated Care Board** of **NHS Staffordshire and Stoke-on-Trent** ("{●} **ICB"**). (Signature)

.....

(Date)

SIGNED by ....

for and on behalf of **Integrated Care Board** of **Herefordshire and Worcestershire** ("{●} **ICB"**). (Signature)

.....

(Date)

SIGNED by ....

for and on behalf of **Integrated Care Board** of **NHS Shropshire, Telford and Wrekin** ("{●} **ICB"**). (Signature)

.....

(Date)

SCHEDULE 1: DEFINITIONS AND INTERPRETATIONS

DEFINITIONS AND INTERPRETATION

1. In this Agreement, unless the context otherwise requires, the following words and expressions shall have the following meanings:

“Agreement"	this agreement between the Partners comprising these terms and conditions together with all schedules attached to it;
“Area”	means the geographical area covered by the ICBs;
"Authorised Officer"	the individual(s) appointed as Authorised Officer in accordance with Schedule 3 (Terms of Reference);
"Change in Law"	a change in Law that is relevant to the arrangements made under this Agreement, which comes into force after the Commencement Date;
“Claim”	means for or in relation to the Joint Functions and Reserved Functions (a) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal or the Secretary of State, any governmental, regulatory or similar body, or any department, board or agency or (b) any dispute with, or any investigation, inquiry or enforcement proceedings by any governmental, regulatory or similar body or agency;
“Clinical Commissioning Policies”	a nationally determined clinical policy sets out the commissioning position on a particular clinical treatment issue and defines accessibility (including a not for routine commissioning position) of a medicine, medical device, diagnostic technique, surgical procedure or intervention for patients with a condition requiring a specialised service;
“Clinical Reference Groups”	means a group consisting of clinicians, commissioners, public health experts, patient and public voice representatives and professional associations, which offers specific knowledge and expertise on the best ways that Services detailed in Schedule 4 should be provided;
“Collaborative Commissioning Agreement”	means an agreement under which NHS Commissioners set out collaboration arrangements in respect of commissioning Services detailed in Schedule 4;
"Commencement Date"	{means 1 April 2023};
"Commissioning Functions"	the respective statutory functions of the Partners in arranging for the provision of services as part of the health service;
"Confidential Information"	means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement or arrangements made pursuant to it and: (a) which comprises Personal Data or which relates to any patient or his treatment or medical history; (b) the release of which is likely to prejudice the commercial interests of a Partner; or

	(c) which is a trade secret;
“Contracting Standard Operating Procedure”	means the Contracting Standard Operating Procedure produced by NHS England in respect of the Services detailed in Schedule 4;
“Core Membership”	means the voting membership of the Joint Committee as set out in the Terms of Reference;
“Data Controller”	shall have the same meaning as set out in the Data Protection Legislation;
“Data Processor”	shall have the same meaning as set out in the Data Protection Legislation;
“Data Guidance”	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement regarding information governance, confidentiality, privacy or compliance with Data Protection Legislation to the extent published and publicly available or their existence or contents have been notified to the ICB or any relevant Regulatory or Supervisory Body. This includes but is not limited to guidance issued by NHS Digital, the National Data Guardian for Health & Care, the Department of Health & Social Care, NHSE, the Health Research Authority, the UK Health Security Agency and the Information Commissioner;
"Data Protection Legislation"	means the UK General Data Protection Regulation, the Data Protection Act 2018, the Regulation of Investigatory Powers Act 2000, the Telecommunications (Lawful Business Practice) (Interception of Communications) Regulations 2000 (SI 2000/2699), the Privacy and Electronic Communications (EC Directive) Regulations 2003 (SI 2426/2003), the common law duty of confidentiality and all applicable laws and regulations relating to the processing of personal data and privacy, including where applicable the guidance and codes of practice issued by the Information Commissioner;
“Data Protection Officer”	shall have the same meaning as set out in the Data Protection Legislation;
“Data Security and Protection Incident Reporting tool”	the incident reporting tool for data security and protection incidents, which forms part of the Data Security and Protection Toolkit available at https://www.dsptoolkit.nhs.uk/;
"Dispute Resolution Procedure"	the procedure set out in Clause 17 (Dispute Resolution);
“Finance Guidance”	guidance, rules and operating procedures produced by ICBs that relate to these Joint Working Arrangements, including but not limited to the following: - Commissioning Change Management Business Rules; - Contracting Standard Operating Procedure; - Cashflow Standard Operating Procedure; - Finance and Accounting Standard Operating Procedure; - Service Level Framework Guidance;

"FOIA"	the Freedom of Information Act 2000 and any subordinate legislation made under it from time to time, together with any guidance or codes of practice issued by the Information Commissioner or relevant government department concerning this legislation;
"ICB Functions"	the Commissioning Functions of the ICB;
"Information"	has the meaning given under section 84 of FOIA;
"Indemnity Arrangement"	mean either: (i) a policy of insurance; (ii) an arrangement made for the purposes of indemnifying a person or organisation; or (iii) a combination of (i) and (ii);
"Information Sharing Agreement"	any information sharing agreement entered into in accordance with Schedule 5 (Further Information Governance and Sharing Provisions);
"Indemnity Arrangement"	means either: (i) a policy of insurance; (ii) an arrangement made for the purposes of indemnifying a person or organisation; or (iii) a combination of (i) and (ii);
"Initial Term"	the period of one year from 1 April 2023;
"Joint Committee"	means the joint committee of the ICBs, established under this Agreement on the terms set out in the Terms of Reference;
"Joint Working Arrangements"	means the arrangements for joint working as set out in Clause 3 (Scope of Joint Working Arrangements);
"Joint Functions"	as set out in Schedule 2, that shall be jointly exercised by the ICBs through the decisions of the Joint Committee in accordance with the Terms of Reference in Schedule 3;
"Law"	means: (a) any statute or proclamation or any delegated or subordinate legislation; (b) any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and (c) any judgment of a relevant court of law which is a binding precedent in England;
"Mandated Guidance"	means any protocol, policy, guidance, guidelines, framework or manual relating to the exercise of the Joint Functions and issued by NHSE from time to time as mandatory in respect of the Joint Working Arrangements. At the Commencement Date the Mandated Guidance in respect of the Joint Functions shall be as set out in Schedule 6;
"National Standards"	means the service standards for each Service, as set by NHSE and included in Clinical Commissioning Policies or National Specifications;

“National Specifications”	the service specifications published by NHSE in respect of Services detailed in Schedule 4 as applicable;
“Need to Know”	has the meaning set out in Schedule 5;
“NHS Act”	the National Health Service Act 2006;
“NHS England Functions”	NHSE’s statutory functions exercisable under or by virtue of the NHS Act;
“Non-Personal Data”	means data which is not Personal Data;
“**Oversight Framework**”	means the NHS Oversight Framework, as may be amended or replaced from time to time, and any relevant associated Guidance published by NHSE;
“Partners”	the parties to this Agreement;
"Personal Data"	has the meaning set out in the Data Protection Legislation;
“Population”	means the population for which an ICB or all of the ICBs have the responsibility for commissioning health services;
“Regional Quality Group”	A group set up to act as a strategic forum at which regional partners from across health and social care can share, identify and mitigate wider regional quality risks and concerns as well as share learning so that quality improvement and best practice can be replicated;
“Regulatory or Supervisory Body”	means any statutory or other body having authority to issue guidance, standards or recommendations with which the relevant Party and/or Staff must comply or to which it or they must have regard, including: (i) CQC; (ii) NHS England; (iii) the Department of Health and Social Care; (iv) NICE; (v) Healthwatch England and Local Healthwatch; (vi) the General Medical Council; (vii) the General Dental Council; (viii) the General Optical Council; (ix) the General Pharmaceutical Council; (x) the Healthcare Safety Investigation Branch; and (xi) the Information Commissioner;

“Relevant Information”	means the Personal Data and Non-Personal Data processed under this Agreement, and includes, where appropriate, “confidential patient information” (as defined under section 251 of the NHS Act), and “patient confidential information” as defined in the 2013 Report, The Information Governance Review – “*To Share or Not to Share?”*);
"Request for Information"	has the meaning set out in the FOIA;
“Reserved Functions”	those aspects of the Specialised Commissioning Functions that are not Joint Functions, including but not limited to those set out in Schedule 6;
“**Relevant Clinical Networks”**	means those clinical networks identified by NHSE as required to support the commissioning of any Services detailed in Schedule 4 for the population;
“Shared Care Arrangements”	these arrangements support patients receiving elements of their care closer to home, whilst still ensuring that they have access to the expertise of a specialised centre and that care is delivered in line with the expectation of the relevant National Specification;
“Single Point of Contact”	the member of Staff appointed by each relevant Partner in accordance with the terms of reference in Schedule 3;
“Special Category Personal Data”	has the meaning set out in the Data Protection Legislation;
“Commissioning Budget”	means the budget identified by NHSE for the purpose of exercising the Joint Functions;
“Specified Purpose”	means the purpose for which the Relevant Information is shared and processed to facilitate the exercise of the Joint Functions and Reserved Functions as specified in Schedule 5 *(Further Information Governance and Sharing Provisions)* to this Agreement;
“Services Staff”	means the Staff carrying out the Joint Services Functions immediately prior to the date of this Agreement;
“Staff”	means the Partners’ employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of any Partner (whether or not the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors’ and their sub-contractors’ personnel;
“System quality group”	means a group set up to identify and manage concerns across the local system. The system quality group shall act as a strategic forum at which partners from across the local health and social care footprint can share issues and risk information to inform response and management, identify and mitigate quality risks and concerns as well as share learning and best practice;
"Term"	the Initial Term, as may be varied by: (a) any extensions to this Agreement that are agreed under Clause 1.1 (Commencement and Duration); or (b) the earlier termination of this Agreement in accordance with its terms;
“Terms of Reference”	means the Terms of Reference for the Joint Committee agreed between the ICBs at the first meeting of the Joint Committee, a draft

	of which is included at Schedule 3 (Joint Committee – Terms of Reference);
“Triple Aim”	the duty on each of the Partners in making decisions about the exercise of their functions, to have regard to all likely effects of the decision in relation to: (a) the health and well-being of the people of England; (b) the quality of services provided to individuals by the NHS; (c) efficiency and sustainability in relation to the use of resources by the NHS;
“UK GDPR”	means Regulation (EU) 2016/679 of the European Parliament and of the Council of 27th April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018;
"Working Day"	any day other than Saturday, Sunday, a public or bank holiday in England.

2. References to statutory provisions shall be construed as references to those provisions as respectively amended or re-enacted (whether before or after the Commencement Date) from time to time.

3. The headings of the Clauses in this Agreement are for reference purposes only and shall not be construed as part of this Agreement or deemed to indicate the meaning of the relevant Clauses to which they relate. Reference to Clauses are Clauses in this Agreement.

4. References to Schedules are references to the schedules to this Agreement and a reference to a Paragraph is a reference to the paragraph in the Schedule containing such reference.

5. References to a person or body shall not be restricted to natural persons and shall include a company, corporation or organisation.

6. Words importing the singular number only shall include the plural.

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

8. Where anything in this Agreement requires the mutual agreement of the Partners, then unless the context otherwise provides, such agreement must be in writing.

9. Any reference to the Partners shall include their respective statutory successors, employees and agents.

10. In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

11. Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

SCHEDULE 2: JOINT COMMITTEE OPERATING MODEL AND ITS SUB GROUPS

1.Introduction

1.1 The Joint Committee wil operate in 2 parts these being

- Part 1: Functions of NHSE that are not yet delegated to ICB's which are desingnated for formal joint working
- Part 2: Functions and services dlegated to it from the individual ICBs

1.2 The Terms of Reference for any sub groups operating on behalf of the joint committee must be formally approved by the Joint Committee

1.3 By entering into this JWA ICBs agree to work collaboratively with regard to the services for which they have commissioning responsibility and/ or delegated responsibility from NHSE as set out in schedule 4**.**

1.4 ICBs will also enter into a JWA agreement with NHSE for the purpose of specialised.

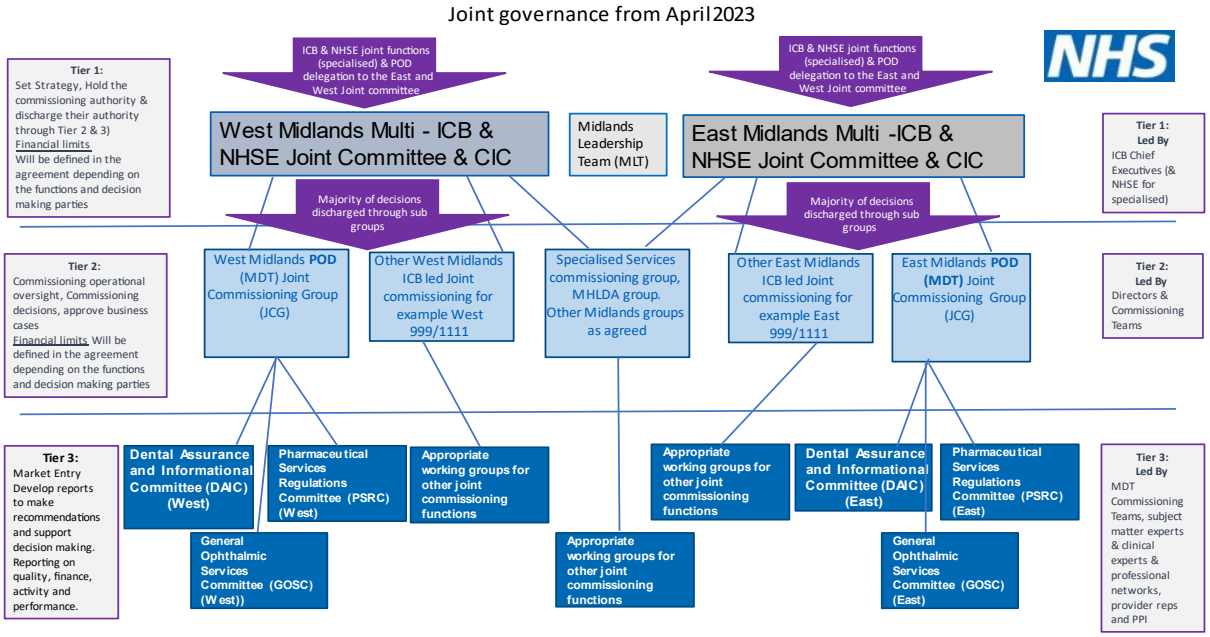
1.5 Both JWA align to the establishment of a single Joint Committee that will govern the discharging of the functions delegated to it.

1.6 The Joint Committee may at is determination establish a structure of commissioning groups/ subgroups through which the Joint Committee will discharge the functions delegated to it. An illustration of such a model ca be seen below.

1.7 This illustration (figure 1 below) should not be considered as the exhaustive or approved structure the Joint Committee will approve the Scheme of Reservation and Delegation and Scheme of Matters Delegated to Officers that sets out how the powers/ functions and duties delegated to it are to be discharges.

1.8 The joint committee will set the parameters of the commissioning committees and subgroups and will approve the Terms of Reference of any aligned commissioning committee or subgroup.

Figure 1



SCHEDULE 3: TIER 1 JOINT COMMITTEE – TERMS OF REFERENCE

Document name:		West Midlands ICB Joint Committee Terms of Reference	
Senior Responsible Owner (SRO):		[Insert]	
Lead:		[Insert]	
Version	[Insert]	**Date:**	[Publish Date]

Document management

Revision history

Version	Date	Summary of changes

Approved by

This document must be approved by the following people:

Name	Signature	Title	Date	Version

Related documents

Title	Owner	Location

Introduction and purpose	The Joint Committee has been established by the ICBs as listed: **Integrated Care Board** of **NHS Derby and Derbyshire ("ICB"**); **Integrated Care Board** of **NHS Leicester, Leicestershire and Rutland** ("{LLR} **ICB"**); **Integrated Care Board** of **NHS Lincolnshire** ("{●} **ICB"**). **Integrated Care Board** of **NHS Northamptonshire** ("{●} **ICB"**). **Integrated Care Board** of **NHS Nottingham and Nottinghamshire** ("{●} **ICB"**). **And** **NHS England** In order to jointly discharge commissioning responsibilities covering the EAST Midlands geographical footprint defined in Schedule 4 of the Joint Working Agreement between the parties. This includes:- • Responsibilities for which the ICBs and NHSE are jointly responsible for commissioning. [PART A of the meeting]. • Responsibilities for which the ICBs are responsible for (including those delegated to them by NHSE England). [PART B of the meeting]. • The Joint Committee will collaboratively make decisions on the strategic planning and delivery, including resource allocation, oversight and assurance, to improve health and care outcomes and reduce health inequalities. • Subject to Clauses 6.1 and 6.2 of the Joint Working Agreement (Further Collaborative Working), the Partners may, to such extent that they consider it desirable, table an item at the Joint Committee relating to any other of their functions that is not a Joint Function to facilitate engagement, promote integration and collaborative working. The Partners may establish sub-groups or sub-committees of the Joint Committee, with such Terms of Reference as may be agreed between them. Any such arrangements that are in place at the commencement of the Joint Working Agreement may be documented in the Local Terms (Schedule 7).

The Terms of Reference	These Terms of Reference support effective collaboration between all Partners acting through this Joint Committee. They set out the role, responsibilities, membership, decision-making powers and reporting arrangements of the Joint Committee in accordance with the Joint Working Agreement between the ICBs, and ICBs & NHSE. The Joint Committee will operate as the decision-making forum for exercising the agreed Joint Functions in accordance with the Joint Working Agreement. By agreement, the Partners may use an alternative title for the Joint Committee that reflects local arrangements, for example, 'Commissioning Committee.'
Statutory Framework	The Partners have arranged to exercise the Relevant Functions jointly pursuant to section 65Z5 of the NHS Act 2006. The Joint Committee is established pursuant to section 65Z6 of the NHS Act 2006. Apart from as set out in the Agreement, the Joint Committee does not affect, and must act in accordance with, the statutory responsibilities and accountabilities of the Partners.
Role of the Joint Committee	The role of the Joint Committee for Part A and Part B is to provide strategic decision-making, leadership and oversight for the Joint Working and Joint Commissioning services and any associated activities. The Joint Committee and aligned subsidiary arrangements will safely, effectively, efficiently and economically discharge the Joint Functions and deliver these services through the following key responsibilities:- • Making relevant joint decisions in relation to the planning and commissioning of the services, and any associated commissioning or statutory functions, for the population, for example, through undertaking population needs assessments; • Making recommendations on population-based services financial allocation and financial plans; • Identifying and setting strategic priorities and undertaking ongoing assessment and review of services within the remit of the Joint Committee and aligned subsidiary arrangements, including tackling unequal outcomes and access; • Supporting the development of partnership and integration arrangements with other health and care bodies that facilitate population health management and providing a forum that enables collaboration to integrate service pathways, improve population health and services and reduce health inequalities. This includes establishing links and working effectively with Provider Collaboratives and cancer alliances, and working closely with other ICBs, Joint Committees and NHSE where there are cross-border patient flows to providers; • Will provide strategic quality leadership and oversight for services outlined in Schedule 4 • Determining the appropriate structure of subsidiary arrangements to enable:- o Oversight and assurance of the services in relation to quality, operational and financial performance, including co-ordinating risk / issue management or escalation; and developing the approach to intervention with Specialised Services Providers where there are quality or contractual issues;

	○ Effective engagement with stakeholders, including patients and the public, and involving them in decision-making; ○ The input of appropriate clinical advice and leadership, including through Clinical Reference Groups and Relevant Clinical Networks; • Otherwise ensuring that the roles and responsibilities set out in the Agreement between the Partners are discharged in compliance with all statutory duties, guidance and good practice, including ensuring that the Joint Committee and aligned subsidiary arrangements have sufficient independent scrutiny of its decision-making and processes. PART A – NHSE & ICB NHS England will be a Partner for the commissioning of Specialised Services defined under a separate Joint Working Agreement. ICB and NHSE under that agreement will make joint decisions for the benefit of the population PART B – ICB Only ICBs defined in the Tier One Joint Committee of the East Midlands will make decisions regarding all services outlined in Schedule 4 and will act as a forum for discussion and make recommendations to ICBs on issues where further joint action or working between ICBs would be of benefit outside the arrangements delegated to it. This might include but would not be limited to:- ○ Joint Policy development ○ Links to other regional structures such as Academic Health Science Networks and Clinical networks.
Accountability and reporting	PART A The Joint Committee will be formally accountable to the Boards of the ICBs and the Board of NHSE through the relevant NHSE regional governance structure for the functions delegated to the Joint Committee through the Schemes of Reservation and Delegation (SORDs). Individual votes for each ICB organisation coupled with NHS England right to substitute an alternative decision: each organisation that is a Core Partners of the Joint Committee has a single vote. However, NHS England can substitute an alternative decision if it considers it is in the best interests of the health service. The reasons for substituting a decision should be documented. Partners also have a right to refer the decision to the regional director for review. PART B The Joint Committee will be formally accountable to the Boards of the ICBs for the functions delegated to the Joint Committee through the Schemes of Reservation and Delegation (SORDs). Where an ICB Board requests that the Joint Committee provides information or reports on its proceedings or decisions, the Partners must comply with that request within a reasonable timescale.

Membership	Core Membership The following individuals will be the core members of the Joint Committee:- • An Authorised Officer (the CEO) from each ICB • An Authorised Officer from NHSE [PART A of the meeting only] Each of the Core Members may nominate a named substitute to attend meetings if they are unavailable or unable to attend or because they are conflicted. Each of the Partners must ensure that the members nominated on their behalf (and any named substitutes) are of a suitable level of seniority and duly authorised to act on its behalf and to agree to be bound by the final position or decision taken at any meeting of the Joint Committee. One of the authorised officers from a single ICB will act as the Executive Lead for the Joint Committee, it is expected therefore that the Chair of the Joint Committee be nominated from another ICB. Discretionary Membership Each of the Partners may be represented at meetings by representatives (who may be officers or, in the case of an ICB, Non-Executive Members / Directors of the ICB) who may observe proceedings and contribute to the deliberations as required, but these will not have the right to vote. The Partners may also identify individuals or representatives of other organisations that may be invited to observe proceedings and contribute to the Joint Committee's deliberations as required. These representatives will not have the right to vote. Term of Membership Members (and any substitutes appointed) will hold their appointment until the partner they represent nominates an alternative member or they cease to hold their substantive role with the relevant partner. Membership Lists The Chair (or in the absence of a Chair, the Partners themselves) shall ensure that there is prepared (and updated from time to time) a list of the members and that this list is made available to the Partners.
Chair	At the first meeting of the Joint Committee, the Core Membership shall select a Chair, or joint Chairs, from among the membership. A Chair will be selected for PART A (NHSE having the casting cote) and PART B of the meeting (these may be the same person or a different person). The Chair(s) shall hold office for a period of two years and be eligible for re-appointment for one further term. At the first scheduled meeting after the expiry of the Chair's term of office, the Core Membership will select a Chair, or joint Chairs, who will assume office at that meeting and for the ensuing term. If the Chair(s) is / are not in attendance at a meeting, the Core Membership will select one of the members to take the chair for that meeting.
Meetings	The Joint Committee shall meet at least quarterly. At its first meeting (and at the first meeting following each subsequent anniversary of that meeting) the Joint Committee shall prepare a schedule of meetings for the forthcoming year ("the Schedule"). The Chair(s), or in the absence of a Chair, the Partners themselves, shall see that the Schedule is notified to the members.

	Any of the Partners may call for a special meeting outside of the Schedule as they see fit, by giving notice of their request to the Chair. The Chair(s) may, following consultation with the Partners, confirm the date on which the special meeting is to be held and then issue a notice giving not less than four weeks' notice of the special meeting.
Quorum	A Joint Committee meeting is quorate if the following are in attendance: • the Authorised Officer (or substitute) nominated by NHSE [PART A only]; • at least one representative member (or substitute) from each ICB. Attendance at meetings by telephone/video conferencing will count towards the quorum.
Decisions and veto.	The Committee must seek to make decisions relating to the exercise of the Joint Functions on a consensus basis. The Partners must ensure that matters requiring a decision are anticipated and that sufficient time is allowed prior to Joint Committee meetings for discussions and negotiations between Partners to take place. Where it has not been possible, despite the best efforts of the Core Membership, to come to a consensus decision on any matter before the Joint Committee, the Chair for Part A (NHSE) and Chair of Part B (s) may require the decision to be put to a vote in accordance with the following provisions:- • For decisions in PART A of the meeting each core member shall have a single vote with a decision made by a simple majority of those present and voting, with the NHSE having a second and casting vote in the event of a tie. Decisions made under this provision will be subject to NHSE having a right to substitute an alternative decision if it considers it is in the best interests of the health service. The reasons for substituting a decision should be documented. Core Members also have a right to refer the decision to the Regional Director for review. • For decisions in PART B of the meeting, each ICB will have one vote with decisions being made by a simple majority of those voting. Any disputes will be resolved using the dispute resolution process outline in sections 17 of the joint working agreement. Decisions of the Joint Committee will be binding on the Partners (subject to the right of NHSE [PART A only] to substitute alternative decisions in line with the provision above).
Conduct and conflicts of interest	Members will be expected to act consistently with existing statutory guidance, NHS Standards of Business Conduct and relevant organisational policies. The NHS Standards of Business Conduct policy is available from: https://www.england.nhs.uk/publication/standards-of-business-conduct-policy/ Members should act in accordance with the Nolan Principles (the Seven Principles of Public Life): https://www.gov.uk/government/publications/the-7-principles-of-public-life Members should refer to and act consistently with the NHSE guidance: *Managing Conflicts of Interest in the NHS: Guidance for staff and organisations*. See: https://www.england.nhs.uk/ourwork/coi/ Where any member has an actual or potential conflict of interest in relation to any matter under consideration, the Chair (with appropriate advice) will

	determine the appropriate action to be taken in line with the principles of proportionality and preserving the spirit of collaborative decision making. Such action could include the member not participating in meetings (or parts of meetings) in which the relevant matter is discussed, or from the decision making and/or voting on the relevant item. A Partner whose Authorised Officer is conflicted in this way may secure . that their named substitute attends the meeting (or part of meeting) in the place of that member. A record of how the conflict has been managed will be recorded in the minutes.
Confidentiality of proceedings	The Committee is not subject to the Public Bodies (Admissions to Meetings) Act 1960. Admission to meetings is at the discretion of the Partners. All members in attendance are required to give due consideration to the possibility that the material presented to the meeting, and the content of any discussions, may be confidential or commercially sensitive, and to not disclose information or the content of deliberations outside of the meeting's membership, without the prior agreement of the Partners.
Publication of notices, minutes and papers	The Partners shall provide sufficient resources, administration and secretarial support to ensure the proper organisation and functioning of the Committee. The Chair(s), or in the absence of a Chair, the Partners themselves, shall see that notices of meetings, together with an agenda listing the business to be conducted and supporting documentation, is issued to the Partners one working week (or, in the case of a special meeting, three calendar days prior to the date of the meeting). The proceedings and decisions taken shall be recorded in minutes, and those minutes circulated in draft form within one week of the date of the meeting. The Committee shall confirm those minutes at its next meeting.
Review of the Terms of Reference	These terms of reference will be reviewed within twelve months of the committee's establishment and then at least annually thereafter. Any changes to the committee's decision-making membership or core functions must be approved by the partners. Other changes to the terms of reference may be agreed by the committee and reported to the Partners for assurance.
Date of Approval of Terms of Reference	TBC

SCHEDULE 4: SCHEDULE OF SERVICES

4A Dental Services
The Joint functions in respect of Dental Care services are those delegated to the ICBs by NHSE which are, in summary:-

- Decisions in relation to the commissioning and management of Primary Prescribed Community Dental Services;
- Planning Primary Dental Services in the Area, in compliance with Mandated Guidance issued by NHS England, including carrying out needs assessments;
- Undertaking reviews of Primary Dental Services in the Area;
- Management of Dental Services Contracts in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services including by:-
    - Reviewing and monitoring spending on services provided pursuant to Dental Services Contracts in the Area;
    - Reviewing and monitoring spending on Primary Dental Services commissioned in the Area;
    - Assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);
    - Managing variations to the relevant Dental Services Contract or services in accordance with national policy, service user needs and clinical developments;
    - Agreeing information and reporting requirements and managing information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);
    - Undertaking annual contract activity negotiations, including agreeing local prices, managing agreements or proposals for local variations and local modifications;
    - Conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes;
    - Allocating sufficient resources for undertaking contract mediation; and
    - Complying with and implementing any relevant Mandated Guidance issued from time to time.
    - Taking timely action to enforce contractual breaches, serve notices or provide discretionary support ensure that it obtains value for money on behalf of NHS England, including by avoiding making any double payments under any Dental Services Contracts and reducing the number of contracts which are under-delivering so that funds can be reallocated to meet local oral health needs;
- Planning of the Provider landscape for Dental services, including considering and taking decisions in relation to:-
    - Establishing new Dental Services Providers in the Area;
    - managing Dental Services Providers providing inadequate standards of patient care;
    - the procurement or award of new Dental Services Contracts (in accordance with any procurement protocol or Guidance issued by NHS England from time to time); and
    - closure of practices.
- Management of the Delegated Funds for Primary Dental Services in the Area;
- Co-ordinating a common approach to the commissioning and delivery of Primary Dental Services with other health and social care bodies in respect of the Area where appropriate including working with NHS England to coordinate the exercise of their respective performance management functions and with a view to achieving greater integration of dentists into the Integrated Care System at the Primary Care Network level; and
- Such other ancillary activities that are necessary in order to exercise the Delegated Functions.

4B Pharmacy Services
The Joint functions in respect of Pharmaceutical services are those delegated to the ICBs by NHSE which are, in summary:-

- Decisions in relation to the commissioning and management of Primary Prescribed Community Pharmaceutical Services;
- Planning Primary Pharmaceutical Services in the Area, in compliance with Mandated Guidance issued by NHS England, including carrying out needs assessments;
- Undertaking reviews of Primary Pharmaceutical Services in the Area;

- Maintaining and submitting Practitioners list of persons who have undertaken to provide pharmaceutical services from premises situated within the Area, including the provision of drugs, appliances, Electronic Prescription Service (Known as the "Pharmaceutical Lists)
- Managing and determining applications for inclusion in a Pharmaceutical List
- Overseeing the compliance of those included in the Pharmaceutical Lists exercising powers in respect of Performance Related Sanctions and Market Exit
- Management of Pharmaceutical Services Contracts in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services including by:-
    - Reviewing and monitoring spending on services provided pursuant to Pharmaceutical Services Contracts in the Area;
    - Reviewing and monitoring spending on Primary Pharmaceutical Services commissioned in the Area;
    - Assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);
    - Managing variations to the relevant Pharmaceutical Services Contract or services in accordance with national policy, service user needs and clinical developments;
    - Agreeing information and reporting requirements and managing information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);
    - Undertaking annual contract activity negotiations, including agreeing local prices, managing agreements or proposals for local variations and local modifications;
    - Conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes;
    - Allocating sufficient resources for undertaking contract mediation; and
    - Complying with and implementing any relevant Mandated Guidance issued from time to time.
    - Taking timely action to enforce contractual breaches, serve notices or provide discretionary support ensure that it obtains value for money on behalf of NHS England, including by avoiding making any double payments under any Pharmaceutical Services Contracts and reducing the number of contracts which are under-delivering so that funds can be reallocated to meet local pharmaceutical health needs;
- Planning of the Provider landscape for Pharmaceutical Services, including considering and taking decisions in relation to:-
    - Establishing new Pharmaceutical Services Providers in the Area;
    - managing Pharmaceutical Services Providers providing inadequate standards of patient care;
    - the procurement or award of new Pharmaceutical Services Contracts (in accordance with any procurement protocol or Guidance issued by NHS England from time to time); and
    - closure of practices.
- Management of the Delegated Funds for Primary Pharmaceutical Services in the Area;
- Co-ordinating a common approach to the commissioning and delivery of Primary Pharmaceutical Services with other health and social care bodies in respect of the Area where appropriate including working with NHS England to coordinate the exercise of their respective performance management functions and with a view to achieving greater integration of dentists into the Integrated Care System at the Primary Care Network level; and
- Such other ancillary activities that are necessary in order to exercise the Delegated Functions.

4C Primary Ophthalmic Services

The Joint functions in respect of Primary Ophthalmic Services are those delegated to the ICBs by NHSE which are, in summary:-

- Decisions in relation to the commissioning and management of Primary Ophthalmic Services;
- Planning Primary Ophthalmic Services in the Area, in compliance with Mandated Guidance issued by NHS England, including carrying out needs assessments;
- Undertaking reviews of Primary Ophthalmic Services in the Area;
- Management of Primary Ophthalmic Services Contracts in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services including by:-

    - Reviewing and monitoring spending on services provided pursuant to Primary Ophthalmic Services Contracts in the Area;
    - Reviewing and monitoring spending on Primary Ophthalmic Services commissioned in the Area;
    - Assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);
    - Managing variations to the relevant Primary Ophthalmic Services Contract or services in accordance with national policy, service user needs and clinical developments;
    - Agreeing information and reporting requirements and managing information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);
    - Undertaking annual contract activity negotiations, including agreeing local prices, managing agreements or proposals for local variations and local modifications;
    - Conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes;
    - Allocating sufficient resources for undertaking contract mediation; and
    - Complying with and implementing any relevant Mandated Guidance issued from time to time.
    - Taking timely action to enforce contractual breaches, serve notices or provide discretionary support ensure that it obtains value for money on behalf of NHS England, including by avoiding making any double payments under any Primary Ophthalmic Services Contracts and reducing the number of contracts which are under-delivering so that funds can be reallocated to meet local eye health needs;
- Planning of the Provider landscape for Primary Ophthalmic Services, including considering and taking decisions in relation to:-
    - Establishing new Primary Ophthalmic Services Providers in the Area;
    - managing Primary Ophthalmic Services Providers providing inadequate standards of patient care;
    - the procurement or award of new Primary Ophthalmic Services Contracts (in accordance with any procurement protocol or Guidance issued by NHS England from time to time); and
    - closure of practices.
- Management of the Delegated Funds for Primary Ophthalmic Services in the Area;
- Co-ordinating a common approach to the commissioning and delivery of Primary Ophthalmic Services with other health and social care bodies in respect of the Area where appropriate including working with NHS England to coordinate the exercise of their respective performance management functions and with a view to achieving greater integration of dentists into the Integrated Care System at the Primary Care Network level; and
- Such other ancillary activities that are necessary in order to exercise the Delegated Functions.

SCHEDULE 5: FURTHER INFORMATION GOVERNANCE AND SHARING PROVISIONS

1. Introduction

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

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

1.3. This Schedule and Data Sharing Agreements entered into under it are designed to:

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

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

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

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

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

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

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

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

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

2. Purpose

2.1. The Specified Purpose of the data sharing is to facilitate the exercise of the Joint Functions and NHSE's Reserved Functions.

2.2. Each Partner must ensure that they have in place appropriate Data Sharing Agreements to enable data to be received from any third party organisations from which the Partners must obtain data in order to achieve the Specified Purpose. Where necessary specific and detailed purposes must be set out in a Data Sharing Agreement that complies with all relevant Legislation and Guidance.

3. Benefits of information sharing

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

4. Lawful basis for sharing

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

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

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

5. Restrictions on use of the Shared Information

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

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

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

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

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

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

6. Ensuring fairness to the Data Subject

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

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

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

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

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

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

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

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

7. Governance: Staff

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

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

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

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

7.4. The Partners shall ensure that:

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

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

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

8. Governance: Protection of Personal Data

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

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

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

8.4. If any Partner

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

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

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

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

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

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

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

8.6. The Partners shall act generally in accordance with Data Protection Legislation requirements. This includes implementing, maintaining and keeping under review appropriate technical and organisational measures to ensure and demonstrate that the processing of Personal Data is undertaken in accordance with Data Protection Legislation, and in particular to protected the Personal Data (and Special Category Personal Data) against unauthorised or unlawful processing, and against accidental loss, destruction, damage, alteration or disclosure. These measures shall:

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

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

8.7. In particular, teach Partner shall:

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

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

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

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

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

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

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

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

9. Governance: Transmission of Information between the Partners

9.1. This paragraph supplements paragraph 8 of this Schedule.

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

9.3. Wherever possible, Personal Data should be transmitted and held in pseudonymised form, with only reference to the NHS number in 'clear' transmissions. Where there are significant consequences for the care of the patient, then additional data items, such as the postcode, date of birth and/or other identifiers should also be transmitted, in accordance with good information governance and clinical safety practice, so as to ensure that the correct patient record / data is identified.

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

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

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

10. Governance: Quality of Information

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

11. Governance: Retention and Disposal of Shared Information

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

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

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

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

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

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

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

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

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

12. Governance: Complaints and Access to Personal Data

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

12.2. Complaints about information sharing shall be reported to the Single Points of Contact and the Joint Committee. Complaints about information sharing shall be routed through each Partners' own complaints procedure unless otherwise provided for in the Joint Working Arrangements or determined by the Joint Committee.

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

12.4. Basic details of the Agreement shall be included in the appropriate log under each Partner's Publication Scheme.

13. Governance: Single Points of Contact

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

14. Monitoring and review

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

SCHEDULE 6: MANDATED GUIDANCE

Generally applicable Mandated Guidance

- National Guidance on System Quality Groups.
- Managing Conflicts of Interest in the NHS.
- Arrangements for Delegation and Joint Exercise of Statutory Functions.
- Guidance relating to procurement and provider selection.
- IG Guidance relating to serious incidents.
- All other applicable IG and Data Protection Guidance.
- Any applicable Freedom of Information protocols.
- Any applicable guidance on Counter Fraud, including from The NHS Counter Fraud Authority.
- Any applicable guidance relating to the use of data and data sets for reporting.

Workforce

- Guidance on the Employment Commitment.

Finance

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

Specialised Services Mandated Guidance

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

SCHEDULE 7: LOCAL TERMS

Guidance notes are provided in red text and can be deleted prior to completing the agreement.

This Schedule should be used by the Partners to agree local terms to the Agreement. Headings and guidance have been provided for areas that may need local agreement. Additional headings can be added as required to support local arrangements.

Sufficient detail should be provided to describe what ICBs have agreed to do, including any role of the relevant Joint Committee, where required.

General

Where there is a dispute as to the content of this Schedule, the Partners should follow the Disputes Resolution procedure set out at Clause 18.

Following signature of the Agreement, this Schedule can be amended by the Partners using the Variations procedure at Clause 10.

Part 1 – Further Governance Arrangements

The Partners can use this Part for any governance arrangements not covered by the main agreement or the existing Schedules.

It is advised that sub-committees (those forums with decision-making power) and sub-groups (those forums without decision-making power, but are advisory in nature) are set out in this part. It is advised that the role, purpose and membership of the sub-committees or sub-groups are set out in this part.

Part 2 – Workforce Arrangements

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Terms of Reference

Dental Governance Group (DGov)

1. Introduction

Terms of reference are used to set out the parameters within which authority is delegated to boards, committees, working groups etc. Amongst other things, they may specify membership, frequency of contact, remit and reporting.

Terms of reference should be produced when establishing a new group and approved via consultation. They should be refreshed at least annually.

2. Purpose

The overarching purpose of the East & West Midlands DGov is to:

- Provide overall leadership to the Dental Commissioning Function in execution of Statutory duties and in delivering the agreed Business and Financial Plan for the East or West Midlands Sub-Region.
- DGov will lead on planning and prioritising the commissioning investment and improvement work, in relation to dental services, across the Sub-Region. DGov will take a lead role in pro-actively driving value and improving performance, quality and outcomes for patients. DGov will lead internal practice improvement for efficient and effective operations, and lead external collaboration to achieve integration of dental commissioning and dental provider delivery.
- Provide the East & West Tier 2 Joint Commissioning Groups (JCGs) with assurance that Midlands dental commissioning operations and aligned programmes are fit for purpose, aligned to achievement of East & West Member ICBs' strategic objectives and compliant with extant guidance and legislation.
- Consider for approval those matters relating to that delegated to it, via extant ICB schemes of delegation, and which cannot be delegated to individual officers within the ICB or Hosted Teams.
- Ensure that in delivering its dental commissioning objectives, proper governance and accountability processes are adopted by East & West Midlands ICBs, taking appropriate steps to safeguard public funds and deliver best value for money in line with established governance requirements

The remit of the DCG is limited to the East & West Midlands ICB geographies.

3. Authority

DGov has been established as a sub-group of the DCOG. The purpose of DGov is to provide leadership, oversight and assurance for dental commissioning operations. In line with the scheme of delegations, DGov has been given the following delegated responsibilities and authority to act, in relation to dental services:

- **Planning** - Develop the dental commissioning contribution to the East & West Midlands ICB Joint Forward Plans (JFPs) through the development/refresh of its Business Plan.
- **Delivery of business objectives** by agreeing strategic priorities and implementation plans for dental commissioning and the portfolio as a whole.
- **Quality** - Work closely with the Tier 2 Quality subgroup and Member ICB local Quality & Safety Committees to identify and monitor key risks to delivery and ensure effective mitigation actions are in place. Review and agree mitigation plans for any escalated quality issues. Receive and assure quality surveillance data and agree overarching action plans in the event of non-compliance.
- **Finance** - review financial performance and QIPP achievement and agree any required remedial action plans.
- **Contracting** – to review and assure performance standards as set out in the contract, support resolution of escalated issues and sign off contracts and variations as required.
- **Transformation** – to review and approve large scale transformation plans or clinical pathway developments. Support resolution of escalated issues with current plans and assure patient and public engagement around large scale change.
- **Service issues** – review and agree mitigation plans for any escalated service issues. This includes workforce, financial sustainability, short term non-compliance and interim transfer arrangements.
- **Risk Register** – To be responsible for assuring the direct commissioning risk register and any associated mitigation plans.
- **Corporate Governance** – To review and agree plans to resolve escalated corporate issues, approval and sign off of FOIs, complaints and parliamentary enquires and general assurance of areas such as IG, MaST, PDRs and running costs.
- **Collaboration** - Ensure effective alignment with interdependent work programmes within each ICB's Integrated Care System programmes.

3. Accountability

The Group will be accountable to the Tier 2 East & West Midlands Joint Commissioning Groups (JCGs).

4. Membership

Name	Organisation	Role
Commissioning Executive		
tbc	East & West Hosted Teams	Heads of Primary Care Commissioning - East & West Midlands
tbc	East & West Hosted Teams	Deputy Heads of Commissioning (Dental) – East & West Midlands
Extended Senior Leadership – monthly		

For agenda items and accountability	ICB	Primary Care nominated leads if required / locally determined
	ICB	Lead commissioning nominated leads if required / locally determined
As required		
	ICB	Other senior functional leads Strategy and Planning, Transformation, Performance, Workforce and OD/HR if agenda items require

5. Frequency of Meetings

DGov will convene on a monthly basis and more frequently as operational circumstances or urgent issues may necessitate.:

1. Finance/Performance/Contracting and QIPP – this would be aligned to get sign off for national reporting.
2. Quality – review any escalated quality issue to ensure progress
3. Service improvement – to sign off any PIDs, Options Appraisals, Business Cases ets and prioritise work programmes
4. Strategic Development – Agree proposals and plans for wider system engagement and development of commissioning strategy

6. Sub-Group working

Functional sub-groups are required to operationalise the ICB business plans and deliver statutory functions. DGov may sanction the formation, and oversee the business of, such sub-groups.

7. Quorum

The meeting is only Quorate if each member is in attendance. If a deputy is sent it must be formally agreed before the meeting that this individual has the right to make decision on behalf of their organisation.

8. Secretariat

East & West Hosted Teams will provide administrative support for the meeting.

9. Review

The Terms of Reference will be reviewed in September 2023 and in April each year thereafter.

East & West Midlands ICBs

General Ophthalmic Services (GOS) Assurance and Improvement Groups

Terms of Reference

Contents

1 Introduction

The Assurance and Improvement Group will be responsible for overseeing and developing East & West Midlands ICBs' NHSE-delegated commissioning responsibilities across the GOS portfolio. It will achieve this through being open, transparent and committed to learning and improvement.

The GOS portfolio covers services delivered within:

- Primary care (mandatory and additional services).

The Group will review the performance and quality (covering safety, effectiveness and experience) of healthcare services commissioned within these settings, based on a basket of key indicators, and will agree and instruct remedial actions where required.

The Group will also have a service development and improvement focus, based around the key objectives in the ICB Joint Forward Plans (JFPs), which will include;

- Mental Health, Learning Disability and Autism
- Prevention and Early Intervention
- Children and Young People
- Patient Safety

2 Duties

1. Review performance of all GOS services using a basket of local and national Indicator of Performance measures, aligned to JFPs and other priority areas, including statutory functions.
2. Review the quality of all GOS services using a basket of local and national Quality Indicators. This is to include patient experiences of services and complaints information.
3. Review of hard and soft intelligence.
4. Identify performance and quality trends / themes and identify areas for potential remedial action / service improvement.
5. To consider opportunities for service improvement and innovation across the Midlands region, instructing Task and Finish group work accordingly.
6. To consider opportunities for commissioning improvement, instructing Task and Finish group work accordingly.
7. Agree procurement plans and reviewing contract variations prior to submission to East & West Midlands ICBs Joint Commissioning Groups for approval.
8. To agree issues to be escalated to other committees, including the Midlands ICBs Joint Commissioning Groups, Quality Surveillance Groups and others as may be necessary and appropriate.
9. Agree assurance reports and briefings to national, regional and external fora.

10. To review GOS commissioning risks and agree risks to be escalated to the regional risk register.

3 Accountability and Quoracy

The Group will be report to the Tier 2 ICB Joint Commissioning Groups.

The Group will also agree items for inclusion in briefings, via the ICBs Joint Commissioning Groups.

Quoracy will be a minimum of

- 1 x Head of Primary Care (HoPC) and/or Deputy HoPC
- 1 Senior Commissioning representative from each GOS East & West Hosted Team and ICB if required.
- 1 x Senior Clinical quality representative (East & West Hosted Team and ICB if required).
- 1 x Finance representative (East & West Hosted Team and ICB if required).

4 Membership *(titles may chance following phase 3 outcomes)*

Members should make every effort to attend every meeting or to send a deputy empowered to make relevant decisions if they are not able to attend.

- HoPC (SRO and Chair) and/or Deputy as Chair
- Relevant Deputy Heads of Commissioning/Senior Commissioning Managers /Programme Leads
- Clinical advisor.
- Delegated ICB POD Finance / Quality / Performance Representatives
- Counter fraud

Additional members may be invited as required in relation to specific topics of discussion.

5 Senior Responsible Owner (SRO)

The SRO is responsible for:

- Chairing meetings and deciding upon the frequency of meetings required.
- Providing strategic direction and decision making.
- Ensure matrix working underpins the operation of the group and its outcomes.
- Ensuring the group achieves its overall objectives and delivers the anticipated benefits.
- Monitoring the progress of objectives.
- Reviewing Terms of Reference and ensuring ongoing synergy both with interdependent groups and the commissioning objectives of Midlands ICBs,
- Escalating issues as necessary and in a timely manner.

6 Membership

Members are responsible for:

- Producing and presenting performance and quality reports
- Taking forward agreed actions
- Providing updates on agreed actions
- Identifying areas of development opportunity for discussion by the group
- Identifying risks and mitigating actions for discussion by the group
- Ensuring feedback and escalation within their individual directorates.

7 Frequency and Venue of meetings

Meetings will be held on a monthly basis for a duration of 2 hours. Video conferencing (MS Teams/Webex) will be the preferred option to minimize travel times.

8 Standing Agenda

The Group will agree a standard basket of measures and standard reporting templates.

9 Secretariat

Secretariat responsibilities include:

- Production of agenda
- Circulation of papers 2 working days prior to the meeting
- Booking of meeting dates and venues
- Recording of minutes and schedule of actions

East and West Midlands ICBs

Terms of Reference for Pharmaceutical Services Regulations Groups (PSRGs)

1. East & West Midlands ICBs have together established the PSRGs to:

- determine those applications and notifications listed in annex A received under the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (the 2013 Regulations);
- determine those applications and notifications listed in annex A received under the NHS (Pharmaceutical Services) Regulations 2012, as amended and the NHS (Pharmaceutical Services) Regulations 2005, as amended, which fall to be dealt with under the transitional provisions contained within Schedule 9 of the 2013 Regulations;
- take overall responsibility for resolving issues of non-compliance with the terms of service as set out in the 2013 Regulations by pharmacy and dispensing appliance contractors.
- take overall responsibility for resolving issues of non-compliance with the terms of service for pharmacy and dispensing appliance contractors that fall to be dealt with under the transitional provisions contained within Schedule 9 of the 2013 Regulations; and

2. As such the committee has delegated authority from the East & West Midlands ICBs to do so.

3. The Assistant Contracts Manager will escalate an application or notification to the pharmaceutical services regulations committee for decision or ratification.

4. All members of the PSRG must have a good knowledge and understanding of the Regulations in order to reduce the likelihood of a successful appeal against decisions made. It is essential that members build up expertise in the Regulations and therefore consistency of attendance is expected.

5. The voting membership of each PSRG shall be as follows:

    - Head of Primary Care who will chair the meeting (HoPC has delegated responsibility for the Director of Commissioning)~~;~~ and
    - Two ICB members (or equivalent).

6. Each PSRG will be quorate if any two of the voting members are present one of which must be an ICB officer.

7. Persons ineligible to be voting or co-opted members of a PSRG are listed in Regulation 62 and in paragraph 26(1) of Schedule 2 to the Regulations.

8. Further representatives from the Midlands ICBs are invited to attend PSRG and will be sent copies of the papers prior to each meeting. All information shared is done so in the strictest confidence and must not be shared any wider unless it has been agreed to do so via PSRG.

