

STW ICS Board papers pack

MEETING
25 May 2022 15:00

PUBLISHED
20 May 2022

Agenda

Location	Date	Owner	Time
	25/05/22		15:00
1. ROS update/sign off - Appendix A		Agenda Item 25-05.007	
2. STW ICB Constitution- Appendix B		Agenda Item. 25-05.007	
3. STW ICS Green Plan		Agenda Item 25-05.008	
4. STW People and Communities involvement strategy (pledge 8)		Agenda Item 25-05.009	

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4. STW People and Communities involvement strategy (pledge 8)	109

Introduction to the Readiness to Operate Statement (ROS) Checklist V5

IMPORTANT - THIS CHECKLIST SHOULD ONLY BE USED ONCE YOU HAVE READ THE ICS ESTABLISHMENT GUIDANCE ENTITLED: 'ICB READINESS TO OPERATE STATEMENT (ROS) AND CHECKLIST' AND THE CONTENT OF THIS TAB.

The ROS checklist has been co-produced by NHS England and NHS Improvement teams, including the legal team, Integrated Care Systems (ICSs) and other stakeholders. It was published via FutureNHS on 18 August 2021. It has been released as appendix B of the guidance document and also as a working Excel document with RAG rating drop-down options to enable systems to self-assess. The Excel document was revised and re-published on 14 October 2021 (V2) to take account of feedback that the RAG ratings needed to include options for 'not started' and 'completed', on 3 November 2021 (V3) to remove 'not started' and provide a 'N/A' option for prompt 3.8, on 2 March 2022 (V4) to reflect the change in the target date for ICB establishment and on 11 May 2022 (V5) to amend the RAG rating options for the final submission and remove projected RAG rating