9. Those who may not take part in any decision made under the 2013 Reg those regulations include anyone who:

- is included in a pharmaceutical list or is an employee of such a person (to avoid doubt this includes anyone who provides services as a locum).
- assists in providing pharmaceutical services under Chapter 1 of Part 7 of the NHS Act 2006.
- is a local pharmaceutical services chemist or provides or assists in providing local pharmaceutical services.
- is a provider of primary medical services; NHS England Policy for determining applications received for new or additional premises under the
- NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 Document Number: OPS_1007 Issue Date: June 2013 Version Number: 01.01 Status:
- is a member of a provider or primary medical services that is a partnership or a shareholder in a provider of primary medical services that is a company limited by shares;
- is employed or engaged by a primary medical services provider; or
- is employed or engaged by an APMS contractor in any capacity relating to the provision of primary medical services,

10. All voting and co-opted members must sign both a declaration to confirm that they are not barred by virtue of this regulation or paragraph, and a conflict of interests form. The Chair can require any co-opted member to leave the room before discussion of a matter and not return until the relevant decision has been made (in virtual meetings all co-opted and voting members are required to on mute or leave the room). The minutes will record the absences of the relevant voting or co-opted member or members.

11. No member may take part in a decision if, in the opinion of the remaining voting members, the circumstances set out in paragraph 26(2) of Schedule 2 to the Regulations apply (reasonable suspicion of bias).

12. Members must advise the Chair of any potential conflict of interest upon receipt of the papers for a meeting. Discussion of those potential conflicts will take place at the beginning of each meeting and will be recorded.

13. Where a conflict is perceived to exist in relation to a matter, the member with that conflict will leave the room before discussion of that matter and will not return until the relevant decision has been made and the reasons for it have been recorded (in virtual meetings all co-opted and voting members are required to on mute or leave the room).

14. Each PSRG will meet monthly (or earlier if needed in order to discuss a case urgently) where there is a need. Where a meeting is not required the pharmacy contract manager will document this in line with local procedures.

15. Each PSRG will report at least every six months to an appropriate senior management committee (to be determined locally) on the decisions taken and the outcome of any appeals on those decisions.

16. HWBs are responsible for identifying current or future needs for, or improvements or better access to, a pharmaceutical service or pharmaceutical services in general via the pharmaceutical needs assessment (PNA). Each PSRG is required to review the PNAs in its area and to record the actions taken to address identified needs, improvements or better access whether this is via the market entry process or through local commissioning processes.

17. Each PSRG may obtain such legal or other independent professional advice as it considers necessary and may co-opt persons with relevant experience and expertise if required. Each PSRG must follow current ICB processes for obtaining legal advice.

18. The following persons will be co-opted to each PSRG:

• Pharmacy Contract Manager (or equivalent); and

• Pharmacy professional adviser (or equivalent) (if applicable).

19. Each ICB has delegated full responsibility for all decisions listed in annex A to the pharmaceutical services regulations committee.

20. If the decision maker is listed as "PSRG", only the local PSRG may make that decision.
21. If the decision maker is listed as "PCM or PSRG", the decision may be made by the local PCM, their suitable nominated deputy or (in circumstances described in Chapter 2) by the local PSRG.

22. If the decision maker is listed as the "PSRG or PLDP", the decision may be made by the local PSRG or (in circumstances described in chapter 2) by the local PLDP.

23. Where an applicant is applying to be included in the relevant pharmaceutical list for the first time and the checks on the fitness information reveal no adverse findings and the references are satisfactory the PSRG or PLDP may nominate an officer of NHS England who has the appropriate clinical experience to make decisions on whether the applicant is suitable to be included in the relevant pharmaceutical list on fitness grounds. Where the checks and/or references reveal adverse findings, which may lead the application to be refused or deferred on fitness grounds or for the applicant to be conditionally included, the PSRG or PLDP will be required to make the decision on the applicant's fitness.

24. **Pharmacy Contract Manager ("PCM") Decision Making**

25. Hosted Teams local Pharmacy Contract Managers ("PCM").

26. ICBs have delegated decision making through the PSRG to each PCM, or their suitable nominated deputy when the PCM is on leave, in relation to matters under the Regulations listed in Chapter 3 where the decision maker is listed as "PCM or PSRG".

27. Regulation 62 and in paragraph 26(1) of Schedule 2 to the Regulations lists those persons who may take no part in determining or deferring an application. Before considering an application or making a decision which has been delegated to them, the PCM must document that they are not barred by virtue of the aforementioned regulation or paragraph.

28. The PCM may not make a decision if the circumstances set out in paragraph 26(2) of Schedule 2 to the Regulations apply (reasonable suspicion of bias).

29. The PCM will be responsible for such matters listed in Chapter 3 where the decision maker is listed as "PCM or PSRG". If, for whatever reason, the PCM is unable to make a decision within the required timeframe (or at all), that decision shall be taken by the PSRG.

30. The PCM will report monthly to the PSRG on decisions taken and the outcome of any appeals on those decisions.

31. **The Role of the Performers Lists Decision Panel**

32. NHS England has established local Performers Lists Decision Panels ("PLDP").

33. NHS England may delegate decision making through the PSRG to each PLDP in relation to matters under the Regulations listed in Chapter 3 where the decision maker is listed as "PSRG or PLDP".

34. The PSRG must ensure that the members of the PLDP are eligible to take part in the matter by ensuring that no members are a type of person listed in Regulation 62 or in paragraph 26 of Schedule 2 to the Regulations.

35. The PSRG will be responsible for such matters listed in Chapter 3 where the decision maker is listed as "PSRG or PLDP". The PSRG may delegate such matters to the PLDP for whatever reason.

36. 30. The PLDP will report monthly to the PSRG on decisions taken and the outcome of any appeals on those decisions

37. The terms of reference will be reviewed annually or earlier if circumstances required.

Reviewed September 2023

Annex A

a. The NHS (Pharmaceutical Services) Regulations 2005, as amended

The committee will receive and determine applications submitted under the NHS (Pharmaceutical Services) Regulations 2005, as amended (the 2005 Regulations) which fall to be determined by virtue of the transitional provisions set out in Schedule 9 of the 2013

Regulations:

1. Regulation 5(1) of the 2005 Regulations – applications by persons wishing to be included in a pharmaceutical list; applications from persons already so included who wish to open new premises or to change the premises from which they provide pharmaceutical services.
2. Regulation 14 – applications to vary directed services in respect of exempted premises
3. Regulation 41 – full applications following approval of a preliminary application.
4. Paragraph 22(1), Schedule 1 – requests for a temporary suspension of services for a set period
5. Paragraph 25, Schedule 1 – applications from pharmacies wishing to change their core opening hours.
6. Paragraph 13, Schedule 3 – applications from dispensing appliance contractors wishing to change their core opening hours.
7. Regulation 60(1) – applications from patients with serious difficulty
8. Regulations 61 and 62 – applications from doctors wishing to be granted the right to provide pharmaceutical services and the taking effect of outline consent and premises approval
9. Regulation 64 – premises approval: change of premises before outline consent takes effect.
10. Regulation 65 – premises approval: additional and new premises after outline consent has taken effect.
11. Regulation 66 – premises approval: practice amalgamations.

The committee will determine under:

1. Regulation 31 whether an area is or is not a controlled locality or is or is not part of one. This may be as a result of a request for such a determination by the local medical committee or the local pharmaceutical committee, or where the committee is satisfied that such a determination is required. Where relevant the committee will also consider the issue of gradualisation; and
2. Regulation 35 whether premises/relevant locations described in an application are in a reserved location.

The committee will ensure that determined controlled localities and reserved locations are clearly delineated on a map or maps and shall ensure these are published in line with Regulations 31 and 35.

The committee will determine notifications under Regulation 39(8) – change of premises prior to opening.

In relation to applications in or within 1.6km of a controlled locality the committee will consider the issue of gradualisation under Regulation 20 as appropriate.

b. The NHS (Pharmaceutical Services) Regulations 2012, as amended

The committee will receive and determine applications submitted under the NHS (Pharmaceutical Services) Regulations 2012, as amended (the 2012 Regulations) which fall to be determined by virtue of the transitional provisions set out in Schedule 9 of the 2013 Regulations:

1. Regulation 12 – routine applications.
2. Regulations 23 to 25, 26(2), 27 and 29 – excepted applications.
3. Regulation 48(2) – serious difficulty applications.
4. Regulations 51 to 61 – applications by doctors relating to outline consent and premises approval.
5. Applications to vary core opening hours from pharmacy and dispensing appliance contractors.
6. Requests to vary supplementary opening hours from pharmacy and dispensing appliance contractors within a shorter period than the required three months.
7. Requests for a temporary suspension of services for a set period.

The committee will determine under:

1. Regulation 36 whether an area is or is not a controlled locality or is or is not part of one. This may be as a result of a request for such a determination by the local medical committee or the local pharmaceutical committee, or where the committee is satisfied that such a determination is required. Where relevant the committee will also consider the issue of gradualisation.
2. Regulation 41 and 42 whether premises/relevant locations described in an application are in a reserved location.

The committee will ensure that determined controlled localities and reserved locations are clearly delineated on a map or maps and shall ensure these are published in line with Regulations 36, 41 or 42 as relevant.

The committee will consider information received regarding non-compliance with the terms of service by a pharmacy contractor or a dispensing appliance contractor, and make one or more of the following decisions:

i. There is no breach of terms of service, or there was good cause for the breach of terms of service
ii. Whether to issue a breach notice and withhold payments in connection with a proven breach of terms of service
iii. Whether to issue a remedial notice and withhold payments in connection with a proven breach of terms of service
i. Whether to remove premises from the relevant pharmaceutical list in line with regulation 74 of the 2012 Regulations.

c. The NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013

The committee will receive and determine applications submitted under the 2013 Regulations:

1. Regulation 12 – routine applications.
2. Regulations 23 to 25, 26(2), 27 and 29 – excepted applications.
3. Regulation 48(2) – serious difficulty applications.
4. Regulations 51 to 61 – applications by doctors relating to outline consent and premises approval.
5. Applications to vary core opening hours from pharmacy and dispensing appliance contractors.
6. Requests to vary supplementary opening hours from pharmacy and dispensing appliance contractors within a shorter period than the required three months.
7. Requests for a temporary suspension of services for a set period.

The committee will determine under:

1. Regulation 36 whether an area is or is not a controlled locality or is or is not part of one. This may be as a result of a request for such a determination by the local medical committee or the local pharmaceutical committee, or where the committee is satisfied that such a determination is required. Where relevant the committee will also consider the issue of gradualisation.
2. Regulation 41 and 42 whether premises/relevant locations described in an application are in a reserved location.

The committee will ensure that determined controlled localities and reserved locations are clearly delineated on a map or maps and shall ensure these are published in line with Regulations 36, 41 or 42 as relevant.

The committee will consider information received regarding non-compliance with the terms of service by a pharmacy contractor or a dispensing appliance contractor, and make one or more of the following decisions:

1. There is no breach of terms of service, or there was good cause for the breach of terms of service
2. Whether to issue a breach notice and withhold payments in connection with a proven breach of terms of service.
3. Whether to issue a remedial notice and withhold payments in connection with a proven breach of terms of service

The committee will consider information received regarding non-compliance with the terms of service by a pharmacy contractor or a dispensing appliance contractor, and make one or more of the following decisions:

1. There is no breach of terms of service, or there was good cause for the breach of terms of service.
2. Whether to issue a breach notice and withhold payments in connection with a proven breach of terms of service.
3. Whether to issue a remedial notice and withhold payments in connection with a proven breach of terms of service.
4. Whether to remove premises from the relevant pharmaceutical list in line with regulation 74 of the 2013 Regulations.

d. All regulations

The committee will respond to all appeals made to the NHS Litigation Authority's Family Health Services Appeal Unit or the First-tier Tribunal against its decisions made under the 2005, 2012 or 2013 Regulations. It will also respond where its decisions are challenged through the courts.

Decisions will be made in line with the timescales set out within the relevant regulations. All decisions will be fully reasoned and documented within the minutes of the meeting.

Annex B

a. The NHS (Pharmaceutical Services) Regulations 2005, as amended

1. Regulation 8 – change of ownership.
2. Regulation 10 – right of return to the pharmaceutical list.

b. The NHS (Pharmaceutical Services) Regulations 2012, as amended

1. Regulation 26 – change of ownership.
2. Regulation 28 – right of return to the pharmaceutical list.
3. Paragraph 31, Schedule 2 – notifications of address following a best estimate routine application.

c. The NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013

1. Regulation 26 – change of ownership.
2. Regulation 28 – right of return to a pharmaceutical list.
3. Paragraph 31, Schedule 2 – notifications of address following a best estimate routine application.
4. Notifications of changes of supplementary opening hours received from pharmacy contractors and dispensing appliance contractors.

The pharmacy contracts manager will respond to all appeals made to the NHS Resolution against their decisions made under the 2005, 2012 or 2013 Regulations.

Decisions will be made in line with the timescales set out within the relevant regulations. All decisions will be fully reasoned and documented.

Proposed Financial Transitional Risk Framework – Pharmacy, Optometry, and Dentistry (PODs)

1. What is a financial risk framework?

The financial risk framework is a set of rules and behaviours (as set out in section 5) which govern the way we manage the risk that may arise from variation in POD budgets between delegated ICBs of the Midlands Region. This is intended to mitigate the potential risks to systems from allocation methodology change, as well as in year budget variation in year by ICB due to unknown factors. This document does not include risk sharing as a result of individual commissioning decisions made by ICBs. The focus of this risk share is the joint management of resources enabling risks to be understood, as well as the impact of overspend risk.

This Risk Framework will be subject to regular review following delegation to ensure it remains relevant and to determine its continuation or cessation.

The document aims to describe;

- How over and underspends are managed within the delegated services managed in East Midlands and West Midlands,
- How the changes to services are managed between organisations and services,
- The risk mechanism that is in place,
- The process for changes to the risk mechanism.

2. Who/What does this document concern?

This document is intended for all ICBs within the Midlands Region that will be in receipt of delegated budgets at the 1st April 2023.

Initial entry into the risk share is for all ICBs in the region but to protect the risk share ICBs can only leave at the point of review (refer to section 8).

This agreement relates to the Pharmacy, Optometry and Dental budgets including Secondary Care Dental delegated at April 2023.

The document has been written with a commissioner focus. As a result, it excludes the financial impact of under/overperformance within providers accounts as part of the risk share.

This risk share excludes previously delegated primary care budgets, on only those that transfer under the current delegation process.

This framework considers risk associated with service delivery and excludes financial risk associated with the hosting of commissioning functions which may be subject to other local risk management arrangements between ICBs.

This document may touch on expected financial reporting routes as part of the risk management, but reporting is subject to the development of a reporting framework. The two documents must be written and read in consideration of each other.

3. Why do we need a financial risk framework?

- ICBs are new organisations, and not all ICBs have experience managing these specific commissioning budgets. Until that knowledge is built up, this may mean additional caution in applying budgets in year, or additional exposure to risk. A risk share allows a mitigation to this while there is a common route to delivery.
- POD budgets are currently managed across the Midlands which provides a large budget in which to manage variability in activity across contracts and movements in patient charge revenue. After delegation budgets and areas covered will be smaller meaning risk management agreements will be needed to manage variability between ICBs.
- Allocations have been established using 2019/20 activity and spend levels. However, two years of alternative financial processes may impact on the accuracy of allocations at an ICS level. In addition, this historical approach to establishing allocations does not take into account relative access requirements across ICBs which may result in financial variation between systems in response to service and access recovery.
- As part of the move to delegated budgets, allocations may change as they are transferred to ICB level. There is an expectation of a move to a more capitated share of budgets after 2024. This raises the risk of variation to in year budgets which may not be fully known when budgets are first delegated, therefore future risk sharing needs to mitigate this risk.
- This document serves to address a number of financial management issues following the delegation of POD budgets to ICBs.
    - How does the system minimise variation to plan?
    - An ICB may wish to make a change to service that is within the risk share, this could include additional investment, change in policy, or pathway. How will this be managed within the risk share?
    - An ICB may wish to withdraw a service from the risk share, how will this be managed?
    - An ICB may work unilaterally on service changes or savings which then impacts on the overall risk share. How is this managed?
    - Should risk sharing be the answer to an overspend?
    - If ICBs disagree on how a risk should be handled, how is this resolved?
    - If there are differential impacts against system allocations due to new allocation methodologies, how are these risks managed?

4. Behaviours and Standards

This document has been written with an expectation of openness, transparency, and trust in mind between ICBs. These risk principles should be considered in the application of the document. This also means that while we use this document there will be elements of clarity and refinement required. It's expected that in these cases partners use judgement for the spirit of document in its application; however, this should **not** be used to challenge each aspect of the framework.

Any ambiguity that cannot be resolved between partners, through use of the Finance and Contracting Sub-Group should then follow the escalation process (section 11); however, this should be avoided wherever possible.

5. In Year Financial Management

- Risk sharing should not be the primary source of net cost avoidance and should only be applied once the Finance and Contracting Sub-Group (FCAG) has assured itself that appropriate mitigations have been put in place.
- Allocation adjustments should not be enacted between services or ICBs without express agreement by the finance subgroup on POD budgets, to allow maximum knowledge gained in this first year by ICBs.
- A ringfence has been applied to dental allocations for 2023/24 which may impact the ability to manage risk across the total POD financial position. The process for financial risk management should therefore be applied with reference to the dental ringfence.
- Should appropriate mitigation and virement proposals not bring the budget back to plan then risk sharing should be considered. Application of the risk sharing should be a recommendation of the Finance subgroup to the East and West Midlands Joint Committees.

6. Financial risk sharing

- The principles of any financial risk (and reward) sharing agreement are based on agreeing fair and equitable funding to control expenditure whilst optimising outcomes.
- The financial risk share will be applied to budgets in proportion to ICB allocations. If dental has to operate separately due to the ringfence, the dental risk share will be applied in proportion to the dental allocations. Pharmacy and Optom risk share will be applied in proportion to these allocations
- Financial risk sharing agreements should be the final option after all efforts have been made to manage the risk in-year.
- The risk management framework allows the movement of budget in year between systems within the hosting organisation in a balanced economy to resolve allocation methodology issues to system allocations mismatching to historical spend.
- The first route recognises individual ICB shortfalls in total POD budgets. Therefore, allowing an adjustment to vire budgets between ICBs below the bottom-line position to bring in line with plan. This excludes individual commissioning decisions made by

ICBs, eg a variance to budget spend caused by investment. As a result, variances to budget should be explained before virement or risk share is made to ensure it is due to unexpected causes.

- If the above is not possible due to an overall shortfall, the position will be shared proportionately based on ICB allocations subject to the caveat related to dental ringfence. This is with the exception of decisions made by individual ICBs e.g., ICB investment/disinvestment above initial financial plan levels decisions are excluded from the risk share unless with the explicit agreement of all ICBs.

- System allocation mismatch assumes an overall balanced economy. As the reporting develops, reporting will also be produced at a system level, and a balancing adjustment between systems will be proposed by the hosted team to bring systems in line with budgets. Any overall shortfall from budget will be dealt with as highlighted in the previous paragraph. The balancing adjustment should be shown within the reporting to support transparency and understanding.

- Quarterly position statements of agreed risk sharing should be produced including a forecast at each quarter. These will form the basis of recommended adjustments, and at Q3 a forecast and recommendation will be made for the year end to support delivery of year end positions. This may be supplemented by a Month 11 update and recommendation.

- Reporting will be in place monthly to support budget monitoring. Reports will demonstrate the position at ICB both before and after the application of the risk share framework. Application of risk arrangements will commence by Q2 of 2023 to allow sufficient actual activity to be available. Reporting will be at a level that allows the drilling down into PODs to understand the cause of variances. A separate proposal on reporting processes is being developed through the FCAG.

- Enacting the risk share will be a recommendation of the Finance subgroup to the East and West Midlands Joint Committees.

- The risk share will be applied at a region wide level, i.e., East and West Midlands. This should be part of a review after year 1 and a better understanding of budget variations.

- All services that are part of the delegation will be included in the risk share. Currently there are not specific risk shares for each speciality with the exception of dental services subject to application of the dental ring fence.

- All risk share adjustments will be made non-recurrently in year unless they relate to a rectification of identified errors in ICB allocations in which case recurrent adjustments may be recommended.

7. Application of non-recurrent resources

- Underperformance against contracts will result in non-recurrent resources being available for additional investment within the financial year.

- Overall performance and availability of capacity will impact the application of non-recurrent resources to ICBs and investment will be made on the basis of service requirements when possible.
- This application of non-recurrent resources may therefore create imbalance between systems if application is not in line with the availability of resource.
- In contrast to specific ICB recurrent investment decisions, in these circumstances the principles of the financial risk share framework will be applied.

8. Dental ringfence

- In 2023/24 dental allocations will be ringfenced and guidance indicates that dental resources must be used for the purpose allocated. There is a risk that unutilised resources will need to be returned to NHS England.
- It is assumed that the dental ringfence will be applied at a regional level and confirmation of this assumption is being pursued. Local management of the dental ringfence will also be at a regional level.
- Consequently, the application of the risk management framework may need to be applied separately for dental services as underspends with dental may not be able to be applied to other service areas.
- Through the application of non-recurrent investments every effort should be used to maximise expenditure against dental allocations.
- Any clawback of unutilised dental allocation will be subject to the application of the financial risk management framework and will be allocated proportionally to ICB allocations.

9. Application of the financial risk share agreement

The application of the financial risk share agreement assumes that all local ICB mitigation within POD budgets has been exhausted.

ICB overspend within an overall underspend

In the circumstance that one or more ICBs have an overspend within POD allocations but the region overall is underspent, a proposal will be developed by the finance subgroup for approval by the East and West Midlands Joint Committees that allocation will be adjusted between ICBs to allocate the overall underspend proportionately to the ICB allocations. This is demonstrated in the table below. Amounts are for illustration .

ICB	£000s	Forecast	Variance	Allocation Proportion	Revised Forecast	Risk Adjusted Variance	Risk Adjustment
NHS Birmingham and Solihull ICB	138,818	136,318	-2,500	13.8%	137,810	-1,008	1,492
NHS Coventry and Warwickshire ICB	78,254	79,254	1,000	7.8%	77,686	-568	-1,568
NHS Herefordshire and Worcestershire ICB	69,161	69,161	0	6.9%	68,659	-502	-502
NHS Derby and Derbyshire ICB	105,600	105,600	0	10.5%	104,833	-767	-767
NHS Leicester, Leicestershire and Rutland ICB	91,523	89,223	-2,300	9.1%	90,858	-665	1,635
NHS Lincolnshire ICB	60,163	59,163	-1,000	6.0%	59,726	-437	563
NHS Northamptonshire ICB	70,018	69,518	-500	7.0%	69,510	-508	-8
NHS Nottingham and Nottinghamshire ICB	109,015	111,015	2,000	10.8%	108,223	-792	-2,792
NHS Shropshire, Telford and Wrekin ICB	49,789	47,789	-2,000	5.0%	49,427	-362	1,638
NHS Staffordshire and Stoke-On-Trent ICB	105,543	104,043	-1,500	10.5%	104,777	-766	734
NHS Black Country ICB	127,396	126,896	-500	12.7%	126,471	-925	-425
Total	**1,005,280**	**997,980**	**-7,300**	**100.0%**	**997,980**	**-7,300**	**0**
Gross Underspend			**-10,300**				
Gross Overspend			**3,000**				

The overall underspend will not be aligned across ICBs with residual surplus being retained by the ICBs to which it accrues.

ICB overspend within a balanced position

In the circumstance that one or more ICBs have an overspend within POD allocations but the region overall is in a balanced position a proposal will be developed by the finance subgroup for approval by the East and West Midlands Joint Committees that allocation will be adjusted between ICBs proportionately to allocations to bring all ICBs into a balanced position. Illustration below

ICB	£000s	Forecast	Variance	Allocation Proportion	Revised Forecast	Risk Adjusted Variance	Risk Adjustment
NHS Birmingham and Solihull ICB	138,818	136,818	-2,000	13.8%	138,818	0	2,000
NHS Coventry and Warwickshire ICB	78,254	79,254	1,000	7.8%	78,254	0	-1,000
NHS Herefordshire and Worcestershire ICB	69,161	69,661	500	6.9%	69,161	0	-500
NHS Derby and Derbyshire ICB	105,600	105,600	0	10.5%	105,600	0	0
NHS Leicester, Leicestershire and Rutland ICB	91,523	89,223	-2,300	9.1%	91,523	0	2,300
NHS Lincolnshire ICB	60,163	60,663	500	6.0%	60,163	0	-500
NHS Northamptonshire ICB	70,018	69,518	-500	7.0%	70,018	0	500
NHS Nottingham and Nottinghamshire ICB	109,015	109,815	800	10.8%	109,015	0	-800
NHS Shropshire, Telford and Wrekin ICB	49,789	50,789	1,000	5.0%	49,789	0	-1,000
NHS Staffordshire and Stoke-On-Trent ICB	105,543	105,543	0	10.5%	105,543	0	0
NHS Black Country ICB	127,396	128,396	1,000	12.7%	127,396	0	-1,000
Total	**1,005,280**	**1,005,280**	**0**	**100.0%**	**1,005,280**	**0**	**0**
Gross Underspend			**-4,800**				
Gross Overspend			**4,800**				

Overall deficit position

In the circumstance that the overall position of the region is a deficit, a proposal will be developed by the finance subgroup for approval by the East and West Midlands Joint Committees that allocation will be adjusted so that the deficit is applied proportionately to ICB allocations. Illustration below.

ICB	£000s	Forecast	Variance	Allocation Proportion	Revised Forecast	Risk Adjusted Variance	Risk Adjustment
NHS Birmingham and Solihull ICB	138,818	136,818	-2,000	13.8%	138,984	166	2,166
NHS Coventry and Warwickshire ICB	78,254	79,254	1,000	7.8%	78,347	93	-907
NHS Herefordshire and Worcestershire ICB	69,161	69,661	500	6.9%	69,244	83	-417
NHS Derby and Derbyshire ICB	105,600	106,100	500	10.5%	105,726	126	-374
NHS Leicester, Leicestershire and Rutland ICB	91,523	89,223	-2,300	9.1%	91,632	109	2,409
NHS Lincolnshire ICB	60,163	60,663	500	6.0%	60,235	72	-428
NHS Northamptonshire ICB	70,018	69,518	-500	7.0%	70,102	84	584
NHS Nottingham and Nottinghamshire ICB	109,015	110,015	1,000	10.8%	109,145	130	-870
NHS Shropshire, Telford and Wrekin ICB	49,789	50,789	1,000	5.0%	49,848	59	-941
NHS Staffordshire and Stoke-On-Trent ICB	105,543	106,043	500	10.5%	105,669	126	-374
NHS Black Country ICB	127,396	128,396	1,000	12.7%	127,548	152	-848
Total	**1,005,280**	**1,006,480**	**1,200**	**100.0%**	**1,006,480**	**1,200**	**0**
Gross Underspend			**-4,800**				
Gross Overspend			**6,000**				

Differential application of non-recurrent resources

In the circumstance that overall underspends are invested differentially to where they are accrued, a proposal will be developed by the finance subgroup for approval by the East and West Midlands Joint Committees that allocation will be adjusted between the underspending ICBs and the ICBs where investment is being made.

Overall clawback of ringfenced dental allocations

In the circumstance that there is a residual underspend within dental allocations that will be reclaimed by NHS England, a proposal will be developed by the finance subgroup for approval by the East and West Midlands Joint Committees that dental allocations are adjusted so that any clawback is proportional to ICB allocations.

It should be noted that in all circumstances above allocation adjustments will be made non-recurrently and baseline recurrent allocations for each ICB will remain unchanged.

Identification of errors in the calculation of recurrent baseline allocations

In the circumstance that any errors are found in the initial calculation of ICB recurrent baseline allocations, a proposal may be developed by the finance subgroup for approval by the East and West Midlands Joint Committees that a recurrent adjustment to ICB baseline allocations is made to rectify the identified error.

10. The future of risk sharing for Pharmacy, Optometry, and Dentistry (PODs)

- This risk share is intended to be in place to allow a greater degree of understanding by ICBs of the risks inherited from delegating budgets either from changes in allocation methodology, or in year changes in spend.
- Whilst the risk share continues to be in place it will be subject to annual review and amendment by consensus agreement
- The risk share is seen as transitional, however the risk share will continue by default in the absence of any agreed changes that would be recommended by the Finance subgroup, and approved by the East/West Board.
- The review should consider the geographical coverage, as well as service coverage.
- Removal and addition of services from the risk share should be by agreement of all members of the risk share group, including resource flow. This means an ICB cannot unilaterally leave the risk share. This should form a review at the end of the first year. Changes should not remove the viability of a risk share.

11. Use of contingency/ unallocated funds

- Best practice looks to avoid holding back significant sums from the planning process, in terms of a central contingency. This is in part because of the requirement on the public sector to use the funds allocated for the purposes intended and in part to discourage organisations relying on such funds to 'bail them out' or ending with last minute year-end expenditure resulting in a sub-optimal use of resources. However, there are often unforeseen costs and a small level of contingency set aside to support may be required.
- To meet unforeseen costs a planned contingency of 1% has been built into the 2023/24 financial plan within the delegated budgets, and will form a part of the mitigation process, however this should be reviewed each time plans are agreed to ensure affordability of contingency creation is possible, and if not possible, a recommended level put forward to the Finance and Contracting Sub-group.

12. Assurance

- Following delegation there will be joint commissioning boards for East Midlands and West Midlands with a specific finance sub-committee. Through delegation from the ICBs this sub-committee will have responsibility for oversight and delivery of the risk management framework. Regular financial performance reporting will facilitate monitoring and management of financial risk and application of the terms of the framework will be the responsibility of the finance sub-committee.

13. Appeals and escalation

- While there may be a financial risk sharing agreement, there will need to be a process for dispute resolution where consensus cannot be agreed.

- Primarily risk sharing disagreements will be managed by the chair of the Finance subgroup, unless conflicted. In the case of conflict, an agreed independent party will provide arbitration.
- Escalation to the East and West Boards is required upon recommendation of the Finance subgroup chair should a disagreement not be settled.
- Should this not be resolved, NHS E will be requested to provide arbitration, however this should be avoided where possible and alternative routes identified.

15. Appendix 1 – Financial Scheme of Delegation (Excerpt from version 3 25.01.23 of Governance Handbook)

The Financial Scheme of Delegation sets out the levels of financial authority that are delegated to different levels of staff within NHS Shropshire, Telford and Wrekin (NHS STW). Staff may only operate within the authority levels delegated to them and any breaches must be reported immediately to the Chief Finance Officer or Deputy Chief Finance Officer. Breaches will also be reported to the Audit Committee.

The Financial Scheme of Delegation is reviewed and amended from time to time. It is the responsibility of the Chief Executive to communicate current policy to staff.

The Financial Scheme of Delegation must be read in conjunction with other relevant financial and other policies of NHS STW, including NHS STW's policies in relation to Conflicts of Interest.

Key:

CEO – Chief Executive Officer
CFO – Chief Finance Officer
CMO – Chief Medical Officer
CNO – Chief Nurse Officer
EDDT – Executive Director of Delivery & Transformation
DSI – Director of Strategy & Integration
Other Dir - Director other than CFO, CMO,CNO, DDT or DSI
Equiv – equivalent staff member (who may be fulfilling work of similar nature or at an equivalent level of seniority relevant and appropriate for the authority level, to be determined by a more senior line manager)

Notes:

1. An authorised individual may appoint another to formally deputise (e.g. during leave). In that case, the deputy has the authority of the individual that has assigned it. Such appointment must be in writing and clear as to the scope and terms of the assignment.

Delegated matter	Authority							Notes
	Board and chair (if delegated)	**Committee**	**Chief Executive Officer**	**ICB Directors**	**Heads of Service (Band 8c & above)**	**Budget Manager (Bands 8b & 8a)**	**Resource Manager (Band 6 & above)**	
Signing of Healthcare Commissioning Annual Contracts & SLAs and Pooled Budgets	n/a	n/a	No Limit	CFO (No Limit) CMO (No Limit) CNO (No Limit) EDDT (No Limit) DSI (No Limit)	No	No	No	If within budget agreed by Board
Authorisation of monthly block payment for agreed contract value to NHS bodies	n/a	n/a	No Limit	CFO (No Limit)	Head of Contracts (No Limit)	No	No	If within signed annual contract value
Variations to healthcare and non-healthcare contracts	n/a	n/a	No Limit	CFO (No Limit) CMO (No Limit) CNO (No Limit) EDDT (No Limit) DSI (No Limit)	No	No	No	If within budget agreed by Board

Delegated matter	Authority							Notes
	Board and chair (if delegated)	**Committee**	**Chief Executive Officer**	**ICB Directors**	**Heads of Service (Band 8c & above)**	**Budget Manager (Bands 8b &8a)**	**Resource Manager (Band 6 & above)**	
Continuing Healthcare - Authorisation of Continuing Healthcare contracts and related weekly cost packages.	n/a	n/a	No Limit	CFO (No Limit) CNO (No Limit) CMO (No Limit) EDDT (No Limit)	Up to £5,000	Up to £3000	Up to £1500	If supported by contract/tendering and quotation approval and within budget. Limits relate to anticipated total weekly package costs
Authorisation of requisitions (or certification of invoices when no requisition/order was raised).	n/a	n/a	No Limit	CFO (No Limit) CMO (No Limit) CNO (No Limit) EDDT (No Limit) DSI (No Limit)	Up to £250,000	Up to £100,000	Up to £1,000	All ICB Staff
Pharmaceutical, Opthalmic and Dental Primary Care Delegation (NHSE Staff): Authorisation of requisitions (or certification of invoices when no requisition/order was raised)/ Contract Variations	n/a	n/a	No Limit	CFO (No Limit) CMO (No Limit) CNO (No Limit) EDDT (No Limit) DSI (No Limit)	Up to £250,000	Up to £100,000	Band 5: Up to £5,000 Band 6: Up to £10,000 Band 7: Up to £30,000	NHSE Staff as part of the delegation of Pharmaceutical, Opthalmic and Dental Primary Care functions

Authority to waive tenders or quotations, or to accept a tender or quotation which is not the lowest.	n/a	n/a	No Limit	CFO (No Limit)	No	No	No	All instances to be reported to the Audit Committee
Delegated matter	**Authority**							**Notes**
	Board and chair (if delegated)	**Committee**	**Chief Executive Officer**	**ICB Directors**	**Heads of Service (Band 8c & above)**	**Budget Manager (Bands 8b & 8a)**	**Resource Manager (Band 6 & above)**	
Approve Special Payments	< £95,001	No	No	No	No	No	No	All cases above £95,000 must be submitted to NHSE for approval
Approve losses, including invoice write-offs	> £50,000 and < £300,001	n/a	Up to £50,000 (in conjunction with CFO)	CFO Up to £1,000 and up to £50,000 (in conjunction with AO)	No	No	No	All instances to be reported to the Audit Committee. All cases above £300,000 must be submitted to NHSE for approval

Approve Consolatory Payments	< £501	No	No	No	No	No	No	All cases above £500 must be submitted to NHSE for approval
Tenancy agreements/ Licences	n/a	n/a	No Limit in conjunction with CFO	CFO - No Limit in conjunction with AO	No	No	No	
Delegated matter	**Authority**							**Notes**
	Board and chair (if delegated)	**Committee**	**Chief Executive Officer**	**ICB Directors**	**Heads of Service (Band 8c & above)**	**Budget Manager (Bands 8b & 8a)**	**Resource Manager (Band 6 & above)**	
Virements between budgets	n/a	n/a	No Limit (capital & revenue)	All Dirs (No Limit) (capital & revenue)	(No Limit) (capital & revenue)	No	No	Must be in accordance with ***Budgetary Control Policy***
Banking arrangements	n/a	n/a	As specified on bank mandate	CFO as specified on bank mandate	Deputy CFO as specified on bank mandate	No	No	In accordance with mandated Government Banking Service arrangements
Payroll forms (starters/changes/ leavers & expense claims)	n/a	n/a	No Limit	All Dirs (No Limit)	(No Limit)	(No Limit)	(No Limit)	In accordance with approval hierarchy in EASY

QUOTATION & TENDERING LIMITS

Value for money should be demonstrated by all staff regardless of the levels of expenditure involved. However, the following limits apply to all expenditure in excess of £25,000:

Value of Expenditure (inclusive of irrecoverable VAT)	Requirement
£25,001-£50,000	2 written quotes
£50,001-£75,000	3 written quotes
>£75,000	Tender

Additional points to note for the inclusion of POD staff:

- The inclusion of lower band staff for the POD team is minimal risk as they are not material values and the staff are still subject to the same policies which is not a fundamental variation;
- The implication of not agreeing this amendment is that the default would be for all POD invoices to require sign off by ICB staff. There is no capacity to resource this within the ICB as the existing resource sits with the POD team.

Dated 2023

(1) **NHS ENGLAND**

- and -

(2) **NHS SHROPSHIRE, TELFORD AND WREKIN INTEGRATED CARE BOARD**

Delegation Agreement in Respect of

(i) Primary Medical Care Services
(ii) Primary Dental Services and Prescribed Dental Services
(iii) Primary Ophthalmic Services
(iv) Pharmaceutical Services and Local Pharmaceutical Services

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DELEGATION AGREEMENT FOR SPECIFIED FUNCTIONS

1. PARTICULARS

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

Integrated Care Board	NHS Shropshire, Telford and Wrekin Integrated Care Board
Area	The area covered by the ICB is aligned with the two unitary authorities; County of Shropshire and Borough of Telford and Wrekin
Date of Agreement	1 April 2023
ICB Representative	Simon Whitehouse, Chief Executive
ICB Email Address for Notices	[Insert Address]
NHS England Representative	Dale Bywater, Regional Director (Midlands)
NHS England Email Address for Notices	england.midlandscorporate@nhs.net

1.2 **The following Delegated Functions are included in this Agreement[1]:**

Delegated Functions	Schedule	Included	Effective Date of Delegation
Primary Medical Services Functions	Schedule 2A –	Yes	
Primary Dental Services and Prescribed Dental Services Functions	Schedule 2B –	Yes	
Primary Ophthalmic Services Functions	Schedule 2C –	Yes	
Pharmaceutical Services and Local Pharmaceutical Services Functions	Schedule 2D –	Yes	

1.3 This Agreement comprises:

1.3.1 the Particulars (clause 1);

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

1.3.2 the Terms and Conditions (clauses 2 to 31);

1.3.3 the Schedules; and

1.3.4 the Mandated Guidance

Signed by **NHS England**

Dale Bywater

Regional Director (Midlands)

(for and on behalf of NHS England)

Signed by **NHS Shropshire, Telford and Wrekin Integrated Care Board**

Simon Whitehouse

Chief Executive

(for and on behalf of NHS Shropshire, Telford and Wrekin Integrated Care Board)

TERMS AND CONDITIONS

2. **INTERPRETATION**

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

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

2.2.1 the Particulars and Terms and Conditions (clauses 1 to 31);

2.2.2 all Schedules excluding Local Terms;

2.2.3 Mandated Guidance; and

2.2.4 Local Terms.

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

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

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

3. **BACKGROUND**

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

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

3.3 This Agreement sets out the terms that apply to the exercise of the Delegated Functions by the ICB and the Parties' associated responsibilities and measures required to ensure the effective and efficient exercise of the Delegated Functions and Reserved Functions.

4. **TERM**

4.1 This Agreement has effect from the Date of Agreement set out in the Particulars and will remain in force unless terminated in accordance with clause 26 *(Termination)* below.

5. **PRINCIPLES**

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

5.1.1 at all times have regard to the Triple Aim;

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

5.1.3 have regard to the intention that commissioning functions in respect of Primary Medical Services, Primary Dental Services and Primary Ophthalmic Services will in future be directly conferred on the ICB;

5.1.4 consider how it can meet its legal duties to involve patients and the public in shaping the provision of services, including by working with local

communities, under-represented groups and those with protected characteristics for the purposes of the Equality Act 2010;

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

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

5.1.7 act in a timely manner;

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

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

6. DELEGATION

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

6.2 The Delegated Functions are the functions described as being delegated to the ICB as have been identified as included in clause 1 (*Particulars*) and included as a Schedule to this Agreement.

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

6.4 NHS England may by Contractual Notice allocate Contracts to the ICB such that they are included as part of the Delegation. The Delegated Functions must be exercised both in respect of the relevant Contract and any related matters concerning any Provider that is a party to Contract or Arrangement.

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

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

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

6.8 Unless expressly provided for in this Agreement, the ICB is not authorised by this Agreement to take any step or make any decision in respect of Reserved Functions. Any such purported decision of the ICB is invalid and not binding on NHS England unless ratified in writing by NHS England in accordance with the NHS England Scheme of Delegation and Standing Financial Instructions. NHS England may, acting reasonably and solely to the extent that the decision relates to the Delegated Functions, substitute its own decision for any decision which the ICB purports to make where NHS England reasonably considers that the impact of the ICB decision could, in relation to the Delegated Functions, cause the ICB to be acting unlawfully, in breach of this Agreement including Mandated Guidance, or in breach of any Contract. The ICB must

provide any information, assistance and support as NHS England requires to enable it to determine whether to make any such decision.

6.9 The terms of clause 6.8 are without prejudice to the ability of NHS England to enforce the terms of this Agreement or otherwise take action in respect of any failure by the ICB to comply with this Agreement.

7. EXERCISE OF DELEGATED FUNCTIONS

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

7.1.1 the terms of this Agreement including Mandated Guidance;

7.1.2 any Contractual Notices;

7.1.3 all applicable Law and Guidance;

7.1.4 the ICB's constitution;

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

7.1.6 Good Practice.

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

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

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

7.5 The ICB must give due consideration to whether any of the Delegated Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under section 65Z5 and section 75 of the NHS Act.

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

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

7.8 The ICB must perform the Delegated Functions:

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

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

8. **PERFORMANCE OF THE RESERVED FUNCTIONS**

8.1 NHS England will exercise the Reserved Functions, including but not limited to those set out in the relevant Schedules to this Agreement.

8.2 For the avoidance of doubt, the Parties acknowledge that the Delegation may be amended, and additional functions may be delegated to the ICB, in which event consequential changes to this Agreement shall be agreed with the ICB pursuant to clause 25 (*Variations*) of this Agreement.

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

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

8.5 The Parties acknowledge that where the ICB shall provide administrative and management services to NHS England in relation to certain Reserved Functions these shall be as set out in clause 9.14. and SCHEDULE *(Administrative and Management Services*).

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

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

9. **FINANCE**

9.1 Without prejudice to any other provision in this Agreement, the ICB must comply with such financial processes as required by NHS England for the management, reporting and accounting of funds used for the purposes of the Delegated Functions.

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

9.3 Subject to clause 9.4 and any provisions in the Schedules or Mandated Guidance, the ICB may use:

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

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

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

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

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

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

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

9.5.1 in order to take into account any monthly adjustments or corrections to the Delegated Funds that NHS England considers appropriate, including without limitation adjustments following any changes to the Delegated Functions, changes in allocations, changes in Contracts, to implement Mandated Guidance under Clause 7.4 or otherwise;

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

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

9.5.4 to take into account any adjustments that NHS England considers appropriate (including without limitation in order to make corrections or otherwise to reflect notional budgets) to reflect funds transferred (or that should have been transferred) to the ICB in respect of the Delegated Functions and/or funds transferred (or that should have been transferred) to the ICB and in respect of which the ICB has management or administrative responsibility under Schedule 10 of this Agreement; or

9.5.5 in order to ensure compliance by NHS England with its obligations under the NHS Act (including without limitation, Part 11 of the NHS Act) or any action taken or direction made by the Secretary of State in respect of NHS England under the NHS Act.

9.6 NHS England acknowledges that the intention of paragraph 9.5 is to reflect genuine corrections and adjustments to the Delegated Funds and may not be used to change the allocation of the Delegated Funds unless there are significant or exceptional circumstances that would require such corrections or adjustments.

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

9.8 NHS England may in respect of the Delegated Funds:

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

9.8.2 by notice, require the ICB to take such action or step in respect of the Delegated Funds, in order to ensure compliance by NHS England of its duties or functions under the NHS (including without limitation, Part 11 of the NHS Act) or any action taken or direction made by the Secretary of State under the NHS Act.

9.9 The Schedules to this Agreement identify further financial provisions in respect of the exercise of the Delegated Functions including but not limited to SCHEDULE 5 (*Financial Provisions and Decision Making Limits*).

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

Payment and Transfer

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

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

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

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

9.12.3 any Capital Investment Guidance; and

9.12.4 the HM Treasury guidance *Managing Public Money* (dated September 2022)

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

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

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

Administrative and/or Management Services

9.14 The provisions of SCHEDULE (*Administrative and Management Services)* in relation to Administrative and/or Management Services shall apply.

Pooled Funds

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

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

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

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

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

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

10. INFORMATION, PLANNING AND REPORTING

10.1 The ICB must provide to NHS England:

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

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

10.2 The provisions of this clause 10 are without prejudice to the ability of NHS England to exercise its other powers and duties in obtaining information from and assessing the performance of the ICB.

Forward Plan and Annual Report

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

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

Risk Register

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

11. FURTHER ARRANGEMENTS

11.1 The ICB must give due consideration to whether any of the Delegated Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under section 65Z5 and section 75 of the NHS Act.

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

11.3 The approval of any Further Arrangements may:

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

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

11.4 All Further Arrangements must be made in writing.

11.5 The ICB must not:

11.5.1 terminate Further Arrangements; or

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

11.5.3 without the prior written approval of NHS England.

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

11.7 The terms of this clause 11 do not prevent the ICB from making arrangements for assistance and support in the exercise of the Delegated Functions with any person, where such arrangements reserve the consideration and making of any decision in respect of a Delegated Function to the ICB.

11.8 NHS England requires the ICB to make arrangements for assistance and support in the exercise of the Delegated Functions with those persons described in the Schedules including, but not limited to SCHEDULE 6 (*Mandated Assistance and Support*) and with such other persons as NHS England may require from time to time.

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

12. STAFFING AND WORKFORCE

12.1 The Staffing Model in respect of each Delegated Function shall at the Effective Date of Delegation be as approved by the relevant National Moderation Panel.

12.2 Where the staffing arrangements include the deployment of NHS England Staff to the ICB for the purposes of carrying out the relevant Delegated Functions then the provisions of SCHEDULE 8 (*Deployment of NHS England Staff to the* ICB) shall apply.

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

12.4 For the avoidance of doubt, any breach by the ICB of the terms of this clause 12 (Staffing), including any breach of any Mandated Guidance issued in accordance with clause 12.3 above, will be a breach of the terms and conditions of this Agreement for the purposes of clauses 9.5 and 15.2.

13. BREACH

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

13.1.1 exercise its rights under this Agreement; and/or

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

13.2 Without prejudice to clause 13.1, if the ICB does not comply with the terms of this Agreement (including if the ICB exceeds its delegated authority under the Delegation), NHS England may (at its sole discretion):

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

13.2.2 ratify any decision in accordance with clause 6.8;

13.2.3 substitute a decision in accordance with clause 6.9;

13.2.4 revoke the whole or part of the Delegation and terminate this Agreement in accordance with clause 26 *(Termination)* below;

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

13.2.6 exercise its rights under common law.

13.3 NHS England may waive any non-compliance by the ICB with the terms of this Agreement provided that the ICB provides a written report to NHS England as required by clause 13.4 and, after considering the ICB's written report, NHS England is satisfied that the waiver is justified.

13.4 If:

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

13.4.2 NHS England notifies the ICB that it considers the ICB has not complied, or may not be able to comply with, this Agreement,

then the ICB must provide a written report to NHS England within ten (10) Operational Days of the non-compliance (or the date on which the ICB considers that it may not be able to comply with this Agreement) or such notification pursuant to clause 13.4.2 setting out:

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

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

14. ESCALATION RIGHTS

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

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

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

14.2 Nothing in clause 14 *(Escalation Rights)* will affect NHS England's right to substitute a decision in accordance with clause 6.9, revoke the Delegation and/or terminate this Agreement in accordance with clause 26 *(Termination)* below.

15. LIABILITY AND INDEMNITY

15.1 NHS England is liable in respect of any Losses arising in respect of NHS England's negligence, fraud, recklessness or deliberate breach in respect of the Delegated Functions and occurring after the Effective Date of Delegation and, if the ICB suffers any Losses in respect of such actions by NHS England, NHS England shall make such adjustments to the Annual Allocation (or other amounts payable to the ICB) in order to reflect any Losses suffered by the ICB (except to the extent that the ICB is liable for such Losses pursuant to clause 15.3).

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

15.3 The ICB is liable to (and shall pay) NHS England for any Losses suffered by NHS England that result from or arise out of the ICB's negligence, fraud, recklessness or breach of the Delegation (including any actions that are taken that exceed the authority

conferred by the Delegation) or this Agreement and, in respect of such Losses, NHS England may, at its discretion and without prejudice to any other rights, either require payment from the ICB or make such adjustments to the Delegated Funds pursuant to clause 9.5. The ICB shall not be liable to the extent that the Losses arose prior to the Effective Date of Delegation.

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

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

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

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

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

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

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

16. CLAIMS AND LITIGATION

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

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

16.3 The ICB must:

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

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

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

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

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

16.4 Subject to clauses 16.3 and 16.5 and SCHEDULE 5 (*Financial Provisions and Decision Making Limits*) the ICB is entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit.

NHS England Stepping into Claims

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

16.5.1 NHS England shall be entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit, provided that if NHS England wishes to invoke clause 16.5.3 it agrees to seek the ICB's views on any proposal to pay or settle that Claim prior to finalising such payment or settlement; and

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

16.5.3 NHS England may, at its discretion and without prejudice to any other rights, either require payment from the ICB for such Claim Losses or make an adjustment to the Delegated Funds pursuant to clause 9.5.3 for the purposes of meeting any Claim Losses associated with that Claim.

Claim Losses

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

16.7 The ICB acknowledges that NHS England will pay to the ICB the funds that are attributable to the Delegated Functions. Accordingly, the ICB acknowledges that it must pay any Claim Losses out of either the Delegated Funds or its Annual Allocation. NHS England may, in respect of any Claim Losses, at its discretion and without prejudice to any other rights, either require payment from the ICB for such Claim Losses or pursuant to clause 9.5.3 make such adjustments to the Delegated Funds to take into account the amount of any Claim Losses (other than any Claim Losses in respect of which NHS England has retained any funds, provisions or other resources to discharge such Claim Losses). For the avoidance of doubt, in circumstances where NHS England suffers any Claim Losses, then NHS England shall be entitled to recoup such Claim Losses pursuant to clause 9.5.3. If and to the extent that NHS England has retained any funds, provisions or other resources to discharge such Claim Losses, then NHS England may either use such funds to discharge the Claim Loss or make an upward adjustment to the amounts paid to the ICB pursuant to clause 9.5.3.

17. DATA PROTECTION, FREEDOM OF INFORMATION AND TRANSPARENCY

17.1 The Parties must ensure that all Personal Data processed by or on behalf of them in the course of carrying out the Delegated Functions and Reserved Functions is processed in accordance with the relevant Party's obligations under Data Protection

Legislation and Data Guidance and the Parties must assist each other as necessary to enable each other to comply with these obligations.

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

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

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

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

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

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

17.5.3 subject only to clause 16 *(Claims and Litigation)*, each Party acknowledges that the final decision as to the form or content of the response to any request is a matter for the Party to whom the request is addressed.

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

17.7

17.8 SCHEDULE **3**

Reserved Functions

1. Introduction

1.1 In accordance with clause 8.4 of this Agreement, all functions of NHS England other than those defined as Delegated Functions are Reserved Functions.

1.2 This **Error! Reference source not found.** (*Reserved Functions*) sets out further provision regarding the carrying out of the Reserved Functions.

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

2. Management of the national performers list

2.1 Subject to Paragraph 2.2, NHS England will continue to perform its functions under the National Health Service (Performers Lists) (England) Regulations 2013.

2.2 The ICB will carry out administrative tasks in respect of the Performers Lists as described at:

2.2.1 Paragraph 9 of Part 2, Schedule 2A;

2.2.2 Paragraph 9 of Part 2, Schedule 2B; and

2.2.3 Paragraph 6 of Part 2, Schedule 2C.

2.3 NHS England's functions in relation to the management of the national performers list include:

2.3.1 considering applications and decision-making in relation to inclusion on the national performers list, inclusion with conditions and refusals;

2.3.2 identifying, managing and supporting primary care performers where concerns arise; and

2.3.3 managing suspension, imposition of conditions and removal from the national performers list.

2.4 NHS England may hold local Performance Advisory Group ("PAG") meetings to consider all complaints or concerns that are reported to NHS England in relation to a named performer and NHS England will determine whether an initial investigation is to be carried out.

2.5 NHS England may notify the ICB of all relevant PAG meetings at least seven (7) days in advance of such meetings. NHS England may require a representative of the ICB to attend such meetings to discuss any performer concerns and/or quality issues that may impact on individual performer cases.

2.6 The ICB must develop a mechanism to ensure that all complaints regarding any named performer are escalated to the Local NHS England Team for review. The ICB will comply with any Mandated Guidance issued by NHS England in relation to the escalation of complaints about a named performer.

3. Management of the revalidation and appraisal process

3.1 NHS England will continue to perform its functions under the Medical Profession (Responsible Officers) Regulations 2010 (as amended by the Medical Profession (Responsible Officers) (Amendment) Regulations 2013).

3.2 All functions in relation to GP appraisal and revalidation will remain the responsibility of NHS England, including:

3.2.1 the funding of GP appraisers;

3.2.2 quality assurance of the GP appraisal process; and

3.2.3 the responsible officer network.

3.3 Funding to support the GP appraisal is incorporated within the global sum payment to Primary Medical Services Provider.

3.4 The ICB must not remove or restrict the payments made to Primary Medical Services Provider in respect of GP appraisal.

3.5 Appraisal arrangements in respect of all other primary care practitioner groups shall also be Reserved Functions.

4. Administration of payments and related performers list management activities

4.1 NHS England reserves its functions in relation to the administration of payments to individual performers and related performers list management activities under the National Health Service (Performers Lists) (England) Regulations 2013 and other relevant legislation.

4.2 NHS England may continue to pay practitioners who are suspended from the national performers list in accordance with relevant determinations made by the Secretary of State.

4.3 For the avoidance of doubt, the ICB is responsible for any ad hoc or discretionary payments to Primary Medical Services Providers (including those under section 96 of the NHS Act) in accordance with **Error! Reference source not found.**A (*Delegated Functions*) Part 2 paragraphs 5.1 and 5.1 of this Agreement, including where such payments may be considered a consequence of actions taken under the National Health Service (Performers Lists) (England) Regulations 2013.

5. Section 7A and Capital Expenditure Functions

5.1 NHS England retains the Section 7A Functions and will be responsible for taking decisions in relation to the Section 7A Functions.

5.2 In accordance with Schedule 10 Part 2, the ICB will provide certain management and/or administrative services to NHS England in relation to the Section 7A Functions.

5.3 NHS England retains the Capital Expenditure Functions and will be responsible for taking decisions in relation to the Capital Expenditure Functions.

5.4 In accordance with Schedule 10 Part 1, the ICB will provide certain management and/or administrative services to NHS England in relation to the Capital Expenditure Functions.

6. Such other ancillary activities that are necessary in order to exercise the Reserved Functions

6.1 NHS England will continue to comply with its obligations under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

6.2 The ICB must assist NHS England's controlled drug accountable officer ("CDAO") to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

6.3 The ICB must nominate a relevant senior individual within the ICB (the "ICB CD Lead") to liaise with and assist NHS England to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

6.4 The ICB CD Lead must, in relation to the Delegated Functions:

6.4.1 on request provide NHS England's CDAO with all reasonable assistance in any investigation involving the Delegated Functions;

6.4.2 report all complaints involving controlled drugs to NHS England's CDAO;

6.4.3 report all incidents or other concerns involving the safe use and management of controlled drugs to NHS England's CDAO;

6.4.4 analyse the controlled drug prescribing data available; and

6.4.5 on request supply (or ensure organisations from whom the ICB commissions services involving the regular use of controlled drugs supply) periodic self–declaration and/or self-assessments to NHS England's CDAO.

7. Reserved Functions – Primary Medical Services

7.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Medical Services Functions"):

7.1.1 determining the outcomes expected from Primary Medical Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes and the Department of Health and Social Care mandate;

7.1.2 designing and delivering national transformation programmes in support of national priorities;

7.1.3 the negotiation and agreement of matters concerning General Medical Services contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary medical services nationally;

7.1.4 the development of national standard Primary Medical Service contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Medical Services providers;

7.1.5 the provision of commissioning and contracting policy and guidance to support ICBs to meet their delegated duties;

7.1.6 the provision of nationally contracted services delivering digital, logistical and support services for Primary Medical Services in England (including but not limited to):

7.1.6.1 Payments;

7.1.6.2 Pensions;

7.1.6.3 Patient Registration;

7.1.6.4 Medical Records;

7.1.6.5 Performer List;

7.1.6.6 Supplies;

7.1.6.7 Call and Recall for Cervical screening (CSAS); and

7.1.6.8 Pharmacy Market Management.

7.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

8. Reserved Functions – Primary Dental Services

8.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Dental Services Functions"):

8.1.1 determining the outcomes expected from Primary Dental Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes; designing and delivering national transformation programmes in line with any applicable commissioning policies and guidance;

8.1.2 the negotiation and agreement of matters concerning Dental Services Contracts with national stakeholders including, without limitation, the

Department of Health and Social Care and bodies representing providers of primary dental services nationally;

8.1.3 the development of national standard Dental Service Contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Dental Services providers;

8.1.4 the provision of all dental commissioning and contracting policy and guidance to support ICBs to meet their delegated duties; and

8.1.5 the provision of nationally contracted services delivering digital, logistical and support services for Primary Dental Services in England (including but not limited to):

8.1.5.1 Payments;

8.1.5.2 Pensions;

8.1.5.3 Performer List; and

8.1.5.4 Market Management.

8.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

9. Reserved Functions – Primary Ophthalmic Services

9.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Ophthalmic Functions"):

9.1.1 the Primary Ophthalmic Services Contracts policy and associated documentation;

9.1.2 the negotiation and agreement of matters concerning Primary Ophthalmic Services with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of Ophthalmic Services nationally; and

9.1.3 the provision of nationally contracted services delivering digital, logistical and support services for Primary Ophthalmic Services in England (including but not limited to):

9.1.3.1 Payments;

9.1.3.2 Performers List;

9.1.3.3 Market Management/Entry; and

9.1.3.4 Contract management, assurance and post-payment verification.

9.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

10. Reserved Functions – Pharmaceutical Services and Local Pharmaceutical Services

10.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Pharmaceutical Functions"):

10.1.1 publication of Pharmaceutical Lists;

10.1.2 functions of NHS England as a determining authority in relation to pharmaceutical remuneration under Part 12 of the Pharmaceutical Regulations;

10.1.3 functions in respect of lists of performers of pharmaceutical services and assistants, noting that as at the date of this Agreement regulations for the purposes of these functions have not been made;

10.1.4 the negotiation and agreement of matters concerning NHS pharmaceutical services with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of Pharmaceutical Services nationally;

10.1.5 the provision of commissioning and contracting policy and guidance to support ICBs to meet their delegated duties; and

10.1.6 administration of the pharmacist pre-registration training grant scheme.

11. Reserved Functions – Primary Dental Services

11.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Dental Services Functions"):

11.1.1 determining the outcomes expected from Primary Dental Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes; designing and delivering national transformation programmes in line with any applicable commissioning policies and guidance;

11.1.2 the negotiation and agreement of matters concerning Dental Services Contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary dental services nationally;

11.1.3 the development of national standard Dental Service Contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Dental Services providers;

11.1.4 the provision of all dental commissioning and contracting policy and guidance to support ICBs to meet their delegated duties;

11.1.5 the provision of nationally contracted services delivering digital, logistical and support services for Primary Dental Services in England (including but not limited to):

11.1.5.1 Payments

11.1.5.2 Pensions

11.1.5.3 Performer List

11.1.5.4 Market Management.

11.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

12. Reserved Functions - Prescribed Dental Services

12.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Prescribed Dental Services Functions"):

12.1.1 determining the outcomes expected from Prescribed Dental Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes; designing and delivering national transformation programmes in line with any applicable commissioning policies and guidance;

12.1.2 in respect of any Prescribed Dental Services contracted pursuant to NHS England's functions under Part 5 of the NHS Act the negotiation and agreement of matters concerning those contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary dental services nationally;

12.1.3 in respect of any Prescribed Dental Services contracted pursuant to NHS England's functions under Part 5 of the NHS Act, the development of standard contracts and national contract variations and guidance;

12.1.4 the provision of all dental commissioning and contracting policy and guidance to support ICBs to meet their delegated duties;

12.1.5 in respect of any Prescribed Dental Services contracted pursuant to NHS England's functions under Part 5 of the NHS Act, the provision of nationally contracted services delivering digital, logistical and support services in England (including but not limited to):

12.1.5.1 Payments

12.1.5.2 Pensions

12.1.5.3 Performer List

12.1.5.4 Market Management.

12.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

17.9 **SCHEDULE 4** (*Further Information Governance and Sharing* Provisions) makes further provision about information sharing and information governance.

18. IT INTER-OPERABILITY

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

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

19. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY

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

19.2 Without prejudice to the general obligations set out in clause 19.1, the ICB must maintain a register of interests in respect of all persons making decisions concerning the Delegated Functions. This register must be publicly available. For the purposes of this clause, the ICB may rely on an existing register of interests rather than creating a further register.

20. PROHIBITED ACTS AND COUNTER-FRAUD

20.1 The ICB must not commit any Prohibited Act.

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

20.2.1 to revoke the Delegation; and

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

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

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

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

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

20.6 The ICB must, on becoming aware of:

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

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

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

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

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

20.7.2 all Staff who may have information to provide;

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

21. CONFIDENTIAL INFORMATION OF THE PARTIES

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

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

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

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

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

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

21.3.1 in connection with any Dispute Resolution;

21.3.2 in connection with any litigation between the Parties;

21.3.3 to comply with the Law;

21.3.4 to any appropriate Regulatory or Supervisory Body;

21.3.5 to its Staff, who in respect of that Confidential Information will be under a duty no less onerous than the Receiving Party's duty under clause 21.2;

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

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

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

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

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

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

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

21.5 This clause 21 does not prevent NHS England from making use of or disclosing any Confidential Information disclosed by the ICB where necessary for the purposes of exercising its functions in relation to the ICB.

21.6 The Parties acknowledge that damages would not be an adequate remedy for any breach of this clause 21 by the receiving Party, and in addition to any right to damages, the disclosing Party will be entitled to the remedies of injunction, specific performance and other equitable relief for any threatened or actual breach of this clause 21.

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

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

22. INTELLECTUAL PROPERTY

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

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

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

23. NOTICES

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

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

24. DISPUTES

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

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

24.2.1 either Party must give to the other written notice of the Dispute, setting out its nature and full particulars ("**Dispute Notice**"), together with relevant

supporting documents. On service of the Dispute Notice, the Agreement Representatives must attempt in good faith to resolve the Dispute;

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

24.2.3 if the people referred to in clause 24.2.2 are for any reason unable to resolve the Dispute within twenty (20) days of it being referred to them, the Parties may attempt to settle it by mediation in accordance with the CEDR model mediation procedure. Unless otherwise agreed between the Parties, the mediator must be nominated by CEDR Solve. To initiate the mediation, a Party must serve notice in writing ('Alternative Dispute Resolution' (**ADR**) **notice**) to the other Party to the Dispute, requesting a mediation. A copy of the ADR notice should be sent to CEDR Solve. The mediation will start not later than ten (10) days after the date of the ADR notice.

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

25. VARIATIONS

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

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

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

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

25.4.1 that it accepts the Variation Proposal; or

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

25.5 If the ICB accepts the Variation Proposal, the ICB agrees (without delay) to take all necessary steps (including executing a variation agreement) in order to give effect to any variation by the date on which the proposed variation will take effect as set out in the Variation Proposal.

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

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

26. TERMINATION

26.1 The ICB may:

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

26.1.2 terminate this Agreement;

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

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

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

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

26.2 NHS England may revoke the Delegation in whole or in part with effect from 23.59 hours on 31 March in any year, provided that it gives notice to the ICB of its intention to terminate the Delegation on or before 30 September in the year prior to the year in which the Delegation will terminate, and in which case clause 26.4 will apply.

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

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

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

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

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

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

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

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

26.3.8 the ICB merges with another ICB or other body.

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

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

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

specified Delegated Functions (or aspects of such Delegated Functions) only, in which case this Agreement shall otherwise remain in effect.

27. CONSEQUENCE OF TERMINATION

27.1 Termination of this Agreement, or termination of the ICB's exercise of any of the Delegated Functions, will not affect any rights or liabilities of the Parties that have accrued before the date of that termination or which later accrue.

27.2 Subject to clause 27.4, on or pending termination of this Agreement or termination of the ICB's exercise of any of the Delegated Functions, NHS England, the ICB and if appropriate any successor delegate will:

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

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

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

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

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

27.3.2 at the reasonable request of NHS England:

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

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

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

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

28. PROVISIONS SURVIVING TERMINATION

28.1 Any rights, duties or obligations of any of the Parties which are expressed to survive, including those referred to in clause 28.2, or which otherwise by necessary implication survive the termination for any reason of this Agreement, together with all indemnities, will continue after termination, subject to any limitations of time expressed in this Agreement.

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

28.2.1 Clause 9 (*Finance*);

28.2.2 Clause 12 (*Staffing and Workforce*);

28.2.3 Clause 15 *(Liability and Indemnity*);

28.2.4 Clause 16 (*Claims and Litigation*);

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

28.2.6 Clause 24 (*Disputes*);

28.2.7 Clause 26 (*Termination*);

28.2.8

28.2.9 SCHEDULE **3**

Reserved Functions

13. Introduction

13.1 In accordance with clause 8.4 of this Agreement, all functions of NHS England other than those defined as Delegated Functions are Reserved Functions.

13.2 This **Error! Reference source not found.** (*Reserved Functions*) sets out further provision regarding the carrying out of the Reserved Functions.

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

14. Management of the national performers list

14.1 Subject to Paragraph 2.2, NHS England will continue to perform its functions under the National Health Service (Performers Lists) (England) Regulations 2013.

14.2 The ICB will carry out administrative tasks in respect of the Performers Lists as described at:

14.2.1 Paragraph 9 of Part 2, Schedule 2A;

14.2.2 Paragraph 9 of Part 2, Schedule 2B; and

14.2.3 Paragraph 6 of Part 2, Schedule 2C.

14.3 NHS England's functions in relation to the management of the national performers list include:

14.3.1 considering applications and decision-making in relation to inclusion on the national performers list, inclusion with conditions and refusals;

14.3.2 identifying, managing and supporting primary care performers where concerns arise; and

14.3.3 managing suspension, imposition of conditions and removal from the national performers list.

14.4 NHS England may hold local Performance Advisory Group ("PAG") meetings to consider all complaints or concerns that are reported to NHS England in relation to a named performer and NHS England will determine whether an initial investigation is to be carried out.

14.5 NHS England may notify the ICB of all relevant PAG meetings at least seven (7) days in advance of such meetings. NHS England may require a representative of the ICB to attend such meetings to discuss any performer concerns and/or quality issues that may impact on individual performer cases.

14.6 The ICB must develop a mechanism to ensure that all complaints regarding any named performer are escalated to the Local NHS England Team for review. The ICB will comply with any Mandated Guidance issued by NHS England in relation to the escalation of complaints about a named performer.

15. Management of the revalidation and appraisal process

15.1 NHS England will continue to perform its functions under the Medical Profession (Responsible Officers) Regulations 2010 (as amended by the Medical Profession (Responsible Officers) (Amendment) Regulations 2013).

15.2 All functions in relation to GP appraisal and revalidation will remain the responsibility of NHS England, including:

15.2.1 the funding of GP appraisers;

15.2.2 quality assurance of the GP appraisal process; and

15.2.3 the responsible officer network.

15.3 Funding to support the GP appraisal is incorporated within the global sum payment to Primary Medical Services Provider.

15.4 The ICB must not remove or restrict the payments made to Primary Medical Services Provider in respect of GP appraisal.

15.5 Appraisal arrangements in respect of all other primary care practitioner groups shall also be Reserved Functions.

16. Administration of payments and related performers list management activities

16.1 NHS England reserves its functions in relation to the administration of payments to individual performers and related performers list management activities under the National Health Service (Performers Lists) (England) Regulations 2013 and other relevant legislation.

16.2 NHS England may continue to pay practitioners who are suspended from the national performers list in accordance with relevant determinations made by the Secretary of State.

16.3 For the avoidance of doubt, the ICB is responsible for any ad hoc or discretionary payments to Primary Medical Services Providers (including those under section 96 of the NHS Act) in accordance with **Error! Reference source not found.**A (*Delegated Functions*) Part 2 paragraphs 5.1 and 5.1 of this Agreement, including where such payments may be considered a consequence of actions taken under the National Health Service (Performers Lists) (England) Regulations 2013.

17. Section 7A and Capital Expenditure Functions

17.1 NHS England retains the Section 7A Functions and will be responsible for taking decisions in relation to the Section 7A Functions.

17.2 In accordance with Schedule 10 Part 2, the ICB will provide certain management and/or administrative services to NHS England in relation to the Section 7A Functions.

17.3 NHS England retains the Capital Expenditure Functions and will be responsible for taking decisions in relation to the Capital Expenditure Functions.

17.4 In accordance with Schedule 10 Part 1, the ICB will provide certain management and/or administrative services to NHS England in relation to the Capital Expenditure Functions.

18. Such other ancillary activities that are necessary in order to exercise the Reserved Functions

18.1 NHS England will continue to comply with its obligations under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

18.2 The ICB must assist NHS England's controlled drug accountable officer ("CDAO") to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

18.3 The ICB must nominate a relevant senior individual within the ICB (the "ICB CD Lead") to liaise with and assist NHS England to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

18.4 The ICB CD Lead must, in relation to the Delegated Functions:

18.4.1 on request provide NHS England's CDAO with all reasonable assistance in any investigation involving the Delegated Functions;

18.4.2 report all complaints involving controlled drugs to NHS England's CDAO;

18.4.3 report all incidents or other concerns involving the safe use and management of controlled drugs to NHS England's CDAO;

18.4.4 analyse the controlled drug prescribing data available; and

18.4.5 on request supply (or ensure organisations from whom the ICB commissions services involving the regular use of controlled drugs supply) periodic self–declaration and/or self-assessments to NHS England's CDAO.

19. Reserved Functions – Primary Medical Services

19.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Medical Services Functions"):

19.1.1 determining the outcomes expected from Primary Medical Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes and the Department of Health and Social Care mandate;

19.1.2 designing and delivering national transformation programmes in support of national priorities;

19.1.3 the negotiation and agreement of matters concerning General Medical Services contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary medical services nationally;

19.1.4 the development of national standard Primary Medical Service contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Medical Services providers;

19.1.5 the provision of commissioning and contracting policy and guidance to support ICBs to meet their delegated duties;

19.1.6 the provision of nationally contracted services delivering digital, logistical and support services for Primary Medical Services in England (including but not limited to):

19.1.6.1 Payments;

19.1.6.2 Pensions;

19.1.6.3 Patient Registration;

19.1.6.4 Medical Records;

19.1.6.5 Performer List;

19.1.6.6 Supplies;

19.1.6.7 Call and Recall for Cervical screening (CSAS); and

19.1.6.8 Pharmacy Market Management.

19.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

20. Reserved Functions – Primary Dental Services

20.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Dental Services Functions"):

20.1.1 determining the outcomes expected from Primary Dental Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes; designing and delivering national transformation programmes in line with any applicable commissioning policies and guidance;

20.1.2 the negotiation and agreement of matters concerning Dental Services Contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary dental services nationally;

20.1.3 the development of national standard Dental Service Contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Dental Services providers;

20.1.4 the provision of all dental commissioning and contracting policy and guidance to support ICBs to meet their delegated duties; and

20.1.5 the provision of nationally contracted services delivering digital, logistical and support services for Primary Dental Services in England (including but not limited to):

20.1.5.1 Payments;

20.1.5.2 Pensions;

20.1.5.3 Performer List; and

20.1.5.4 Market Management.

20.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

21. Reserved Functions – Primary Ophthalmic Services

21.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Ophthalmic Functions"):

21.1.1 the Primary Ophthalmic Services Contracts policy and associated documentation;

21.1.2 the negotiation and agreement of matters concerning Primary Ophthalmic Services with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of Ophthalmic Services nationally; and

21.1.3 the provision of nationally contracted services delivering digital, logistical and support services for Primary Ophthalmic Services in England (including but not limited to):

21.1.3.1 Payments;

21.1.3.2 Performers List;

21.1.3.3 Market Management/Entry; and

21.1.3.4 Contract management, assurance and post-payment verification.

21.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

22. Reserved Functions – Pharmaceutical Services and Local Pharmaceutical Services

22.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Pharmaceutical Functions"):

22.1.1 publication of Pharmaceutical Lists;

22.1.2 functions of NHS England as a determining authority in relation to pharmaceutical remuneration under Part 12 of the Pharmaceutical Regulations;

22.1.3 functions in respect of lists of performers of pharmaceutical services and assistants, noting that as at the date of this Agreement regulations for the purposes of these functions have not been made;

22.1.4 the negotiation and agreement of matters concerning NHS pharmaceutical services with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of Pharmaceutical Services nationally;

22.1.5 the provision of commissioning and contracting policy and guidance to support ICBs to meet their delegated duties; and

22.1.6 administration of the pharmacist pre-registration training grant scheme.

23. Reserved Functions – Primary Dental Services

23.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Dental Services Functions"):

23.1.1 determining the outcomes expected from Primary Dental Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes; designing and delivering national

transformation programmes in line with any applicable commissioning policies and guidance;

23.1.2 the negotiation and agreement of matters concerning Dental Services Contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary dental services nationally;

23.1.3 the development of national standard Dental Service Contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Dental Services providers;

23.1.4 the provision of all dental commissioning and contracting policy and guidance to support ICBs to meet their delegated duties;

23.1.5 the provision of nationally contracted services delivering digital, logistical and support services for Primary Dental Services in England (including but not limited to):

23.1.5.1 Payments

23.1.5.2 Pensions

23.1.5.3 Performer List

23.1.5.4 Market Management.

23.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

24. Reserved Functions - Prescribed Dental Services

24.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Prescribed Dental Services Functions"):

24.1.1 determining the outcomes expected from Prescribed Dental Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes; designing and delivering national transformation programmes in line with any applicable commissioning policies and guidance;

24.1.2 in respect of any Prescribed Dental Services contracted pursuant to NHS England's functions under Part 5 of the NHS Act the negotiation and agreement of matters concerning those contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary dental services nationally;

24.1.3 in respect of any Prescribed Dental Services contracted pursuant to NHS England's functions under Part 5 of the NHS Act, the development of standard contracts and national contract variations and guidance;

24.1.4 the provision of all dental commissioning and contracting policy and guidance to support ICBs to meet their delegated duties;

24.1.5 in respect of any Prescribed Dental Services contracted pursuant to NHS England's functions under Part 5 of the NHS Act, the provision of nationally contracted services delivering digital, logistical and support services in England (including but not limited to):

24.1.5.1 Payments

24.1.5.2 Pensions

24.1.5.3 Performer List

24.1.5.4 Market Management.

24.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

28.2.10 **SCHEDULE 4** (*Further Information Governance and Sharing Provisions*).

29. **COSTS**

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

30. **SEVERABILITY**

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

31. **GENERAL**

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

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

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

SCHEDULE 1

Definitions and Interpretation

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

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

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

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

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

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

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

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

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

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

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

Assigned Staff	means those NHS England staff as agreed between NHS England and the ICB from time to time;
Best Practice	means any methodologies, pathway designs and processes relating to this Agreement or the Delegated Functions developed by the ICB or its Staff for the purposes of delivering the Delegated Functions and which are capable of wider use in the delivery of healthcare services for the purposes of the NHS, but not including inventions that are capable of patent protection and for which patent protection is being sought or has been obtained, registered designs, or copyright in software;
Caldicott Principles	means the patient confidentiality principles set out in the report of the Caldicott Committee (December 1997 as amended by the 2013 Report, The Information Governance Review – "*To Share or Not to Share?"*) and now included in the NHS Confidentiality Code of Practice, as may be amended from time to time;
Capital	shall have the meaning set out in the Capital Investment Guidance or such other replacement Mandated Guidance as issued by NHS England from time to time;
Capital Expenditure Functions	means those functions of NHS England in relation to the use and expenditure of Capital funds (but excluding the Premises Costs Directions Functions);
Capital Investment Guidance	means any Mandated Guidance issued by NHS England from time to time in relation to the development, assurance and approvals process for proposals in relation to: • the expenditure of Capital, or investment in property, infrastructure or information and technology; and • the revenue consequences for commissioners or third parties making such investment;
CEDR	means the Centre for Effective Dispute Resolution;
Claims	means, for or in relation to the Delegated Functions (a) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal or the Secretary of State, any governmental, regulatory or similar body, or any department, board or agency or (b) any dispute with, or any investigation, inquiry or enforcement proceedings by, any governmental, regulatory or similar body or agency;
Claim Losses	means all Losses arising in relation to any Claim;
Combined Authority	means a body of that name established under the provisions of the Local Democracy, Economic Development and Construction Act 2009;
Community Dental Services	means specialised dental services commissioned for patients who are unable to access treatment from Primary Dental

	Services due to a disability or medical condition, being a form of Prescribed Dental Service;
Community Pharmacy Contractual Framework	means the Community Pharmacy Contractual Framework as published by the Department of Health and Social Care from time to time;
Complaints Regulations	means the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009/309;
Confidential Information	means any information or data in whatever form disclosed, which by its nature is confidential or which the disclosing Party acting reasonably states in writing to the receiving Party is to be regarded as confidential, or which the disclosing Party acting reasonably has marked 'confidential' (including, financial information, strategy documents, tenders, employee confidential information, development or workforce plans and information, and information relating to services) but which is not information which is disclosed in response to a FOIA request, or information which is published as a result of NHS England or government policy in relation to transparency;
Contracts	Means any Prescribed Dental Services Contract, Primary Care Contract or Arrangement or other contract or arrangement in respect of the commissioning of any other Delegated Services;
Contractual Notice	means a contractual notice issued by NHS England to the ICB, or some or all ICBs (as the case may be), from time to time and relating to the allocation of contracts for the purposes of the Delegated Functions and/or the manner in which the Delegated Functions should be exercised by the ICB;
CQC	means the Care Quality Commission;
Data Controller	shall have the same meaning as set out in the UK GDPR;
Data Guidance	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement regarding information governance, confidentiality, privacy or compliance with Data Protection Legislation to the extent published and publicly available or their existence or contents have been notified to the ICB by NHS England and/or any relevant Regulatory or Supervisory Body. This includes but is not limited to guidance issued by NHS Digital, the National Data Guardian for Health & Care, the Department of Health and Social Care, NHS England, the Health Research Authority, the UK Health Security Agency and the Information Commissioner;
Data Processor	shall have the same meaning as set out in the UK GDPR;
Data Protection Legislation	means the UK GDPR, the Data Protection Act 2018 and all applicable Law concerning privacy, confidentiality or the processing of personal data including but not limited to the Human Rights Act 1998, the Health and Social Care (Safety

	and Quality) Act 2015, the common law duty of confidentiality and the Privacy and Electronic Communications (EC Directive) Regulations 2003;
Data Sharing Agreement	means a data sharing agreement which should be in substantially the same form as the Data Sharing Agreement template shared by NHS England in respect of this Agreement;
Data Subject	shall have the same meaning as set out in the UK GDPR;
Delegated Functions	means the statutory functions delegated by NHS England to the ICB under the Delegation and as set out in detail in this Agreement;
Delegated Funds	means the funds defined in Clause 9.2;
Delegated Services	Means the services commissioned in exercise of the Delegated Functions;
Delegation	means the delegation of the Delegated Functions from NHS England to the ICB as described at clause 6.1;
Dental Care Services	means: (i) Primary Dental Services; and (ii) the Prescribed Dental Services;
Dental Services Contract	means: (i) a GDS Contract; (ii) a PDS Agreement (except for any Community Dental Services PDS Agreement, which constitutes a Prescribed Dental Services Contract); and (iii) any other contract for the provision of health services made pursuant to NHS England's functions under Part 5 of the NHS Act; in each case as amended or replaced from time to time and including all ancillary or related agreements directly relating to the subject matter of such agreements, contracts or arrangements;
Dental Services Provider	means a natural or legal person who holds a Dental Services Contract;
Direct Commissioning Guidance Webpage	means the webpage maintained by NHS England at https://www.england.nhs.uk/commissioning/how-commissioning-is-changing/;
Dispute	a dispute, conflict or other disagreement between the Parties arising out of or in connection with this Agreement;
Effective Date of Delegation	means the Effective Date of Delegation as set out in the Particulars;

EIR	means the Environmental Information Regulations 2004
Enhanced Services	means the nationally defined enhanced services, as set out in such directions made by the Secretary of State pursuant to his powers contained in sections 98A, 114A, 125A and 168A of the NHS Act as are in force from time to time, or which may be prescribed by NHS England under its Reserved Functions, and any other enhanced services schemes locally developed by the ICB in the exercise of its Delegated Functions (and excluding, for the avoidance of doubt, any enhanced services arranged or provided pursuant to the Section 7A Functions);
Escalation Rights	means the escalation rights as defined in clause 14 *(Escalation Rights)*;
Financial Year	shall bear the same meaning as in section 275 of the NHS Act;
FOIA	the Freedom of Information Act 2000;
Further Arrangements	means arrangements for the exercise of Delegated Functions as defined at clause 11.2;
GDS Contract	means a General Dental Services contract made under section 100 of the NHS Act;
GMS Contract	means a General Medical Services contract made under section 84(1) of the NHS Act;
Good Practice	means using standards, practices, methods and procedures conforming to the law, reflecting up-to-date published evidence and exercising that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced commissioner;
Guidance	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the ICB has a duty to have regard (and whether specifically mentioned in this Agreement or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified to the ICB by any relevant Regulatory or Supervisory Body but excluding Mandated Guidance;
HSCA	means the Health and Social Care Act 2012;
ICB	means an Integrated Care Board established pursuant to section 14Z25 of the NHS Act and named in the Particulars;
ICB Deliverables	all documents, products and materials developed by the ICB or its Staff in relation to this Agreement and the Delegated Functions in any form and required to be submitted to NHS England under this Agreement, including data, reports, policies, plans and specifications;

IG Guidance for Serious Incidents	IG Guidance for Serious Incidents NHS Digital's Checklist Guidance for Information Governance Serious Incidents Requiring Investigation June 2013, available at: https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-informationgovernance/data-security-and-protection-toolkit
Indemnity Arrangement	means either: (i) a policy of insurance; (ii) an arrangement made for the purposes of indemnifying a person or organisation; or (iii) a combination of (i) and (ii);
Information Law	the UK GDPR, the Data Protection Act 2018, regulations and guidance made under section 13S and section 251 of the NHS Act; guidance made or given under sections 263 and 265 of the HSCA; the Freedom of Information Act 2000; the common law duty of confidentiality; the Human Rights Act 1998 and all other applicable laws and regulations relating to processing of Personal Data and privacy;
IPR	means inventions, copyright, patents, database right, trademarks, designs and confidential know-how and any similar rights anywhere in the world whether registered or not, including applications and the right to apply for any such rights;
Law	means any applicable law, statute, rule, bye-law, regulation, direction, order, regulatory policy, guidance or code, rule of court or directives or requirements of any regulatory body, delegated or subordinate legislation or notice of any regulatory body (including any Regulatory or Supervisory Body);
Local Authority	means a county council in England, a Combined Authority, a district council in England, a London borough council, the Common Council of the City of London or the Council of the Isles of Scilly;
Local Incentive Schemes	means an incentive scheme developed by the ICB in the exercise of its Delegated Functions to extend the range or quality of essential and additional services provided under a Primary Medical Services Contract and support national frameworks in order to meet differing local population needs;
Local Pharmaceutical Services Contract	means • a contract entered into pursuant to section 134 of the NHS Act; or • a contract entered into pursuant to Paragraph 1 of Schedule 12 to the NHS Act;
Local Terms	means the terms set out in SCHEDULE 7 *(Local Terms)* and/or such other Schedule or part thereof as designated as Local Terms;
Losses	means all damages, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional

	services) proceedings, demands and charges whether arising under statute, contract or common law;
Managing Conflicts of Interest in the NHS	the NHS publication by that name available at: https://www.england.nhs.uk/about/board-meetings/committees/coi/
Mandated Guidance	means any protocol, policy, guidance, guidelines, framework or manual relating to the exercise of the Delegated Functions and issued by NHS England to the ICB as Mandated Guidance from time to time, in accordance with clause 7.2 which at the Effective Date of Delegation shall include the Mandated Guidance set out in the Schedules**;**
National Moderation Panel	Means the NHS England panel in respect of the relevant Delegated Function that will have the delegated authority to approve the ICB arrangements in respect of a Delegated Function;
Need to Know	has the meaning set out in paragraph 6.2 of **Error! Reference source not found.** (*Further Information Governance and Sharing Provisions)*;
NHS Act	means the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022 or other legislation from time to time);
NHS Business Services Authority	means the Special Health Authority established under the NHS Business Services Authority (Establishment and Constitution Order) 2005 SI 2005/2414;
NHS Counter Fraud Authority	means the Special Health Authority established by and in accordance with the NHS Counter Fraud Authority (Establishment, Constitution, and Staff and Other Transfer Provisions) Order 2017/958;
NHS England	means the body established by section 1H of the NHS Act;
NHS England Deliverables	means all documents, products and materials NHS England in which NHS England holds IPRs which are relevant to this Agreement, the Delegated Functions or the Reserved Functions in any form and made available by NHS England to the ICB under this Agreement, including data, reports, policies, plans and specifications;
NHS England Functions	means all functions of NHS England as set out in Legislation excluding any functions that have been expressly delegated;
Non-Personal Data	means data which is not Personal Data;
Out of Hours Contract	means a primary medical services contract for the provision of primary medical services solely during the out of hours period (6.30pm Monday to Thursday until 8am the next day, 6.30pm Friday to 8am Monday, Christmas Day, Good Friday and bank holidays);

Operational Days	a day other than a Saturday, Sunday, Christmas Day, Good Friday or a bank holiday in England;
Particulars	means the Particulars of this Agreement as set out in clause 1 *(Particulars)*;
Party/Parties	means a party or both parties to this Agreement;
PDS Agreement	means a Personal Dental Services Agreement made under section 107 of the NHS Act;
Performers Lists	The lists of healthcare professionals maintained by NHS England pursuant to the National Health Service (Performers Lists) (England) Regulations 2013;
Personal Data	shall have the same meaning as set out in the UK GDPR and shall include references to Special Category Personal Data where appropriate;
Pharmaceutical List	means a list of persons who undertake to provide pharmaceutical services pursuant to regulation 10 of the Pharmaceutical Regulations;
Pharmaceutical Regulations	means the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013/349;
Pharmaceutical Services	means:- (i) services provided pursuant to arrangements under section 126 of the NHS Act; and (ii) Additional Pharmaceutical Services
Pharmaceutical Services Arrangement	means an arrangement for the provision of Pharmaceutical Services, including inclusion in a Pharmaceutical List;
Pharmaceutical Services Provider	means a natural or legal person who is party to a Pharmaceutical Services Arrangement or Local Pharmaceutical Services Contract;
PMS Agreement	means an agreement made in accordance with section 92 of the NHS Act;
Population	means the individuals for whom the ICB is responsible for commissioning health services;
Premises Agreements	means tenancies, leases and other arrangements in relation to the occupation of land for the delivery of services under the Primary Medical Services Contracts;
Premises Costs Directions	means the National Health Service (General Medical Services Premises Costs) Directions 2013, as amended;
Premises Costs Directions Functions	means NHS England's functions in relation to the Premises Costs Directions;

Prescribed Dental Services	means the dental services prescribed by such regulations made pursuant to section 3B(1)(a) of the NHS Act as are in force from time to time (including, for the avoidance of doubt, services commonly known as secondary care dental services and Community Dental Services);
Prescribed Dental Services Contract	means any contract for the provision of Prescribed Dental Services;
Primary Care Contract or Arrangement (PCCA)	means: (i) a Primary Medical Services Contract; (ii) a Dental Services Contract; (iii) a Primary Ophthalmic Services Contract; (iv) a Local Pharmaceutical Services Contract; and (v) a Pharmaceutical Services Arrangement.
Primary Care Functions	means:- (i) the statutory functions conferred on NHS England under Parts 4, 5, 6 and 7 of the NHS Act and secondary legislation made under those Parts; and (ii) the other statutory functions conferred on NHS England by either primary legislation, secondary legislation or by arrangement with another person in so far as they are applicable to the discharge of those functions set out at (i) above;
Primary Care Provider	means a natural or legal person who holds a Primary Care Contract, or is a Pharmaceutical Services Provider;
Primary Care Provider Personnel	means all persons (whether clinical or non-clinical) employed or engaged by a Primary Care Provider or by any Sub-Contractor (including volunteers, agency, locums, casual or seconded personnel) in the provision of Services or any activity related to or connected with the provision of the Services;
Primary Care Services	means the services in respect of which NHS England has a duty or power to make arrangements pursuant to the Primary Care Functions;
Primary Dental Services	means primary dental care services provided under arrangements made pursuant to Part 5 of the NHS Act, and in accordance with a Dental Services Contract;
Primary Medical Services	means primary medical services provided under arrangements made pursuant to Part 4 of the NHS Act, and in accordance with a Primary Medical Services Contract;
Primary Medical Services Contract	means:

(i) a PMS Agreement;

(ii) a GMS Contract;

(iii) an APMS Contract; and

(iv) any other contract for the provision of health services made pursuant to NHS England's functions under Part 4 of the NHS Act;

in each case as amended or replaced from time to time and including all ancillary or related agreements directly relating to the subject matter of such agreements, contracts or arrangements but excluding any Premises Agreements and excluding any Out of Hours Contracts[2];

Primary Medical Services Provider means a natural or legal person who holds a Primary Medical Services Contract;

Primary Ophthalmic Services Contract means:

(i) a General Ophthalmic Services Contract; and

(ii) any other contract for the provision of health services made pursuant to NHS England's functions under Part 6 of the NHS Act;

in each case as amended or replaced from time to time and including all ancillary or related agreements directly relating to the subject matter of such agreements, contracts or arrangements;

Primary Ophthalmic Services Provider means a natural or legal person who holds a Primary Ophthalmic Services Contract;

Principles of Best Practice means the Mandated Guidance in relation to property and investment which is to be published either before or after the date of this Agreement;

Prohibited Act the ICB:

(i) offering, giving, or agreeing to give NHS England (or any of their officers, employees or agents) any gift or consideration of any kind as an inducement or reward for doing or not doing or for having done or not having done any act in relation to the obtaining of performance of this Agreement, the Reserved Functions, the Delegation or any other arrangement with the ICB, or for showing or not showing favour or disfavour to any person in relation to this Agreement or any other arrangement with the ICB; and

(ii) in connection with this Agreement, paying or agreeing to pay any commission, other than a payment, particulars of which (including the terms

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

and conditions of the agreement for its payment) have been disclosed in writing to NHS England; or

(iii) committing an offence under the Bribery Act 2010;

QOF	means the quality and outcomes framework;
Regulatory or Supervisory Body	means any statutory or other body having authority to issue guidance, standards or recommendations with which the relevant Party and/or Staff must comply or to which it or they must have regard, including: (i) CQC; (ii) NHS England; (iii) the Department of Health and Social Care; (iv) the National Institute for Health and Care Excellence; (v) Healthwatch England and Local Healthwatch; (vi) the General Medical Council; (vii) the General Dental Council; (viii) the General Optical Council; (ix) the General Pharmaceutical Council; (x) the Healthcare Safety Investigation Branch; and (xi) the Information Commissioner;
Relevant Information	means the Personal Data and Non-Personal Data processed under the Delegation and this Agreement, and includes, where appropriate, "confidential patient information" (as defined under section 251 of the NHS Act), and "patient confidential information" as defined in the 2013 Report, The Information Governance Review – "*To Share or Not to Share?"*);
Reserved Functions	means statutory functions of NHS England that it has not delegated to the ICB including but not limited to those set out in the Schedules to this Agreement;
Secretary of State	means the Secretary of State for Health and Social Care from time to time;
Section 7A Functions	means those functions of NHS England exercised pursuant to section 7A of the NHS Act and relating to Primary Care Services;
Section 7A Funds	shall have the meaning in Schedule 10 Part 2;
Special Category Personal Data	shall have the same meaning as in UK GDPR;

Specified Purpose	means the purpose for which the Relevant Information is shared and processed, being to facilitate the exercise of the ICB's Delegated Functions and NHS England's Reserved Functions as specified in paragraph 2.1 of **Error! Reference source not found.** *(Further Information Governance and Sharing Provisions)* to this Agreement;
Staff or Staffing	means the Parties' employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of either Party (whether or not the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors' and their sub-contractors' personnel;
Staffing Model	means the employment model for the exercise of the Delegated Functions including those as defined in Appendix 2 of the NHS England and NHS Improvement operating models: HR Framework for developing Integrated Care as may be amended or replaced from time to time;
Statement of Financial Entitlements Directions	means the General Medical Services Statement of Financial Entitlements Directions 2021, as amended or updated from time to time;
Sub-Delegate	shall have the meaning in clause 11.2;
Transfer Regulations	means the Transfer of Undertakings (Protection of Employment) Regulations 2006, as amended;
Triple Aim	means the duty to have regard to the wider effects of decisions, which is placed on each of the Parties under section 13NA (as regards NHS England) and section 14Z43 (as regards the ICB) of the NHS Act;
UK GDPR	means Regulation (EU) 2016/679 of the European Parliament and of the Council of 27th April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018;
Variation Proposal	means a written proposal for a variation to the Agreement, which complies with the requirements of clause 25.3.

SCHEDULE 2

Delegated Functions

Schedule 2A: Primary Medical Services

Part 1: General Obligations

1. Introduction

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

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

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

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

1.1.4 management of the Delegated Funds in the Area;

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

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

2. General Obligations

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

2.2 The role of the ICB includes:

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

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

2.3 In respect of integrated working, the ICB must:

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

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

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

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

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

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

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

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

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

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

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

2.4.6.1 name of the Primary Medical Services Provider;

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

2.4.6.3 location of provision of services; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part 2: Specific Obligations

1. Introduction

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

2. Primary Medical Services Contract Management

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

3. Enhanced Services

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

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

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

3.4 When commissioning newly designed Enhanced Services the ICB must:

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

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

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

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

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

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

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

4. Design of Local Incentive Schemes

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

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

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

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

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

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

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

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

4.3 The ICB must be able to:

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

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

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

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

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

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

5. Making Decisions on Discretionary Payments or Support

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

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

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

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

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

6.3 For the purposes of paragraph 6.1, urgent care means the provision of primary medical services on an urgent basis.

7. Transparency and freedom of information

7.1 The ICB must:

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

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

8. Planning the Provider Landscape

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

8.1.1 establishing new Primary Medical Services Providers in the Area;

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

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

8.1.4 closure of practices and branch surgeries;

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

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

8.2 In relation to any new Primary Medical Services Contract to be entered into, the ICB must, without prejudice to any obligation in paragraph 14 (*Procurement and New Contracts*) below, and paragraph 2.5 of Part 1 of this Schedule 2A:

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

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

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

9. Primary Care Networks

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

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

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

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

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

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

10. Approving Primary Medical Services Provider Mergers and Closures

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

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

10.3 Prior to making any decision in accordance with this paragraph 10 (*Approving Primary Medical Services Provider Mergers and Closures*), the ICB must be able to clearly demonstrate the grounds for such a decision and must have fully considered any impact on the Primary Medical Services Provider's registered population and that of surrounding practices. The ICB must be able to clearly demonstrate that it has considered other options and has entered into dialogue with the Primary Medical Services Provider as to how any closure or merger will be managed.

10.4 In making any decisions pursuant to this paragraph 10 (*Approving Primary Medical Services Provider Mergers and Closures*), the ICB shall act in accordance with relevant Mandated Guidance and also take account of its obligations as set out in paragraph 14 *(Procurement and New Contracts)*, below, where applicable.

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

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

11.2 In accordance with paragraph 11.1 above, the ICB must:

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

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

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

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

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

12. Premises Costs Directions Functions

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

12.2 In particular, but without limiting paragraph 12.1, the ICB shall make decisions concerning:

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

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

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

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

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

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

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

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

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

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

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

13. Maintaining the Performers List

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

14. Procurement and New Contracts

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

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

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

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

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

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

14.4.3 made transparently; and

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

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

14.5.1 improve outcomes for patients;

14.5.2 reduce inequalities in the population; and

14.5.3 provide value for money.

15. Complaints

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

16. Commissioning ancillary support services

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

16.1.1 collection and disposal of clinical waste;

16.1.2 provision of translation and interpretation services;

16.1.3 occupational health services.

17. Finance

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

18. Workforce

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

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

Schedule 2B: Dental Care Services

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

Part 1A: General Obligations – Primary Dental Services

1. Introduction

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

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

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

1.1.3 undertaking reviews of Primary Dental Services in the Area;

1.1.4 management of the Delegated Funds in the Area;

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

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

2. General Obligations

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

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

2.3 In respect of integrated working, the ICB must:

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

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

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

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

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

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

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

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

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

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

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

2.4.6.1 name of Dental Services Provider;

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

2.4.6.3 location of provision of services; and

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

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

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

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

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

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

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

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

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

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

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

2.5.10 allocating sufficient resources for undertaking contract mediation; and

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

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

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

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

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

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

Part 1B: Specific Obligations – Primary Dental Services only

1. Introduction

1.1 This Part 1B of Schedule 2B *(Dental Care Services)* sets out further provision regarding the carrying out of each of the Delegated Functions in relation to Primary Dental Services.

2. Dental Services Contract Management

2.1 The ICB must:

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

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

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

2.2 The ICB must undertake the annual reconciliation of monies claimed by providers against the services provided under any contract for the provision of Dental Care Services made pursuant to NHS England's functions under Part 5 of the NHS Act procuring such ancillary support services as are required for the performance of this function.

3. Transparency and freedom of information

3.1 The ICB must:

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

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

4. Planning the Provider Landscape

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

4.1.1 establishing new Dental Services Providers in the Area;

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

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

4.1.4 closure of practices.

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

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

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

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

5. Finance

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

6. Staffing and Workforce

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

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

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

7. Integrating dentistry into communities at Primary Care Network level

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

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

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

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

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

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

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

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

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

9. Maintaining the Performers List

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

10. Procurement and New Contracts

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

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

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

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

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

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

10.4.3 made transparently, and

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

11. Complaints

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

12. Commissioning Ancillary Support Services

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

12.1.1 provision of translation and interpretation services; and

12.1.2 occupational health services.

Part 2A: General Obligations – Prescribed Dental Services

1. Introduction

1.1 This Part 2A of Schedule 2B *(Dental Care Services)* sets out general provisions regarding the carrying out of those Delegated Functions relating to Prescribed Dental Services. Prescribed Dental Services constitute Community Dental Services and Secondary Care Dental Services. These include:

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

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

1.1.3 undertaking reviews of Prescribed Dental Services in the Area;

1.1.4 management of the Delegated Funds in respect of Prescribed Dental Services in the Area;

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

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

1.2 For the purposes of this Schedule 2B, "Secondary Care Dental Services" refers to Prescribed Dental Services which are not Community Dental Services.

2. General Obligations

2.1 The ICB is responsible for commissioning Prescribed Dental Services for its Population which for the purpose of this Part 2A of Schedule 2B *(Dental Care Services)*, shall refer to a group of people for whom the ICB has core responsibility, as established under the rules published by NHS England under section 14Z31 of the Act.

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

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

2.4 The provisions of Paragraph 2.4, 2.5 and 2.6 of Part 1A of this Schedule 2B shall apply in respect of Prescribed Dental Services as if "Dental Services Contract" includes all contracts for Prescribed Dental Services and "Primary Dental Services" include Prescribed Dental Services.

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

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

2.5.2 use the current NHS Standard Contract published by NHS England from time to time; or an appropriate contract for the provision of Dental Care Services made pursuant to NHS England's functions under Part 5 of the NHS Act; and

2.5.3 where the NHS Standard Contract is used, pay for the Services in accordance with the NHS Payment Scheme (as defined in the Health and Social Care Act 2012).

Part 2B: Specific Obligations – Prescribed Dental Services

1. Introduction

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

2. Community Dental Services Commissioning Obligations

2.1 Community Dental Services may currently be contracted for by way of either an NHS Standard Contract or a PDS Agreement, as appropriate to the particular service. Accordingly:

2.1.1 where Community Dental Services are commissioned on PDS Agreement terms (or it is appropriate to commission a new agreement for Community Dental Services on a PDS Agreement or other agreement made pursuant to NHS England's functions under Part 5 of the NHS Act), those contracts must be managed in accordance with the relevant provisions of Part 1A and Part 1B of this Schedule 2B as if they were Primary Dental Services for the purposes of that Part. The provisions of this Part 2A of Schedule 2B also apply; and

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

3. Secondary Care Dental Services Commissioning Obligations

3.1 For the first financial year following delegation of Secondary Care Dental Services to the ICB (the "Initial Year of Delegation"), the Secondary Care Dental Services shall be commissioned through wider NHS Standard Contracts made between NHS England and the relevant providers that a) cover the whole population of England; and b) typically also cover other services. Accordingly, unless otherwise stated within a Contractual Notice, for the Initial Year of Delegation ONLY the following shall apply:

3.1.1 The commissioning responsibility for the Secondary Care Dental Service elements of the relevant NHS Standard Contracts is delegated to the ICB to the extent that they relate to its Population;

3.1.2 NHS England is, and will remain, the "co-ordinating commissioner" (as defined in the NHS Standard Contract) for those contracts, meaning that NHS England retains core contract management responsibility;

3.1.3 Delegation of commissioning responsibility for the Secondary Care Dental service elements of the relevant NHS Standard Contracts is permitted by clause GC12 of those contracts. NHS England has confirmed these delegation arrangements by letter to each affected provider so that they are aware of the ICB's role as Secondary Care Dental Services commissioner.

3.1.4 whilst the ICB is commissioner of the Secondary Care Dental Service elements of the contract that relate to its Population, it does not have any direct contract management role and must work with NHS England as co-ordinating commissioner, raising any contractual issues with NHS England for consideration and any appropriate action;

3.1.5 The ICB shall ensure that contractual payments are made to providers for the provision of Secondary Care Dental Services in respect of the ICB's Population, as required by the terms of those contracts. This may represent only a proportion of the overall payment due to the provider for Secondary Care Dental Services delivered more widely under that contract.

3.2 For all subsequent financial years following the Initial Year of Delegation the ICB will be responsible for ensuring that appropriate contractual arrangements are in place to ensure continuity of Secondary Care Dental Services for its Population.

4. Prescribed Dental Services Contract Management

4.1 Subject to Paragraph 4.2 of this Part 2B of Schedule 2B, the ICB must:

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

4.1.2 monitor contract performance and prescribed care dental spending, with a view in particular to ensuring the delivery of agreed contract activity, and the reallocation of unused resources to meet the oral health needs of the Area;

4.1.3 monitor contract performance with a view in particular to addressing patient safety concerns and promoting patient safety; and

4.1.4 ensure appropriate oversight of the Prescribed Dental Services, including, where appropriate, procuring such ancillary support services as are required for the performance of this function.

4.2 For the Initial Year of Delegation in respect of Secondary Care Dental Services the requirements set out in paragraph 4.1 of this Part 2B of Schedule 2B do not apply and the terms of the relevant Contractual Notice shall apply.

5. Transparency and freedom of information

5.1 The ICB must:

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

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

6. Planning the Provider Landscape

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

6.1.1 establishing new providers of Prescribed Dental Services in the Area;

6.1.2 managing providers of Prescribed Dental Services providing inadequate standards of patient care; and

6.1.3 the procurement or award of new contracts for Prescribed Dental Services (in accordance with any procurement protocol or Guidance issued by NHS England from time to time).

6.2 In relation to any new contracts for Prescribed Dental Services to be entered into, the ICB must, without prejudice to any obligation in paragraph 12 (*Procurement and New Contracts*):

6.2.1 consider and use the form of contract that will ensure compliance with NHS England's obligations under Law taking into account the persons to whom such contracts may be awarded;

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

7. **Staffing and Workforce**

7.1 The provisions of paragraph 6 of Part 1B of this Schedule 2B shall apply.

8. Finance

8.1 The ICB must ensure the financial delivery of the Prescribed Dental Services in accordance with any Mandated Guidance provided by NHS England.

9. Integrating dentistry into communities at Primary Care Network level

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

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

10.1 The ICB must make decisions in relation to the management of poorly performing providers of Prescribed Dental Services and including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards.

10.2 In accordance with paragraph **Error! Reference source not found.** above, the ICB must:

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

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

10.2.3 respond to CQC assessments of providers of Prescribed Dental Services where improvement is required;

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

10.2.5 take appropriate contractual action in response to CQC findings.

11. Maintaining the Performers List

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

12. Procurement and New Contracts

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

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

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

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

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

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

12.4.3 made transparently, and

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

13. Commissioning Ancillary Support Services

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

13.1.1 provision of translation and interpretation services; and

13.1.2 occupational health services.

14. Complaints

14.1 The ICB shall be responsible for handling complaints made in respect of Prescribed Dental Services.

Schedule 2C: Primary Ophthalmic Services

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

Part 1: General Obligations

1. Introduction

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

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

1.1.2 undertaking reviews of Primary Ophthalmic Services in the Area;

1.1.3 management of the Delegated Funds in the Area;

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

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

2. General Obligations

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

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

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

2.4 In respect of integrated working, the ICB must:

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

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

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

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

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

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

timely action to enforce contractual breaches, serve notices or provide discretionary support;

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

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

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

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

2.5.6.1 name of the Primary Ophthalmic Services Provider;

2.5.6.2 any practice or trading name by which the Primary Ophthalmic Services Provider is known (if different to the name recorded under paragraph **Error! Reference source not found.**);

2.5.6.3 location of provision of services; and

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

2.6 Without prejudice to clause 9 *(Finance)* or paragraph **Error! Reference source not found.** above, the ICB must actively manage each of the relevant Primary Ophthalmic Services Contracts including by:

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

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

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

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

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

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

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

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

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

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

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

Part 2: Specific Obligations

1. Introduction

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

2. Primary Ophthalmic Services Contract Management

2.1 The ICB must:

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

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

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

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

in each case acknowledging that the NHS Business Services Authority provides end-to-end support services in relation to these functions, as referred to in SCHEDULE 6 (*Mandated Assistance and Support*). The ICB accordingly agrees to co-operate with the NHS Business Services Authority in the delivery of these functions.

3. Transparency and freedom of information

3.1 The ICB must:

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

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

4. Maintaining the Performers List

4.1 On receiving a notice from a practitioner (who is party to a Primary Ophthalmic Services Contract) of an amendment to information recorded about them in the Performers List,

pursuant to regulation 9(1) of the National Health Service (Performers Lists) (England) Regulations 2013, the ICB must support NHS England's amendment of the performers list as soon as possible after receiving the notice using the Primary Care Support services provided by NHS England, insofar as that amendment relates to a change in contractor details.

5. Finance

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

6. Workforce

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

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

7. Integrating optometry into communities at Primary Care Network level

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

8. Complaints

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

9. Commissioning ancillary support services

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

9.1.1 provision of translation and interpretation services; and

9.1.2 occupational health services.

Schedule 2D: Delegated Functions – Pharmaceutical Services

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

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

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

Pharmaceutical Regulations	means the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and reference to a Regulation refers to a provision of the Pharmaceutical Regulations, unless otherwise stated;
Rurality Decisions	means decisions made under Part 7 of the Pharmaceutical Regulations;
Terms of Service	means the terms upon which, by virtue of the Pharmaceutical Regulations, a person undertakes to provide Pharmaceutical Services;

Delegated Pharmaceutical Functions

2. Except in so far as they fall within the scope of the Reserved Functions, and subject to paragraphs **Error! Reference source not found.**, **Error! Reference source not found.**, 4 and 5, the ICB agrees to perform the following functions of NHS England in respect of the Area (the "Delegated Pharmaceutical Functions"), in all cases in accordance with relevant Law, Mandated Guidance and other Guidance:

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

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

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

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

collectively referred to in this Schedule as the "Pharmaceutical Lists". In doing so, it is sufficient for the lists referred to at paragraphs **Error! Reference source not found.** and **Error! Reference source not found.** to include a marker showing which persons are also participating in the Electronic Prescription Service, rather than preparing a separate list for the purposes of paragraph **Error! Reference source not found.**.

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

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

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

2.1.7 overseeing the compliance of those included in the Pharmaceutical Lists with:

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

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

2.1.7.2 relevant Conditions of Inclusion; and

2.1.7.3 requirements of the Community Pharmacy Contractual Framework.

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

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

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

2.1.11 pandemic; and

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

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

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

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

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

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

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

2.1.19 determining LPS matters[10] in respect of LPS Schemes;

2.1.20 determining Rurality Decisions and other rurality matters[11];

2.1.21 determining Dispensing Doctor Decisions[12];

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

2.1.22 preparing and maintaining Dispensing Doctor Lists[13];

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

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

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

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

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

2.1.28 responding to Claims in respect of the Delegated Pharmaceutical Functions;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2.3 Where the Area comprises part of the area of a Health and Wellbeing Board (the "Relevant Health and Wellbeing Board"):

2.3.1 NHS England shall by Contractual Notice designate:

2.3.1.1 the ICB;

2.3.1.2 another ICB whose area comprises in part the area of the Relevant Health and Wellbeing Board; or

2.3.1.3 NHS England;

as the body responsible for maintaining the Relevant Lists (as defined in paragraph **Error! Reference source not found.** of this Schedule 2D) in respect of the Relevant Health and Wellbeing Board ("the Designated Commissioner");

2.3.2 the ICB shall exercise the Delegated Pharmaceutical Functions in respect of that part of the Relevant Health and Wellbeing Board's area that falls within the Area but in doing so shall liaise with any Designated Commissioner for the purposes of maintaining the accuracy of the Relevant Lists (as defined in paragraph **Error! Reference source not found.** of this Schedule 2D) in respect of the Relevant Health and Wellbeing Board; and

2.3.3 the ICB shall comply with all Contractual Notices issued by NHS England for the purposes of determining responsibilities in the circumstances described in this paragraph 2.3.

Prescribed Support

3. Notwithstanding the inclusion of the following within the Delegated Functions, the ICB shall discharge the functions set out at:

3.1 Paragraph 2.1.1 (maintaining Pharmaceutical Lists)

3.2 Paragraph 2.1.2 (managing applications for inclusion)

3.3 Paragraph 2.1.3 (managing applications from those included in a list)

3.4 Paragraph 2.1.5 (overseeing compliance with Terms of Service and Conditions of Inclusion)

3.5 Paragraph 2.1.10 (Fitness to Practise)

3.6 Paragraph 2.1.18 (maintaining and publishing Dispensing Doctors Lists)

3.7 Paragraph 2.1.25 (recovery of overpayments)

[16] Regulation 114 of the Pharmaceutical Regulations

with the assistance and support of the NHS Business Services Authority, Primary Care Support England or such other person as NHS England shall designate by Contractual Notice for these purposes from time to time and in accordance with the allocation of operational responsibilities described by NHS England in Mandated Guidance.

LPS Schemes

4. The ICB shall not without the prior written consent of NHS England make any new LPS Schemes.

Barred Persons

5. The ICB must ensure that persons barred from involvement in specific elements of the Delegated Functions are excluded from such involvement in accordance with the Pharmaceutical Regulations.

Other Services

6. The provisions of this schedule are without prejudice to the ability of the ICB to make arrangements for the provision of Locally Commissioned Services for the purposes of the NHS in accordance with its own commissioning functions and using its own financial resources.

Payments

7. In exercising the Delegated Pharmaceutical Functions, the ICB must ensure that:

    7.1 all payments to which the Drug Tariff applies are made solely in accordance with the Drug Tariff; and

    7.2 any other payments for services (including without limitation those relating to LPS Schemes and Enhanced Services) are made in accordance with recognised contractual mechanisms intended to apply to those services.

Flu vaccinations

8. The Parties acknowledge and agree that:

    8.1 responsibility for arranging any national scheme for flu vaccinations remains with NHS England as part of its Section 7A Functions; and

    8.2 where any such national scheme is arranged by NHS England, the ICB is required to commission flu vaccines as Advanced Services. For the purposes of this Agreement, this forms part of the ICB's responsibilities under this Agreement.

Integration

9. In respect of integrated working, the ICB must:

    9.1 take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Authorities, Healthwatch, acute and community providers, professional representative groups, contractor representative groups and other stakeholders;

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

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

Integrating pharmacy into communities at Primary Care Network level

10. The ICB must exercise the Delegated Functions with a view to achieving greater integration of community pharmacy into the Integrated Care System at the Primary Care Network level including participation in network governance arrangements.

Complaints

11. The ICB will handle complaints made in respect of Pharmaceutical Services and Local Pharmaceutical Services in accordance with the Complaints Regulations.

Commissioning ancillary support services

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

12.1 collection and disposal of clinical waste; and

12.2 provision of translation and interpretation services; and

12.3 occupational health services.

Finance

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

Workforce

14. Further requirements in respect of workforce will be specified in Mandated Guidance.

SCHEDULE 3

Reserved Functions

25. Introduction

25.1 In accordance with clause 8.4 of this Agreement, all functions of NHS England other than those defined as Delegated Functions are Reserved Functions.

25.2 This **Error! Reference source not found.** (*Reserved Functions*) sets out further provision regarding the carrying out of the Reserved Functions.

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

26. Management of the national performers list

26.1 Subject to Paragraph 2.2, NHS England will continue to perform its functions under the National Health Service (Performers Lists) (England) Regulations 2013.

26.2 The ICB will carry out administrative tasks in respect of the Performers Lists as described at:

26.2.1 Paragraph 9 of Part 2, Schedule 2A;

26.2.2 Paragraph 9 of Part 2, Schedule 2B; and

26.2.3 Paragraph 6 of Part 2, Schedule 2C.

26.3 NHS England's functions in relation to the management of the national performers list include:

26.3.1 considering applications and decision-making in relation to inclusion on the national performers list, inclusion with conditions and refusals;

26.3.2 identifying, managing and supporting primary care performers where concerns arise; and

26.3.3 managing suspension, imposition of conditions and removal from the national performers list.

26.4 NHS England may hold local Performance Advisory Group ("PAG") meetings to consider all complaints or concerns that are reported to NHS England in relation to a named performer and NHS England will determine whether an initial investigation is to be carried out.

26.5 NHS England may notify the ICB of all relevant PAG meetings at least seven (7) days in advance of such meetings. NHS England may require a representative of the ICB to attend such meetings to discuss any performer concerns and/or quality issues that may impact on individual performer cases.

26.6 The ICB must develop a mechanism to ensure that all complaints regarding any named performer are escalated to the Local NHS England Team for review. The ICB will comply with any Mandated Guidance issued by NHS England in relation to the escalation of complaints about a named performer.

27. Management of the revalidation and appraisal process

27.1 NHS England will continue to perform its functions under the Medical Profession (Responsible Officers) Regulations 2010 (as amended by the Medical Profession (Responsible Officers) (Amendment) Regulations 2013).

27.2 All functions in relation to GP appraisal and revalidation will remain the responsibility of NHS England, including:

27.2.1 the funding of GP appraisers;

27.2.2 quality assurance of the GP appraisal process; and

27.2.3 the responsible officer network.

27.3 Funding to support the GP appraisal is incorporated within the global sum payment to Primary Medical Services Provider.

27.4 The ICB must not remove or restrict the payments made to Primary Medical Services Provider in respect of GP appraisal.

27.5 Appraisal arrangements in respect of all other primary care practitioner groups shall also be Reserved Functions.

28. Administration of payments and related performers list management activities

28.1 NHS England reserves its functions in relation to the administration of payments to individual performers and related performers list management activities under the National Health Service (Performers Lists) (England) Regulations 2013 and other relevant legislation.

28.2 NHS England may continue to pay practitioners who are suspended from the national performers list in accordance with relevant determinations made by the Secretary of State.

28.3 For the avoidance of doubt, the ICB is responsible for any ad hoc or discretionary payments to Primary Medical Services Providers (including those under section 96 of the NHS Act) in accordance with **Error! Reference source not found.**A (*Delegated Functions*) Part 2 paragraphs 5.1 and 5.1 of this Agreement, including where such payments may be considered a consequence of actions taken under the National Health Service (Performers Lists) (England) Regulations 2013.

29. Section 7A and Capital Expenditure Functions

29.1 NHS England retains the Section 7A Functions and will be responsible for taking decisions in relation to the Section 7A Functions.

29.2 In accordance with Schedule 10 Part 2, the ICB will provide certain management and/or administrative services to NHS England in relation to the Section 7A Functions.

29.3 NHS England retains the Capital Expenditure Functions and will be responsible for taking decisions in relation to the Capital Expenditure Functions.

29.4 In accordance with Schedule 10 Part 1, the ICB will provide certain management and/or administrative services to NHS England in relation to the Capital Expenditure Functions.

30. Such other ancillary activities that are necessary in order to exercise the Reserved Functions

30.1 NHS England will continue to comply with its obligations under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

30.2 The ICB must assist NHS England's controlled drug accountable officer ("CDAO") to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

30.3 The ICB must nominate a relevant senior individual within the ICB (the "ICB CD Lead") to liaise with and assist NHS England to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

30.4 The ICB CD Lead must, in relation to the Delegated Functions:

30.4.1 on request provide NHS England's CDAO with all reasonable assistance in any investigation involving the Delegated Functions;

30.4.2 report all complaints involving controlled drugs to NHS England's CDAO;

30.4.3 report all incidents or other concerns involving the safe use and management of controlled drugs to NHS England's CDAO;

30.4.4 analyse the controlled drug prescribing data available; and

30.4.5 on request supply (or ensure organisations from whom the ICB commissions services involving the regular use of controlled drugs supply) periodic self–declaration and/or self-assessments to NHS England's CDAO.

31. Reserved Functions – Primary Medical Services

31.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Medical Services Functions"):

31.1.1 determining the outcomes expected from Primary Medical Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes and the Department of Health and Social Care mandate;

31.1.2 designing and delivering national transformation programmes in support of national priorities;

31.1.3 the negotiation and agreement of matters concerning General Medical Services contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary medical services nationally;

31.1.4 the development of national standard Primary Medical Service contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Medical Services providers;

31.1.5 the provision of commissioning and contracting policy and guidance to support ICBs to meet their delegated duties;

31.1.6 the provision of nationally contracted services delivering digital, logistical and support services for Primary Medical Services in England (including but not limited to):

31.1.6.1 Payments;

31.1.6.2 Pensions;

31.1.6.3 Patient Registration;

31.1.6.4 Medical Records;

31.1.6.5 Performer List;

31.1.6.6 Supplies;

31.1.6.7 Call and Recall for Cervical screening (CSAS); and

31.1.6.8 Pharmacy Market Management.

31.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

32. Reserved Functions – Primary Dental Services

32.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Dental Services Functions"):

32.1.1 determining the outcomes expected from Primary Dental Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes; designing and delivering national transformation programmes in line with any applicable commissioning policies and guidance;

32.1.2 the negotiation and agreement of matters concerning Dental Services Contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary dental services nationally;

32.1.3 the development of national standard Dental Service Contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Dental Services providers;

32.1.4 the provision of all dental commissioning and contracting policy and guidance to support ICBs to meet their delegated duties; and

32.1.5 the provision of nationally contracted services delivering digital, logistical and support services for Primary Dental Services in England (including but not limited to):

32.1.5.1 Payments;

32.1.5.2 Pensions;

32.1.5.3 Performer List; and

32.1.5.4 Market Management.

32.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

33. Reserved Functions – Primary Ophthalmic Services

33.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Ophthalmic Functions"):

33.1.1 the Primary Ophthalmic Services Contracts policy and associated documentation;

33.1.2 the negotiation and agreement of matters concerning Primary Ophthalmic Services with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of Ophthalmic Services nationally; and

33.1.3 the provision of nationally contracted services delivering digital, logistical and support services for Primary Ophthalmic Services in England (including but not limited to):

33.1.3.1 Payments;

33.1.3.2 Performers List;

33.1.3.3 Market Management/Entry; and

33.1.3.4 Contract management, assurance and post-payment verification.

33.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

34. Reserved Functions – Pharmaceutical Services and Local Pharmaceutical Services

34.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Pharmaceutical Functions"):

34.1.1 publication of Pharmaceutical Lists;

34.1.2 functions of NHS England as a determining authority in relation to pharmaceutical remuneration under Part 12 of the Pharmaceutical Regulations;

34.1.3 functions in respect of lists of performers of pharmaceutical services and assistants, noting that as at the date of this Agreement regulations for the purposes of these functions have not been made[17];

34.1.4 the negotiation and agreement of matters concerning NHS pharmaceutical services with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of Pharmaceutical Services nationally;

34.1.5 the provision of commissioning and contracting policy and guidance to support ICBs to meet their delegated duties; and

34.1.6 administration of the pharmacist pre-registration training grant scheme.

35. Reserved Functions – Primary Dental Services

35.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Dental Services Functions"):

35.1.1 determining the outcomes expected from Primary Dental Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes; designing and delivering national transformation programmes in line with any applicable commissioning policies and guidance;

35.1.2 the negotiation and agreement of matters concerning Dental Services Contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary dental services nationally;

35.1.3 the development of national standard Dental Service Contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Dental Services providers;

35.1.4 the provision of all dental commissioning and contracting policy and guidance to support ICBs to meet their delegated duties;

[17] Part 7, Chapter 4A of the NHS Act (not currently in force)

35.1.5 the provision of nationally contracted services delivering digital, logistical and support services for Primary Dental Services in England (including but not limited to):

35.1.5.1 Payments

35.1.5.2 Pensions

35.1.5.3 Performer List

35.1.5.4 Market Management.

35.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

36. Reserved Functions - Prescribed Dental Services

36.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Prescribed Dental Services Functions"):

36.1.1 determining the outcomes expected from Prescribed Dental Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes; designing and delivering national transformation programmes in line with any applicable commissioning policies and guidance;

36.1.2 in respect of any Prescribed Dental Services contracted pursuant to NHS England's functions under Part 5 of the NHS Act the negotiation and agreement of matters concerning those contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary dental services nationally;

36.1.3 in respect of any Prescribed Dental Services contracted pursuant to NHS England's functions under Part 5 of the NHS Act, the development of standard contracts and national contract variations and guidance;

36.1.4 the provision of all dental commissioning and contracting policy and guidance to support ICBs to meet their delegated duties;

36.1.5 in respect of any Prescribed Dental Services contracted pursuant to NHS England's functions under Part 5 of the NHS Act, the provision of nationally contracted services delivering digital, logistical and support services in England (including but not limited to):

36.1.5.1 Payments

36.1.5.2 Pensions

36.1.5.3 Performer List

36.1.5.4 Market Management.

36.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

SCHEDULE 4

Further Information Governance and Sharing Provisions

1. Introduction

1.1 The purpose of this

1.2 SCHEDULE **3**

Reserved Functions

37. Introduction

37.1 In accordance with clause 8.4 of this Agreement, all functions of NHS England other than those defined as Delegated Functions are Reserved Functions.

37.2 This **Error! Reference source not found.** (*Reserved Functions*) sets out further provision regarding the carrying out of the Reserved Functions.

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

38. Management of the national performers list

38.1 Subject to Paragraph 2.2, NHS England will continue to perform its functions under the National Health Service (Performers Lists) (England) Regulations 2013.

38.2 The ICB will carry out administrative tasks in respect of the Performers Lists as described at:

38.2.1 Paragraph 9 of Part 2, Schedule 2A;

38.2.2 Paragraph 9 of Part 2, Schedule 2B; and

38.2.3 Paragraph 6 of Part 2, Schedule 2C.

38.3 NHS England's functions in relation to the management of the national performers list include:

38.3.1 considering applications and decision-making in relation to inclusion on the national performers list, inclusion with conditions and refusals;

38.3.2 identifying, managing and supporting primary care performers where concerns arise; and

38.3.3 managing suspension, imposition of conditions and removal from the national performers list.

38.4 NHS England may hold local Performance Advisory Group ("PAG") meetings to consider all complaints or concerns that are reported to NHS England in relation to a named performer and NHS England will determine whether an initial investigation is to be carried out.

38.5 NHS England may notify the ICB of all relevant PAG meetings at least seven (7) days in advance of such meetings. NHS England may require a representative of the ICB to attend such meetings to discuss any performer concerns and/or quality issues that may impact on individual performer cases.

38.6 The ICB must develop a mechanism to ensure that all complaints regarding any named performer are escalated to the Local NHS England Team for review. The ICB will comply with any Mandated Guidance issued by NHS England in relation to the escalation of complaints about a named performer.

39. Management of the revalidation and appraisal process

39.1 NHS England will continue to perform its functions under the Medical Profession (Responsible Officers) Regulations 2010 (as amended by the Medical Profession (Responsible Officers) (Amendment) Regulations 2013).

39.2 All functions in relation to GP appraisal and revalidation will remain the responsibility of NHS England, including:

39.2.1 the funding of GP appraisers;

39.2.2 quality assurance of the GP appraisal process; and

39.2.3 the responsible officer network.

39.3 Funding to support the GP appraisal is incorporated within the global sum payment to Primary Medical Services Provider.

39.4 The ICB must not remove or restrict the payments made to Primary Medical Services Provider in respect of GP appraisal.

39.5 Appraisal arrangements in respect of all other primary care practitioner groups shall also be Reserved Functions.

40. Administration of payments and related performers list management activities

40.1 NHS England reserves its functions in relation to the administration of payments to individual performers and related performers list management activities under the National Health Service (Performers Lists) (England) Regulations 2013 and other relevant legislation.

40.2 NHS England may continue to pay practitioners who are suspended from the national performers list in accordance with relevant determinations made by the Secretary of State.

40.3 For the avoidance of doubt, the ICB is responsible for any ad hoc or discretionary payments to Primary Medical Services Providers (including those under section 96 of the NHS Act) in accordance with **Error! Reference source not found.**A (*Delegated Functions*) Part 2 paragraphs 5.1 and 5.1 of this Agreement, including where such payments may be considered a consequence of actions taken under the National Health Service (Performers Lists) (England) Regulations 2013.

41. Section 7A and Capital Expenditure Functions

41.1 NHS England retains the Section 7A Functions and will be responsible for taking decisions in relation to the Section 7A Functions.

41.2 In accordance with Schedule 10 Part 2, the ICB will provide certain management and/or administrative services to NHS England in relation to the Section 7A Functions.

41.3 NHS England retains the Capital Expenditure Functions and will be responsible for taking decisions in relation to the Capital Expenditure Functions.

41.4 In accordance with Schedule 10 Part 1, the ICB will provide certain management and/or administrative services to NHS England in relation to the Capital Expenditure Functions.

42. Such other ancillary activities that are necessary in order to exercise the Reserved Functions

42.1 NHS England will continue to comply with its obligations under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

42.2 The ICB must assist NHS England's controlled drug accountable officer ("CDAO") to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

42.3 The ICB must nominate a relevant senior individual within the ICB (the "ICB CD Lead") to liaise with and assist NHS England to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

42.4 The ICB CD Lead must, in relation to the Delegated Functions:

42.4.1 on request provide NHS England's CDAO with all reasonable assistance in any investigation involving the Delegated Functions;

42.4.2 report all complaints involving controlled drugs to NHS England's CDAO;

42.4.3 report all incidents or other concerns involving the safe use and management of controlled drugs to NHS England's CDAO;

42.4.4 analyse the controlled drug prescribing data available; and

42.4.5 on request supply (or ensure organisations from whom the ICB commissions services involving the regular use of controlled drugs supply) periodic self–declaration and/or self-assessments to NHS England's CDAO.

43. Reserved Functions – Primary Medical Services

43.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Medical Services Functions"):

43.1.1 determining the outcomes expected from Primary Medical Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes and the Department of Health and Social Care mandate;

43.1.2 designing and delivering national transformation programmes in support of national priorities;

43.1.3 the negotiation and agreement of matters concerning General Medical Services contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary medical services nationally;

43.1.4 the development of national standard Primary Medical Service contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Medical Services providers;

43.1.5 the provision of commissioning and contracting policy and guidance to support ICBs to meet their delegated duties;

43.1.6 the provision of nationally contracted services delivering digital, logistical and support services for Primary Medical Services in England (including but not limited to):

43.1.6.1 Payments;

43.1.6.2 Pensions;

43.1.6.3 Patient Registration;

43.1.6.4 Medical Records;

43.1.6.5 Performer List;

43.1.6.6 Supplies;

43.1.6.7 Call and Recall for Cervical screening (CSAS); and

43.1.6.8 Pharmacy Market Management.

43.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

44. Reserved Functions – Primary Dental Services

44.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Dental Services Functions"):

44.1.1 determining the outcomes expected from Primary Dental Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes; designing and delivering national transformation programmes in line with any applicable commissioning policies and guidance;

44.1.2 the negotiation and agreement of matters concerning Dental Services Contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary dental services nationally;

44.1.3 the development of national standard Dental Service Contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Dental Services providers;

44.1.4 the provision of all dental commissioning and contracting policy and guidance to support ICBs to meet their delegated duties; and

44.1.5 the provision of nationally contracted services delivering digital, logistical and support services for Primary Dental Services in England (including but not limited to):

44.1.5.1 Payments;

44.1.5.2 Pensions;

44.1.5.3 Performer List; and

44.1.5.4 Market Management.

44.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

45. Reserved Functions – Primary Ophthalmic Services

45.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Ophthalmic Functions"):

45.1.1 the Primary Ophthalmic Services Contracts policy and associated documentation;

45.1.2 the negotiation and agreement of matters concerning Primary Ophthalmic Services with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of Ophthalmic Services nationally; and

45.1.3 the provision of nationally contracted services delivering digital, logistical and support services for Primary Ophthalmic Services in England (including but not limited to):

45.1.3.1 Payments;

45.1.3.2 Performers List;

45.1.3.3 Market Management/Entry; and

45.1.3.4 Contract management, assurance and post-payment verification.

45.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

46. Reserved Functions – Pharmaceutical Services and Local Pharmaceutical Services

46.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Pharmaceutical Functions"):

46.1.1 publication of Pharmaceutical Lists;

46.1.2 functions of NHS England as a determining authority in relation to pharmaceutical remuneration under Part 12 of the Pharmaceutical Regulations;

46.1.3 functions in respect of lists of performers of pharmaceutical services and assistants, noting that as at the date of this Agreement regulations for the purposes of these functions have not been made;

46.1.4 the negotiation and agreement of matters concerning NHS pharmaceutical services with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of Pharmaceutical Services nationally;

46.1.5 the provision of commissioning and contracting policy and guidance to support ICBs to meet their delegated duties; and

46.1.6 administration of the pharmacist pre-registration training grant scheme.

47. Reserved Functions – Primary Dental Services

47.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Dental Services Functions"):

47.1.1 determining the outcomes expected from Primary Dental Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes; designing and delivering national transformation programmes in line with any applicable commissioning policies and guidance;

47.1.2 the negotiation and agreement of matters concerning Dental Services Contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary dental services nationally;

47.1.3 the development of national standard Dental Service Contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Dental Services providers;

47.1.4 the provision of all dental commissioning and contracting policy and guidance to support ICBs to meet their delegated duties;

47.1.5 the provision of nationally contracted services delivering digital, logistical and support services for Primary Dental Services in England (including but not limited to):

47.1.5.1 Payments

47.1.5.2 Pensions

47.1.5.3 Performer List

47.1.5.4 Market Management.

47.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

48. Reserved Functions - Prescribed Dental Services

48.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Prescribed Dental Services Functions"):

48.1.1 determining the outcomes expected from Prescribed Dental Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes; designing and delivering national transformation programmes in line with any applicable commissioning policies and guidance;

48.1.2 in respect of any Prescribed Dental Services contracted pursuant to NHS England's functions under Part 5 of the NHS Act the negotiation and agreement of matters concerning those contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary dental services nationally;

48.1.3 in respect of any Prescribed Dental Services contracted pursuant to NHS England's functions under Part 5 of the NHS Act, the development of standard contracts and national contract variations and guidance;

48.1.4 the provision of all dental commissioning and contracting policy and guidance to support ICBs to meet their delegated duties;

48.1.5 in respect of any Prescribed Dental Services contracted pursuant to NHS England's functions under Part 5 of the NHS Act, the provision of nationally contracted services delivering digital, logistical and support services in England (including but not limited to):

48.1.5.1 Payments

48.1.5.2 Pensions

48.1.5.3 Performer List

48.1.5.4 Market Management.

48.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

1.3 **SCHEDULE 4** *(Further Information Governance and Sharing Provisions* is to set out the scope for the secure and confidential sharing of information between the Parties on a **Need To Know** basis, in order to enable the Parties to exercise their functions in pursuance of this Agreement.

1.4 References in this

1.5 SCHEDULE **3**

Reserved Functions

49. Introduction

49.1 In accordance with clause 8.4 of this Agreement, all functions of NHS England other than those defined as Delegated Functions are Reserved Functions.

49.2 This **Error! Reference source not found.** (*Reserved Functions*) sets out further provision regarding the carrying out of the Reserved Functions.

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

50. Management of the national performers list

50.1 Subject to Paragraph 2.2, NHS England will continue to perform its functions under the National Health Service (Performers Lists) (England) Regulations 2013.

50.2 The ICB will carry out administrative tasks in respect of the Performers Lists as described at:

50.2.1 Paragraph 9 of Part 2, Schedule 2A;

50.2.2 Paragraph 9 of Part 2, Schedule 2B; and

50.2.3 Paragraph 6 of Part 2, Schedule 2C.

50.3 NHS England's functions in relation to the management of the national performers list include:

50.3.1 considering applications and decision-making in relation to inclusion on the national performers list, inclusion with conditions and refusals;

50.3.2 identifying, managing and supporting primary care performers where concerns arise; and

50.3.3 managing suspension, imposition of conditions and removal from the national performers list.

50.4 NHS England may hold local Performance Advisory Group ("PAG") meetings to consider all complaints or concerns that are reported to NHS England in relation to a named performer and NHS England will determine whether an initial investigation is to be carried out.

50.5 NHS England may notify the ICB of all relevant PAG meetings at least seven (7) days in advance of such meetings. NHS England may require a representative of the ICB to attend such meetings to discuss any performer concerns and/or quality issues that may impact on individual performer cases.

50.6 The ICB must develop a mechanism to ensure that all complaints regarding any named performer are escalated to the Local NHS England Team for review. The ICB will comply with any Mandated Guidance issued by NHS England in relation to the escalation of complaints about a named performer.

51. Management of the revalidation and appraisal process

51.1 NHS England will continue to perform its functions under the Medical Profession (Responsible Officers) Regulations 2010 (as amended by the Medical Profession (Responsible Officers) (Amendment) Regulations 2013).

51.2 All functions in relation to GP appraisal and revalidation will remain the responsibility of NHS England, including:

51.2.1 the funding of GP appraisers;

51.2.2 quality assurance of the GP appraisal process; and

51.2.3 the responsible officer network.

51.3 Funding to support the GP appraisal is incorporated within the global sum payment to Primary Medical Services Provider.

51.4 The ICB must not remove or restrict the payments made to Primary Medical Services Provider in respect of GP appraisal.

51.5 Appraisal arrangements in respect of all other primary care practitioner groups shall also be Reserved Functions.

52. Administration of payments and related performers list management activities

52.1 NHS England reserves its functions in relation to the administration of payments to individual performers and related performers list management activities under the National Health Service (Performers Lists) (England) Regulations 2013 and other relevant legislation.

52.2 NHS England may continue to pay practitioners who are suspended from the national performers list in accordance with relevant determinations made by the Secretary of State.

52.3 For the avoidance of doubt, the ICB is responsible for any ad hoc or discretionary payments to Primary Medical Services Providers (including those under section 96 of the NHS Act) in accordance with **Error! Reference source not found.**A (*Delegated Functions*) Part 2 paragraphs 5.1 and 5.1 of this Agreement, including where such payments may be considered a consequence of actions taken under the National Health Service (Performers Lists) (England) Regulations 2013.

53. Section 7A and Capital Expenditure Functions

53.1 NHS England retains the Section 7A Functions and will be responsible for taking decisions in relation to the Section 7A Functions.

53.2 In accordance with Schedule 10 Part 2, the ICB will provide certain management and/or administrative services to NHS England in relation to the Section 7A Functions.

53.3 NHS England retains the Capital Expenditure Functions and will be responsible for taking decisions in relation to the Capital Expenditure Functions.

53.4 In accordance with Schedule 10 Part 1, the ICB will provide certain management and/or administrative services to NHS England in relation to the Capital Expenditure Functions.

54. Such other ancillary activities that are necessary in order to exercise the Reserved Functions

54.1 NHS England will continue to comply with its obligations under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

54.2 The ICB must assist NHS England's controlled drug accountable officer ("CDAO") to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

54.3 The ICB must nominate a relevant senior individual within the ICB (the "ICB CD Lead") to liaise with and assist NHS England to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

54.4 The ICB CD Lead must, in relation to the Delegated Functions:

54.4.1 on request provide NHS England's CDAO with all reasonable assistance in any investigation involving the Delegated Functions;

54.4.2 report all complaints involving controlled drugs to NHS England's CDAO;

54.4.3 report all incidents or other concerns involving the safe use and management of controlled drugs to NHS England's CDAO;

54.4.4 analyse the controlled drug prescribing data available; and

54.4.5 on request supply (or ensure organisations from whom the ICB commissions services involving the regular use of controlled drugs supply) periodic self–declaration and/or self-assessments to NHS England's CDAO.

55. Reserved Functions – Primary Medical Services

55.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Medical Services Functions"):

55.1.1 determining the outcomes expected from Primary Medical Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes and the Department of Health and Social Care mandate;

55.1.2 designing and delivering national transformation programmes in support of national priorities;

55.1.3 the negotiation and agreement of matters concerning General Medical Services contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary medical services nationally;

55.1.4 the development of national standard Primary Medical Service contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Medical Services providers;

55.1.5 the provision of commissioning and contracting policy and guidance to support ICBs to meet their delegated duties;

55.1.6 the provision of nationally contracted services delivering digital, logistical and support services for Primary Medical Services in England (including but not limited to):

55.1.6.1 Payments;

55.1.6.2 Pensions;

55.1.6.3 Patient Registration;

55.1.6.4 Medical Records;

55.1.6.5 Performer List;

55.1.6.6 Supplies;

55.1.6.7 Call and Recall for Cervical screening (CSAS); and

55.1.6.8 Pharmacy Market Management.

55.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

56. Reserved Functions – Primary Dental Services

56.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Dental Services Functions"):

56.1.1 determining the outcomes expected from Primary Dental Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes; designing and delivering national transformation programmes in line with any applicable commissioning policies and guidance;

56.1.2 the negotiation and agreement of matters concerning Dental Services Contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary dental services nationally;

56.1.3 the development of national standard Dental Service Contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Dental Services providers;

56.1.4 the provision of all dental commissioning and contracting policy and guidance to support ICBs to meet their delegated duties; and

56.1.5 the provision of nationally contracted services delivering digital, logistical and support services for Primary Dental Services in England (including but not limited to):

56.1.5.1 Payments;

56.1.5.2 Pensions;

56.1.5.3 Performer List; and

56.1.5.4 Market Management.

56.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

57. Reserved Functions – Primary Ophthalmic Services

57.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Ophthalmic Functions"):

57.1.1 the Primary Ophthalmic Services Contracts policy and associated documentation;

57.1.2 the negotiation and agreement of matters concerning Primary Ophthalmic Services with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of Ophthalmic Services nationally; and

57.1.3 the provision of nationally contracted services delivering digital, logistical and support services for Primary Ophthalmic Services in England (including but not limited to):

57.1.3.1 Payments;

57.1.3.2 Performers List;

57.1.3.3 Market Management/Entry; and

57.1.3.4 Contract management, assurance and post-payment verification.

57.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

58. Reserved Functions – Pharmaceutical Services and Local Pharmaceutical Services

58.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Pharmaceutical Functions"):

58.1.1 publication of Pharmaceutical Lists;

58.1.2 functions of NHS England as a determining authority in relation to pharmaceutical remuneration under Part 12 of the Pharmaceutical Regulations;

58.1.3 functions in respect of lists of performers of pharmaceutical services and assistants, noting that as at the date of this Agreement regulations for the purposes of these functions have not been made;

58.1.4 the negotiation and agreement of matters concerning NHS pharmaceutical services with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of Pharmaceutical Services nationally;

58.1.5 the provision of commissioning and contracting policy and guidance to support ICBs to meet their delegated duties; and

58.1.6 administration of the pharmacist pre-registration training grant scheme.

59. Reserved Functions – Primary Dental Services

59.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Dental Services Functions"):

59.1.1 determining the outcomes expected from Primary Dental Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes; designing and delivering national transformation programmes in line with any applicable commissioning policies and guidance;

59.1.2 the negotiation and agreement of matters concerning Dental Services Contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary dental services nationally;

59.1.3 the development of national standard Dental Service Contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Dental Services providers;

59.1.4 the provision of all dental commissioning and contracting policy and guidance to support ICBs to meet their delegated duties;

59.1.5 the provision of nationally contracted services delivering digital, logistical and support services for Primary Dental Services in England (including but not limited to):

59.1.5.1 Payments

59.1.5.2 Pensions

59.1.5.3 Performer List

59.1.5.4 Market Management.

59.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

60. Reserved Functions - Prescribed Dental Services

60.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Prescribed Dental Services Functions"):

60.1.1 determining the outcomes expected from Prescribed Dental Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes; designing and delivering national transformation programmes in line with any applicable commissioning policies and guidance;

60.1.2 in respect of any Prescribed Dental Services contracted pursuant to NHS England's functions under Part 5 of the NHS Act the negotiation and agreement of matters concerning those contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary dental services nationally;

60.1.3 in respect of any Prescribed Dental Services contracted pursuant to NHS England's functions under Part 5 of the NHS Act, the development of standard contracts and national contract variations and guidance;

60.1.4 the provision of all dental commissioning and contracting policy and guidance to support ICBs to meet their delegated duties;

60.1.5 in respect of any Prescribed Dental Services contracted pursuant to NHS England's functions under Part 5 of the NHS Act, the provision of nationally contracted services delivering digital, logistical and support services in England (including but not limited to):

60.1.5.1 Payments

60.1.5.2 Pensions

60.1.5.3 Performer List

60.1.5.4 Market Management.

60.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

1.6 **SCHEDULE 4** *(Further Information Governance and Sharing Provisions)* to the **Need to Know** basis or requirement (as the context requires) should be taken to mean that the Data Controllers' personnel will only have access to Personal Data or Special Category Personal Data if it is lawful for such personnel to have access to such data for the Specified Purpose in paragraph 2.1 and the function they are required to fulfil at that particular time, in relation to the Specified Purpose, cannot be achieved without access to the Personal Data or Special Category Personal Data specified.

1.7 This Schedule and the Data Sharing Agreements entered into under this Schedule are designed to:

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

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

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

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

1.7.5 apply to the sharing of Relevant Information relating to Delegated Functions in respect of

1.7.5.1 Primary Care Providers and Primary Care Provider Personnel; and

1.7.5.2 Dental Services Providers and their personnel;

1.7.5.3 All other providers of Delegated Functions.

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

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

1.7.8 apply to the activities of the Parties' personnel; and

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

2. Purpose

2.1 The Specified Purpose of the data sharing is to facilitate the exercise of the ICB's Delegated Functions and NHS England's Reserved Functions as described in this Agreement.

2.2 ICBs must ensure that they have in place appropriate Data Sharing Agreements to enable data to be received by it from NHS Digital (or the successor to the relevant statutory functions of NHS Digital) and any other third party organisations from which the ICB must obtain data for the purpose of exercising the Delegated Functions. Specific and detailed purposes must be set out the Data sharing Agreement that complies with all relevant Legislation and Guidance.

3. Benefits of information sharing

3.1 The benefits of sharing information are the achievement of the Specified Purpose set out above, with benefits for service users and other stakeholders in terms of the improved delivery of the NHS services to which this Agreement relates.

4. Lawful basis for Sharing

4.1 Each Party shall comply with all relevant Information Law requirements and good practice in relation to the processing of Relevant Information shared further to this Agreement.

4.2 The ICB shall ensure that there is a Data Protection Impact Assessment ("DPIA") that covers all Delegated Functions. The ICB shall identify the lawful basis for sharing Relevant Information for each purpose and data flow, and where appropriate, enter into a Data Sharing Agreement.

5. Relevant Information to be shared

5.1 The Relevant Information to be shared shall be set out in a Data Sharing Agreement.

6. Restrictions on use of the Shared Information

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

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

6.3 Neither the provisions of this

6.4 SCHEDULE **3**

Reserved Functions

61. Introduction

61.1 In accordance with clause 8.4 of this Agreement, all functions of NHS England other than those defined as Delegated Functions are Reserved Functions.

61.2 This **Error! Reference source not found.** (*Reserved Functions*) sets out further provision regarding the carrying out of the Reserved Functions.

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

62. Management of the national performers list

62.1 Subject to Paragraph 2.2, NHS England will continue to perform its functions under the National Health Service (Performers Lists) (England) Regulations 2013.

62.2 The ICB will carry out administrative tasks in respect of the Performers Lists as described at:

62.2.1 Paragraph 9 of Part 2, Schedule 2A;

62.2.2 Paragraph 9 of Part 2, Schedule 2B; and

62.2.3 Paragraph 6 of Part 2, Schedule 2C.

62.3 NHS England's functions in relation to the management of the national performers list include:

62.3.1 considering applications and decision-making in relation to inclusion on the national performers list, inclusion with conditions and refusals;

62.3.2 identifying, managing and supporting primary care performers where concerns arise; and

62.3.3 managing suspension, imposition of conditions and removal from the national performers list.

62.4 NHS England may hold local Performance Advisory Group ("PAG") meetings to consider all complaints or concerns that are reported to NHS England in relation to a named performer and NHS England will determine whether an initial investigation is to be carried out.

62.5 NHS England may notify the ICB of all relevant PAG meetings at least seven (7) days in advance of such meetings. NHS England may require a representative of the ICB to attend such meetings to discuss any performer concerns and/or quality issues that may impact on individual performer cases.

62.6 The ICB must develop a mechanism to ensure that all complaints regarding any named performer are escalated to the Local NHS England Team for review. The ICB will comply with any Mandated Guidance issued by NHS England in relation to the escalation of complaints about a named performer.

63. Management of the revalidation and appraisal process

63.1 NHS England will continue to perform its functions under the Medical Profession (Responsible Officers) Regulations 2010 (as amended by the Medical Profession (Responsible Officers) (Amendment) Regulations 2013).

63.2 All functions in relation to GP appraisal and revalidation will remain the responsibility of NHS England, including:

63.2.1 the funding of GP appraisers;

63.2.2 quality assurance of the GP appraisal process; and

63.2.3 the responsible officer network.

63.3 Funding to support the GP appraisal is incorporated within the global sum payment to Primary Medical Services Provider.

63.4 The ICB must not remove or restrict the payments made to Primary Medical Services Provider in respect of GP appraisal.

63.5 Appraisal arrangements in respect of all other primary care practitioner groups shall also be Reserved Functions.

64. Administration of payments and related performers list management activities

64.1 NHS England reserves its functions in relation to the administration of payments to individual performers and related performers list management activities under the

National Health Service (Performers Lists) (England) Regulations 2013 and other relevant legislation.

64.2 NHS England may continue to pay practitioners who are suspended from the national performers list in accordance with relevant determinations made by the Secretary of State.

64.3 For the avoidance of doubt, the ICB is responsible for any ad hoc or discretionary payments to Primary Medical Services Providers (including those under section 96 of the NHS Act) in accordance with **Error! Reference source not found.**A (*Delegated Functions*) Part 2 paragraphs 5.1 and 5.1 of this Agreement, including where such payments may be considered a consequence of actions taken under the National Health Service (Performers Lists) (England) Regulations 2013.

65. Section 7A and Capital Expenditure Functions

65.1 NHS England retains the Section 7A Functions and will be responsible for taking decisions in relation to the Section 7A Functions.

65.2 In accordance with Schedule 10 Part 2, the ICB will provide certain management and/or administrative services to NHS England in relation to the Section 7A Functions.

65.3 NHS England retains the Capital Expenditure Functions and will be responsible for taking decisions in relation to the Capital Expenditure Functions.

65.4 In accordance with Schedule 10 Part 1, the ICB will provide certain management and/or administrative services to NHS England in relation to the Capital Expenditure Functions.

66. Such other ancillary activities that are necessary in order to exercise the Reserved Functions

66.1 NHS England will continue to comply with its obligations under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

66.2 The ICB must assist NHS England's controlled drug accountable officer ("CDAO") to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

66.3 The ICB must nominate a relevant senior individual within the ICB (the "ICB CD Lead") to liaise with and assist NHS England to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

66.4 The ICB CD Lead must, in relation to the Delegated Functions:

66.4.1 on request provide NHS England's CDAO with all reasonable assistance in any investigation involving the Delegated Functions;

66.4.2 report all complaints involving controlled drugs to NHS England's CDAO;

66.4.3 report all incidents or other concerns involving the safe use and management of controlled drugs to NHS England's CDAO;

66.4.4 analyse the controlled drug prescribing data available; and

66.4.5 on request supply (or ensure organisations from whom the ICB commissions services involving the regular use of controlled drugs supply) periodic self–declaration and/or self-assessments to NHS England's CDAO.

67. Reserved Functions – Primary Medical Services

67.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Medical Services Functions"):

67.1.1 determining the outcomes expected from Primary Medical Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes and the Department of Health and Social Care mandate;

67.1.2 designing and delivering national transformation programmes in support of national priorities;

67.1.3 the negotiation and agreement of matters concerning General Medical Services contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary medical services nationally;

67.1.4 the development of national standard Primary Medical Service contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Medical Services providers;

67.1.5 the provision of commissioning and contracting policy and guidance to support ICBs to meet their delegated duties;

67.1.6 the provision of nationally contracted services delivering digital, logistical and support services for Primary Medical Services in England (including but not limited to):

67.1.6.1 Payments;

67.1.6.2 Pensions;

67.1.6.3 Patient Registration;

67.1.6.4 Medical Records;

67.1.6.5 Performer List;

67.1.6.6 Supplies;

67.1.6.7 Call and Recall for Cervical screening (CSAS); and

67.1.6.8 Pharmacy Market Management.

67.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

68. Reserved Functions – Primary Dental Services

68.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Dental Services Functions"):

68.1.1 determining the outcomes expected from Primary Dental Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes; designing and delivering national transformation programmes in line with any applicable commissioning policies and guidance;

68.1.2 the negotiation and agreement of matters concerning Dental Services Contracts with national stakeholders including, without limitation, the

Department of Health and Social Care and bodies representing providers of primary dental services nationally;

68.1.3 the development of national standard Dental Service Contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Dental Services providers;

68.1.4 the provision of all dental commissioning and contracting policy and guidance to support ICBs to meet their delegated duties; and

68.1.5 the provision of nationally contracted services delivering digital, logistical and support services for Primary Dental Services in England (including but not limited to):

68.1.5.1 Payments;

68.1.5.2 Pensions;

68.1.5.3 Performer List; and

68.1.5.4 Market Management.

68.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

69. Reserved Functions – Primary Ophthalmic Services

69.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Ophthalmic Functions"):

69.1.1 the Primary Ophthalmic Services Contracts policy and associated documentation;

69.1.2 the negotiation and agreement of matters concerning Primary Ophthalmic Services with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of Ophthalmic Services nationally; and

69.1.3 the provision of nationally contracted services delivering digital, logistical and support services for Primary Ophthalmic Services in England (including but not limited to):

69.1.3.1 Payments;

69.1.3.2 Performers List;

69.1.3.3 Market Management/Entry; and

69.1.3.4 Contract management, assurance and post-payment verification.

69.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

70. Reserved Functions – Pharmaceutical Services and Local Pharmaceutical Services

70.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Pharmaceutical Functions"):

70.1.1 publication of Pharmaceutical Lists;

70.1.2 functions of NHS England as a determining authority in relation to pharmaceutical remuneration under Part 12 of the Pharmaceutical Regulations;

70.1.3 functions in respect of lists of performers of pharmaceutical services and assistants, noting that as at the date of this Agreement regulations for the purposes of these functions have not been made;

70.1.4 the negotiation and agreement of matters concerning NHS pharmaceutical services with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of Pharmaceutical Services nationally;

70.1.5 the provision of commissioning and contracting policy and guidance to support ICBs to meet their delegated duties; and

70.1.6 administration of the pharmacist pre-registration training grant scheme.

71. Reserved Functions – Primary Dental Services

71.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Dental Services Functions"):

71.1.1 determining the outcomes expected from Primary Dental Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes; designing and delivering national transformation programmes in line with any applicable commissioning policies and guidance;

71.1.2 the negotiation and agreement of matters concerning Dental Services Contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary dental services nationally;

71.1.3 the development of national standard Dental Service Contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Dental Services providers;

71.1.4 the provision of all dental commissioning and contracting policy and guidance to support ICBs to meet their delegated duties;

71.1.5 the provision of nationally contracted services delivering digital, logistical and support services for Primary Dental Services in England (including but not limited to):

71.1.5.1 Payments

71.1.5.2 Pensions

71.1.5.3 Performer List

71.1.5.4 Market Management.

71.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

72. Reserved Functions - Prescribed Dental Services

72.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Prescribed Dental Services Functions"):

72.1.1 determining the outcomes expected from Prescribed Dental Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes; designing and delivering national transformation programmes in line with any applicable commissioning policies and guidance;

72.1.2 in respect of any Prescribed Dental Services contracted pursuant to NHS England's functions under Part 5 of the NHS Act the negotiation and agreement of matters concerning those contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary dental services nationally;

72.1.3 in respect of any Prescribed Dental Services contracted pursuant to NHS England's functions under Part 5 of the NHS Act, the development of standard contracts and national contract variations and guidance;

72.1.4 the provision of all dental commissioning and contracting policy and guidance to support ICBs to meet their delegated duties;

72.1.5 in respect of any Prescribed Dental Services contracted pursuant to NHS England's functions under Part 5 of the NHS Act, the provision of nationally contracted services delivering digital, logistical and support services in England (including but not limited to):

72.1.5.1 Payments

72.1.5.2 Pensions

72.1.5.3 Performer List

72.1.5.4 Market Management.

72.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

6.5 **SCHEDULE 4** *(Further Information Governance and Sharing Provisions)* nor any Data Sharing Agreements entered into in accordance with this Schedule should be taken to permit unrestricted access to data held by any Party. It lays the parameters for the safe and secure sharing and processing of information on a justifiable **Need to Know** basis.

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

6.7 Neither Party shall cause or allow Data to be transferred to any territory outside the United Kingdom without the prior written permission of the responsible Data Controller.

6.8 Any particular restrictions on use of certain Relevant Information are included in the Personal Data Agreement annexed to this Schedule.

7. Ensuring fairness to the Data Subject

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

7.1.1 amendment of internal guidance to improve awareness and understanding among personnel;

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

7.1.3 ensuring that information and communications relating to the processing of data is easily accessible and easy to understand, and that clear and plain language be used; and

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

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

7.3 Each Party shall reasonably cooperate with the other in undertaking any Data Protection Impact Assessment associated with the processing of data further to this Agreement, and in doing so engage with their respective Data Protection Officers in the performance by them of their duties pursuant to Article 39 UK GDPR.

7.4 Further provision in relation to specific data flows should be included in Data Protection Agreements.

8. Governance: personnel

8.1 Each Party must take reasonable steps to ensure the suitability, reliability, training and competence, of any personnel who have access to the Personal Data (and Special Category Personal Data) including reasonable background checks and evidence of completeness should be available on request by each Party.

8.2 The Parties agree to treat all Relevant Information as confidential and imparted in confidence and must safeguard it accordingly. Where any of the Parties' personnel are not healthcare professionals (for the purposes of the Data Protection Act 2018) the

employing Parties must procure that personnel operate under a duty of confidentiality which is equivalent to that which would arise if that person were a healthcare professional.

8.3 Each Party shall ensure that all personnel required to access the Personal Data (including Special Category Personal Data) are informed of the confidential nature of the Personal Data and each Party shall include appropriate confidentiality clauses in employment/service contracts of all personnel that have any access whatsoever to the Relevant Information, including details of sanctions for acting in a deliberate or reckless manner that may breach the confidentiality or the non-disclosure provisions of Information Law requirements, or causes damage to or loss of the Relevant Information.

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

8.5 Each Party shall ensure that:

8.5.1 only those personnel involved in delivery of the Agreement use or have access to the Relevant Information; and

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

8.5.3 specific limitations on the personnel who may have access to the Information are set out in the relevant Data Sharing Agreement

9. Governance: Protection of Personal Data

9.1 At all times, the Parties shall have regard to the requirements of Information Law and the rights of Data Subjects.

9.2 Wherever possible (in descending order of preference), only anonymised information, or strongly or weakly pseudonymised information will be shared and processed by Parties, without the need to share easily identifiable Personal Data. The Parties shall cooperate in exploring alternative strategies to avoid the use of Personal Data in order to achieve the Specified Purpose. However, it is accepted that some Relevant Information shared further to this Agreement may be Personal Data/Special Category Personal Data.

9.3 Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a **Need to Know** basis. If either Party:

9.3.1 becomes aware of any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted or unusable; or

9.3.2 becomes aware of any security vulnerability or breach,

in respect of the Relevant Information it shall promptly (and within 48 hours) notify the other Party. The Parties shall fully cooperate with one another to remedy the issue as soon as reasonably practicable, and in making information about the incident available to the Information Commissioner and Data Subjects where required by Information Law.

9.4 In processing any Relevant Information further to this Agreement, each Party shall:

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

9.4.2 process the Personal Data (including Special Category Personal Data) only to the extent as is necessary for the provision of the Specified Purpose or as is required by law or any regulatory body;

9.4.3 process the Personal Data (including Special Category Personal Data) only in accordance with Information Law requirements and shall not perform its obligations under this Agreement in such a way as to cause any other Data Controller to breach any of their applicable obligations under Information Law; and

9.4.4 process the Personal Data in accordance with the requirements of Information Law and in particular the principles set out in Article 5(1) and accountability requirements set out in Article 5(2) UK GDPR.

9.5 Each Party shall act generally in accordance with Information Law requirements, and in particular shall implement, maintain and keep under review appropriate technical and organisational measures to ensure and to be able to demonstrate that the processing of Personal Data is undertaken in accordance with Information Law, and in particular to protect the Personal Data (and Special Category Personal Data) against unauthorised or unlawful processing and against accidental loss, destruction, damage, alteration or disclosure. These measures shall:

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

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

9.6 In particular, each Party shall:

9.6.1 ensure that only personnel authorised under this Agreement have access to the Personal Data (and Special Category Personal Data);

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

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

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

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

9.7 Each Party shall adhere to the specific requirements as to information security set out in the Data Sharing Agreements.

9.8 Each Party shall use best endeavours to achieve and adhere to the requirements of the NHS Digital Data Security and Protection Toolkit.

9.9 The Parties' Single Points of Contact set out in paragraph 14 *(Governance: Single Points of Contact)* below will be the persons who, in the first instance, will have oversight of third party security measures.

10. Governance: Transmission of Information between the Parties

10.1 This paragraph supplements paragraph 9 *(Governance: Protection of Personal Data)* of this Schedule.

10.2 Transfer of Personal Data between the Parties shall be done through secure mechanisms including use of the N3 network, encryption, and approved secure (NHS.net / gcsx) email.

10.3 Wherever possible, Personal Data should be transmitted (and held) in pseudonymised form, with only reference to the NHS number in 'clear' transmissions. Where there are significant consequences for the care of the patient, then additional data items, such as the postcode, date of birth and/or other identifiers should also be transmitted, in accordance with good information governance and clinical safety practice, so as to ensure that the correct patient record/data is identified.

10.4 Any other special measures relating to security of transfer should be included in a Data Sharing Agreement.

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

10.6 The Parties' Single Point of Contact notified pursuant to paragraph 14 *(Governance: Single Points of Contact)* will be the persons who, in the first instance, will have oversight of the transmission of information between the Parties.

11. Governance: Quality of Information

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

11.2 Special measures relating to ensuring quality are set out in the Personal Data Agreement annexed to this Schedule.

12. Governance: Retention and Disposal of Shared Information

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

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

12.3 If either Party is required by any law, regulation, or government or regulatory body to retain any documents or materials that it would otherwise be required to return or destroy under this paragraph 12 *(Governance: Retention and Disposal of Shared Information)*, it shall notify the other Party in writing of that retention, giving details of the documents or materials that it must retain.

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

12.5 Any special retention periods should be set out in the Data Sharing Agreements.

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

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

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

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

13. Governance: Complaints and Access to Personal Data

13.1 Each Party shall assist the other in responding to any request made under Information Law made by persons who wish to access copies of information held about them ("**Subject Access Requests**"), as well as any other purported exercise of a Data Subject's rights under Information Law or complaint to or investigation undertaken by the Information Commissioner.

13.2 Complaints about information sharing shall be routed through each Party's own complaints procedure but reported to the Single Points of Contact set out in paragraph 14 *(Governance: Single Points of Contact)* below.

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

13.4 Basic details of the Agreement shall be included in the appropriate log under each Party's Publication Scheme.

14. Governance: Single Points of Contact

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

15. Monitoring and review

1. The Parties shall monitor and review on an ongoing basis the sharing of Relevant Information to ensure compliance with Information Law and best practice. Specific monitoring requirements must be set out in the relevant Data Sharing Agreement.

SCHEDULE 5

Financial Provisions and Decision Making Limits

Part 1 - Financial Limits and Approvals for Primary Care

1. The ICB shall ensure that any decisions in respect of the Delegated Functions and which exceed the financial limits set out below are only taken:

   1.1 by the following persons and/or individuals set out in column 2 of Table 1 below; and

   1.2 following the approval of NHS England (if any) as set out in column 3 of the Table 1 below.

2. NHS England may, from time to time, update Table 1 by sending a notice to the ICB of amendments to Table 1.

Table 1 – Financial Limits		
Decision	**Person/Individual**	**NHS England Approval**
General		
Taking any step or action in relation to the settlement of a Claim, where the value of the settlement exceeds £100,000	ICB Chief Executive Officer or Chief Finance Officer or Chair	NHS England Head of Legal Services and Local NHS England Team Director or Director of Finance
Any matter in relation to the Delegated Functions which is novel, contentious or repercussive	ICB Chief Executive Officer or Chief Finance Officer or Chair	Local NHS England Team Director or Director of Finance or NHS England Region Director or Director of Finance or NHS England Chief Executive or Chief Financial Officer
Revenue Contracts		
The entering into of any Primary Care Contract or Arrangement which has or is capable of having a term which exceeds five (5) years	ICB Chief Executive Officer or Chief Finance Officer or Chair	Local NHS England Team Director or Director of Finance
Capital Note: As at the date of this Agreement, the ICB will not have delegated or directed responsibility for decisions in relation to Capital expenditure (and these decisions are retained by NHS England) but the ICB may be required to carry out certain administrative services in relation to Capital expenditure under paragraph 13 *(Financial Provisions and Liability).*		

SCHEDULE 6

Mandated Assistance and Support

1. Primary Dental Services

1.1 NHS Business Services Authority has existing agreements with NHS England to support its delivery of the following services:

1.1.1 Contract management – end-to-end administration of contract variations and other regional team/ICB support activities;

1.1.2 Performance management - provide mid and end of year administration process to support regional teams and ICBs and undertake risk based assurance reviews - PPV can also be instigated by the ICS or Counter Fraud;

1.1.3 Clinical assurance reviews – provide clinical assurance of quality of dental services delivered, working in collaboration with regional teams/ICBs to identify and seek to address any concerns;

1.1.4 Provide data reports to teams defining quantity and service delivery at a contractor level.

2. Primary Ophthalmic Services

2.1 NHS Business Services Authority have existing agreements with NHS England to support its delivery of the following services:

2.1.1 Contract management. End-to-end administration of new contract applications, contract variations and contract terminations.

2.1.2 Contract assurance. Administration of the annual contractor assurance declaration and additional in-depth assurance declaration where appropriate. Provision of assurance reports at ICS and contractor level, supporting further assurance decisions.

2.1.3 GOS complaints. Administration of the annual GOS complaints survey.

2.1.4 Post-Payment Verification (PPV). End-to-end process for identifying and verifying GOS claims as part of the national PPV framework. This includes obtaining and reviewing claims and carrying out a financial recovery where appropriate. PPV can also be instigated by the ICS or Counter Fraud.

2.1.5 GOS 4 pre-authorisation of repair or replacement glasses.

3. Pharmaceutical Services and Local Pharmaceutical Services

3.1 NHS Business Services Authority has existing agreements with NHS England to support ICBs to discharge their assurance responsibilities by the delivery of the following services to ICBs:

3.1.1 Performance management – direct support to commissioners and community pharmacy contractors to implement corrective and preventative intervention;

3.1.2 Contract assurance – administration of the annual contractor assurance declaration and additional in-depth assurance declaration where

appropriate, provision of assurance reports at ICS and contractor level supporting further assurance decisions by the ICB;

3.1.3 Post-Payment Verification (PPV) – end-to-end process for identifying and verifying claims as part of the national PPV framework to support ICBs to play their part in ensuring compliance with contractual requirements and delivery of quality and value for money. This includes obtaining and reviewing claims, investigation of outliers and other potential inappropriate claims, along with referrals and investigatory reports to the ICB to consider and decide overpayment recoveries, and carrying out the financial recovery where appropriate. PPV can also be instigated by the ICS or Counter Fraud.

4. Support Services directed by DHSC

4.1 NHS Business Services Authority is directed by DHSC to undertake specific activities as well as having existing agreements with NHS England to support its delivery of primary care services. These include (without limitation):

4.1.1 The administration of national payment platforms for primary care services to dentists, pharmacy contractors, appliance contractors, oxygen contractors and special school eye care providers;

4.1.2 The calculation of payment for covid-19 and flu vaccinations to PCNs and GP practices as well as payments to Dispensing Doctors and prescribing only doctors for personal administration claims and sharing this information accurately and in a timely manner;

4.1.3 Clinical advisory support;

4.1.4 Administration functions;

4.1.5 Assurance services - performance and contract management of primary care providers;

4.1.6 The provision of information to primary care organisations for all contractor groups via standardised reporting (eg. ePACT2, eDEN and eOPS);

4.1.7 Working with NHS England and ICB Counter Fraud Teams to reduce loss across the system.

SCHEDULE 7

Local Terms

The Operational Framework will detail the ways of working for the transition of the POD workforce and NHSE and ICS operational support.

SCHEDULE 8

Deployment of NHS England Staff to the ICB

Note: This schedule relates to the Deployment of Staff who are employed by NHS England only.

Deployment of NHS England Staff

1. NHS England may deploy Staff to the ICB for the purposes of carrying out the Delegated Functions.

2. The Parties have agreed that arrangements for the provision of NHS England Staff and the associated employment model envisaged by section 5.9 of the HR Framework **https://www.england.nhs.uk/wp-content/uploads/2021/06/B1427-Human-resources-framework-for-developing-integrated-care-boards-version-2-March-2022.pdf**) will be determined by the National Moderation Panel convened for this purpose and endorsed by NHS England's Executive Group.

3. The Parties agree and acknowledge that the Staffing Models will be developed in conjunction with the ICB and are subject to the decision of the National Moderation Panel and cannot be varied without the express agreement of NHS England.

4. A proposal for a variation to any Staffing Model must be made by means of a formal submission to the National Moderation Panel which will determine the proposal, following which the proposal if approved, will be endorsed by NHS England's Executive Group.

5. Subject to any variation made in accordance with paragraphs 3 and 4 above, a Staffing Model determined in accordance with paragraph 2 will apply for the duration of this Agreement.

Availability of NHS England Staff

6. In addition to any Staff deployed in any communicated Staffing Model arrangement, NHS England may deploy additional Staff to the ICB to perform administrative and management support services together with such other services specified in **Error! Reference source not found.** (Local Terms) (the "Services") so as to facilitate the ICB in undertaking the Delegated Functions pursuant to the terms of this Agreement.

7. NHS England will take all reasonable steps to ensure that the NHS England Staff deployed for the purposes of carrying out the Delegated Functions shall:

    a. faithfully and diligently perform duties and exercise such powers as may from time to time be reasonably assigned to or vested in them; and

    b. perform all duties assigned to them pursuant to this Schedule 8.

8. The ICB shall notify NHS England if the ICB becomes aware of any act or omission by any NHS England Staff which may have a material adverse impact on the provision of the Services or constitute a material breach of the terms and conditions of employment of the NHS England Staff.

9. NHS England shall use all reasonable efforts to make its Staff available for the purposes of this Schedule 8 whilst the NHS England Staff are absent:

    a. by reason of industrial action;

    b. as a result of the suspension or exclusion of employment or secondment of any Staff by NHS England;

c. in accordance with the NHS England Staff's respective terms and conditions of employment and policies, including, but not limited to, by reason of training, holidays, sickness, injury, trade union duties, paternity leave or maternity or where absence is permitted or required by Law;

d. if making the NHS England Staff available would breach or contravene any Law;

e. as a result of the cessation of employment of any individual NHS England Staff; and/or

f. at such other times as may be agreed between NHS England and the ICB.

Employment of the NHS England Deployed Staff

10. NHS England shall employ their Staff and shall be responsible for the employment of their Staff at all times on whatever terms and conditions as NHS England and their Staff may agree from time to time.

11. NHS England shall pay their Staff their salaries and benefits and make any deductions for income tax liability and national insurance or similar contributions it is required to make from the Staff's salaries and other payments.

12. NHS England shall not, and shall procure that the NHS England Staff shall not, hold themselves out as employees of the ICB.

Management of NHS England staff

13. NHS England where appropriate, shall in consultation with the ICB, make arrangements to ensure the day-to-day control of the activities of their Staff is shared with the ICB and deal with any relevant management issues concerning their Staff including, without limitation, performance appraisal, discipline and leave requests.

14. The ICB agrees to provide all such assistance and co-operation that NHS England may reasonably request from time to time to resolve grievances raised by NHS England Staff and to deal with any disciplinary allegations made against NHS England Staff arising out of or in connection with the provision of the Services which shall include, without limitation, supplying NHS England with all information and the provision of access to all documentation and NHS England Staff as NHS England requires for the purposes of considering and dealing with such issues and participating promptly in any action which may be necessary.

Conduct of Claims

15. If the ICB becomes aware of any matter that may give rise to a claim by or against a member of NHS England Staff, notice of that fact shall be given as soon as possible to NHS England. NHS England and the ICB shall co-operate in relation to the investigation and resolution of any such claims or potential claims.

16. No admission of liability shall be made by or on behalf of the ICB and any such claim shall not be compromised, disposed of or settled without the consent of NHS England.

Confidential Information and Property

17. For the avoidance of doubt, this paragraph 17 (Confidential Information and Property) is without prejudice to any other provision of this Agreement in relation to confidential information.

18. It is acknowledged that to enable the NHS England Staff to provide the Services, the Parties may share Confidential Information.

19. The Parties agree to adopt all such procedures as the other party may reasonably require and to keep confidential all Confidential Information.

Intellectual Property

20. All IPR made, written, designed, discovered or originated by Staff (People Resources) deployed by NHS England, shall be the property of NHS England to the fullest extent permitted by Law and NHS England shall be the absolute beneficial owner of the copyright in any such IPR.

SCHEDULE 9

Mandated Guidance

Primary Medical Care

- Primary Medical Care Policy and Guidance Manual.
- The 'Principles of Best Practice' and any other guidance relating to *the Premises Cost Directions 2013.*
- Guidance relating to the Minimum Practice Income Guarantee.
- Guidance relating to Primary Medical Care discretionary payments.
- Guidance for Commissioners: Interpreting and Translation Services in Primary Care.
- Framework for Patient and Public Participation in Primary Care Commissioning.
- NHS England National Primary Care Occupational Health Service Specification.
- Guidance relating to list cleansing in relation to Primary Medical Care providers.
- Guidance relating to mergers and closures of GP practices and/or Primary Medical Care providers.
- Guidance relating to Primary Medical Care and POD contract reviews.
- Guidance relating to the escalation of complaints from a named 'performer'.
    - Including: *Framework for Managing Performer Concerns.*

Pharmaceutical Services and Local Pharmaceutical Services

- Pharmacy Manual.
- NHS England National Primary Care Occupational Health Service Specification.
- The NHS Pharmacy Regulations Guidance 2020[1].
- Guidance for ICSs and STPs on transformation and improvement opportunities to benefit patients through integrated pharmacy and medicines optimisation.

Primary Ophthalmic Services

- Policy Book for Eye Health.
- NHS England National Primary Care Occupational Health Service Specification.

Primary and Prescribed Dental Services

- Policy Book for Primary Dental Services.
- Securing Excellence in Commissioning NHS Dental Services.
- Securing Excellence in Commissioning NHS Dental Services: Key facts.
- Securing Excellence in Commissioning NHS Dental Services: FAQs.
- Quick Guide: Best use of unscheduled dental care services.
- How to update NHS Choices for Dental Practices.
- Flowchart for managing patients with a dental problem/pain.
- Guidance on NHS 111 Directory of Services for dental providers.
- Definitions – Unscheduled Dental Care.
- Introductory Guide for Commissioning Dental Specialties.
- Guide for Commissioning Dental Specialties: Orthodontics.
- Guide for Commissioning Dental Specialties: Oral Surgery and Oral Medicine.
- Guide for Commissioning Dental Specialties: Special Care Dentistry.
- Guide for Commissioning Service Standards: Conscious Sedation in a Primary Care Setting.
- Commissioning Standard for Dental Specialties: Paediatric Dentistry.
- Commissioning Standard for Urgent Dental Care.
- Commissioning Standard for Restorative Dentistry.

[1] https://www.england.nhs.uk/primary-care/pharmacy/pharmacy-manual/nhs-pharmacy-regulations-guidance-2020/

- Commissioning Standard for Dental Care for People with Diabetes.
- Accreditation of Performers and Providers of Level 2 Complexity Care.
- NHS England National Primary Care Occupational Health Service Specification.
- Dental Access Controls.

Finance

- Guidance on NHS System Capital Envelopes.
- Finance and Payments Guidance for Community Pharmacy, Dental and Primary Care Ophthalmology Services Delegated to ICBs from 2022.
- Managing Public Money (HM Treasury).
- Guidance relating to Personal Service Medical Reviews.
    - Including: *Implementing Personal Medical Services Reviews.*
- Dental Commissioning and Financial Management Guidance.

Workforce

- Guidance on the Employment Commitment.

Other Guidance

- National Guidance on System Quality Groups.
- Managing Conflicts of Interest in the NHS.
- Arrangements for Delegation and Joint Exercise of Statutory Functions.
- Guidance relating to procurement and provider selection.
- IG Guidance relating to serious incidents.
- All other applicable IG and Data Protection Guidance.
- Any applicable Freedom of Information protocols.
- Any applicable guidance on Counter Fraud, including from The NHS Counter Fraud Authority.
- Any applicable guidance relating to the use of data and data sets for reporting.
- Any applicable guidance relating to the commissioning and management of clinical waste in primary care e.g.
    - Including: Management and disposal of healthcare waste.

SCHEDULE 10

Administrative and Management Services

1. The ICB shall provide the following administrative and management services to NHS England:

   1.1 the administrative and management services in relation to the Capital Expenditure Functions and the Capital Expenditure Funds as more particularly set out in this Part 1 of this SCHEDULE (*Administrative and Management Services*); and

   1.2 the administrative and management services in relation to the Section 7A Functions and Section 7A Funds as more particularly set out in Part 2 of this Schedule 10.

   1.3 the administrative and management services in relation to other Reserved Functions as more particularly set out in Part 3 of this SCHEDULE (*Administrative and Management Services*).

Part 1: Administrative and/or Management Services and Funds in relation to the Capital Expenditure Functions

1. The Parties acknowledge that the Capital Expenditure Functions are a Reserved Function.

2. The Parties further acknowledge that:

   2.1 accordingly, the Delegated Funds do not include any funds in respect of amounts payable in relation to the Capital Expenditure Functions (**"Capital Expenditure Funds"**); and

   2.2 NHS England remains responsible and accountable for the discharge of the Capital Expenditure Functions and nothing in Part 1 of this SCHEDULE (*Administrative and Management Services*) shall be construed as a divestment or delegation of NHS England's Capital Expenditure Functions.

3. Without prejudice to paragraph 3 above, the ICB will comply with any Mandated Guidance issued in relation to the Capital Expenditure Functions and shall (on request from NHS England) provide the following administrative services to NHS England in respect of the Capital Expenditure Funds:

   3.1 the administration and payment of sums that NHS England has approved as payable in relation to the Capital Expenditure Functions;

   3.2 if requested by NHS England and taking into account (i) any other support or services provided to NHS England by NHS Property Services Limited or otherwise and (ii) any Mandated Guidance issued in respect of the Capital Expenditure Functions, the provision of advice and/or recommendations to NHS England in respect of expenditure to be made under the Capital Expenditure Functions; and

   3.3 such other support or administrative assistance to NHS England that NHS England may reasonably request in order to facilitate the discharge by NHS England of its responsibilities under or in respect of the Capital Expenditure Functions.

4. NHS England may, at the same time as it allocates the Delegated Funds to the ICB under Clause 9.11, transfer to the ICB such amounts as are necessary to enable the discharge of the ICB's obligations under this Part 1 of SCHEDULE (*Administrative and Management Services*) in respect of the Capital Expenditure Functions.

Part 2 - Administrative and/or Management Services and Funds in relation to Section 7A Functions

1. The Parties acknowledge that the Section 7A Functions are part of the Reserved Functions.

2. The Parties further acknowledge that:

   2.1 accordingly, the Delegated Funds do not include any funds in respect of amounts payable in relation to the Section 7A Functions (whether such arrangements are included in or under Primary Care Contracts or Arrangements or not) (**"Section 7A Funds"**); and

   2.2 NHS England remains responsible and accountable for the discharge of the Section 7A Functions and nothing in this Schedule 10 Part 2 shall be construed as a divestment or delegation of the Section 7A Functions.

3. The ICB will provide the following services to NHS England in respect of the Section 7A Funds:

4. the administration and payment of sums that NHS England has approved as payable under or in respect of arrangements for the Section 7A Functions; and

5. such other support or administrative assistance to NHS England that NHS England may reasonably request in order to facilitate the discharge by NHS England of its responsibilities under or in respect of the Section 7A Funds.

6. NHS England shall, at the same time as it allocates the Delegated Funds to the ICB under Clause 9.11, allocate to the ICB such amounts as are necessary to enable the discharge of the ICB's obligations under this Schedule 10 Part 2 in respect of the Section 7A Funds.

Part 3: Administrative and/or Management Services and Funds in relation to other Reserved Functions

1. NHS England may ask the ICB to provide certain management and/or administrative services to NHS England (from a date to be notified by NHS England to the ICB) in relation to the carrying out of any of the Reserved Functions.

2. If NHS England makes such a request to the ICB, then the ICB will, but only if the ICB agrees to provide such services, from the date requested by NHS England, comply with:

3. provisions equivalent to those set out above in relation to the Capital Expenditure Functions (Part 1 of this Schedule 10) and the Section 7A Functions (Part 2 of this Schedule 10) including in relation to the administration of any funds for such functions but only to the extent that such provisions are relevant to the management or administrative services to be provided; and

4. such other provisions in respect of the carrying out of such management and administrative services as agreed between NHS England and the ICB.

Agenda item ICB 29-03-076.1

Quality and Performance Committee Chair's Report for meetings held on 23 November 2022 and 25 January 2023

NHS Shropshire, Telford and Wrekin
ICS Quality & Performance Committee Meeting

Wednesday 25th January 2023 at 9.00am to 11.00am

Via Microsoft Teams

Present:

Meredith Vivian - Chair & Non-Executive Director, NHS Shropshire, Telford, and Wrekin
Alison Bussey – Chief Nursing Officer - NHS Shropshire, Telford and Wrekin
David Lee – Non-Executive Director, SaTH
Lynn Cawley, Chief Officer, Healthwatch Shropshire
Julie Garside – Director of Planning and Performance, NHS Shropshire Telford and Wrekin
Vanessa Whatley Director of Qulaity & Safety,/Deputy CNO , NHS Shropshire, Telford and Wrekin
Liz Noakes - Director of Public Heath, Telford & Wrekin Council
Nick White – Chief Medical Officer, NHS Shropshire Telford and Wrekin
Sara Ellis-Anderson - Chief Nurse RJAH
Liz Lockett –Chief Nurse and Director of Quality & Professional Leadership, MPFT
Rosi Edwards – Associate NED – SaTH
Clair Hobbs – Director of Nursing, Shropshire Community Health NHS Trust

Attendees:

Cathy Purt – None Executive Director, SCHT
Sam Cook, Interim Deputy Director of Performance, NHS Shropshire Telford, and Wrekin
Gloria Onwubiko – Director of Elective Care NHS Shropshire Telford and Wrekin
Helen White – Transformation and Commissioning Project Manager for Adult Mental Health, NHS Shropshire Telford and Wrekin
Linda Vaughan – Service Manager, NHS Shropshire Telford and Wrekin
Lisa Rowley – Corporate PA, Note Taker, NHS Shropshire Telford, and Wrekin

1.0 Minute No. QPC-23-01.01 – Welcome/Apologies by: Meredith Vivian

1.1 The Chair of the Committee welcomed members and attendees to the meeting. The Chair thanked members of the Committee for their hard work despite the prevailing conditions within the system.

Apologies:

- Hayley Flavell – Director of Nursing – SaTH
- Simmy Akhtar – NED MPFT Simmy will be attending future Quality & Performance meetings on behalf of Jacqueline Small who has taken up the role of interim chair of MPFT.
- Tina Long NED SCHT – Represented by Cathy Purt
- Barry Parnaby – Chief Officer, Healthwatch Telford & Wrekin

2.0 QPC-23-01.02 - Members' Declarations of Interests

2.1 There were no declarations or conflicts of interest noted.

3.0 Minute No. QPC-23-01.03 - Minutes of Meeting held on

3.1 The minutes of the meeting held on 25th November 2022 were reviewed and accepted as an accurate record.

4.0 QPC-23-01.04 Matters Arising and Action Log

4.1 Actions have been updated and are outlined on the action log.

4.2 Julie Garside highlighted that there is an outstanding action which she is still chasing regarding reporting and whether or not, through contractual monitoring, the number of patients who are on the serious mental issue register, who die can be tracked, Julie Garside said that as soon as she has an update she will inform the committee rather than wait to provide an update at the next QPC meeting.

4.3 Vanessa Whatley advised the Committee of an outstanding action she has regarding overlaying the inequalities or health inequalities in each of the risks. This is currently with the risk owners who have varying levels of understanding of the whole agenda. This is work in progress and new ways are being looked at with regard to updating the register.

5.0 Minute No. QPC-23-01.05 - System Quality Risk Register – Vanessa Whatley

The report was received as read, a discussion ensued and the following key points were highlighted:

5.1 The risk register continues to be developed and risk owners have been asked to review their risks to ensure confidence in the management of risks. Each provider has been asked to update their risks on a monthly basis and to forward their updates to the QPC meeting administrator in order that the master risk register can be updated. Discussions are underway to look at how the current risk register is linked to the ICB Risk Register and Board Assurance framework.

5.2 No further updates have been received regarding Safeguarding Children and Young People since November 2022; this is moving to the iThrive model, which is the out of hospital care support structure aimed at psychological support and prevention of mental health illness.

5.3 Continuous updates on palliative and end of life care and the early prevention of Protection of Children Young People's mental health activities are being pursued though steering groups. PEoLC risk has been discussed last week and is considered to be a decreasing risk. There is confidence regarding the governance structure across the integrated care system, improvements have been seen in primary care and the hospices are supportive of all the actions being undertaken across the system. A series of focused quality reviews and quality visits have taken place to look at the quality of care out of hospital and how further improvements can be made to keep people in community environments at end of life. This information is currently being collated and the final report is currently in a draft stage.

5.4 Liz Noakes referred to the Quality Risk Register and Children's Mental Health and said that she had attended the new Children and Young Persons Family Board, set up by Claire Parker, which is the first of this Board for some time however, an update on

Children's Mental Health Services has not been received at this meeting. An update on speech and language therapy was given but felt that there was a sense that this Board had been set up because the Local Authorities were questioning where risks relating to Children and Young Adults were being escalated to and where to have that joined up conversation. Liz Noakes stated that the CYP Family Board did not have sight of the risks highlighted at this meeting.

Action : Vanessa Whatley to link in with Claire Parker and share the QPC Risk Register in order that the CYP Family Board can be sighted on current risks.

5.5 Vanessa Whatley referred to the Urgent Emergency Care risk which is being managed through the Urgent and Emergency Care Board.

5.6 Paediatric ophthalmology risk is a reducing risk, and this is being updated on a weekly basis. Work is being undertaken in this area trying to secure an external contract, once achieved a date will be agreed to re-open the service at SaTH.

5.7 There have been further improvements with imaging and imaging reporting delays.

5.8 There have been improvements in relation to diabetes and the system is on track for that to go from extreme to red by the end of this year.

5.9 Meredith Vivian asked how confident the system is that progress is being made regarding risks associated with Children and Young People Services and Palliative End of Life Care and stated that SaTH appear to have no input into these risks.

5.10 Vanessa Whatley responded that SaTH are involved in both working groups and have an action plan in place which is monitored through the various groups.

5.11 Julie Garside commented that Imaging is regularly tracked through the Planned Care Board and is also covered in the Deep Dive Report being presented at this meeting. The diagnostic position of elective and cancer care is delivering and is recovering at the fastest rate. Reporting was the issue however, the additional provider brought in is on top of this and that rate is now decreasing. The X-ray backlog has now been cleared which was a source of considerable concern within Primary Care, and information has been received that this is flowing through the governance route.

5.12 Lynn Cawley referred to the work on Children and Young People and highlighted that Healthwatch Shropshire compiled a report about the Children and Young People's Mental Health crises and will start the process of looking at their forward plan for 2023/24 where they will be revisiting the work around children. Lynn Cawley stated that it is her concern that if this work is carried out the same messages that they have had will be found and she would rather wait until significant changes have been seen in this service provision so that when she speaks to the young people hopefully that will reflect the difference. She said that it was important to acknowledge that the Safeguarding Partnerships from Shropshire, Telford and Wrekin are still concerned about children and young people's mental health.

5.13 Alison Bussey responded that conversations have taken place at the Strategic Safeguarding Partnership Board meetings and there are plans in place and changes made already but there is a broader piece of work around the strategic direction and what that service model will look like.

5.14 Liz Lockett added it is still quite challenging and there are medium to longer-term plans in place around how the services for young people in crisis are delivered. One of the biggest challenges is recruiting workforce as there are significant challenges recruiting into roles into particularly Children and Family Services within Shropshire, Telford and Wrekin. Different ways of recruiting are being looked into for different types of roles that might support children and young people in crisis. Rebuild of the 136 suite at the Redwood Centre are currently being undertaken so that children and young people in

crisis can be provided with a safe place whilst they are awaiting either Tier 4 provision or to go back into the community. Cathy Riley and the operational services at MPFT have been looking at the current safety of children and young people and the provision risk assessments in terms of those that are priority.

5.15 Cathy Purt referred to the Paediatric Ophthalmology risk and asked whether this going to be part of the Children and Young People's Committee work as she voiced concern that there still is no service for those children in place and the impact that may have on their schooling and home life. The risk register has it noted that this is a reducing risk as there is a delay in this service and it is expected to commence in February which it may not and felt that this should remain as a risk but there are mitigations in place. Julie Garside commented that there is a limited service in place and SaTH are managing some of the demand, sustainability of this service is the main risk and a contract is in place with a third party. The third-party arrangement will provide confidence to maintain that service therefore in terms of the risk to children is how this continues to be monitored.

Action : Julie Garside and Vanessa Whatley to discuss wording and update the Risk Register so it is clear that there is a limited service in place regarding Paediatric Ophthalmology and to note that the risk is around the sustainability of this service.

Following discussion, the Committee:

- Considered risks for ongoing progress/action

6.0 Minute No. QPC-23-01.06– Performance Exception Report by: Julie Garside

The report was received as read, a discussion ensued and the following key points were highlighted:

6.1 There has been a significant improvement in urgent care position during January 2023; the additional adult social care funding is starting to take effect. There has been a significant reduction in demand; a lot of the actions that were planned and being delivered in December were impacted by the Strep outbreak with the increase in paediatric attendances. Outbreaks of COVID19 and flu impacted demand during December which not only effects demand but also affects staffing. In order to provide assurance to the Committee, data currently received is showing a significant improvement in ambulance handovers during January.

6.2 Liz Noakes asked whether there are any further updates on cancer pathways as the report identifies that there was little improvement during November 2022. Julie Garside responded that she has been assured by provider colleagues that the 62-day backlog trajectory is going to be achieved by the end of January 2023 however, there has been some delays around the pathway actions which are ow being addressed. There are added issues around the colorectal pathway, in particular the linking to the FIT testing, this pathway has gone out to tender and the provider will be providing that service going forwards. This will need to be in place before any improvements will be seen.

6.3 The Elective hub will be set up from June 2023 which will offer some ringfence capacity that again will maintain and continue that focus on cancer. The Cancer Group have advised that the local position target of 65% will be delivered by the end of March 2023 with an anticipated target of 75% by March 2024 which translates into 2.5% increments each quarter. Cathy Purt asked if there was assurance that patients who move through the system are tracked as this was not highlighted in the performance report. Julie

Garside replied that patients that get moved to other providers are being tracked, however patients who choose not to go through the system are not routinely monitored separately as it is part of the overall picture.

Action: Julie Garside to discuss with Gloria Onwubiko information provided in the performance report regarding tracking patients and to ensure specific information regarding specialities is reported in order to provide QPC with assurance that targets are being achieved.

6.4 Meredith Vivian referred to the no criteria to reside in the report and sought clarification on this position. Julie Garside responded that the no criteria to reside is a national definition. If this criterion is applied, it is being measured consistently across all providers in the country and this is also part of the new data that all providers submit. There is a national system called the Foundry which presents all the systems data back to provides them with the appropriate comparator analysis. In terms of moving away from Medically Fit for Discharge (MFFD) to no criteria to reside, all data flows will be aligned in February 2023 and from March 2023 no criteria to reside will be reported on rather than MFFD.

Following Discussion, the Committee:

- Noted the content of the report and provided feedback for incorporation into future reports.
- Noted the mitigations to address current risks/trends supporting continual improvement journey across the ICS.
- Noted improvement in the detail of the recovery actions and associated timescales for recovery included in this report as performance recording is developed by the team.

7.0 Minute No. QPC-23-01.07 – System Quality Metrics – Vanessa Whatley

The report was received as read, a discussion ensued and the following key points were highlighted:

7.1 Meredith Vivian highlighted that the report stated that the rates of mental health patients with a length of stay of over 90 days has increased and asked if MPFT were looking into this. Liz Locket responded that MPFT's inpatient environment has increased. The acuity of the people being seen into the mental health wards has increased and the number of people detained under the Mental Health Act versus those informal admissions is greater for those detained, which then has an impact on length of stay for treatment. Other factors are those patients that are medically ready for discharge but are awaiting a placement or are awaiting some other source for discharge that is not home. There are also challenges around capacity to enable those patients to go on to placements. Mental Healthcare is a changing environment and patients admitted onto wards as acute inpatients admissions, and patients on these wards are unwell for longer periods of time which has an impact on length of stay.

Following discussion, the Committee:

- Considered the metrics with performance metrics and system risks

8.0 Minute No. QPC-23-01.08 – Exception Report – System Quality Group Chairs Report:
Meredith Vivian

The report was received as read, a discussion ensued and the following key points were highlighted:

8.1 Meredith Vivian said that reflecting on the process and the contributions that go into it, is there confidence that things are working smoothly, albeit in a very difficult environment? Vanessa Whatley responded that contributions from members at the meeting are often good with regular contributions from Health Education England and others around the table that help to support discussions. It also provides a forum to be sighted on any issues and to minimise risks.

Following discussion, the Committee:

- Considered the alerts in this report and further assurance required.

9.0 Minute No. QPC-23-01.09 – SOAG Exception Report: Vanessa Whatley

The report was received as read, a discussion ensued and the following key points were highlighted:

9.1 The purpose of the SOAG meeting is that it is a mechanism whereby the overall aim is to provide support and challenge to drive continued quality ensuring assurance of progress against CQC conditions.

9.2 The key purpose of SOAG is to share actions being taken by the Trust to mitigate risks ensuring a sustained delivery of safe services . SOAG also provide scrutiny for operational and quality risks, providing stakeholders with assurance of the improvements within the Trust's quality improvement plans.

9.3 SOAG meeting has not always run smoothly which is mainly due to the way the agenda for the meeting has been put together however, clear agendas are now in place providing the opportunity to discuss issues at SaTH which will be fed into other Committees.

9.4 Lynn Cawley advised that she had on the SOAG since its inception and a clear view of its duration and end point is needed.

Action: Vanessa Whatley to remove reference to the CCG and replaced with ICB within the report.

Following discussion, the Committee:

- Noted the content of the report

10.0 Minute No. QPC-23-01.10 – Healthwatch Shropshire Verbal Update – Lynn Cawley

A verbal update was given and the following points were brought to the Committee's attention:

10.1 Healthwatch Shropshire have been successful in retaining their contract for the next three years with the potential for two additional years. However, did not secure the Telford and Wrekin contract. There will continue to be two Healthwatch providers.

10.3 In order for Healthwatch's forward plan to be meaningful Lynn Cawley said that it would be helpful to know timescales of when Healthwatch can get people's voice into the system so that it is valuable.

10.4 Healthwatch Shropshire are trying to do some work as part of the Healthwatch England campaign to raise the number of comments they receive, particularly amongst older people with long term conditions.

10.5 Healthwatch Shropshire are also looking at partly feeding into the work that is currently being carried out with the Experience of Care Group to gather people's experiences of raising concerns and complaints within the system and whether or not they feel that it is a valuable exercise.

Following discussion, the Committee:

- Noted the comments made in the verbal update.

11.0 Minute No. QPC-23-01.11 – Healthwatch Telford & Wreken Verbal Update – Barry Parnaby

No representative from Healthwatch Telford & Wrekin were present at the meeting.

12.0 Minute No. QPC-23-01.12 – Deep Dive into Elective Care and Diagnostics – Gloria Onwubiko

The report was received as read, a discussion ensued and the following key points were highlighted:

12.1 Rosi Edwards referred to Page 7 of the report where it states that clinical engagement continues to be a challenge for the clinical lead with resistance from some areas on anything new or different and not open to considering new ways of working and asked for clarity on this comment about what was lacking and what is needed to rectify this challenge. Gloria Onwubiko responded that she would not say it is the lack of clinical engagement but the fact that the clinical leads at SaTH and also the operational managers have been pulled in to support UEC and it has always been an issue for in terms of where the balance of risk is resulting in elective recovery then taking a backseat. Consequently, patients could potentially get sicker and end up presenting as non-elective attendances. It is a cycle that has been discussed and raised previously with SaTH colleagues around what is the best way to ensure that there is the right level of engagement and support from across the staff focusing on elective care and also on emergency care. There is also some resistance from clinicians around embracing new ways of working particularly around virtual consultation; virtual consultation would not be a model that feeds all patient groups however, would like the ability to offer this as an alternative option to patients.

12.2 Rosi Edwards said that it would be helpful if she could be provided with further clarity about what the issues are at SaTH and what is expected to be done at an executive level. If guidance could be given as to what is needed, she will then feed this back to Executives at SaTH.

12.3 Examples are primarily within outpatients transformation, where different ways of working are being looked at to ensure that targets are met in terms of reducing face to face appointments where necessary. This appears to be where the most resistance has been seen from clinicians in terms of embracing those new ways of working. There are some pathways that would be suitable for virtual appointments and there are some pathways that would also be suitable for what is called patient-initiated follow-ups.

Action : Rosi Edwards to raise with SaTH Exec Board issues highlighted in the report regarding ring fencing capacity and custom and practice around ways of working.

12.4 Liz Noakes asked whether analysis has been carried out regarding waiting lists for diagnostics and whether they are disproportionately waited to certain groups within certain areas such as deprived population and/or small excluded groups and also whether there has been any work done around virtual consultations and any feedback received.

12.5 Gloria Onwubiko responded that work is underway in relation to health inequalities for planned care and a report will be completed by the end of this January 2023 and would be happy to share some of the findings once this work has been completed.

12.6 In terms of virtual consultation and patient experience, surveys were sent out towards the end of 2022. The surveys have now been closed however, the outcomes have not yet been received and this is underway with the Communications Team to pull the outcomes together and that will be presented at the next Outpatients Steering Group. In terms of mitigations, routine traditional appointments will continue to be offered to patients where suitable. Virtual appointments will be offered to patients who have indicated that this is the best way for them.

12.7 Sara Ellis queried what the impact of harm would be on the longest waiting patients and whether that should be cited in the report. Gloria Onwubiko replied that harm reviews are conducted for all long waiting patients and the severity and agreed that this information should be included within the report.

Action : Gloria Onwubiko to provide an update to QPC in April 2023.

Action: Gloria Onwubiko to ensure that abbreviations in the report are made Clearer as requested by the Chair of the meeting.

Following discussion, the Committee:

- Noted the content of the report, the breadth of work underway and the arrangements in place currently to monitor performance improvement and impact and plans to develop this further
- Received assurance on the scale and detail of the improvement plan and the governance in place to monitor its delivery and impact.

13 .0 Minute No. QPC-23-01.13 – Safeguarding Policy – Vanessa Whatley

The report was received as read, the following key points were highlighted:

13.1 The Safeguarding Court of Protection Policy refers to the ICS, however, the vast majority of it affects the work of those in the individualised commissioning team at the ICB and their role in court, should it be required.

13.2 This policy has been received by the System Quality Group who have agreed and approved this policy and is brough to QPC for ratification on behalf of the ICS Board.

Following discussion, the Committee:

- Ratified the Court of Protection Policy that has previously been approved by the Systems Quality Group

14.0 Minute No. QPC-23-01.14 – Update on the Recovery of Shropshire Telford & Wrekin Dementia Diagnostics Rate – Helen White

The report was received as read, a discussion ensued and the following key points were highlighted:

14.1 There has been modest improvement in Dementia Diagnosis in November 2022 however, in December it did decrease due to winter trends.

14.2 695 patients need to go onto the register to hit the achievement of 66 points, 67% is the national target. However, it is anticipated that more patients will need to go on the register because there will be people that have dropped off because of their passing away. It is anticipated that there will be some significant improvement in quarter one and will take approximately six to nine months to recover.

14.3 Telford GPs have been written to requesting details of patients who are on dementia drugs who are not on the register to be reviewed.

14.4 A small number of care home patients who are not diagnosed. An advanced nurse practitioner who will be concentrating on care home assessments and they are triaging 85 plus patients which means that patients will be able to get diagnosed a little bit quicker and have more capacity within the team.

14.5 It has been agreed that a deep dive into assessment and diagnosis will be carried out and will be undertaken by the system Implementation Manager, Linda Vaughan looking at the whole process and working within the system to be able to diagnose people within a timely manner as this is not currently happening.

Following discussion, the Committee:

- Noted the current dementia diagnosis rates and the recovery plan and the actions that will be undertaken in order to achieve the national target and to ensure equity of provision.
- Noted that the deep dive into A&D and transformation programme commences during Q4 of this year

15.0 Minute No. QPC-23-01.15 – Evaluation of Meeting – All

15.1 Meredith Vivian commented that he had received two helpful comments from the last meeting and asked members to email him with any comments regarding the format and content of the meeting.

16.0 Minute No. QPC-23-01.16 - Items for escalation/referral to other Board Committees by: Chair

16.1 Meredith Vivian to highlight to the ICS Board issues around dementia.

17.0 Minute No. QPC-23-01.17 – Any Other Business

17.1 There was no other business to report other than a scoping exercise has been undertaken to see what the best date would be for QPC to be held from April 2023 as the current dates are the same as ICS Board meetings.

Date and Time of Next Meeting

Wednesday 22nd February 2023, 9.00am, via Microsoft Teams.

11:07:41 – Meeting Closed

SIGNED …….. DATE ……

NHS Shropshire, Telford and Wrekin
ICS Quality & Performance Committee Meeting

Wednesday 23rd November 2022 at 9.00am to 11.00am

Via Microsoft Teams

Present:

Meredith Vivian - Chair & Non-Executive Director, NHS Shropshire, Telford, and Wrekin
Alison Bussey – Chief Nursing Officer - NHS Shropshire, Telford and Wrekin
David Lee – Non-Executive Director, SaTH
Jacqueline Small - Non-Executive Director MPFT
Lynn Cawley, Chief Officer, Healthwatch Shropshire
Julie Garside – Director of Planning and Performance, NHS Shropshire Telford and Wrekin
Vanessa Whatley, Deputy Director of Nursing and Quality, NHS Shropshire, Telford and Wrekin
Liz Noakes - Director of Public Heath, Telford & Wrekin Council
Nick White – Chief Medical Officer, NHS Shropshire Telford and Wrekin
Sara Ellis-Anderson - Chief Nurse RJAH
Laura Tyler – Assistant Director Joint Commissioning Shropshire Council and NHS Shropshire, Telford and Wrekin
Liz Lockett –Chief Nurse and Director of Quality & Professional Leadership, MPFT
Claire Horsfield - Deputy Director for Quality & Chief AHP, Shropshire Community Healthcare NHS Trust
Rosi Edwards – Associate NED - SaTH
Barry Parnaby – Chair of Board – Healthwatch Telford and Wrekin

Attendees:

Tracey Slater, Assistant Director of Quality, NHS Shropshire Telford and Wrekin
Sam Cook, Interim Deputy Director of Performance, NHS Shropshire Telford, and Wrekin
Sharon Fletcher, Senior Perinatal Quality Lead and Patient Safety Specialist NHS Shropshire Telford and Wrekin
Fiona Smith - Transformation and Commissioning Partner – Community NHS Shropshire Telford and Wrekin
Gareth Robinson - Director of Delivery & Transformation, NHS Shropshire Telford and Wrekin
Hayley Cavanagh - Interim Senior Quality Lead NHS Shropshire Telford and Wrekin
Cynthia Fearon – Corporate PA, Note Taker, NHS Shropshire Telford, and Wrekin

1.0 Minute No. QPC-22-11.50 – Welcome/Apologies by: Meredith Vivian

1.1 The Chairperson of the Committee - Meredith Vivian welcomed members and attendees to the meeting.

Apologies:

Clair Hobbs – Director of Nursing, Shropshire Community Healthcare NHS Trust
Tina Long – Non-Executive Director, Shropshire Community Health NHS Trust

Apologies were noted as above

2.0 QPC-22-11.51 - Members' Declarations of Interests

There were no declarations or conflicts of interest noted.

3.0 Minute No. QPC-22-11.52 - Minutes of Meeting held on 26thth October 2022

The minutes of the meeting held on 26th October 2022 were reviewed and accepted as an accurate record subject to the following amendment:

Page 5 - System Quality Metrics. Julie Garside requested the sentence that reads "Whilst suicide is one component it is more about how well we are looking after the physical health and physical mental health" the word physical should be removed and should say "***mental health***".

4.0 QPC-22-11.53 Matters Arising and Action Log

Points raised as matter arising with actions have been outlined on the action log.

5.0 Minute No. QPC-22-11.54 - System Quality Risk Register – Vanessa Whatley

Report received as read.

Vanessa Whatley stated that most of the risks that have been listed in the report have now been updated as per the request at the last QPC meeting. Vanessa Whatley stated that there were eight risks detailed in the report.

Julie Garside referred to risk SQG 8 diabetes stating this is the subject of today's deep dive report. Julie Garside stated that an update which will include imaging and imaging reporting delays (risk SQG 7), is scheduled for QPC in January 2023.

Action: Julie Garside to arrange an update on Imaging and Imaging Reporting Delays for the QPC meeting to be held in January 2023.

Meredith Vivian suggested, if possible, to outline overlaying of inequalities on each of the risks in future reporting.

Meredith Vivian requested that all columns for the gaps and controls as far as possible are completed for each of the risks outlined in the report.

Action: Vanessa Whatley to revise the risk register to outline overlaying of inequalities on each of the risks and to complete columns for gaps and controls for each risk where possible.

Following discussion, the Committee:

- Considered and supported the Diabetes risk SQG8 for further escalation following hearing the paper at the next scheduled ICB meeting.
- Supported the decision to de-escalate the IPC risk to the IPS IPC Group risk and issues log.
- Considered other risks for ongoing progress/action.

Vanessa Whatley highlighted that there is a possible additional risk that could be added to the risk register which is the lack of anaesthesia for community dentistry. This was previously mentioned by Ruth Longfellow at a previous QPC meeting. Vanessa Whatley added that the risk is currently within SCHT with the team advising that risks have been mitigated. Any further concerns raised on this subject will be considered as a system risk.

6.0 Minute No. QPC-22-11.55– Performance Exception Report by: Julie Garside

Report received as read.

Julie Garside apologised and stated that the updates in the report had been delayed for the elective care update due to some key information being lost with the migration of Office 365. Julie Garside added that the most up-to-date information will be reported at the next scheduled QPC meeting in January 2023.

Julie Garside highlighted that the system continues to be under considerable pressure as it strives to recover from the disruption and delays caused by the pandemic. Julie Garside added that the report outlines the pressures across several key areas and details the latest risks and mitigation. In addition, where key performance targets are not being met, any agreed recovery trajectories are now being included in the report with progress against key actions; the main risks to delivery being noted. Where possible, any data that has been processed has used the Making Data Count methodology to enable clearer analysis.

Meredith Vivian requested clarification on the 104-week target and whether they have been achieved. Julie Garside stated that the local target had been achieved but not the national target.

Meredith Vivian highlighted that the figures for the 78 weeks were very high and queried what measures are being put in place to reduce the figures. Julie Garside replied that all those involved are tracking and monitoring to reduce those figures significantly. Julie Garside made reference that there is significant risk, especially with the spinal cohort, ongoing continued bed gap and non-elective pressures at Shrewsbury and Telford Hospital with the real solution to that is to ring fence capacity which will be brought on the new PRH elective hub. This is due to be operational by June 2023.

Julie Garside reported that good progress is being made with the Royal Orthopaedic Hospital in Birmingham with the possibility of Shropshire patients being treated there.

Rosi Edwards made reference to page 17 of the report where it outlines SaTH is yet to achieve trajectory. Rosi Edwards stated that it is a collective issue across the system. Rosi Edwards added that SaTH are taking a lot of action, however the challenge is to get patients into the right place once they are medically fit and ready for discharge and this is what needs to be explored as a System.

Liz Noakes queried whether there was any improvement or any further update regarding health inequalities within the community in relation to radiology. Julie Garside stated that there has been some improvement and that the update will be included within the report for the QPC meeting in January 2023. Gareth Robinson stated that there are plans in place for the implementation of a community diagnostic centre which will form a major part of the recovery plan for 2023.

Meredith Vivian queried the FIT test for colorectal and noticed from the report that it had been escalated to Nick White. Nick White stated that there are two elements to this, the first being that it has gone out to FIT test and this is currently going through a procurement process for a new provider with the intention for that to commence in the next financial year. The second element will be about refills and primary care to secondary care around the colorectal wait times.

Laura Tyler made reference to the Children and Young People's LD Pathways and queried the route of escalation for waiting times. Julie Garside stated that the ICB currently have a Planned Care Board, Urgent Care Board, Mental Health and LD Board. Julie Garside added that they do have a Children and Young People Board, however, it has not been made clear how frequently this group currently meets. Julie Garside added that she has had discussions with Sam Cook as they are going to strengthen the community reporting of which the Children and Young People come under.

Deep Dive Update

Julie Garside highlighted that an action from the last Quality and Performance Committee was to provide an update on the Deep Dive. Julie Garside added that an update report had been circulated to the Quality and Performance Committee for this meeting. Julie Garside highlighted that the Quality and Performance Committee have previously expressed a need to fully explore priority performance areas

through a focused programme of 'Deep Dives'. Julie Garside added that the 'Deep Dives' should explore the issues affecting performance, the actions that are being taken to improve performance, progress against those plans and highlighting any risks that remain. Julie Garside added that she had met with Meredith Vivian and Vanessa Whatley to identify a list of priority and specific areas of concern that they consider would assist the Committee in gaining a deeper understanding and assurance of risks and mitigating actions. The agreed proposal is that the 'Deep Dive' is added to the Quality Performance Committee agenda as a standing item and a report is provided with the meeting papers.

Julie Garside stated that the schedule of areas for exploration and the order of priority proposed are as follows:

- Progress of Improvement Plan – report update from UEC – November 2022
- Impact of long waits and risk of harm to patients – report update to be provided from Planned Care, January 2023
- Delays in testing and reporting and the impact on elective and cancer performance – report update to be provided from Diagnostics – January 2023
- Update to be provided from SMI and LD Health Checks on how can higher rates be achieved and spread more evenly throughout the year – report– February 2023.
- Access and patient experience – report update to be provided from Primary Care – March 2023

Meredith Vivian emphasised the reason why those areas have been specifically chosen is that they are areas of concerns throughout the system.

Liz Noakes requested that the report updates highlight any health inequities where possible.

7.0 Minute No. QPC-22-11.56 – System Quality Metrics – Vanessa Whatley

Report received as read.

Liz Noakes stated that she had previously requested that the paragraph on excess death for mental health illness needed to be adjusted. Liz Noakes added that the paragraph is still in the report and needs to be adjusted.

Action: Vanessa Whatley to adjust paragraph on excess deaths for mental illness.

Sara Ellis-Anderson highlighted that the date on the Metrics outlined August and asked if the forecasting could be more recent. Vanessa Whatley stated that it is the most up to date data that is currently available to give the correct position. Liz Lockett added that she has found from her personal experience with MPFT it remains a challenge of marrying up the regional and national data as the availability and timing of the data differs.

David Lee stated in terms of the document control, which he thought was excellent. David Lee requested if that could be put to the end of the document for future reporting. David Lee also requested whether the statistical process control could be highlighted when it goes beyond the control line. Alternatively, some narrative could be added to the report to state that and to explain why it has gone beyond the control line.

Following discussion, the Committee:

- Considered additional assurance required in relation to the metrics

8.0 Minute No. QPC-22-11.57 – Escalation Report – System Quality Group Chairs Report: Meredith Vivian

The report was received as read.

There were no further comments from the Quality Performance Committee.

9.0 Minute No. QPC-22-11.58 – SOAG Update by: Vanessa Whatley

The report was received as read.

Vanessa Whatley highlighted that the 'Exit block' at SaTH and increased workforce resignations remains a risk to the actions taken to improve the UEC flow and processes. Significant UEC pressures were referred to and discussions have been held regarding this challenging area. It was acknowledged that there were numerous actions with system partners co-ordinated through the UEC Board.

Alison Bussey highlighted that Nick White now Co-Chairs together the SOAG with Jess Sokolov which take place on the fourth Wednesday of every month. Nick White informed the Committee that overall SOAG is progressing well.

Following discussion, the Committee: Noted the content of the report

10.0 Minute No. QPC-22-11.59 – Diabetes Redesign Update: Fiona Smith

The paper was received as read.

Fiona Smith highlighted that Diabetes is currently sitting as an extreme risk on the STW Quality and Performance risk register.

A Project Initiation Document (PID) was presented to the Planned Care Board on 3rd November, 2022 requesting that Diabetes is a priority for a System Wide Transformational redesign of Diabetes pathways for 2022/23 which has been approved.

A Business Case was presented to the investment Panel on 21st November, 2022 for the proposal for Shropshire, Telford and Wrekin's Continuous Glucose Monitoring in line with NICE Guidance 17, 18 and 27, which should support the reduction in patients being admitted to hospital with Diabetic Ketoacidosis and Severe Hypoglycaemia as well as supporting patients in managing their glucose levels more effectively and therefore protecting themselves against longer term complications. This proposal was not approved.

Winter Protected Learning Time (PLT) is being used specifically for Diabetes Training for all staff within General Practices as well as a further 22 places made available for more in-depth Diabetes Training for GP's, Pharmacists and Practice Nurses.

Two Weekly Clinical Advisory Group meetings are taking place to map out current pathways and to look at future pathways

Two patient engagement events have recently taken place in Telford and Shrewsbury in collaboration with Diabetes UK to gain an understanding of what patients think and what needs to be improved which is going well.

Despite agreeing to 2 initiatives with transformation monies from NHSE of £110,000, SaTH have been unable to start either project and this is looking unlikely to happen before the end of March 2023.

Currently there are 10 practices in Shropshire not undertaking Low Risk Diabetic Foot Screening as part of the patient's annual review. There is currently a lack of engagement within Primary Care with any of the transformation pathways.

Julie Garside stated that it is positive to get Diabetes as a priority and the Planned Care Board needs to have input from the clinical advisory group to get a project plan in place for Diabetes Transformation. Julie Garside added that there is currently an issue around the financial position in that there is no funding in place in the system for continuous glucose monitoring. Julie Garside

added that she has had discussions with Claire Skidmore regarding funding and this will be discussed with Executive Directors when they meet.

Liz Noakes referred to the lack of primary care engagement and queried whether that was within the Transformation Pathway Group or whether it was part of the broader agenda. Fiona Smith confirmed that it was part of the broader agenda and added that she has a meeting scheduled with Claire Parker and Emma Pyrah to discuss how they move things forward.

Rosi Edwards stated that the glucose monitors have been transformational for patients' lives and have improved their quality of life immensely. Rosi Edwards added that this needs to be continuously supported.

Action : Meredith Vivian requested that Fiona Smith is invited back to a Quality Performance Committee in February 2023 to provide an update on progress on the Diabetes Redesign.

11.0 Minute No. QPC-22-11.60 – UEC Improvement plan: Gareth Robinson

The report was received as read.

Gareth Robinson highlighted from the report that as part of the ongoing aspiration to make improvements to the delivery of Urgent and Emergency Care (UEC) in Shropshire, Telford and Wrekin (STW), the system has developed a refreshed UEC Improvement Plan for 2022/23. The ongoing vision for urgent and emergency care in STW remains to transform services into an improved, simplified and financially sustainable 24 hour/7 day model, delivering the right care, in the right place and at the right time. The local approach has been modelled on the national UEC policies and guidance. Gareth Robinson stated that this report sets out a summary of the programmes of work within and aligned to the UEC Improvement Plan and subsequent programmes of work that have been initiated since its creation. It also sets out the link to improvement metrics and highlights the governance and assurance process in place to oversee progress against the plan.

Gareth Robinson highlighted the three areas from the report:

Ambulance Receiving Area - Recently Implemented on both acute sites with dual management by WMAS and SaTH whilst permanent recruitment of WMAS staff is completed This scheme aims to improve ambulance handover delays Early indications show a positive impact UEC daily operational calls and to be brought into UEC performance reporting cycle.

Next Patient Model - Operational on both acute sites from mid-October. The aim is to create improvements across the whole pathway from ambulance handover delay, waiting times in ED, patient flow and discharge in particular. Early indications show a positive impact on ambulance handover delays. Activity is currently monitored via UEC daily operational calls and to be brought into UEC performance reporting cycle.

System Control Centre - In planning and implementation stage. Gareth Robinson stated that it will go live on: 1 December 2022 and run 365 days a year. The aim is to have a fully co-ordinated and dedicated focus on the management of the whole UEC pathway to manage risk across pre-hospital, in hospital and discharge into the community and to focus on ensuring all the improvement opportunities we are aspiring to are being transacted and the maximum benefit is being gained. Gareth Robinson added, the UEC daily dashboard that has been set up to support this will provide a wide range of data to support performance monitoring. This will feed into the UEC reporting structure once live.

Gareth Robinson also highlighted that the projects currently being worked on need to have clinical input. Gareth Robinson added that performance is a very clear proxy for quality as the quicker patients can be moved through the system, the better outcomes the patient will have. Vanessa Whatley stated that she has been involved in one of the projects - the single point of access and rapid response meeting with WMAS twice daily, there have people from the Quality Team joining those calls while they are established to support decision making. Vanessa Whatley emphasised from those meetings that a lot of patients are going to the ambulance service which could be dealt with in primary or community care. Vanessa Whatley stated that there needs to be a long-term plan to maintain this success as the meetings are a temporary measure.

Vanessa Whatley also stated that she is involved in another project - Leading a Falls Response and Quality Improvement Programme. This addresses non-healthcare functions to reduce falls conveyances to ED. The Fire Service are engaged in providing a response to pick patients up. For market towns, possibly linking with Domiciliary Care to get better referrals into them. Extra funds have come in from NHS England to support that.

Claire Horsfield stated that from a virtual ward perspective, this work is ongoing. Virtual wards sit under the local care transformation programme as one of the projects in it. Claire Horsfield added that there are risks around workforce. There is a lot of work that needs to be done to be able to recruit recurrently into the clinical posts as that is one of the largest obstacles for the business case. As previously reported the business case has been successfully approved by the Investment panel and they now have approval to appoint to substantive posts.

Claire Horsfield stated that they have had issues around digital technology. Shropcom have been able to expedite the on-boarding of Docker Bow.

Claire Horsfield reported that Shropcom now have in place a click system clinical buy in. Claire Horsfield added that Shrop Com tend to have ten to fifteen patients come through their virtual wards and ten hospice beds online. Shropcom intends to get to fifty overall by the beginning December 2022.

Gareth Robinson highlighted the first issue he would like to point out with regard to the virtual ward capacity is predominantly step-up patients as opposed to step down. At this point Gareth Robinson is unclear of the numbers of patients who are putting pressure into the UEC pathway. Gareth Robinson added that they still do not have all the solutions to the issues that Claire Horsfield has mentioned in her update, such as the issues around workforce/recruitment.

Following discussion, the Committee:

- Noted the content of the report, the breadth of work underway and the arrangements in place currently to monitor performance improvement and impact and plans to develop this further. This was achieved.
- Received assurance on the scale and detail of the improvement plan and the governance in place to monitor its delivery and impact. The Committee received this information.
- Considered whether a quality representative should attend the UEC Delivery Board. The Committee agreed that Vanessa Whatley would attend the UEC Delivery Board meetings.

12 .0 Minute No. QPC-22-11.61 – LMNS Update by: Sharon Fletcher

Report received as read.

Sharon Fletcher highlighted that there is more information underpinning the report such as a quality dashboard, risk register oversight, updates on the maternity transformation programme, regional/national reporting against the first and final Ockenden report, the East Kent report actions, the clinical negligence scheme for Trusts and those maternity safety actions.

Sharon Fletcher highlighted the following alerts from the report for the Quality Performance Committee to note:

- The LMNS Equity and Equality Action plans were shared with the Midlands Regional Perinatal Team in October 2022. Feedback was received that there were areas where the action plans required more detail and needed to be more robust prior to resubmission and publication early in 2023. An Action plan is in place and a System Task and Finish Group has

been formed with stakeholders. Progress of the task and finish group will be monitored by the LMNS Board bi-monthly. This will be published early 2023 and the action plans will be tracked by the LMNS programme management team monthly.

- Tobacco Dependency in Pregnancy funding – there is a gap in the funding allocated to this Maternity Transformation workstream and there is on-going work to secure the required funding both nationally and regionally to fully support this workstream for 2023/24.

- The Midwifery teams at SaTH have reported that they have been 'served notice' on several GP premises where antenatal and postnatal care is being provided, therefore restricting access to services for women – there is on-going work by stakeholders within the ICB to understand fully the impact and scope of this issue, and there is a commitment to ensure that there is a robust and accessible service for maternity service in collaboration with Primary Care across the ICS - this will be monitored by the LMNS Board with an update due in January 2023.

Meredith Vivian queried the funding source around Tobacco Dependency in pregnancy. Sharon Fletcher clarified that the funding source comes from NHS England and LMNS. Sharon Fletcher stated that they have identified a gap of £100,000 if they want to continue with the same level of service going into 2024. Sharon Fletcher added that they are now in negotiations with the business manager at SaTH and Public Health to find out how they can deliver that service. Sharon Fletcher is confident that putting a business case together to the ICB and the national team and if successful would reduce the gap. A mapping exercise is currently being undertaken regarding that. Sharon Fletcher stated that she would like to give assurance to the Quality and Performance Committee that there is no current risk to the service.

David Lee stated, that one of things coming out of SaTH about the programme - smoking in pregnancy, is that it could be offered to other services.

Julie Garside stated that she had spoken with Alison Bussey around the performance of maternity and have agreed that Sam Cook will support the LMNS by working on the dashboards and the performance reporting.

The LMNS Board wishes to advise members of the Quality Performance Committee of the below:

- Antenatal Education and Infant Feeding projects are currently underway and there are plans in place for funding to be secured from Telford and Wrekin Start for Life funding.

- LMNS Programme management team staffing update:

    - LMNS Programme manager – to start January 2023
    - LMNS Maternity Commissioner – Started 7th November.

13 .0 Minute No. QPC-22-11.62 – Quality Insight report Update by: Hayley Cavanagh

Report received as read.

Hayley Cavanagh highlighted key points from the report regarding the Clinical Voice (N2N reporting route):

- Feedback regarding discharge related issues is predominant again in Quarter 2 2022/23. Medicines Management Team and Quality Team are continuing to work with SaTH to support with improvements.
- SaTH Service Improvement Team have contacted ICB to request support with working more closely with Care Homes and GPs to work on issues that are impacting on the quality of information on discharge and
- New theme of referral concerns has emerged in Quarter 2.

Patient Voice (complaints/PALS/MP enquiries):

- Quarters 1 and 2 have seen a significant increase in enquiries received from one MP's; Patient Services Team have met with the MP office to explain processes.

Insight Reporting

- Patient Services Team, Communications and Engagement Team, Medicines Management and Quality Team are collaborating to provide a combined Patient & Clinical Voice monthly report to provide commissioners with information about experience of care feedback and emerging themes from a range of sources.

Hayley Cavanagh stated clinical and patient voices continue to be heard and used to identify areas of concern and inform improvements across the system.

Hayley Cavanagh reported that there has been collaboration across various NHS STW teams including, Medicines Management, Primary Care and the Communication and Engagement teams working together with Quality colleagues to improve communication and align systems that capture and learn from both clinical and patient experience of care. The suite of Insight reports continues to develop and are being co-produced across the teams to ensure they continue to meet the needs of this broadening audience.

Alison Bussey stated that this is such an important piece of work and there is considerable work to be done. Alison Bussey emphasised how pleased she was of the progress of work that has been undertaken so far.

Liz Noakes suggested for future reporting that the report has two sections. Firstly, to highlight the issues i.e., the patients experience. Secondly, what has changed for the patient(s) once issues have been addressed.

Vanessa Whatley stated that they have now had their first professionals meeting around the Experience of Care Group. They have had a discussion of what is the key purpose of the Group which is predominantly about oversight of all the national quality guidance. One of the three principles from statutory guidance of measuring is around complaints across the system. An exercise was done around this with a small group as a test. The score was low which was to be expected at this stage in the ICS development. Vanessa Whatley added that there is a plan to do that exercise wider to include people who use the services and to provide an update to the February 2023 Quality and Performance Committee.

Following discussion, the Committee:

- Noted the contents of the report.

14.0 Minute No. QPC-22-11.63 – Healthwatch Shropshire Update (Verbal Update) by: Lynn Cawley

Lynn Cawley stated that she wanted to support the conversation around ensuring that inequalities are the focus of some of the deep dives. The key areas of work by Healthwatch Shropshire and Healthwatch Telford and Wrekin is currently a report which has been drafted about people's experiences of calling for an ambulance in an emergency with about 170 responses. Responses were qualitative, outlining people's experiences. Lynn Cawley did approach Gareth Robinson for a system response following discussion at the October QPC to that report but unfortunately, that has not been possible. Lynn Cawley mentioned that she has been asked to go out to all of the providers individually to get their responses to the report.

Lynn Cawley highlighted that Healthwatch Telford and Wrekin, and Healthwatch Shropshire are always listed towards the end of the agenda to provide their updates. Lynn Cawley added, by then a number of people would have left the meeting.

Action: Alison Bussey, Meredith Vivian and Vanessa Whatley to review agenda so Healthwatch Telford and Wrekin and Healthwatch Shropshire can be put on an earlier slot on the agenda.

Vanessa Whatley suggested if both Healthwatch organisations could present reports as completed to the System Quality Group to ensure time for discussion and then that can escalated to the Quality and Performance Committee.

15.0 Minute No. QPC-22-11.64 – Healthwatch Telford & Wrekin Update (Verbal Update): Barry Parnaby

Barry Parnaby stated that Healthwatch Telford and Wrekin are currently undertaking a survey which involves homeless people. Barry Parnaby added that he will feedback the outcome to the Performance and Quality Committee once they have the outcomes from the survey.

Barry Parnaby reported that Healthwatch Telford and Wrekin are hoping after Christmas to recommence enter and view visits to hospital wards. These have now recommenced in residential care homes.

16.0 Minute No. QPC-22-11.65 - Evaluation of the meeting – All

Meredith Vivian stated that he had received positive feedback from the last meeting. Meredith Vivian added, if anyone wants to feedback on how today's meeting went, to send feedback to Cynthia Fearon.

17.0 Minute No. QPC-22-11.66 - Items for escalation/referral to other Board Committees by: Chair

Escalate the diabetes transformation risk to the ICB.

18.0 Minute No. QPC-22-11.67 – Any Other Business

Meredith Vivian informed the Quality and Performance Committee that - David Lee will be stepping down from SaTH as a Non-Executive Director and will not be attending the Quality and Performance Committee meetings in the New Year. Rosi Edwards will be replacing David Lee on QPC. Meredith Vivian gave special thanks to David Lee for his contributions and time of service on the Quality and Performance Committee.

Alison Bussey stated that they will need to review the dates of the Quality Performance Committee to another day of the week in the new financial year.

Action: Alison Bussey requested a catch-up meeting with her Meredith Vivian, Vanessa Whatley, Julie Garside and Nicola Dymond – regarding the Quality Performance Committee memberships and terms of reference.

Date and Time of Next Meeting

Wednesday 25th January 2023, 9.00am, via Microsoft Teams.

11.09am – Meeting Closed

SIGNED …….. DATE ……

Agenda item ICB 29-03-076.2

Finance Committee Chair's Reports for meetings held on 29 November 2022 and 31 January 2023

NHS Shropshire, Telford and Wrekin
ICS System Finance Committee (Section 2) Meeting
Wednesday 29th November 2022 at 16.00 pm
Via Microsoft Teams

Present:

Name:	**Title:**
Trevor J McMillan OBE (Chair)	Non-Executive Director NHS STW
Claire Skidmore	Chief Finance Officer NHS STW
Helen Troalen	Director of Finance Shrewsbury and Telford Hospitals NHS Trust
Nicola Dymond (part)	Director of Strategy and Integration NHS STW
Michelle Brockway	Telford and Wrekin Council (Deputising for K Clarke)

Attendees:

Gareth Robinson	Director of Delivery and Transformation NHS STW
Laura Claire	Deputy Director of Finance NHS STW

Apologies:

Ken Clarke	S151 Officer Telford and Wrekin Council
Chris Sands	Chief Finance Officer MPFT
Craig MacBeth	Chief Finance Officer RJAH
Sarah Lloyd	Director of Finance Shropshire Community Health NHS Trust
Mark Salisbury	Operational Director of Finance RJAH (Deputising for C Macbeth)
Peter Featherstone	Shropshire Community Heath Finance Committee Chair (NED)
Ben Jay	Assistant Director of Finance (S151 Officer) Shropshire Council (deputising for James Walton)
Glen Head	Head of Financial Management MPFT (deputising for Chris Sands)
James Walton	Chief Finance Officer (S151 Officer) Shropshire Council
Sarfraz Nawaz	Director of Finance and Procurement Corporate Enablers (RJAH)
Kate Owen	Programme Management Office

Minute No. SFC-29.11.001 Introductions and Apologies

1.1 The Chair, **TMcM,** welcomed everyone to the meeting and apologies were received as noted.

Minute No. SFC-29.11.002 Members' Declarations of Interests

2.1 No Declarations of Interest in addition to those already declared were noted. COI forms have been sent out to members of the committee for return to Tracy Eggby-Jones.

Minute No. SFC-29.11.003 Minutes of the Previous Meeting held on 2nd November 2022

3.1 No points of accuracy were noted for the minutes, which were duly signed off as complete.

Minute No. SFC-29.11.004 Matters Arising and Action List from Previous Meeting

4.1 The action list from the previous meeting was reviewed. Item SFC-29-09-006 was agreed to be closed.
CS commented that in response to the two items on risk SFC-28-09-007, an updated risk register would be brought to the next meeting.

Minute No. SFC-29.11.005 Month 7 Position Update – Revenue and Capital

5.1 **CS** wished for it to be captured in the minutes that today's meeting was not quorate. She said that there were no material decisions that needed to be taken, therefore a decision to proceed was made, thus ensuring an opportunity to clarify any messages that should be escalated to the ICS Board.

CS explained that in terms of the month 7 position, the headlines in the pack would not be a surprise to the committee, and that the position has not materially worsened at the current time. She is concerned however that it was not improving. **CS** said that distance from plan on a 'month on month' basis was going to become more extreme now, as there is a much more challenging plan in the latter half of the year with the £11m stretch target phased in months 7 to 12. She noted a significant amount of reported risk and that we have very limited mitigation for this at this point. She said we do now have a national protocol for the amendment of forecasts and in line with that protocol, the reported forecast is held until such time as a reforecast is signed off. **CS** pointed out that Chief Executives and Directors of Finance from the System NHS organisations would be meeting the National Director of Finance, Julian Kelly, and Team on 5th December to discuss the reforecast.

CS said the drivers of the deficit were what are recognised from previous months, pressures around flow through the hospital and discharge. These are manifesting in the ICB position around the costs of discharge into the community and the work being done with LA colleagues, and also manifesting within SATH given the level of escalation beds that are open, and the premium cost of agency staff. She said we can see in our performance figures that we are not reducing our 'no right to reside' numbers in the beds, and length of stay is still very long.

CS mentioned the overspend in independent sector activity around ophthalmology which was discussed in the Part 1 meeting. **CS** told the committee that they had exhausted all efforts at the moment, to reduce that expenditure and that any change now would be driven by a change to patient choice rules which is unlikely. This is a topic which will be flagged at the meeting on 5th December.

CS explained that we are seeing significant pressures in CHC costs, given some of the market forces and the inflation pressures they are seeing. We have released significant amounts out of the balance sheet for the ICB to cover those in year, albeit this does not support the underlying position, **CS** also reminded the committee that there are no plans in place that will deliver the £11m stretch savings target in year. **CS** felt that as a system we have not given up, and we are not saying we are never going to deliver those savings however, we have to be realistic about what we can physically land and achieve in this financial year. **CS** explained that **GR** and the operational teams within each of the partner organisations are working hard on what that profile looks like heading into next year. She said they had also started to look at their efficiency programs internally for next year, which she hoped would give some assurance to the committee that they had not stopped working in that area.

CS mentioned the underlying position and that finance teams are working on mapping that as we prepare for planning for next year. She commented that there are some parts where she believes we have seen a deterioration in that position and that more information will be brought to future meetings to enable greater understanding of the position.

TMcM asked if anyone had any questions on the Month 7 position.

HT referred to a spreadsheet and information that she had received, based on the work around pursuing the £11m of savings. Given what she had seen, **HT** noted that we need to make sure that we are putting effort into the right areas to stand the most chance of reducing costs. For example, she felt that if efforts were concentrated on hospital discharge and getting that into a different place, we may actually save more than the £11m.

TMcM asked **GR** to provide a response to the points raised by **HT**. **GR** noted the point about effective prioritisation, he said we have worked through operational leads and the Chief Execs to agree this approach. Recognising what **HT** had said, **GR** thought that the decision was taken that we have these key priorities that are sat with all organisations at the moment around flow, around elective recovery, and around financial improvement. He said it was quite clear that the focus on the financial improvement is not as great as it is with those other areas and the issuing of that information was very much around raising the profile and raising the direction for the Operational Leads to commit their time to this with the support of their Chief Executive. The plan being to work with those leads, to ask 'what do you need to let go to allow that to happen'?

GR said that might be different for other organisations, but we are putting this on the desk of people that are already very busy, and asking the individual organisations to manage that, because this is something we all signed up to at the start of the year. **GR** suggested to have that first discussion, to understand who is going to lead it, what it is going to take, and can it be delivered? **GR** pointed out that we need to have that first 'turn of the handle' to work out whether it is possible or not and if there is an opportunity cost to that resource.

HT also commented on preparedness for developing the plan for future years. **CS** noted that there are a number of work streams which are not part of the delegated committee structure but feed through to it, for example the Planning Working Group and the Intelligent Fixed Payment Group, which is a subcommittee of this committee, with very close links into the Directors of Finance. **HT** said that she had raised the point for the benefit of Finance Committee to demonstrate that governance is in place. She said that it was about making sure that on record we are all aligned with the discipline of doing that. **CS** thanked **HT** for raising that point.

TMcM asked how did the subcommittees of this committee, report to this committee. He said that at this committee they had not had sight of minutes from those committees.

CS told the committee that we had an IFP paper last month, and a Capital paper will come in January. She said that there is a rolling cycle of updates from those sub committees planned into the committee timetable. The third sub committee is the Finance Staff Development Committee and as that gets off the ground, the Terms of Reference will be presented to this meeting for sign off.

TMcM asked if there was anything further to highlight in the paper. **CS** wished to point out the conversation that had been held in the Part 1 meeting, particularly around discharge and the request they had been sent to the Integrated Delivery Committee to provide the committee with assurance around the work that's happening to review the Better Care Fund. She said from a Finance Committee point of view, we are interested in how the numbers build into the finance model for next year and beyond. The Integrated Delivery Committee will be interested in the programme of work and what is going to be delivered.

CS said that from this committees' point of view we must continue to seek assurances that our teams are doing everything that we can to manage the forecast outturn. She expected the conversation with Julian Kelly on 5th December to be challenging and that she thought Julian would be pushing us all to see what more we can do by the end of the year. She said she realised that this was tough given that we are in winter and there is not long left until the end of March, but we need to be prepared for that.

TMcM asked if there would be a crib sheet for Monday and if it could be shared with committee members. **CS** agreed to share the briefing pack with committee members.

Action: Briefing pack for Meeting with NHSE Regional and National Teams (5th December) to be shared with committee members. **(CS)**

Minute No. SFC-29.11.006 23/24 Plan Paper – Finance Plan Update

6.1 **CS** noted that the document provided was one that all partner organisations could take into their own organisations and use if they want to. This would enable consistency of messaging and avoid duplication of effort to write similar reports. She said that the paper was written so that people can take away and provide some assurance that we have a process in place to produce our planning information, particularly around our financial work. She felt it important to also point out that we do not do financial planning in isolation.

CS said that what we know so far about the funding settlement for next year is that it is probably better than we could have expected, but by no means does it go a long way at all to address the funding issues in Shropshire, Telford and Wrekin. She also noted that there were a lot of aspects of work that need to be completed to have a full suite of planning information ready for review, not just the mechanics of building the finance model, but also running our work on the intelligent fixed payment mechanics etc. As noted in the report, this is all underway.

CS said this paper also takes the opportunity to seek agreement from our NHS partners to both reconfirm the overarching financial principles that we adopted previously as a system, which she felt still stand and hold firm and true and, also to confirm the core financial planning principles that we want to maintain throughout the work that we are doing. She said it was really important, that this committee, endorses those principles, and also that our colleagues have the opportunity to go back into their organisations and make sure that that endorsement prevails through there as well. **CS** wished for this action to be captured in the minutes at the next meeting.

HT said that she had already taken the paper to her Finance Committee as it had met the day before. She noted that support for the principles was given and that her committee were particularly interested in the development of the IFP arrangements. (It has been flagged last year that we expected a maturation of approach over time). The committee had also asked for future updates on discharge, BCF etc, in order, to better understand the wider context of hospital flow issues. **HT** said that the Finance Committee will want to see that as a key planning component of 23/24.

HT noted that one of the committee NEDs had brought to her attention that under the EQIA section of the planning report the regulation and legal section and the Environmental Impact section, said 'no impact'. She suggested that in this context this was correct given that the paper describes a plan for a plan which **CS** agreed with but when presenting the plan itself, it was noted that we will need further detail in those sections as a there may be impacts on those areas in driving a compliant financial plan.

HT concluded that her committee were happy to recommit to the six principles that we set out last year and the Financial Planning principles.

Action: DoFs to present the Financial Planning paper to their respective Finance Committees (or equivalent) to gain explicit sign off for the overarching principles and core financial principles. Note that ICB support is through agreement at this committee and that SaTH have provided support as minuted above.

Minute No. SFC-29.11.007 NOF4 exit Criteria Action Plan – Finance Elements

7.1 **ND** reminded the committee that as part of being an ICS in SOF Level 4, we have been required to develop an improvement plan to show how we move forward against a range of identified issues and concerns, She said that in order to help us build that improvement plan, we have broken that down into a number of areas for which we have constructed a plan on a page with some key metrics and deliverables, and risks noted. She noted that finance in itself, does have its own plan on a page, for a number of criteria and these are being cross

referenced with other aspects of the overall improvement plan. **ND** pointed out that nothing is taken in isolation in the overall document, but in terms of our governance it seemed relevant that the Finance Committee should receive and review the plan on a page that's been developed as part of the exit criteria for finance.

LC described the exit criteria, noting that a refresh and development of a finance strategy is a core area of focus. The plan describes developing the plan for the new financial year as well as a 5+ year Medium Term Financial Plan and an overall financial strategy that will dovetail into the work that **ND's** team are doing on strategy. She explained that this also links into the planning paper that they discussed earlier. **LC** said that the finance team have a work plan for modelling, strategy, and projects such as development of budgets at place level. The NOF4 exit plan, is a reflection, of that plan.

TMcM asked if the committee had any questions regarding **LC** comments.

HT raised a number of points, firstly regarding the exit criteria which puts the development of the 23/24 plan ahead of the development of the five year plan, which is not traditionally the way things are carried out, she said she did not think we would get a 23/24 plan agreed without it being in the context of a 5-year recovery trajectory. **HT** also noted that there was limited detail on how the 5-year financial strategy underpins the 5-year system improvement plan. Also, reflecting on the risk noted about availability of activity and workforce data, she was unsure as to why this was flagged as a risk and suggested that the risk was more around the capacity to turn the data into an underlying model rather than availability.

CS said disaggregation of the 1-year and 5-year models was not intended in the format and agreed that next year's plan would be in the context of it being year 1 of multiple years. The intention remains to build one model and then take the parts we need depending on what we are reporting. **CS** hoped that this provided assurance that this was not suggesting they were running separate process. **HT** felt that it should be presented like that, rather than it looking sequential. **CS** agreed to revisit the presentation in the plan.

CS picked up **HT's** second point about development of the strategy itself and noted all the other moving parts that are sat in multiple pages beyond the finance ones. **ND** and Julie Garside had discussed this with some of the ICB Execs that morning, and said that once the pack is complete, it will be shared in its entirety so that the committee would be able to see it.

CS referred to **HT's** third point about whole time equivalent and activity information and agreed with **HT**. there is a concern that people spend a lot of time on getting everything else ready and then leave finance a small amount of time to assimilate all of the information into the finance model. **CS** said she would look to re-word the entry to say, 'late availability of data' rather than saying 'late or no availability'.

TMcM noted that he thought the document reads like a governance document rather than a 'this is what we are going do to get ourselves out of this mess' document. **ND** agreed that it does as we do need to demonstrate metrics and plans against the criteria we have been given to Exit NOF4. This allows system oversight of what we are doing though is not intended to replace our strategic, operational and programme plans.

TMcM flagged a concern regarding language used in the document saying that wording such as 'works to' or 'work towards', suggested a lack of confidence in delivery. **CS** and **ND** agreed that this was a good point. **CS** noted that for the two areas where this language had been used, there were challenges in developing a finance timeline as we are reliant on development of other aspects of the overall work programme from which to build the finance. This will be refined and firmed up as plans develop.

Action: **CS/LC** to update finance elements of the NOF4 plan on a page to reflect discussion at the November Finance Committee**. (CS/LC)**

Action: **ND** to share the full NOF4 document with committee members once complete. **(ND)**

Minute No. SFC-29.11.008 ANY OTHER BUSINESS

8.1 **TMcM** asked if there was any other business. **HT** said that they had had a brief conversation in their Finance Committee about NED attendance from SaTH on this committee, and they would like to know what the time commitment would be. It was agreed that this would be one hour to attend the meeting plus time to prepare for the meeting.

Date and Time of Next Meeting

TO BE CONFIRMED

NHS Shropshire, Telford and Wrekin
ICB Finance Committee (Section 1) Meeting
Tuesday 31st January 2023 at 9.00am
Via Microsoft Teams

Present:

Name	**Title**
Trevor J McMillan (Chair)	Non-Executive Director NHS STW
Claire Skidmore	Chief Finance Officer NHS STW
Nicola Dymond	Director of Strategy and Transformation NHS STW

Attendees:

Gareth Robinson	Director of Delivery and Transformation NHS STW
Laura Clare	Deputy Director of Finance NHS STW

Apologies:

Minute Taker:

Cynthia Fearon	PA to Claire Skidmore

Minute No. SFC-23-01.001 – Introduction and Apologies

1.1 The Chair, **TMcM**, welcomed everyone to the meeting and **CS** confirmed that no apologies had been received.

Minute No. SFC-23-01.002 – Declarations of Interests

2.1 No declarations of interest were noted.

Minute No. SFC-23-01.003 – Minutes from the Previous Meeting held on: 2nd November 2022.

3.1 **TMcM** asked if there were any points raised within the minutes of the previous meeting. There being no amendments, the minutes were taken as a true and accurate record.

Minute No. SFC-23-01.004 Matters Arising and Action List from Previous Meetings

4.1 **TMcM** referred to the action list from the previous meeting:

With reference to the closed action FC-29.11.005 outlined on the action log. **GR** stated, that there are two planned workshops in February 2023. One with the Local Authorities and the other with SATH and SCHT. **GR** added that after both of those sessions, they hope to have in principle – an arrangement for delivering the overall services within the BCF and agreement of any extended funding within the BCF envelope, plus a timeline for the programme of work. **GR** emphasised that this will remain a high risk, as it will be challenging to deliver this programme of work.

Minute No. SFC-23-01.005 – Month 9 Position Update – Revenue and Capital

Report received as read.

5.1 **LC** highlighted from the report, that the year-to-date position for month 9 for the ICB, including the system and stretch target position was a deficit of £16.2 million. Which is £13.6 million adverse variance to the plan. Of which £6.6 million deficit is for the ICB and £7 million deficit is for the System.

LC stated at Month 9 the ICB planned surplus for the year is £2.2m and the current reported FOT position is a surplus of £1.2m i.e. a £1.0m adverse variance. These values include assumed delivery of the £13.9m stretch target included for the System. The forecast has been produced at a category level based on expenditure run rates and known mitigations. Assumptions around additional mitigations remain included though until there is an agreed and signed off action plan, these mitigations remain reported as very high risk.

LC added there were a number of operational pressures that were impacting on our system and the financial impact of these is manifesting in the expenditure run rate. **LC** emphasised since September 2022 the system has been in regular dialogue with NHSE colleagues regarding the projected forecast based on run rate and known mitigations. A number of meetings have taken place with Julian Kelly. It is expected that a change to the forecast outturn position will be agreed and enacted at Month 10, using the recently issued FOT change protocol.

LC highlighted from the paper the small number of key drivers of increased expenditure for the ICB and actions are being taken to mitigate the impact of these.

Regarding the underlying position, **LC** stated that the 22/23 financial position has also been supported in year by a significant amount of non-recurrent prior year benefits and balance sheet flexibility. **LC** added as part of the work to develop the 23/24 plan the underlying position is being tested and confirmed but the current working draft underlying position for the ICB is a £43.6m underlying deficit. That position will form the start point of the 23/24 financial plan.

CS stated, that we have been relatively consistent in our forecast for the last few months. However, the forecast masks that each month when we come to look at the position, we have to work harder each time to hit the position as unexpected pressures emerge, for example with prescribing. **CS** added that budget managers are encouraged to work closely with Business Managers to look at what they have been spending over the past few months, to ensure that they land the number that has been agreed.

CS mentioned that she was due to have a meeting with Julian Kelly this Friday, 3rd February 2023 to review the position to date.
TMcM reflected on the past year and the delay in coming up with transformation projects which has impacted greatly on the current financial position. **GR** added, that there were things that could have also been done differently as an ICB Board to keep more of a grip on things. Which goes back to recent discussions about how we operate as a system and get more traction from system partners.

CS mentioned the social care fund and explained that the money previously allocated is being used to support discharge costs. She added that there is now another second round of money to become available. A further £1.7 million is available to the system to support specific schemes to help with flow.

TMcM made reference to spend with the two Local Authorities – the paper referred to enablement costs - and queried whether that was an unexpected cost. **LC** clarified that the figures are expected and now align in phasing to how the councils are spending. **LC** added that we have recently been sent an invoice for £4.4 million which is added to the working capital that is showing in this report. **LC** gave assurances that the figures presented were illustrating cash flow and not highlighting any unexpected costs.

The System Finance Committee are asked to note the following recommendations:

- The year-to-date deficit for the ICB of £16.2m, £13.6m adverse to the ICB plan (£6.6m ICB and £7.0m system).
- The reported forecast surplus for the ICB of £1.2m (being £1m adverse to the ICB plan).
- A gross risk of £26.7m for the year (£12.8m ICB and £13.9m system) on top of the current deficit and that so far, only £2.0m of potential mitigations (£2.0m ICB and £0.0m system) have been identified to address that risk if it were to materialise.
- The exercise underway with NHSE to scrutinise and challenge the forecast position in order to produce a revised forecast position in line with the NHSE protocol for amending forecasts.

Minute No. SFC-23-01.006 – Finance Plan 23/24 (Revenue and Capital) Updates Preparation

Report received as read.

LC stated the first draft of the 23/24 financial plan is due to be submitted nationally on 23rd February 2023 with a final version signed off by Boards by the end of March 2023.

LC highlighted from the report that in line with the internal planning timetable, all organisations have submitted a first working cut of plans to be collated at system level. **LC** added that these plans are now being worked through to test assumptions, review cost pressure and investment requests, ensure efficiency and transformation plans are worked up and included and to triangulate with activity and workforce plans across the system. The report allows the finance committee to see the key information received through the planning guidance, the first cut of the ICB plan numbers and the next steps that are being worked through.

LC stated that Claire Skidmore and Simon Whitehouse are planning to meet with all ICB Executive Directors and Deputies to review budgets for each directorate within the STW ICB.

LC mentioned in 2021/22 the overall spend position within the ICB and across the system was stabilised. However, in 2022/23 the underlying position has deteriorated, as per recent discussions in this meeting. That position has now become the start point for the 2023/24 plan. **LC** added that the team are currently going through all the figures to ensure all the assumptions are sound. **LC** highlighted that at the moment the opening underlying deficit is £43.6 million for the ICB.

Regarding the draft allocations**, LC** clarified that programme allocations have increased by 4.3%. Which benchmarks high when compared to other ICBs across the country. **LC** highlighted that the ICB will also be receiving £49.8 million from NHSE for pharmacy, optometry, and dentistry. The finance team are currently working with NHSE with all the plans regarding that.

LC made reference to the Efficiency Plan, which has been provided by Kate Owen which shows a figure of £7.9 million of current identified schemes. They are at varying levels of confidence and are 'RAG' rated accordingly on the table presented in the report. **LC** stated, that equates to roughly 1.6% of the underlying expenditure. **LC** added, that after a discussion at the DoF meeting this week it has been agreed that 2.2% will be applied as the generic 'business as usual' efficiency target for each organisation. Kate Owen is working with ICB teams on actions to bridge the gap.

CS explained that there are two parts that make up the overall efficiency percentage. One which is 'business as usual' where we record work managed by individual organisations and the other is the transformation programme (where multiple organisations contribute or realise an impact) . **CS** stated that there needs to be a clear description of the total amount that is generated by those two programmes.

LC made reference to the table in the report that outlines cost savings and investments identified from an ICB perspective. Which highlights what has been identified as currently happening and is unavoidable. as well as areas where decisions need to be made for the financial plan.

Regarding elective recovery, and the contractual mechanisms for next year. **LC** stated that she was expecting the guidance and targets this week. **LC** highlighted, for 2023/24 there is an absolute clear steer from the national team – that all elective activity will be paid on a cost and volume basis and providers will be reimbursed in full for the elective activity that they deliver. The contract issued will be based on a API basis, which means the contract will be based on previous years activity with various uplifts. **LC** added that payments to providers will be paid on the basis of activity delivery and the ICB can claw back monies accordingly if they don't deliver in line with the contract. Those monies can then be used to buy activity from other providers that are able to deliver in order to meet the overall recovery target.

LC highlighted that the contractual mechanisms for next year (2023/24) need to be reviewed as these are not aligned to the current mechanism. LC stated that an IFP Management Group meeting took place last week to review that. It was agreed at the meeting to explore management of contracts via the API route.

Action: CS and GR to have a further conversation around teams and back-office function outside of this meeting.

TMcM queried what baseline is used for the elective recovery, in terms of the underpinning waiting times and underlying performance on delivery. **CS** stated that the teams look at what was budgeted for last year, they look at what was outturned for last year and then build in any assumptions around growth/new investments. **CS** added, they also look at any changes to services. **LC** added that for the elective recovery work, our system have a trajectory given to deliver 103% of activity when compared to 2019/20 as a baseline.

TMcM queried what was currently being undertaken to improve data collection and sharing. **ND** stated that the BI team are currently pulling together a piece of work around capability and capacity for BI. **ND** added that Rebecca Gallimore has been very instrumental in undertaking the mapping exercise for that piece of work.

Regarding the joint forward plan, **LC** mentioned, that there will be a five-year strategic plan that will be underpinned with a financial recovery programme for five years. **LC** added that Kate Owen and Jan Heath from the PMO team will be attending this week's System Finance Group meeting, to give an update on the 2023/24 Efficiency and Transformation Programme and provide an update on what the forward financial plan looks like.

The System Finance Committee were asked to note the following recommendations:

- The summary information from the 23/24 planning guidance
- The initial first cut of financial plan numbers for the ICB and the significant amount of work underway over the next few weeks to refine the position to be submitted.
- The discussion to take place at the IFP Management Group following the latest elective Recovery and contracting guidance and to discuss options moving forward.
- The work underway to develop the Joint Forward Plan and in particular the financial elements including a five-year financial plan model and financial strategy document.

Minute No. SFC-23-01.007 – Finance Risk Register/BAF review

LC gave a verbal update on progress with the development of the risk register and Board Assurance Framework (BAF). She mentioned that a workshop was held with system DoFs on 5th December 2022 - to shape the risk profiles for going forward. **LC** added that there have also been two workshops for the ICS, facilitated by the Good Governance Institute. These were to provide support to develop the BAF and the risk registers that sit below the BAF. **LC**

explained that a paper has been put together based on the suggested formats for the BAF and risk register and will be presented at section two of the System Finance Committee scheduled at 3.00pm this afternoon. The information in that paper will also be presented to the ICB Board meeting scheduled in March 2023.

Minute No. SFC-23-01.008 – Any Other Business

There was no other business for discussion.

Meeting closed at 10.03am

Date And Time Of Next Meeting

Wednesday 8th March 2023 at 14.00 – 15.00 via Teams.

NHS Shropshire, Telford and Wrekin
ICS System Finance Committee (Section 2) Meeting
Tuesday 31st January 2023 at 15.00 pm
Via Microsoft Teams

Present:

Name:	**Title:**
Trevor J McMillan OBE (Chair)	Non-Executive Director NHS STW
Claire Skidmore	Chief Finance Officer NHS STW
Helen Troalen (Part)	Director of Finance Shrewsbury and Telford Hospitals NHS Trust
Nicola Dymond	Director of Strategy and Integration NHS STW
Sarah Lloyd	Director of Finance Shropshire Community Health NHS Trust
Sarfraz Nawaz	Non-Executive – RJAH
Chris Sands	Chief Finance Officer MPFT
Craig McBeth	Chief Finance Officer RJAH
Richard Peach	Group Accountant, Telford and Wrekin Council

Attendees:

Laura Clare	Deputy Director of Finance NHS STW
Cynthia Fearon	Corporate PA NHS STW **(Note Taker)**

Apologies:

Ken Clarke	S151 Officer Telford and Wrekin Council
Michelle Brockwell	Telford and Wrekin Council (Deputising for K Clarke)
Gareth Robinson	Director of Delivery and Transformation NHS STW
Peter Featherstone	Shropshire Community Heath Finance Committee Chair (NED)

Minute No. SFC-23-01.001 Introductions and Apologies

1.1 The Chair, **TMcM,** welcomed everyone to the meeting and apologies were received as noted.

Minute No. SFC-23-01.002 Members' Declarations of Interests

2.1 No Declarations of Interest in addition to those already declared were noted.

Minute No. SFC-23.01.003 Minutes of the Previous Meeting held on: 29th November 2022

3.1 For point of accuracy Sarfraz Nawaz stated that on the minutes he is down as Director of Finance and Procurement Corporate Enablers (RJAH). That is correct as that is his role for his day job. However, Sarfraz Nawaz clarified that he attends this meeting in the capacity of Non-Executive for RJAH.

Noting the above amendment, the minutes were agreed as an accurate record of the meeting.

Minute No. SFC-23.01.004 Matters Arising and Action List from Previous Meeting

4.1 The action list from the previous meeting was reviewed and updated accordingly.

Minute No. SFC-23.01.005 Month 9 Position Update – Financial position Revenue and Capital

5.1 **Report received as read.**

CS highlighted from the report that The System holds a £19m deficit plan for 2022/23 and carries a significant underlying deficit.

CS mentioned that a number of operational pressures are impacting on the system and the financial impact of these is specifically within the expenditure run rate. **CS** highlighted that there is a gross risk of £76.2 million with only £31.1 million mitigation identified. **CS** added that she has been in regular dialogue with NHSE colleagues regarding the projected forecast based on run rate and known mitigations. **CS** will be meeting with Julian Kelly – national NHS Director of Finance in early February 2023, the meeting will also include Simon Whitehouse. From that meeting, **CS** is hoping to get the go ahead to update the forecast for month 10 (or potentially for month 11).

Action: CS to give an update of the outcome from meeting (scheduled early February 2023) with Julian Kelly at the next scheduled meeting.

CS stated that she has also been having weekly meetings with DoFs, not only to discuss how they model the cost base as we plan for next year, but also to discuss cost out, whether that is based on efficiency, transformation, or any other action. **CMcB** added that we are now in receipt of the activity baseline requirements for 23/24 planning. As a system, we need to achieve 103% activity (ie target to do more than the 2019/20 baseline) , which will trigger eligibility for elective recovery fund monies. **TMcM** queried as system if we were near the 103% target. **CS** replied that there still needs a lot more work to be done in the upcoming weeks across the system to give a realistic position.

CS stated that the key drivers continue to be:

- Increases to agency/bank expenditure driven by open escalation areas, staff sickness, extremely high levels of NRTR (No Right to Reside) patients and lack of discharge capacity.
- Expenditure with Local Authorities on additional discharge support earlier in the year. Non-recurrent Social Care Funding is now in place for the remainder of the year.
- Increases to independent sector ophthalmology activity driven through patient choice and long waiting times at our main provider.
- Increases in capital charges due to the need for capital improvements to support service improvement. Relative to other systems, this is a large sum for STW ICS.
- Increased package prices in Individual Commissioning due to inflationary pressures.
- Prescribing- inflationary pressures in Cat M and NCSO pricing.
- Lack of delivery of the system stretch efficiency target.

The System Finance Committee noted the following:

- The year-to-date deficit for the system of £49.8m (being £28.8m adverse to the plan).
- The current forecast deficit for the system of £23.2m (being £4.1m adverse to the plan).
- A gross risk of £76.2m for the year on top of the current deficit and that so far, only £31.1m of potential mitigations have been identified to address that risk if it were to materialise.
- The exercise underway with NHSE to scrutinise and challenge the forecast position in order to produce a revised forecast position in line with the new NHSE protocol around amending forecasts. The forecast is likely to be amended at month 10.

Minute No. SFC-23-01.006 Plan Paper – Finance Plan Update

Report received as read.

6.1 **LC** highlighted from the report that the first cut of the STW plan shows a pre- efficiency system deficit for 23/24 of £146.2m. (Currently a £125.1m deficit including efficiency plans). It would therefore require an overall 14% efficiency delivery to achieve a break-even plan position. This is impossible to deliver in one year and therefore LC noted that it is important that a longer-term financial recovery plan is developed to show the trajectory to return to financial balance (both in year and in underlying terms) over multiple years.

Regarding the underlying position **LC** highlighted from the report that the recurrent element of the 22/23 plan submitted to NHSE demonstrated a recurrent deficit of £61m. In the 22/23 plan this was then addressed with some non-recurrent measures to submit a planned deficit for the year of £19m. **LC** added at M9 the risk adjusted forecast for the system based on run rate is a £65.9m deficit but this is after the use of a number of non-recurrent measures and balance sheet flexibility which, once these are removed, takes the overall underlying position for 22/23 to a £89m deficit

LC highlighted that as a system we will receive an overall increase of 4.3% to the core programme allocation (including COVID and ERF allocations but not SDF). This is the third highest allocation increase in the country. LC highlighted that there will also be £49.8m of new ringfenced allocation for Pharmacy, Optometry and Dentistry (POD), 2023/24 will be the first year that the ICB will be responsible for commissioning these services as it transfers from NHSE and therefore financial planning for this area will be done in conjunction with NHSE.

Regarding tariff uplifts **LC** mentioned that the team have now applied uplifts to contracts as per the tariff guidance which has been consulted on and responded to last week. **LC** also added in terms of efficiency there is currently 2.2% delivery assumption built into the plan.

TMcM queried whether there were sufficient monies budgeted for Dentistry and Pharmacy. **LC** replied that at the moment we have assurances from NHSE that monies budgeted for Dentistry and pharmacy are sufficient but we will continue with our due diligence.

CMcB stated that investments which have been caught up in the triple lock for some time need to be captured in the plan figures.

CS made reference to the escalation cost in SATH and emphasised that any tail end of escalation capacity that is open at the end of March will not be switched off on the 31st March 2023 therefore costs will need to be built into the 23/24 plan to represent a view of capacity that will be required through the year. CS also added that there is still a lot of work that needs to be done to get to an underlying stable position and it will take more than one year to achieve that.

SL made reference to the paper that came to the previous meeting, as she was unable to attend. **SL** stated that she took that paper to SCHT finance committee at which the general principles of the report were supported. However, there was a comment in terms of the expression used to describe the 'left shift.' The paper noted "There will be a change in expenditure patterns over a length of time". However, there was a very strong view that was not ambitious enough. **SL** stated that we need to be more aggressive about that movement. Which should be highlighted in shift in resource (when we do things and how we do things).

SL mentioned the new contracting arrangements and noted concern about non-elective services not being prioritised since Covid and the growth in these waiting lists. **SL** emphasised that this needs to be flagged as a priority to ensure all those areas are targeted for investment where required.

CMcB stated, that he also took the planning paper to RJAH's Finance Committee in November

2022. **CMcB** added that RJAH's Finance Committee accepted the principles of the report. However, recognise that things have moved on considerably since then. So, the planning paper will need to be re-visited.

CHS stated a lot of the issues with planning that **CS** and **LC** are currently experiencing are the same experiences
they are also having in Staffordshire. **CHS** added that he is happy to put both **CS** and **LC** in contact with the Staffordshire ICB team. So that some work can be undertaken across both systems regarding benchmarking of inflation and growth rates etc.

Action: CS and LC to follow-up with Staffordshire ICB team to benchmark planning assumptions.

The System Finance Committee noted the following:

- The summary information from the 23/24 planning guidance
- The initial first cut of financial plan numbers for the system and the significant amount of work underway over the next few weeks to refine the position to be submitted.
- The discussion to take place at the IFP Management Group following the latest elective recovery and contracting guidance and to discuss options moving forward.
- The work underway to develop the Joint Forward Plan and in particular the financial elements including a five-year financial plan model and financial strategy document.

Minute No. SFC-23.01.007 Capital Prioritisation and Oversight Group (CPOG) Update

Report received as read.

7.1 **CS** stated the Capital Prioritisation and Oversight Group (CPOG) has been established as a sub-committee of the Finance Committee to monitor the system capital programme against the capital envelope, gain assurance that the estates and digital plans are built into system financial plans and to ensure effective oversight of future prioritisation and capital funding bids.

CS clarified that the focus of the meeting on 12th December 2022 was to take a first look at the draft system capital plan for 2023/24. The draft plan for 'business as usual' capital has an overcommitment of £0.97m but this is in line with national guidance (a plan for 105% spend is allowable as it is common for projects to slip in-year).

The System Finance Committee noted the following:

- The work of the Capital Prioritisation and Oversight Group to model the initial draft 2023/24 capital plan and to clarify the revenue consequences of national capital programmes.

Minute No. SFC-23.01.008 Finance Risk Register/BAF review

Report received as read.

8.1 **LC** mentioned that during November 2022 two facilitated system workshops were held with the Good Governance Institute in order to develop the overall STW system Board Assurance Framework, system risk appetite and risk management policy from which draft information was issued in January 2023. In order to make sure that the risks discussed by the Directors of Finance are aligned with the emerging framework further work is now required.

LC highlighted that the proposals for the system BAF, risk appetite and risk management policy are in draft form and are currently being discussed across the system. **LC** added that an operational risk register will also be updated to underpin the strategic finance risk on the BAF.

LC requested that SFC members feed back to her directly on the draft entries tabled. Information will be collated, brought back to the next scheduled SFC for ratification and then presented at the Board meeting in March 2023.

Action: SFC members to feedback to LC comments to help the construction of the risk register entries for finance.

The System Finance Committee noted the following:

- The work that has been done across the system with the Good Governance Institute to produce a proposed risk appetite, policy and Board Assurance Framework
- The next steps in place to take feedback on proposals and finalise a proposal for Board by the end of March for use in 23/24.
- Note and discuss the draft template for the strategic finance risk for the BAF and feedback on format, content and scoring.
- That an operational risk register will also be updated to underpin the strategic finance risk on the BAF.

Minute No. SFC-23.01.009 Any Other Business

9.1 There was nothing noted under this agenda item.

Date and Time of Next Meeting

To be confirmed.

NHS Shropshire, Telford and Wrekin
ICB Finance Committee (Section 1) Meeting
Wednesday 29th November 2022 at 14.00 pm
Via Microsoft Teams

Present:

Name	**Title**
Trevor J McMillan (Chair)	Non-Executive Director NHS STW
Claire Skidmore	Chief Finance Officer NHS STW
Nicola Dymond	Director of Strategy and Transformation NHS STW

Attendees:

Gareth Robinson	Director of Delivery and Transformation NHS STW
Laura Clare	Deputy Director of Finance NHS STW

Apologies:

Minute Taker:

Sally-Anne Smith	PA to Claire Skidmore

Minute No. FC-29.11.001 – Introduction and Apologies

1.1 The Chair, **TMcM**, welcomed everyone to the meeting and **CS** confirmed that no apologies had been received.

Minute No. FC-29.11.002 – Declarations of Interests

2.1 No declarations of interest were noted.

Minute No. FC-29.11.003 – Minutes from the Previous Meeting held on 2nd November 2022

3.1 **TMcM** asked if there were any points raised within the minutes of the previous meeting. There being no amendments, the minutes were taken as a true and accurate record.

Minute No. FC-29.11.004 – Matters Arising and Action List from Previous Meetings

4.1 **TMcM** referred to the action list from the previous meeting:

FC-22-07.003& FC-28-09.003: CCG Finance Committee minutes were noted as now complete.

ACTION: **CS** said that this action could now be closed. She said that in the future, if there was any additional information that would be of value, the report could be updated

ACTION: **TMcM** asked if any progress had been made in the appointment of a second Lay Advisor to the Finance Committee. **CS** noted that she was working with Alison Smith to finalise the role description and get the post out to advert**. TMcM** said that in a meeting with **AS**, she had told him that they were trying to cover off two or three other

committees, **TMcM** asked if that was still the intention. **CS** confirmed that a firm decision had not been made but consideration was being given as to how to make the lay advisor role work best for the post holder.

ND said that the priority would be to have the right person for the finance committee and, if they had the skill set or the capacity to do something else, this would be considered. **ND** felt that we should not compromise in finding the right person, even if this meant that we would have to go out to advert more than once. **CS** agreed.

ACTION: To be closed – comments incorporated into the finance report.

ACTION: **LC** and **CS** attended the recent Board risk workshops, and will review the finance risk register and BAF with system DoFs on 5th December. An update will be provided to the next meeting.

Minute No. FC-29.11.005 – Month 7 Position Update – Revenue and Capital

5.1 **LC** shared the headlines from the month 7 position, highlighting a £4.9m adverse variance to the year-to-date plan. **LC** said that **£**2.6m of that was within the ICB, the other £2.3m was part of the system stretch target that is held on behalf of the system. **LC** pointed out that this was the first time in month 7, that we have seen the system stretch target start to feature in the figures because it's planned delivery is phased between month 7 and 12.

LC said that there is a new protocol and policy that has been released by NHSE, for changes to forecast outturn/ movements from financial plan. **LC** pointed to a summary of this in Appendix B. We are already in conversations with Regional and National colleagues about the finance position and will need to apply the protocol once figures are agreed. **LC** noted that one of the things in the protocol is NHSE attendance at finance committees. The committee chair will be briefed if this is requested to happen.

LC highlighted that the £2.6m ICB overspend has the same three drivers that have been discussed previously, these being independent sector ophthalmology spend; LA discharge support that has continued to be funded despite there not being national funding, and CHC increases in pricing of packages of care. These are offset in part by prior year benefits and balance sheet flexibility. The report narrative has been structured this month to include more information on actions being taken in those areas to manage spend.

LC pointed out that the paper had been written before the Social Care Fund announcement was made nationally, and therefore assumptions made previously in drafting a projected forecast had been superseded. She explained that we now have the figures and the conditions that are associated with that, sent via letter on 18th November. **GR** and **CS** are involved in conversations about this with Chief Executives. **LC** stated that we are now exploring what we may or may not do with the Social Care funding and how that will impact on the discharge position.

TMcM asked for clarity, what the projected ICB forecast is looking like without mitigation. **CS** stated that it is around £21m away from the planned figure, £11m of which is the system stretch target that will not be met, which is significant. CS explained a net risk of about £10m for the ICB itself, which captures the areas of pressure and balance sheet mitigation already discussed.

TMcM asked how much the Social Care fund would bring into the system**.** **CS** explained that the Social Care Fund is just over £5m, some of that is going directly to the two LA's and £3.4m will come straight to the ICB, so not an insubstantial amount. **CS** told the committee however that this figure is not sufficient as £10m additional expenditure compared to last year is already modelled with the LA's flagging a requirement for a further £6m on top of that, projected to year end.

CS explained, that in conversation with the LA's the previous day, we had been very clear that we cannot allocate the additional monies in addition to the forecast spend but rather that we needed to use the £5m as best we could against the forecast position. **CS** pointed out that we

also need to see some improved outcomes as part of that, as we cannot keep putting more and more money in, without seeing an improvement in things like the no right to reside numbers and the length of stay in the hospital.

GR said that he thought it was going to be a real challenge for the LA's to deliver benefit from the new monies, given that we have not seen this in the first eight months of the year. He said that Simon Whitehouse used the terms of the allocation to highlight a non-negotiable 5 or 6 measures that we will hold ourselves to, and we expect to see an improvement against that baseline, and within the conditions of the funding.

TMcM asked if we might use the £3.4m new money for the ICB to offset the forecast overspend. **CS** explained that we could, but she thought that in that scenario, outcomes and performance would worsen, placing greater operational pressure into the system. Our best option would be to maximise the use of the whole £5m to manage and look to improve the flow trajectory to the end of the year.

CS also explained that whilst we may be looking for additionality, this may not even be possible as the beds/care packages may not be available in the market for various reasons such as workforce and geography. We need to be realistic about what is achievable within the pot that we have got. She said that the core aim that everyone is agreed on is that we need to attract the funding into the system, so we will do whatever we can to make sure that that comes through.

GR noted that we have got some really useful information from our LA colleagues in terms of the impact of growth in use of care homes, the transition of patients that over time have traditionally gone to Domiciliary Care, now ending up in care homes as well as the length of stay of people in care home packages. He said there is a raft of intelligence which is really helping demonstrate that the LA, the care home market and domiciliary care market is significantly under pressure. **GR** said that from a health perspective, we have always looked at the MFFD position as the ultimate barometer of how successful our LAs are, and by that one measure, they aren't because it's deteriorated relentlessly for the last three years, apart from one little spike with COVID. **GR** pointed out that from the information they are sharing, we can see that they are delivering more, though not enough, and with limited efficiencies in terms of reducing the cost of delivery or anything ambitious in terms of care is provided. **GR** said if we had not spent this money, it would have been significantly worse. He said he had a degree of sympathy for LA colleagues, but what he did not see is the appetite for improvement of the same pace as we are working to in the health sector.

TMcM said that at some point, we have got to turn off the money. **CS** agreed that we have either got to turn off the money in this particular area or we've got to turn it off somewhere else to be able to fund this if we believe that this is the recurrent position. She said that she didn't believe it was, and that was the work that Gareth's team are doing at the moment with the LAs, to say, we don't feel we are getting the best out of our Better Care fund, and if we do things differently, we could be more efficient in terms of patient flow. **CS** hoped that there would be some money that drops out of that as well.

GR explained that we have got £63m in the two Better Care Funds however our current spend profile significantly exceeds that. Additional recurrent funding has been promised for future years but the value of that or terms attached to it are unknown. We need to remain within our funding envelope in future years.

He noted that we have hit an obstacle in that the LAs believe that all spend is required and therefore it is hard to scale spend back to within the envelope. **GR** asked for support from the Finance Committee to seek assurance from the Integrated Delivery Committee that they had reviewed and were content with the outputs of the BCF review once it is complete. Given the

potential to undermine the underlying financial position, this was agreed to be a reasonable request.

Action: CS to draft an email on behalf of TMcM to Harry Turner, chair of IDC to seek assurance on the outputs of the BCF review. This will request feedback to the January Finance Committee

In relation to the ophthalmology overspend**, CS** pointed out that we are not the only system that is experiencing overspends relating to activity in private providers and that through regional contacts we know of at least two other systems who are experiencing very similar issues to ours where the private sector have got the capacity and the workforce to work through the activity with very little wait for the patient. **CS** felt assured from the conversations that we have had that we are doing everything in our power to manage what we can, and unless national constitutional rights change, we are limited in what more we can do.

CS described that the way the rules are set up at the moment, they promote competition as patient choice is a driver of where activity goes. She said if a provider can deliver really good results, really quick appointments to suit you around your busy life, you will choose them over someone else locally, that might take a bit longer **CS** felt that the bigger job for us as a commissioner is about helping to improve the confidence of the public in our local NHS providers and also to have a conversation about what those providers may or may not wish to provide in the future.

GR felt the analysis is really clear that backlog clearance for ophthalmology will take 2 years, therefore the opportunity to build the capacity is really constrained, for example we could recruit a number of ophthalmologists, then by the time we built that option, the demand would have been significantly reduced. **CS** explained that that is why we need to do the demand and capacity modelling, and have that built into the longer-term plan. We should be presenting that as non-recurrent, it's backlog clearance. **CS** said our actual core underlying rate is less than that, and we have to try and make that judgment and get that in the plan.

CS then noted that there are no material risks for delivery of the ICB efficiency plan, although the system target cannot be ignored and this would be discussed in the Part 2 meeting. **GR** felt that we are making good progress on next year's plan. **CS** explained that her biggest concern at the moment is that Julian Kelly, quite rightly, is going to want us to work harder on our numbers, particularly thinking about the ICB position, as the ICB and SATH are the two big variances against plan. **CS** said in her assessment, she could not see that there was anywhere else to go in the in-year ICB numbers that would take a material sum out of what we have forecast so far.

TMcM asked **GR** about progress with system wide efficiency and transformation plans given that there is not a lot of time left within the financial year. **GR** replied that after an aborted effort to relaunch the programme, chief executives were now on board with Patricia Davies, CEO for Shropshire Community Health Trust leading support to establish and operate a new Financial Recovery Board. **GR** said that unfortunately they would not be able to squeeze material savings into this year however the work programme will provide recurrent benefit into next year.

TMcM noted that this had been discussed in previous meetings and we are now four or five months on, flagging that this was of some concern.

TMcM asked the committee if there was any preparation required for the part 2 meeting. **CS** replied that there were no new issues to raise in Part 2, but highlighted that the meeting would not be quorate, she explained that the meeting could still take place, as there were no material decisions that needed to be made.

TMcM noted that there was lot of information on workforce in the part 2 meeting but that this was not available in such detail to the people committee. **CS** said that **AB** (Alison Bussey) had also noted that and suggested that this could be raised when the people committee met.

Minute No. FC-29.11.006- ANY OTHER BUSINESS

6.1 No other business was noted.

14.40 pm – Meeting Closed.

DATE AND TIME OF NEXT MEETING

Tuesday 31st January 2023 at 09.00 – 10.00 am.

Agenda item ICB 29-03-076.4

Strategy Committee Chair's Report for meetings held on 19 January 2023 and 16 February 2023

NHS Shropshire Telford and Wrekin
Strategy Committee

Thursday 16 February 2023 at 12.30 p.m.
Via Microsoft Teams

Present:	
Cathy Purt	Chair and Non-Executive Director, Shropshire Community Health NHS Trust
David Brown	Non-Executive Director, Shrewsbury, and Telford Hospital NHS Trust
Mark Large	Non-Executive Director, Midlands Partnership NHS Foundation Trust Partnership Foundation Trust
Prof. Paul Kingston	Non-Executive Director, Robert Jones Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Nye Harries	NHSE National Improvement Team
Nigel Lee	Interim Director of Strategy and Partnerships Shrewsbury and Telford Hospital NHS Trust

In Attendance:	
Edna Boampong	ICB Director of Communications and Engagement
Julie Garside	ICB Director for Planning and Performance
Nia Jones	Managing Director for Planning and Strategy, The Robert Jones Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Claire Parker	ICB Director of Partnerships and Place
Rebecca Gallimore	Director of Digital Transformation Shrewsbury and Telford hospital NHS Trust
Trisha Finch	Associate Director of Transformation, Planning and Performance Shropshire Community Health NHS Trust
Jayne Knott	Personal Assistant to Nicola Dymond and minute taker.

Minute No. SC-16-02.010 Introduction and Apologies:

10.1 The Chair opened the meeting of the STW Strategy Committee and welcomed everyone. The following apologies were noted:

Nicola Dymond	ICB Director of Strategy and Integration
Sarah Lloyd	Director of Finance Shropshire Community Health NHS Trust
Alison Smith	ICB Director of Corporate Affairs
Rachel Robinson	Executive Director of Health, Wellbeing and Prevention Health, Wellbeing and Prevention Directorate Shropshire Council
Liz Noakes	Director Health & Wellbeing Telford & Wrekin Council

Minute No. SC 16-02.011 Declarations of Interest:

11.1 It was noted that no new Declarations of Interest had been declared and none declared that conflicted with any agenda item. Mr Nigel Lee wanted it recording that he had recently taken up a role as Trustee of Hadley learning Community Trust but did not think there was any conflict of interest.

Mr Mark Large commented that he had an issue opening the spreadsheet to update.

Action: Miss Alison Smith to rectify this and resend to Committee members before next meeting (Mr David Brown circulated the word version of this during the meeting).

The Register of Board Members Interests can be found at: Register of Interests - NHS Shropshire Telford and Wrekin (shropshiretelfordandwrekin.nhs.net)

Minute No. SC 16-02.012 Minutes and action list from the meeting held on 19th January 2023

12.1 The minutes were approved as an accurate record and the Chair signed them off in readiness for the ICB Board.

Action list:

12.2 Action No. SC-23-01.004 Mrs Julie Garside and Miss Alison Smith to work through this action on behalf of Mrs Nicola Dymond. Update to be given to Committee members before next meeting.

12.3 Action No. SC-23-01.005 Mrs Jayne Knott to circulate the draft workplan to Committee members.

All other actions were noted as complete.

Minute No. SC-16-02.013 National Operational Planning Objectives for 2023/24

13.1 Mrs Garside presented a number of slides and offered to circulate the slides after the meeting. The following points were highlighted.

13.2 Planning guidance came out and was released by NHS England on the 23rd of December and it had three high level priorities:

- Service recovery – including efficiency and productivity improvements.
- Delivery of ambitions in LTP – Prevention, reduce inequalities, joined up coordinated care,

- Transformation of services to deliver a safe, sustainable health and care system through integration – better care, better outcomes results in better value

13.3 The three key areas within the planned recovery for the NHS over the next year.

- Urgent and emergency care
- Elective care.
- Primary care

Also linked to the pressures have been the difficulties around ambulance response times. Detail included:

- Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
- Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
- Reduce adult general and acute (G&A) bed occupancy to 92% or below.
- Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
- Achieve the system- specific activity target 103% for STW (agreed through the operational planning process)

13.4 **Cancer/Diagnostics**

- Continue to reduce the number of patients waiting over 62 days (STW target 257)
- Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days.
- Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028.
- Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95% Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition.

13.5 **Community Service/Primary Care**

- Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard.
- Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals.
- Achieve 80% utilisation of the Virtual Ward Capacity
- Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
- Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024
- Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
- Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels.

NB Final national guidance on Primary Care Recovery not released yet – due end of February.

13.6 **Maternity/Prevention & Health Inequalities**

- Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury.
- Increase fill rates against funded establishment for maternity staff.
- Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
- Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
- Continue to address health inequalities and deliver on the Core20PLUS5 approach.

NB Final national guidance re Maternity Plan not released yet.

13.7 **Workforce/Use of Resources**

- Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise
- Deliver a balanced net system financial position for 2023/24

13.8 **Mental Health/Learning Disabilities & Autism**

- Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)
- Increase the number of adults and older adults accessing IAPT treatment.
- Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services.
- Work towards eliminating inappropriate adult acute out of area placements
- Recover the dementia diagnosis rate to 66.7%
- Improve access to perinatal mental health services.
- Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024
- Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit.

13.9 **Timeline/key milestones**

- Draft 23/24 Operational plan to NHSE 23rd February
- Final Operational plan to NHSE 30th March, following sign off at IDC and Board
- Draft 1 & 2yr Integrated System Improvement Plan (ISIP) – end of Jan (to Strategy Committee in Feb)
- Draft 5yr ISIP end of March to NHSE (Strategy and ICB board in March) based on item above +yrs. 3-5 from JFP.
- Draft to NHSE JFP March 30th
- System engagement on JFP April-June
- Final JFP end of June 23

13.10 Mrs Claire Parker commented that GPs, Primary Care networks and the local medical Committee have come together to form a GP Board. Diabetes is one of the six clinical priorities and is also part of the Joint Forward Plan linking in with the clinical strategy and the clinical and professional networks. Primary care committee will need to look at how we bring in the dental element from a contractual perspective.

13.11 The Chair asked when will this Committee see the clinical strategy and clinical work that Mr Nick White has been leading on.
Mrs Garside thought that this would have sight of this at the March meeting.

Mr Nigel Lee requested early sight of the clinical strategy as SaTH are finalising their own clinical services strategy.

Action: Mrs Garside to liaise with Mr Nick White about the clinical strategy coming to the Committee in March.
Action: Mrs Garside to ask Mrs Claire Skidmore if the Committee could have sight of the Finance strategy

Minute No. SC-16-02.014 Monthly report on NHS STW, Integrated System Improvement Plan, (ISIP) and Progress against the NOF 4 Exit Criteria

Mrs Julie Garside and Mr Nye Harries introduced the item and highlighted the following:

14.1 Monthly reports will be produced for this Committee each month.

14.2 Need to set some clear criteria that are achievable but stretching within a defined period. Target date for exit criteria has been put back to the end of 23/34.

14.3 Mr David Brown pointed out that the wording in Appendix 4 around financial performance in SaTH was unfair and suggested using the word reviewing rather than stabilising.

14.4 Levels of staff sickness across the Board are high. The Chair suggested that we feed this into the ICB People Committee as part of their strategy, and to feed back to this Committee about what is being done about sickness levels.

Action: Professor Paul Kingston will link in with the ICB People Committee and emphasis this Committees concerns medium term.

14.5 Mr Nye Harries suggested that there might be merit in the Chair having conversations with counterpart Chairs of ICB committees to remind them about some of the responsibilities or portfolio responsibilities that they have that impact directly, on achieving the exit criteria.

Action: Mrs Cathy Purt to feedback to Chairs at the next Board meeting to get them involved

Minute No. SC-16-02.015 MCAP update

Mrs Julie Garside introduced the item and highlighted the following:

15.1 Letter has now been circulated to all partners. Responses are being chased.

15.2 Meetings to be arranged with the three main providers to go through their particular data. Only Shropcom have been able to do this so far, RJAH had to be stood down due to industrial action, but now in for 17 March. Meeting with SaTH still needs arranging.

15.3 Data being used to help ensure the link between our HTP strategy and our local care program.

Action: Mrs Garside to bring further update to next Committee.

Minute No. SC-16-02.016 Joint Forward Plan Update

Mrs Edna Boampong and Mrs Claire Parker introduced the item and noted the following:

16.1 Rapid progress has been made and the process, contents and engagement questions will be presented at a Board development session on the 22 February.

16.2 Weekly meetings are taking place with good engagement, with stakeholders involved. Draft document proposed for end of March.
Linked in with NHS England around the assurance reporting and the assurance checklist for what needs to go into the plan.

16.3 Next steps - timelines, the place development work, the delegation, what the strategy from the board is around place and provider collaboratives. Some of that content will be in more detail ready for the June final submission.

16.4 The Engagement strategy has been signed off by the ICP and ICB in January.

16.5 First draft of the Joint Forward Plan will be presented at the ICP on or around 10th – 14th March.

16.6 Post March, there we will further engagement, to inform the refinement of the draft forward plan.

Action: Committee members to send Board dates and when papers are required to Mrs Boampong if they wish to share the Joint Forward Plan with their Organisations Board. Mrs Boampong will incorporate these dates in the timeline.

16.7 Work will carry on with other system partners to plan additional activity from April onwards. There will be several visits to do more engagement in Telford, Bishops Castle, Ludlow and Market Drayton.

16.8 Senior Stakeholder engagement objectives and approach – The approach is designed to enable discussions and to debate a number of strategic planning issues to shape our system Joint Forward Plan. A series of questions will be posed, using a five point scale.

Action: Mrs Boampong to share draft public questions with Committee members

16.9 A recruitment process is taking place to sign up to 300 people to join the People's network. This is a virtual community of local residents which will enable us to gather public views and opinions on a wide variety of heath topics.

The Chair closed the meeting at 2:00pm.
Date and time of next meeting: Thursday 16th of March 2023 at 12:30pm

NHS Shropshire Telford and Wrekin
Strategy Committee

Thursday 19th January 2023 at 12.30 p.m.
Via Microsoft Teams

Present	
Cathy Purt	Chair and Non-Executive Director, Shropshire Community Health NHS Trust
Nicola Dymond	ICB Director of Strategy and Integration (Vice Chair)
David Brown	Non-Executive Director, Shrewsbury, and Telford Hospital NHS Trust
Mark Large	Non-Executive Director, Midlands Partnership NHS Foundation Trust Partnership Foundation Trust
Prof. Paul Kingston	Non-Executive Director, Robert Jones Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Peter Featherstone	Non- Executive Director, Shropshire Community Health NHS Trust
Liz Noakes	Director of Public Health, Telford, and Wrekin Council
Rachel Robinson	Director of Public Health, Shropshire Council
Nye Harries	NHSE National Improvement Team
In Attendance	
Alison Smith	ICB Director of Corporate Affairs
Julie Garside	ICB Director for Planning and Performance
Edna Boampong	ICB Director for Communications and Engagement
Nigel Lee	Director of Strategy and Partnerships, Shrewsbury, and Telford Hospital NHS Trust
Nia Jones	Representing Craig MacBeth, Robert Jones Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Amie Simmonds	Personal Assistant to ICB Director of Strategy and Integration
Apologies:	
Rebecca Gallimore	ICS Digital Lead
Craig Macbeth	Chief Finance and Planning Officer, Robert Jones Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Steve Grange	Director of Strategy and Strategic Transformation, Midlands Partnership NHS Foundation Trust

Minute No. SC-23-01.001 – Introductions & Apologies

1.1 Mrs Purt welcomed ICB Strategy Committee members to the meeting and introduced three new members:

- Mr Nye Harris
- Mr Mark Large
- Mr Peter Featherstone

1.2 Apologies received were noted as above.

Minute SC-23-01.002 – Members' Declarations of Interests

2.1 Declarations of Interest:

Mrs Purt asked everyone if they had completed their Declaration of Interest forms which had been circulated following the last meeting. If this had not been done, can they be completed and sent across to Miss Simmonds.

There were no declarations of interest in connection with the agenda.

Minute No. SC-23-01.003 - Minutes and action list from the meeting held on 15th December 2022

3.1 Mrs Purt noted that all actions have been completed and will be discussed during the meeting and asked that the actions are closed.

Minute No. SC-23-01.004 – Strategy Committee Terms of Reference

4.1 Miss Smith introduced the item and reminded Committee members that a number of suggested amendments were raised at the last meeting which have all been actioned and shown on the attached copy of the terms of reference as tracked changes. Two suggestions have not been actioned:

- The first was whether the terms of reference needed to include a specific reference to the "left shift". Miss Smith explained that the left shift is a strategic approach to the issues facing the system which would be collated into the Joint Forward Plan (JFP). As the terms of reference already include oversight of the JFP it was felt that an additional reference to the "left shift" would be an unnecessary duplication.
- The second was the point made regarding whether the development of strategy in operational boards should be presented at this Committee for oversight. Mrs Purt and Mrs Dymond are arranging a meeting with the Chair of the ICB Integrated Delivery Committee and its Executive Lead to discuss how this can be managed between the two committees and therefore advised that any amendments to the Terms of Reference are made as a result of these discussions and brought back to a future committee meeting for consideration.

4.2 Professor Kingston raised a query regarding whether these terms of reference needed to include responsibility for oversight of research and innovation. Mrs Dymond agreed that this was an important point and that it was not clear as to whether this sat in this Committee's remit or in the Integrated Delivery Committee remit, but confirmed that she would raise this as part of the meeting with the Chair and Executive Lead for the Integrated Delivery Committee.

ACTION – Mrs Dymond to raise the query regarding which Committee's remit oversight of research and innovation should be part of.

4.3 Mr Lee noted that "left shift" would be captured in 3.3.7 under the reference to key major programmes and the alignment with Integrated Delivery Committee 's remit under 8.5 which is a catch-all statement.

4.4 Mrs Boampong asked whether the Committee needed to have a representative from workforce, as much of what the system needs to do strategically will rely on developing the system's workforce capacity and capability.

4.5 Miss Smith acknowledged the important interdependency between this committee and that of the System People Committee which has direct oversight of the development and delivery of the System's People Plan and the need to have clear reporting lines and avoid duplication. Miss Smith suggested that rather than having a voting member from workforce on the Committee, that instead the Chief People Officer is invited as a standing attendee of the Committee to provide direct access. This suggestion was agreed by the Committee.

4.6 Professor Kingston highlighted to the Committee that he also is a member of the System People Committee and therefore would provide a natural link between the two. He went onto query if the local authorities had any internal committees or sub committees that it would be useful to have a reporting line into this Committee. Mrs Dymond confirmed that she would explore this suggestion with the Mrs Robinson and Mrs Noakes outside of this meeting.

ACTION – Mrs Dymond to confirm with Mrs Robinson and Mrs Noakes if any Local Authority committee or sub committee meetings need to have a reporting line into the ICB Strategy Committee.

4.6 The following amendments were also agreed:

- Section 3.3.2 – amend reference to "Healthy Together Programme" to "Hospital Transformation Programme" (HTP)
- 6.2.1 – delete additional full stop
- Amend "up to 2" members for primary care and VCS to "1 member from each sector" to ensure the membership of the Committee does not become too unwieldy

The Committee was asked to review the attached terms of reference and agree the proposed amendments in red text.

RESOLVE: The Committee APPROVED the amended terms of reference for recommendation to the Board in January as presented, with the additional amendments outlined above.

ACTION – the Committee requested that any further amendments arising from the meeting that is being planned between the chairs of Strategy and Integrated Delivery Committee is brought back to a future meeting for consideration.

Minute No. SC-23-01.005 – Draft Committee Workplan

5.1 Miss Smith presented an early draft of the Committee's workplan for comment. Unfortunately due to the Christmas break not all colleagues have been able to input into the detail, so further work is required.
5.2 Mrs Dymond explained that there will be a calendar of relevant work programmes and agenda items so people know when to expect them and they can be worked through throughout the year.

5.2 Mr Large queried if business intelligence needed to be part of the work plan. Mrs Dymond explained that the outputs of business intelligence would be feeding through into strategy development and that there is work developing around analytics at the moment.

5.3 Mr Featherstone felt the work plan had generally good alignment, but that the tail end of the terms of reference that covered specific outputs were missing.

5.3 Mr Harries suggested there might be some benefit in setting out in addition one or two key milestones that the board in particular and the public indeed would recognise.

5.4 Mrs Purt suggested members send any further comments to Alison Smith after the meeting.

The Committee was asked to review the attached draft work plan and to consider the content and make suggestions of additions and amendments.

RESOLVE: The Committee APPROVED the work plan as presented.

ACTION – the Committee acknowledged that further detail was required on the work plan and asked that an updated version be presented at the next meeting.

Minute No. SC-23-01.006 - Development of the ICS Joint Forward Plan

6.1 Mrs Dymond introduced the item and made the following points:

- The draft IC Strategy sets a vision for what the Integrated Care System wants to achieve through greater partnership and collaboration and is built on the health and wellbeing strategies in Place as well as Joint Strategic Needs Assessment (JSNA) data.
- The IC Strategy development working group, comprised of ICB, Local Authority and local Health Watch members, has developed this draft strategy. It was presented to the ICB Strategy Committee and the Integrated Care Partnership (ICP) board in their respective meetings in December 2022 – see updated version 8.0/ND as Appendix 1.
- The draft strategy was published with the papers for the ICP board meeting on 21 December 2022. ICP board papers In the meeting of the ICP board the draft strategy was presented by the Director of Strategy & Integration, NHS T&W, and the Directors of Public Health from Shropshire Council and Telford and Wrekin Council.
- The ICP:
    - noted the content of the paper in which the draft strategy was presented
    - agreed the outline approach and timeline

    - asked that the ideas and suggestions of the ICP for additional engagement and briefing of key partners as set out in the minutes of the meeting to be taken into account moving forward. Minutes of ICP meetings are published on ICP board papers
- Feedback from the ICP board on the IC strategy will be taken into consideration and the IC Strategy working group will further develop the document. A final version will be brought back to the next ICP board meeting (anticipated to be held mid-March 2023).
- On 23 December 2022, NHS England (NHSE) released its guidance for the development of the Joint Forward Plan. The guidance sets out a flexible framework for JFPs to build on existing system and place strategies and plans, in line with the principle of subsidiarity. It also states specific statutory requirements that plans must meet.
- See full guidance document Guidance for the JFP A summary, listing:
    - minimum requirements for the JFP
    - JFP principles
    - Relationship with NHS planning
    - Legislative framework for the JFP
    - Supporting resources available
    - Consultation details
    - Actions required of ICBs is attached as Appendix 2.
- Edna Boampong, Director of Communications and Engagement, presented a paper on the STW Integrated Care Strategy and Joint Forward Plan Development on the Engagement Approach, titled 'Shropshire, Telford and Wrekin health and wellbeing conversation' to the ICP board in December 2022 and the ICB Strategy Committee in January 2023. The plan provides details on the communications and engagement activities which will take between January and June 2023. A copy of the paper is attached as Appendix 3.
- The JFP and the operating plan will be produced at the same time as the financial plan fro submission to NHSE at which point we will receive some formal feedback. Mrs Dymond expressed her hope that she can bring some feedback on the developing content of the JFP to the Februarys committee meeting.

6.2 Mrs Purt asked for any comments from the Committee on the content of the Integrated Care Strategy and the engagement approach.

6.3 Mr Harries suggested distilling everything into one document and trying to make it a story refinement of what the system's journey will be, because a strategic document is about other people getting there so thinking about the language in the strategies.

6.4 Mrs Dymond explained that we are required to produce two documents – the first is the Integrated Care Strategy which is a distillation of the two Health and wellbeing board strategies. The second is the Joint Forward Plan which is the ICB's response to the areas highlighted in the Integrated Care Strategy. Part of what is being done at the moment is working with providers to design and perfect the content of the JFP. Bringing the conversation around our providers and stakeholders, to take what we know of the ICS and to take what we know from our other pieces of work and to shape it together for evidence and clarity.

6.5 Mrs Purt asked for clarity as to whether a first draft of the JFP needed to be produced by 27th February.

6.6 Mrs Dymond confirmed that it is likely not to be a formal submission of the draft at that point to NHSE but will be an opportunity to receive feedback on the direction of travel.

6.7 Mr Featherstone asked how the timeline for developing the JFP will align with local authority deadlines around the annual budget setting process.

6.8 Mrs Dymond has said that they are working very closely with local authority and keeping them updated through the process. Our local authority colleague will still be involved in the development process as part of our governance arrangement. As for NHS England we have a 1st submission date in March and a second in June giving us time to make any changes before resubmitting.

6.9 Mr Lee observed that this was a complex process which was being carried out in very short time frame and suggested that the system should not be overly critical of its progress so far as there is time to refine the detail.

6.10 Mrs Dymond added that the process for creating the Integrated Care Strategy was late starting but nevertheless the system has attempted to be authentic and develop genuine relationships despite the very short turnaround.

6.11 Professor Kinston added that this was a huge take and it was important to lay the foundations for trust and communication across system partners in this process and that the system should view this as an experiential year that will align over time.

6.12 Mr Harries highlighted that the system is facing significant financial challenges and therefore by having a credible strategy that includes the whole health and care community it will allow the system to move at pace.

6.13 Mrs Purt commented that getting all the finances and all of the different strategies to align will give confidence to NHS England and went onto invite Mrs Boampong to highlight the engagement approach that was described in the paper.

6.14 Mrs Boampong described her main goal was to involve people and set out some core principles. The approach would ensure we hear the voices of people in communities, working with staff, building relationship and trust, really understanding the needs of our communities and involving people in the development of the Joint Forward Plan.

6.15 Mrs Boampang explained the real key element of this engagement is not solely about what we can do for people , but also about addressing how people themselves can manage your own health and well-being and promoting self-care and resilience. The approach described will allow the system to engage with some of our marginalised groups and our ethnic minority communities who we need to try harder to reach.

6.16 Mrs Boampang explained the next step will be having conversations with the public because this will help make some of our decisions. We need to get that insight from our communities to understand what is important to them and how we can support them. We will use a range of mechanisms to reach out to the public: online, face to face and a social media campaign.

6.13 Mrs Boampong confirmed that the NHS Communications and Engagementteam are working closely with colleagues in the local authorities.

NHS Shropshire, Telford and Wrekin is asked to:
• Note the update on the development of the draft Integrated Care Strategy (IC Strategy)
• note the summary of guidance on the development of the JFP
• note the information on the Comms and Engagement activities for the IC Strategy and the JFP

RESOLVE: The Committee NOTED the report and appendices presented

Minute No. SC-23-01.007 - System Utilisation Review

7.1 Mrs Garside presented a number of slides outlining an overview summary of the review and offered to circulate the slides after the meeting. The following points were highlighted:

- Acute Executive Summary
    - For the 2 acute trusts, 8.3% of admissions were non-qualified and 48.3% of continued days of stay were non-qualified.
    - 87.9% of patients admitted had significant risk factors with 'Co-occurring conditions' being the most prominent at 63.9% of all admissions- indicator of complexity.
    - Only 20% of reviews showed that patients had a discharge plan done.
    - 14% of admissions were readmissions.
    - An Estimated Date of Discharge (EDD) was available in 93% of reviews on patients
    - 47% of the reasons for non-qualified days were within the control of the hospital (i.e. 'Internal').
    - 63.1% of non-qualified days could have been provided at home with a variety of services.

- Community Executive summary
    - For the 3 community hospitals, 10.1% of admissions were non-qualified and 51% of continued days of stay were non-qualified.
    - 91.1% of patients admitted had significant risk factors with 'Co-occuring conditions' being the most prominent at 73.4% of all admissions.
    - Only 55% of reviews showed that patients had a discharge plan done.
    - An Estimated Date of Discharge (EDD) was available in 47% of reviews on patients
    - 13% of the reasons for non-qualified days were within the control of the hospital (i.e. 'Internal').
    - 62.4% of non-qualified days could have been provided at home with a variety of services.

7.2 Mrs Garside has suggested she will continue to bring a regular update on the progress on the outcomes form this review to the Committee.

ACTION – For Mrs Garside to email the slides presented in the meeting providing some information on the System Utilisation Review to the Committee.

7.3 Mrs Garside explained that the information found was not to challenge any decisions made but to understand whether our patients are in the best possible place of care and for their care at that propriate time.

7.4 Mrs Garside clarified that the results where from a split between: Princess Royal, Royal Shrewsbury and the community beds at Oswestry, Whitchurch, Ludlow and Bishops Castle. (Including the Sheldon Ward and the elective orthopaedic beds at Robert Jones)

7.5 Mr Featherstone observed that the information collected will provide two important things going forward. One is how we can improve care for patients and secondly helping to identify the financial opportunities for savings.

The Committee was asked to NOTE the update provided.

RESOLVE: The Committee NOTED the presentation

Minute No. SC-23-01.008 - SOF 4 Exit Criteria and Metrics

8.1 Due to the meeting running over its allotted time there was no opportunity to discuss the paper provided. Mrs Purt asked that members email any queries they have on the information provided to Mrs Garside outside the meeting.

Minute No. SC-23-01.009 - Any Other Business

9.1 No business had been indicated to the Chair before the meeting.

14.30p.m. Meeting Closed

Date and Time of Next Meeting

The next meeting of ICB Strategy Committee will take place on Thursday 16th February 2023 at 12.30 p.m. via Microsoft Teams.

SIGNED: **DATE:**

Agenda item ICB 29-03-076.5

System People Committee Chair's Report for meeting held on 15 March 2023

NHS Shropshire, Telford and Wrekin

System People Committee

Terms of Reference

1. Constitution

1.1 The System People Committee (the Committee) is established by the Board of NHS Shropshire, Telford and Wrekin (the Board or NHS STW) as a Committee of the Board in accordance with its Constitution.

1.2 These terms of reference, which must be published on NHS STW website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

1.3 The Committee is an executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of NHS STW.

2. Authority

2.1 The System People Committee is authorised by the Board to:

- Investigate any activity within its terms of reference;
- Seek any information it requires within its remit, from any employee or member of NHS STW (who are directed to co-operate with any request made by the committee) within its remit as outlined in these terms of reference;
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the committee must follow any procedures put in place by NHS STW for obtaining legal or professional advice;
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with NHS STW's constitution, standing orders and SoRD but may not delegate any decisions to such groups.

2.2 For the avoidance of doubt, in the event of any conflict, NHS STW Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference.

3. Purpose

3.1 The Committee's main purpose is to contribute to the overall delivery of ICB objectives by providing oversight and assurance to the Board in the

development and delivery of the STW ICS People Plan and its People Agenda.

3.2 The Committee also assures NHS STW of the discharge of its statutory duties as an employer.

3.2 The Committee has no executive powers, other than those delegated in the SoRD and specified in these terms of reference.

4. Membership and attendance

4.1 Membership

4.1.1 The Committee members shall be appointed by the Board in accordance with NHS STW Constitution.

4.1.2 The Board will appoint no fewer than four members of the Committee including one independent Non-Executive member of the Board. Other members of the Committee need not be members of the Board, but they may be.

4.1.3 Members will possess between them knowledge, skills and experience in:

- Human Resource Management
- Succession Planning and Talent Management
- Organisational Development
- Equality, Diversity & Inclusion
- Education and training
- Strategic Workforce Planning
- Risk management
- And technical and specialist issues pertinent to NHS STW's business

4.1.4 When determining the membership of the Committee, active consideration will be made to diversity and equality.

4.1.5 The core membership of the People Committee will be:

- Chair of an NHS Trust Partner ICB Member (Chair)
- Non-Executive Director of NHS STW
- 4 Non-Executive Directors, one from each partner provider
- System People Lead if not covered by a provider post
- ICS SRO for People
- ICS SRO for Equality, Diversity & Inclusion
- People Director/Lead from each Partner provider member of NHS STW:
    a) Shropshire Community Healthcare NHS Trust
    b) Shrewsbury and Telford Hospital NHS Trust
    c) Midlands Partnership Foundation Trust

d) The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS FT

4.2 Chair and Vice Chair

4.2.1 The Committee will be chaired by the Chair of a Partner Provider NHS Trust of the Board appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee.

4.2.2 In the event of the Chair being unable to attend, the System People Lead or the ICS SRO for People who are joint Vice Chairs will chair the meeting.

4.2.3 In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number to Chair the meeting.

4.2.4 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference.

4.3 Attendees

4.3.1 Only members of the Committee have the right to attend Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Committee.

4.3.2 Meetings of the Committee may also be attended by the following individuals who are not members of the Committee for all or part of a meeting as and when appropriate. Such attendees will not be eligible to vote:

- Directors of Nursing from each provider organisation
- A representative from Shropshire Council
- A representative from Telford and Wrekin Council
- Director of Strategy & Integration NHS STW
- Associate Director of Primary Care NHS STW, representing PCNs
- Chair of ICS AHP Council
- Representatives from local further education institutions
- Representatives from local higher education institutions
- Representative from Shropshire Partners in Care (SPiC)
- Representative from Shropdoc
- Representative from the Voluntary Community and Social Enterprise (VCSE)
- Representative from Health Education England (HEE)
- At least one representative from any working groups created by or reporting to the Committee

4.3.3 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

5. Meetings Quoracy and Decisions

5.1 Meetings

5.1.1 The Committee will meet at least four times a year and arrangements and notice for calling meetings are set out in the Standing Orders 4.1. Additional meetings may take place as required.

5.2.1 The Board, Chair or Chief Executive(s) may ask the People Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

5.3.1 In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

5.2 Quorum

5.2.1 For a meeting to be quorate a minimum of 50% members is required including the Chair or Vice Chair (or their deputy), and one NED (NHS STW or provider).

5.2.2 If any member of the Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

5.2.3 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

5.2.4 Decisions deemed by the Chair to be 'urgent' can be taken outside of the meeting via email communication, and with the agreement of a quorate number of members.

5.3 Decision Making and Voting

5.3.1 Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

5.3.2 Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

5.3.3 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

6. Responsibilities of the Committee

6.1 The Committee's duties can be categorised as:

6.1.1 The aims of the People Committee are to:

- Provide assurance to the ICB on all aspects of workforce, education and OD supporting the provision of safe, high quality, patient-centred care across Shropshire, Telford and Wrekin;

- Ensure strategic priorities and System ambitions, in relation to workforce and OD, are delivered in an affordable manner and that corporate risks are identified and managed.

6.1.2 The objectives of the People Committee are to:

- Align partners across the ICS, to co-create and support a shared approach to the people agenda.
- Promote creativity in the design, delivery and evaluation of workforce solutions across all partners in the ICS;
- Oversee the development and delivery of workforce, OD and cultural change strategies that support the ICB's strategic priorities, in the context of System and national picture (including the National People Plan);
- Oversee the development and delivery of education, training and learning strategies to upskill and reskill the workforce of the future;
- Actively seek to reduce inequalities in the staff experience and to promote equality, diversity and inclusion in a systematic and effective way;
- Receive reports relating to the creation and delivery of NHS STW and member organisations' operational workforce plans, to ensure alignment to ICS strategies and provide assurance that the System has adequate staff with the necessary skills and competencies to meet the future health and care needs of patients and service users;
- Consider the control and mitigation of workforce related risks and provide assurance to the Board that such risks are being effectively controlled and managed;
- Oversee the work of identified sub-committees by receiving quarterly reports from those committees.
- Receive reports on workforce specific FTSU Issues
- Review and provide assurance on those elements of the Board Assurance Framework delegated to the People Committee, seeking where necessary further action/ assurance.

Shropshire Telford & Wrekin ICS

People Committee Meeting

Wednesday 30th November 2022

Meeting Title	**People Committee**	**Date**	**30.11.2022**
Chair	**Catriona McMahon**	**Time**	**09:30 – 11:30**
		Venue / Location	SECC RSH

Attendance-

Item	Title	Notes
2022.01	Welcome & Apologies	All members were welcomed to the meeting, introductions and apologies were made and the meeting commenced
2022.02	Minutes of Previous Meeting and Actions Log	The Minutes from the previous meeting were taken as accurate record. The action log was updated with the following comments to note: **ACTION**: THI to update the action log with reference numbers within the ToR to reflect update. FTSU Issues that are People specific need to be sighted at this Committee. Higher Education is mentioned within the ToR, however Further Education is not.

2022.03	Revised ToRs	The ToRs were reviewed with the following comments noted: Higher Education is mentioned within the ToR, however Further Education is not. CMC noted that Exec Members have been added to the membership. NEDs invited to join the meeting that have been removed from the membership list.
2022.04	ICB People Pledges/People Plan	The ICB People Pledges/People Plan was reviewed with the following comments noted: THI noted that within STW as a system, there is a commitment to the 10 system pledges, whilst there is explicit one to workforce, workforce does relate to all pledges. It was noted that the People Plan has been amended to focus on 5 key priority area's. - Looking After our People - Belonging in STW - New Ways of Working and Delivering Care - Growing for the Future - Focus on Nursing and HCSW CMC asked what within the plan is not traditional public sector/primary care? RBO - The integration of improvement and education, many ways the NHS is in a state where staff moral and engagement isn't improving, a lot of it is around improvement but individuals cannot make the decisions within their teams. CPU raised that there is a real problem across the NHS in relation to HCSW workforce. Strategically we needs to think differently for that group.

2022.05	Workshop	The aim of the workshop is to challenge each other to prioritise next steps within the system. CMC asked the committee to split into 3 groups and answer 4 questions. These were then discussed at the end of the workshop. The 4 Questions were: - What does STW have to offer, that we can leverage (more) to enhance workforce? - What opportunities would we have if we worked/related differently? - What innovative opportunities are there, for us to explore eg digital… - What could we prioritise, to maximise the opportunity? **Group 1 feedback:** - The portfolio of different organisations. Older staff should be seen as experienced and not necessarily about retired workforce, morality and what does rural health mean in terms of practice. - Career pathways and education, which we currently don't do. Finance tends to drive and how that is a barrier, front end of peoples careers in terms of students, - How do we have a higher education and further education that is combined. Do something radical about training rather than traditional training. Developing comprehensive pathways that can let people in with no qualifications but with a more flexible pathway between HE and FE. - Accommodation is a barrier in terms of recruitment and retention. How we work together and view it culturally as a way of working. There was a view that each organisation is trying to cling on to it's own sovereignty, a portfolio job instead of career, experience every week in different parts of the organisation. - International recruit, not drawing on the third sector as we should. What is right and not right to do together and that distinction is not there. Career pathways and how we offer this across all organisations so that everyone is on the same page.

		- Engage workforce itself when coming up with pathways. Support the new generations coming in and what we are doing around retaining and development for our existing staff. People coming out of education are wanting to control their own career, and not down a pathway. **Group 2 Feedback**: - Passport to practice around system, matrix opportunities for people, mono organisation education - mono plus one whereby we can offer opportunities to join to health sector, but you're not restricting people. Pathways have been around for a long time, so if there is an opportunity to create a brand for the system which makes it different? We don't necessarily understand the funding opportunities available, so we can't use it to its full potential. Stronger partnerships with HE and that colleges aren't just for young people more learning around that. - Location, rurality, people who don't know the area don't understand how easy it is to travel here, promoting STW as an attractive place for a diverse family, potentially celebrate that were a developing system and that there is opportunity to give ideas and help shape the system. - A lot of talent and need to stop trying to retain talent in our own organisations. What could we maximise, links with education and vocational passports. - Well led and the difficulty is we have experts in their own field but not in other areas. Behaviors and encourage honest conversations. - Recognising that we're operating in a difficult economic environment. Organisations are adopting exclusive inclusion; on the back of the challenges it's creating even more tension. Looking at EDI and strategy we have to look at it from a intercultural perspective, and make it feel more belonging. - We are not commercial and don't look at enough of the return of investment. Benefit of being more commercially focused?

		Group 3 Feedback: - Acknowledging that the matters we need to deal with cannot be solved overnight, we know where we're heading and we need to stick to that. Frequently distracted. Recognised the opportunity for one workforce across one system. Inclusion it's about the language and the mindset that as leaders and colleagues across the system we have. What is the piece of work that's needed from an organisational development. - Benefits of the location, and the variety of places to work, HEIs, Chester Uni, Keele and Wolverhampton, lots of benefits to come and work here. The way kids are going to be thinking now is around progression. If were too radical then royal colleges will just say no, so we have to work with them but also push for change. FE and HE model of taking them in at 16 taking them so far, with an apprenticeship type of post, all of those things exist in one form or another but not in a coordinated way. What is the Shropshire experience for education. For many of late teens 20's the expectation is that they will have at least 3 careers and how we have that mindset. Lets not control it and develop a framework. The Committee opened a discussion on the feedback: - Being brave around the recruitment and retention strategy, if it is around our rurality, and how we move the dial towards the younger generation, then we might want to go to the city areas, for those members of staff that want to relocate with their families, we then need to think about a more mature workforce. - Bringing a different experience and a more stable experience, to celebrate that and recruit individuals with that skill set as a parallel workforce. - It's difficult to feel as though you belong, which is a deeper cultural issue. If individuals first language isn't English or if individuals are from a diverse background, it's even harder to feel that sense of belonging. How do we make joining easier and streamlined. The process needs to be the same across the system.

		- How do we integrate school learning into early pathways to help them achieve the educational pathway they need. - How do we twin track the work, lack of CPD, lack of work life balance, we need to be clear about what we want across the system. - To advertise different, and not just 'health' and 'care' There is a need for electricians, plumbers, neuroscientists, HR etc. People may not think about these roles coming under Health Care. When recruiting Clinically for those families wishing to relocate is there a non-clinical role we can recruit into. - An alternative to staff going on sick leave, they are to be offered another role within the system. **Next Steps (12 Month Timeline)** - Cost of living crisis will massively impact the workforce. People not going to work as they can't afford to go to work. Within the next 12 months this might get worse, what support can the third sector give that the NHS can't help retain the workforce. - Have a system strategy instead of organisations having their own strategies. Real opportunity for people to take Centre stage and lead it across the system. - Run sessions for staff and across the system. Explaining what help is there in relation to the cost of living. Shropshire Council have been running those sessions and offered to share when those sessions are for our staff to attend. - Clear understanding around our clinical priorities that we can then align for our people, no committee has been sighted on this due to needing more clinical engagement around those workforce plans, engagement plans. - Funding a workforce planning hub, and training for workforce leaders. - Think about workforce within the framework – How do we bring realism into the planning.
2022.06	Any Other Business	Nothing raised.

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Agenda item ICB 29-03-076.6

Primary Care Commissioning Committee Chair's Report held on 3 February 2023

NHS Shropshire, Telford and Wrekin
Primary Care Commissioning Committee Part 1 Meeting

Friday 2 December 2022 at 9.30 a.m.
Via Microsoft Teams

Present:

Mrs Niti Pall	**Non-Executive Director, (Chair)**
Mr Nick White	**Chief Medical Officer (Deputy Chair)**
Mr Roger Dunshea	**Non-Executive Director**
Mrs Laura Clare	**Deputy Director of Finance (On Behalf of Claire Skidmore)**
Mrs Tracey Jones	**Deputy Director – Partnerships (On Behalf of Claire Parker)**

Attendees:

Mrs Julie Garside	**Director of Planning & Performance**
Dr Julian Povey	**Primary Care Partner Member**
Dr Ian Chan	**Primary Care Partner Member**
Mr Tom Brettell	**Partnership Manager**
Mrs Janet Gittins	**Partnership Manager**
Ms Jane Sullivan	**Senior Quality Lead**
Mrs Bernadette Williams	**Primary Care Lead for Contracting & Delegated Commissioning**
Mrs Vanessa Barrett	**Chair, Healthwatch Shropshire**
Mrs Chris Billingham	**Corporate PA; Minute Taker**

Apologies:

Ms Alison Bussey	**Chief Nursing Officer**
Mrs Claire Skidmore	**Chief Finance Officer**
Ms Nicola Dymond	**Executive Director of Strategy & Integration**
Mr Gareth Robinson	**Executive Director of Delivery & Transformation**
Dr Deborah Shepherd	**Deputy Chief Medical Officer**
Ms Claire Parker	**Director of Partnerships & Place**
Ms Emma Pyrah	**Associate Director of Primary Care**
Mrs Angharad Jones	**Finance Business Partner**

Minute No. PCCC 22-12.30

1.1 Apologies received were as noted above.

Minute No. PCCC 22-12.31 – Members' Declarations of Interests

2.1 Members had previously declared their interests, which were listed on the ICB's Register of Interests and was available to view on the website at: Register of Interests - NHS Shropshire, Telford and Wrekin (shropshiretelfordandwrekin.nhs.uk)

2.2 Mrs Pall declared that as an independent health systems consultant she has been working with the national Cavell Centre programme. When that item is discussed, she will step down as Chair and ask Mr Dunshea to Chair the meeting for that item of discussion.

Minute No. PCCC-22.12.32 – Minutes of Meeting held on 7 October 2022

3.1 The minutes of the meeting held on 7 October 2022 were accepted and approved as a true and accurate record of the meeting.

Minute No. PCCC-22.12.33 – Actions Raised from Previous Meetings and Matters Arising

4.1 The Action Tracker was reviewed and updated as appropriate.

Minute No. PCCC-22.12.34 – GP Access Report to ICB

5.1 Mrs Jones advised the Committee that her report had been submitted to the ICB Board meeting which took place on Wednesday 30 November 2022.

5.2 The report was prepared by Ms Emma Pyrah, Associate Director of Primary Care, and reported on the issues around GP access. Points to note were:-

- Face-to-face appointments had increased. The November data showed that seven out of ten patients were seen face-to-face.
- Issues exist around workforce and estate which are limiting factors for some Practices in terms of improving access.

5.3 Discussion at the ICB Board reflected the fact that Primary Care can be accessed via other routes which we must ensure patients are aware of. Consideration must also be given as to how performance is monitored in relation to answering calls, and how to help Practices whose data identifies issues with length of call wait and call abandonment. Ms Pyrah and Ms Parker have discussed how this piece of work can be taken forward over the coming months.

5.4 Mrs Jones invited questions.

5.5 Dr Chan made the following points: -

- It would be useful for NHS STW to benchmark ourselves against other systems in the Region.
- Trainee GPs were included in the figures and should be shown separately in future as they were inflating the number of GPs in the system.
- Data relating to Telford Practices should be compared with data relating to Shropshire Practices in terms of telephone access. It may be useful to benchmark that data at a point in the future to stress the difference in demographics between Shropshire and Telford and the health inequalities which play a part in patients' perception of the service.

5.6 Mrs Jones agreed with Dr Chan's point in relation to benchmarking NHS STW against other systems in the Region, advising that within the GMS contract there were no standards or targets, and it would be necessary to identify a way by which the data could be compared.

5.7 Mr Dunshea suggested that it would be helpful if the report contained tables and graphs to highlight trends, demand, etc.

He also suggested that future reports should identify the issues and possible solutions to mitigate them.

ACTION: Mrs Jones to feed Mr Dunshea's comments regarding the style and format of the GP Access report back to Ms Pyrah.

5.8 Dr Garside currently had a member of staff who had been recruited on a fixed term basis into the BI Team from the Commissioning Support Unit to focus solely on Primary Care data. She suggested that this colleague could work with the Primary Care team to improve benchmarking and data reporting.

She had discussed with Dr Lyttle how the BI team can support Primary Care in measuring demand and capacity. Work is currently under way to identify how we can better support demand and capacity for Primary Care appointments. This work will help to inform potential solutions. Dr Garside will report back to a future Committee once this work has been completed and analysed.

5.9 Mr Dunshea offered his support and input to this work if required.

He believed that as NHS STW is an integrated care system, it would be important to gain input from Shropcom, SaTH, and colleagues in Social Services to gain a more generic picture as to how these concerns can be addressed.

5.10 Primary Care Commissioning Committee was asked to note the contents of the report and the recommendations made to ICB Board as follows: -

a) Request PCCC to drive and review the refreshed Primary Care Strategy as a development from the overall ICS strategy and as a core component of the system five-year plan.
b) Request PCCC to receive and review the report from the Deputy Medical Director on the implications, opportunities and actions resulting from the Fuller report and ensure they are included in the development of the Primary Care Strategy. Specific consideration will be attached to how the PCNs are maximised in delivering the integration agenda.
c) Request that PCCC urgently review telephone access, agree an improvement plan with Practices and update the Board on the progress being made.
d) Request that the One Public Estate approach be looked at regarding the future of General Practice premises.

The Committee discussed the recommendations within the report.

Recommendation (a): Mrs Jones provided assurance that both she and Claire Parker, Director of Partnerships & Place, were very much involved in the Integrated Care Partnership strategy, therefore the elements of Primary Care will have been included.

Recommendation (b): The Committee discussed whether the recommendations of the Fuller report should be included in development of the Primary Care Strategy.

Mr White advised that the Fuller report was the first of two pieces of work which outlined high level aspirations. More detailed actions were still to follow in the next report. He was supportive of everything that came out of the report but was cautious of treating aspirations as actions to be implemented.

Committee members agreed that the ICB should await the Government response regarding the Fuller report and recommendations.

Recommendation (c): Review of telephone access had already been discussed. Mr Dunshea referred to the fact that there is no requirement upon Practices to provide the ICB with data relating to telephone access. After discussion, the meeting concluded that the subject of access in general needs to be considered, and not merely telephone access.

Recommendation (d): A discussion took place at Board regarding public estate. Mrs Jones will follow this up and identify which Board member was actioned to follow this up.

ACTION: Mrs Jones to follow up with the relevant Board member the discussions and actions at the November Board meeting regarding Public Estate.

RESOLVE: ***The Committee noted the contents of the report and supported the recommendations made to ICB as outlined above.***

Minute No. PCCC-22.12.35 – Community Pharmacy Consultation Service – Implementation Update

6.1 The purpose of Mrs Williams' report was to provide the Committee with information on progress with implementation of the GP Community Pharmacy Consultation Service (GP CPCS).

6.2 Since January 2022, there has been steady progress with implementation of the service and an increase in the number of referrals into community pharmacies.

6.3 The GP Community Pharmacy Consultation Service (GP CPCS) offers patients same day minor illness consultations with a community pharmacist. The service was developed to allow Practice teams to refer low acuity patients for convenient, same day consultations with clinical advice.

6.4 The aim of this service is to alleviate pressure on GP appointments. It is believed that 6-10% of Practice appointment capacity could be effectively directed into community pharmacy.

6.5 As of 28 November 2022, 433 referrals had been completed.

6.6 Mr Dunshea referred to the numbers within the report and believed them to be small. He queried what kind of increase could be expected throughout the County and whether there were targets to be met.

6.7 Mrs Williams confirmed that referrals into community pharmacies must be a suitable minor illness. There is an investment and impact target of 0.65 per 1,000. However, there are also workforce issues in pharmacy and care must be taken not to overwhelm local pharmacies.

6.8 Mr Brettell wished to ensure Committee members were aware that in a rural community such as Shropshire there are areas of the County where access to pharmacy is difficult.

RESOLVE: ***The Committee noted the contents of the report which was submitted to the Committee for information.***

Minute No. PCCC-22.12.36 Ethnically Diverse Staff Survey

7.1 Mrs Gittins presented the Ethnically Diverse Staff Survey report on behalf of Mr Morgan who was unable to attend the meeting.

7.2 The report was compiled following the launch of the Ethnically Diverse Staff Network earlier in the year. That group had developed the survey and want to understand the experience of all staff working in Primary Care around issues of ethnic diversity.

7.3 The survey includes questions around role, training, work choices, complaints, and racism at work.

7.4 The overall aim of the survey is to understand the issues, challenges and barriers faced by Practices and individuals. The aim is to have information to better inform staff retention and recruitment campaigns.

7.5 The survey has been tried and tested elsewhere. The group now seeks approval of the Committee to go live.

7.6 Mrs Gittins invited questions.

7.7 Mrs Jones asked whether, during the survey, there was an opportunity to look at other protected characteristics to make it a wider survey, for example LGBT communities. Certain members of staff may feel excluded by a survey that has a particular focus on one characteristic.

Mrs Gittins advised that the survey was based on a model from elsewhere.

7.8 Ms Robinson asked whether the survey requested demographic characteristics to be completed.

7.9 Mrs Gittins confirmed that questions were asked such as ethnic group, religion and age, but no others around any other characteristics.

7.10 A short discussion took place around contents of future surveys.

Mrs Pall summarised the views of the Committee, stating that the Committee approved the survey to go live but going forward any future surveys should include all other protected characteristics.

Mr Dunshea suggested that the Committee should see the survey questionnaire to establish what had been covered and see the results in due course.

ACTION: The results of the Ethnically Diverse Staff Survey to be brought back to the Committee to highlight and inform workforce implications.

RESOLVE: ***The Committee noted the contents of the report which had been submitted to Committee for information and confirmed that the survey should now go live.***

However, the Committee highlighted that any future surveys should include all other protected characteristics.

Minute No. PCCC-22.12.37 Shrewsbury Health & Wellbeing Hub

8.1 Mrs Pall stepped down as Chair for this item due to a potential conflict of interests and declared that in the event of the Committee being required to vote on any action, she would not vote.

Mr Dunshea chaired the discussion of this Agenda item.

8.2 Jackie Robinson, Associate Director – Comms & Engagement, presented her paper which provided the Committee with an update on the Comms & Engagement Plan in relation to SHWBH.

8.3 For the purposes of assurance, Ms Robinson provided a brief update on the key points of the plan outlined in her paper.

- With regard to the timeline, the project is currently at Stage 4 which is applying essential criteria.
- Potential locations were submitted to a meeting with the GPs which included the six Practices who are fully relocating and the two Practices that are going to do an extended provision to allow the GPs to share what their preference would be.
- All locations will still go through a full assessment, the outcome of which will not be known until the middle of January 2023.
- The outcome of the preferred option will then be shared with the Stakeholder Reference Group and this Committee.

8.4 Ms Robinson invited questions.

8.5 Dr Povey referred to the timeline being pushed back and expressed concerns around the impact of the lack of space within some Practices in the Primary Care network if the timeline continues to slip. There must be a balance between being realistic in the timeline and having a timeline we are confident we can adhere to.

8.6 Ms Robinson advised that the Planning Department within the Local Authority had carried out an overview of the first tranche of potential locations. However, for the next 14 locations to be considered in January, a full process would be required which will take longer.

She expressed the importance of following due process. Failure to do so could leave the ICB open to legal challenge which will stop the process and cost a considerable amount of money in litigation. We must work with our partners in the Local Authority Planning Department and ensure that all appropriate steps are taken.

8.7 Mr Dunshea requested a more structured plan of the various steps within the process.

8.8 Mrs Jones had discussed this paper with Ms Pyrah and her understanding was that the discussion around potential locations that is taking place in mid-January will allow preparation of a timeline in terms of all the subsequent next steps.

8.9 Mr Dunshea suggested that the Committee should be regularly updated via email on a key step basis and kept informed as to progress. Risks should be highlighted.

He referred to the communications strategy, stating the importance of good communication. He requested that the Committee should be kept informed and given the opportunity to be involved in that part of the work.

Mr Dunshea handed Chairmanship of the meeting back to Mrs Pall.

Minute No. PCCC-22.12.38 PCN Maturity Survey Results and Output from the King's Fund OD Work

9.1 Mrs Jones' report was submitted to the Committee for information.

9.2 The report described two pieces of work that has taken place around PCN development.

9.3 On the whole, most PCNs are progressing.

9.4 The report also refers to the work of the King's Fund which was a piece of survey work carried out by that organisation with six of our eight PCNs and followed up by a PCN Development Day where the themes were discussed. The report provides a rich narrative around discussions that are taking place regarding PCN development. As we consider the wider ICS strategy, PCNs need to be developing and maturing to start having conversations with Shropcom and consider working differently.

9.5 The one topic that PCNs rated themselves lowest at was population health management.

9.6 Mrs Jones invited questions.

9.7 Mrs Pall referred to population health management and asked how involved Public Health colleagues were in that risk stratification. She requested information as to what risk tools were being utilised and asked whether Public Health colleagues in the PCNs have an idea of evidence-based interventions that can be put in place.

9.8 Mrs Jones advised that both Directors of Public Health are very much engaged with our PCNs in terms of development around our population's health. Helen Onions (Telford) and Bernie Lee (Shropshire) are leading cross-system groups. One group is looking at CVD early detection, and the other is looking at early diagnosis around cancer.

9.9 Population health management is a relatively new concept, which is probably why PCNs had scored it as an area where they need most support.

9.10 Mrs Jones then referred to risk stratification, advising that we do have a risk stratification tool in Aristotle. She referred to the other areas that the PCN survey reviewed and believed that those other areas need to be developed in order to provide a support infrastructure for population health management.

9.11 Dr Chan believed that in terms of the longer-term development of PCNs, the maturity index needed to be more comprehensive and longer term. Not all Practices within PCNs are ready for some of the objectives.

9.12 Mr Dunshea referred to the aims and objectives of the PCNs and asked whether it was possible to begin to consider what they are aiming to achieve in the next financial year.

Mrs Jones stated that she and Ms Pyrah would be happy to discuss PCNs and their deliverables with him. The objectives of the PCNs are currently all being delivered via the national DES. However, in terms of aspirations, the ICB would want PCNs to be moving more towards the place-based space, integrating more with the Community Trust, and delivering services differently to the neighbourhood.

9.13 Dr Povey believed that many Practices viewed the PCN merely as a method of delivering the PCN DES specification. He and Dr Chan were working on a piece of work with the LMC around establishing a GP Voice which they are trying to bring together under the auspices of the LMC.

ACTION: Mrs Jones, Ms Pyrah, Mr Dunshea and Mrs Pall to meet to discuss PCN background, DES, and requirements around reporting and look at the functions of PCNs with Public Health colleagues to see where the connections are with the ICB.

Minute No. PCCC-22.12.39 Risk Register

10.1 Mrs Jones referred to the updated Risk Register and drew the attention of the Committee to Risk No. 8 relating to Highley Medical Practice. Risk 8 was closed as the situation relating to the Practice had changed and there is now a new risk.

10.2 Mrs Jones will check the coding of Risk 10 with Ms Pyrah.

10.3 Three new risks had been added to the register - workforce, and two risks relating to Shrewsbury Health and Wellbeing Hub.

10.4 Committee members were assured by the Risk Register which underpinned both the information regarding Primary Care in the system and the information submitted to Board.

Minute No. PCCC-22.12.40 Finance Update

11.1 Mrs Clare reviewed the Finance report and drew the attention of the Committee to the following key points:-

11.2 At Month 7 there was an underspend in delegated budgets of £2.9m year to date with a reported full year forecast underspend of £3.3m. This is mainly in relation to the release of prior year benefits.

11.3 The underlying in year position is a year-to-date underspend of £1.3m. This is currently being reviewed with the Primary Care team as part of 2023-24 financial planning to establish whether that funding is already committed.

11.4 The 2023-24 planning round is already under way across the whole system, of which Primary Care is a key element. Committee will be provided with regular updates in the Finance report as to how the financial plan is developing.

11.5 It is expected that national guidance on the plan – normally issued on Christmas Eve - will not be issued until the end of December. As soon as more information is received, an update will be provided by the Finance team.

11.6 Mrs Clare referred to the POD (Pharmacy, Optometry and Dentistry) delegation which is due to come across to the ICB in April. Those financial budgets are being incorporated into planning and updates will be provided to the Committee going forward.

11.7 The Finance report included a risk framework produced by NHS England. 2023-24 will be the first year that the ICB has taken delegation of these budgets. Conversations across systems and across the Region indicate that it would be beneficial to have a risk framework between ICBs in the initial period at least to help possible variations in budgets to be managed across the Region.

11.8 Mrs Clare requested the Committee's support to progress that framework with NHS England. Mrs Skidmore, Chief Finance Officer, is part of the group across the Region who will be considering the way forward with this work.

11.9 The meeting requested information regarding capital for Estates.

Mrs Clare confirmed that the capital for Primary Care Estates sits with NHS England. It was referred to in paragraph 19 of the report as GP Estates Capital. It is an allocation, although the ICB must bid for it.

11.10 There were no further questions from Committee members regarding the Finance report.

11.11 The Committee was asked to: -

Note the financial position for the delegated budgets and that small risks are expected to be mitigated within the current budget.
Note the non-delegated primary care position and the risk of volatility in the prescribing budget driven by factors outside of the ICB's control.
Note that work is underway on the 23/24 plan and that further information will be brought to the February Committee.
Note that delegated responsibility for Community Pharmacy, Optometry and Dental (POD) services will transfer to the ICB from April 23 and discussions are ongoing around options for risk sharing arrangements.
Support the principles of the Draft POD Delegation Financial Risk Framework.

RESOLVE: ***Primary Care Commissioning Committee Members NOTED the contents of the Finance report.***

The Committee supported the principles of the Draft POD Delegation Financial Risk Framework and supported its development going forward.

Minute No. PCCC-22.12.41 Primary Care Team Update

12.1 The Primary Care report was taken as read.

12.2 Mr Brettell referred to the mass rollout by NHS England of patients being able to access their records which was due to be implemented on 30 November 2022. He advised that the BMA have negotiated an agreement with NHS England to place this on hold.

12.3 Mrs Clare asked about the work that had been done on estates around the Primary Care Estates Strategy and asked how that had been linked in with the wider estates work across the system to avoid individual groups working in isolation.

12.4 Mr Brettell replied that both he and Mr Francis regularly attend several strategic forums including the System Estates Group and One Public Estate Group. There should not be an occasion where there is a lack of linking up or an opportunity missed.

ACTION: Mr Brettell to provide an update on Estates, including visuals, in the Primary Care Update report to the next Committee.

12.5 Mr Dunshea suggested that the Primary Care Update paper should have higher prominence on the Agenda.

He then referred to adverse performance where certain targets are not being met, e.g. the national Diabetes Prevention Programme, and suggested that it would help the Committee to know the way forward in terms of how that is addressed, whether the target is unrealistic, or if steps need to be taken to improve mechanisms.

Referring to the discussion on population health, he suggested acquiring a read-across to what other sectors are doing and suggested obtaining a view across some of these programmes going into Social Services or within Shropcom.

12.6 Dr Garside advised that the Quality & Performance Committee have asked for an update and a "deep dive" into severe mental illness health checks and the LD health checks due in February. That information should be submitted to February PCCC before submission to Quality & Performance Committee at the end of the month.

RESOLVE: ***Primary Care Commissioning Committee Members NOTED the contents of the Primary Care Update report.***

Minute No. PCCC-22.12.42 Any Other Business

13.1 **PCCC**
Dr Pall advised the meeting that she would be discussing PCCC and how it is run in the future with Mr White, Mr Dunshea, and Sir Neil McKay, Chair of the ICB.

Dr Povey requested that he and Dr Chan should be included in the above discussions.

13.2 **RCN Strike Action**
Dr Pall referred to risks posed to the ICB by the strike action.

Dr Povey confirmed that there would be no direct impact on Practices because of the strike action. SaTH is not part of the strike action, but the Community Trust is, therefore there may be an impact on patient services in the community.

Ms Whateley confirmed that the main Unions – RCN and Unison – had not reached the threshold for agreeing strike action. None of the Unions were proposing strike action to extend to Shropshire.

Minute No. PCCC-22.12.43 Date of Next Meeting

The next Primary Care Commissioning Committee will take place on Friday 3 February 2023.

NHS Shropshire, Telford and Wrekin Primary Care Commissioning Committee RESOLVED that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (section 1(2) Public Bodies (Admission to Meetings) Act 1960.)

Agenda item ICB 29-03-076.7

Integrated Delivery Committee Chair's Report for meetings held on 13 February 2023 and 13 March 2023

ICB Integrated Delivery Committee
Date of 13th February 2023
Minutes of Meeting

Present	Initials	Present	Initials
Harry Turner	HT	Tanya Miles	TM
Gareth Robinson	GR	Liz Walker	LW
Jan Heath	JH	Angie Wallace	AW
Will Nabih	WN	Gloria Onwubiko	GO
Paula Davies	PD	Nigel Lee	NL
Sara Biffen	SB	Julie Garside	JG
Mike Carr	MC	Jonathan Rowe	JR
Cathy Riley	CR	Alison Wright	AW
Claire Skidmore	RC	Claire Parker	CP
Kate Owen	KO	Ian Bett	IB
Rebecca Gallimore	RG	Mark Hayward	MH
Lisa Keslake	LK	Betty Lodge	BL
Sarah Smith	SS		

Apologies

Sarah Dillion	Tracy Hill
Nicola Dymond	Nye Harries

In attendance

Gill Harrill	GH

Minute No Date & No. Format	Title
IDC-13.02.001	**Introduction and Apologies***
IDC-13.02.002	**Declarations of Interest*** • No declarations of interest • Attendees will be asked to complete a declaration of interest due to occasion when the Committee need make a decision.
IDC-13.02.003	**Minutes from the previous meeting of January** • Agreed
IDC-13.02.004	**Matters arising and action list from previous meetings*** • Action log updated.
IDC-13.02.005	**Chairs Report** • Taken as read and noted. • Paper to be submitted to the next Integrated Care Board
IDC-13.02.006	**Local Care benefits realisation paper** • Lisa Keslake is the new Programme Director • Presentation shared. • Information based on the benefits realisation modelling shared with IDC at the end of 2022. • Benefits realisation have been socialised in different forms in different places and have received on the whole positive feedback. • It was noted the benefits are in the right place for the things that are being delivered, and in places being under ambitious. • Local care looking at 2 primary programmes. • Key assumptions are virtual ward is a system programme not just SCHT

	• Co-development in the clinical engagement requires more work with Primary Care and require development of detailed milestones and KPIs that become the local care initiatives.
	• NL has asked PA consulting who are supporting HTP to look at the Local care benefits realisation model.
	• CS requested that SaTH clearly sign up to the plan and impact on growth – needs to see clarity in the longer term trajectory aligned to local plans
	• AW flagged that some cost reduction sits within LAs not just SaTH
	• NL confirmed need single view of demand and capacity model for the whole system
	• NL clear how this dovetails into HTP but still work to do on the short term detail although model won't change
	• JG has supported work with PA on demand and capacity model to use for projecting forwards, system analysts group working on this – made point that shouldn't underestimate demand in primary care if we get the anticipatory care right and nationally, dedicated funding as anticipatory care was a priority but now pulled from the national agenda. Shift from urgent to planned has to be a priority for us so we need to retain anticipatory care as a priority and focus.
	• SB requested more detail as keen to plan how to turn off escalation in 24/25, 25/26 onwards.
	• AW offered to work with SB on some joint ops comms to ensure everyone signed up to the same targets
	• GR thanked AW and the team for the clearest description of the benefits to date and summarised the requirement that:
	  ○ A benefits realisation framework be formally signed off by the LCTP board, HTP, operational teams including SB, LAs (JR and TM), JG on behalf of the system operational planning process and the System Finance Group and brought back to the IDC for final approval
	  ○ Sign off to be progressed by AW and LK on behalf of the system as the system leads for the LCTP
	  ○ The benefits realisation framework to include a 5-yr programme aligned to HTP setting out both operational and financial impact and setting out the detailed model of the budgets impacted, by how much and when, in terms of growth avoidance and cost out.
	  ○ The framework also to include a monitoring mechanism including KPIs, trajectories and reporting

IDC-13.02.007	**HTP Update**
	• HTP plan to provide HOSC an update on the plan emphasising the fact that it is part of a wider system plan.
	• There are 5 different sections, which are broadly on track.
	• The commercial and management cases are currently being refined.
	• Working on the financial and economic cases, work is ongoing in terms of the refinement of the design and costings
	• To note the HTP is not part of the new hospital programme
	• Assumptions and the SOC are correct but there are two areas of risk.
	  ○ Inflation
	  ○ Design and costs are done correctly – working with the national team on when the Joint Investment Committee date will be – possibly July

IDC-13.02.008	**Financial Improvement Programme Update** **Local CIP plans**

	• No risks to escalate, overall confidence on delivery of these programmes of work. • The majority of plans are on track and there's overall confidence in the delivery of these programmes of work where possible. • Organisations are still looking to increase any forecasting with non-recurrent benefits to help with the shortfall in delivery of some of the other programs of work. • The year-to-date position is £13.5 million of savings have been achieved. • Although the run rate starting to slow down the forecast is to deliver 18.5 million pounds against a plan of 18.2 - £300,000 overperformance **BTI's and efficiencies** • BTI's are being monitored through the individual program boards and deep dives are being presented to the IDC on a rotational basis. • As at month 9, the overall savings forecasting to be delivered are £8.6 million, which is short of the plan by just over £3 million. • The shortfall is mainly relating to the stretch target of £2.9 million that was included in the plans at the beginning of the year. • This is unlikely to be to be delivered, and so the remaining shortfall has been addressed through the acceleration of some the workforce program and additional benefit through the steps. • Work is underway to develop detail savings plans for next year and will again consist of the local CIP plans and BTI efficiency, delivery and the opportunities that are identified and monitored through the financial improvement programme group (FIP) • The FIP met in early February and very much focused on the preparation of plans for next year. • A designated senior responsible officer has been agreed for each of the opportunities that have been identified and the responsible officers are committed to being helped to support the programs in delivery or opportunities. • It was noted that it was disappointing that at this point in the year, to not have achieved the £2.9 million stretch. • It was also the noted the focus, effort and energy has to be on the new financial year and the plan moving into the next few years. • Looking at CIPs two thirds of the target is unidentified and already into February. • It was noted the need to start these programmes of work should be 1st April if we have any chance on delivering to the levels noted. • There is a need to convert to delivery and action as soon as plans are identified. • In reference to the BTIs there was a challenge to convert into deliverables and increase confidence • Action – each BTI SRO to review and revisit their modelling to understand what is the current state and more importantly how do they deliver the requirements without relying on growth avoidance **Operational Planning Activity** • No activity-based assumptions around the big-ticket items agreed across the system. • This is concerning as the draft plan has to be submitted to NHSE/me on the 23rd February. • The issue will be raised at the Operational Leads meeting.

	• Agreed Sara Biffen, Julie Garside, Mike Carr and Cathy Riley to oversee the delivery of the activity submissions • Acknowledged this would be work in progress but to share with JH by Thursday 16th February • Going forward there needs to be a method where colleagues are held to account for delivery – what mechanism as committee can we enact to ensure delivery. • If risks have mitigations identified? • It was noted from March, Workforce, estates and PBJC will report to FIP. • Estates will report quarterly to IDC re Infrastructure The recommendation was approved noting comments from WN.
IDC-13.02.009	**MSK Deep Dive** • The new MMST service has gone live today. • Thanks to colleagues from across the system in supporting this. • Good progress on trying to have consistent services across STW. • There are quite a few legacy patients due to services having a long wait. • Patients that have been referred up to the go live date today will continue on the pathways that they're currently on • By August will have completely moved across to the new processes. • Conversations have been taken place alongside clinical colleagues around Orthopaedics, • This will be the next step in taking what is in place for the MSK Transformation Board and making it fit for purpose for a broader scope in terms of its focus. This will be done over the next few months. • MSK is attending the ICC on the 29th of March, and hoping to have proposals developed to present • Work is also being done by the operational teams to try and improve Consultant access to theatres across the system. • It was recommended and agreed that the MSK and Outpatients Programme becomes part of the Planned Care Board and effectively comes out of the Integrated Delivery Committee.
IDC-13.02.010	**78 week waits.** • Paper circulated for information. • Current position on patients waiting longer than 78 weeks for elective care. • NHSE/I have recently moved the provider (SaTH) into tier one due to them not seeing the level of improvement therefore more scrutiny from national teams. • In relation to the operating plan NHSE/I didn't give indication But just to say also that in terms of our operating plan, what we submitted for this year, they didn't give any indication that the target was zero 78 week waits by the end of March • At the time the paper was submitted for this meeting the system position for the end of March was forecast to be 458, 211 for SaTH and 247 for Robert Jones which was accepted by NHSE/me at the time. • There is a national mandate from NHSE/I that all systems are now required to deliver zero patients waiting longer than 78 weeks. • Some improvements have been made over the last week since this paper was submitted. • There is regular oversight on this is issue to assure the committee and is assessed on a weekly basis, but internally for STW system and also

	with NHSE as well on the weekly basis and Gareth has requested that we provide a weekly update to yourself, Harry and also the IDC members on our progress going forward. • It was noted that although this is high profile work the importance is to reduce waiting times for patients • Going forward will share weekly updates on the position to IDC
IDC-13.02.011	**Finance Plan 23/24 Update** • Numbers shared on screen are now a week old. • Presentation has also been shared with CEOs. • Trying to break up the moving all the different moving parts in the finance plan into all the different areas that we need to focus on. • Planning guidance requests the system has a plan that delivers financial break even. • Noting the system is already in financial recovery and need to be demonstrating that reducing the underlying recurrent deficit. • Mapped out what the underlying position looks like • Exit position for 22/23 approx. £89 million underlying deficit – worse from where the system was previously. • Even with incoming allocation and efficiency – still exceed monies coming in – no cash releasing estimate's for the BTIs • Forecasting approx. 67 million for the financial year – have discussed with CEOs and setting the ambition to reduce to £50 million • Investment panel prioritises where monies should be allocated/spent.
IDC-13.02.012	**ARMS Business Case** • Deferred as hasn't been to Investment Panel
Papers submitted for Information and to be taken as read – Quarterly update schedule being produced.	
IDC-13.02.013	**Strategic Estates Group Update* -** agreed to feed into the Planned Care Board but provide quarterly updated to IDC on physical infrastructure.
IDC-13.02.014	**TWIPP Chairs Report*** • no meeting due to industrial action
IDC-13.02.015	**SHIPP Chairs Report*** • December report circulated. • January meeting was cancelled to due industrial action.
IDC-13.02.016	**Digital Delivery Group update *** • No paper submitted.
IDC-13.02.017	**Vaccination Update** • At the end of the autumn campaign for COVID vaccinations. • Next series of reports will be received in August/September in preparation for the next campaign. • Thanks was expressed to AW and Shropcom for this work • The vaccination centre at RJAH completed their final vaccines. • Recognition and thanks for all the support that RJAH colleagues have provided and as part of the whole ICB programme.
IDC-13.02.018	**UEC Board: Chairs Report*** • No paper submitted.

IDC-13.02.019	**Commissioning update*** • Paper taken as read and for info
IDC-13.02.020	**Any Other Business*** • There will be a need to bring forward a paper regarding he potential for an extension of the single point of access service, which will be submitted to the investment panel • GR to brief HT
	Date and Time of Next Meeting – 13th March 2023 14:00 – 16:00

ICB Integrated Delivery Committee
Date of 16th January 2023
Minutes of Meeting

Present	Initials	Present	Initials
Harry Turner	HT	Tanya Miles	TM
Gareth Robinson	GR	Liz Walker	LW
Jan Heath	JH	Angie Wallace	AW
Will Nabih	WN	Gloria Onwubiko	GO
Paula Davies	PD	Nigel Lee	NL
Sara Biffen	SB	Julie Garside	JG
Mike Carr	MC	Kay Holland	KH
Cathy Riley	CR	Jonathan Rowe	JR
Ruth Chambers	RC		

Apologies			
Rebecca Gallimore		Tracy Hill	
Sarah Dillion		Nye Harries	
Kate Owen			

In attendance	
Gill Harrill	GH

Minute No Date & No. Format	Title
IDC-23-01.001	**Welcome & Apologies** • The Chair advised in view of exceptional system pressures during December and January, the decision was taken to hold a shortened meeting in January to consider key decisions that could not be postponed until the February meeting.
IDC-23-01.002	**NHS 111** • The SRO for the Midlands 111 Procurement Project set out the current position of three contracts currently in place for the NHS111 service across the Midlands and the proposed Provider Selection Process by which a provider for the future NHS111 service will be selected. • The SRO advised that both the West and East Midlands Collaborative Commissioning Boards had agreed that of the options proposed at meetings on 6th January, Option 3 had been agreed i.e. to enter into a Midlands-wide contract. A team has been established to align end dates for existing contracts and to procure and implement a new Midlands-wide contract that is in line with national guidance for commencement in April 2024. • Both Collaborative Commissioning Boards had agreed that the tender and specification would be signed off by a nominated lead on behalf of the Midlands although confirmed that appropriate consultation would take place. • In order to achieve the timeline for the new contract, a PIN needed to be issued in February 2023.

	The IDC approved the proposal for both the Midlands-wide contract and the proposed Provider Selection Process.

IDC-23-01.003	**Direct Award Contracts**
	• A proposal was submitted by the Commissioning Team regarding the direct award of contracts due to expire at end March 2023.
	• Following discussion, the IDC approved that:
	  ○ All the proposed contract extensions should be limited to one year to facilitate transformation except in cases where this presented a risk to degradation of service provision. In that case the Commissioning Team could extend to two years without referral back to the IDC
	  ○ The contracts for which budget was in place were approved to proceed
	  ○ Two contracts for which there is no budget currently in place were not approved to proceed at this time. The IDC requested that the affordability issue be addressed through the appropriate route, either the planning round or the Investment Panel before coming back to the IDC for contract award.
	  ○ The two contracts for which there is no budget will be highlighted to the board

IDC-22-11.021	**AOB**
	Date and Time of Next Meeting – 13th February 2023 14:00 – 16:00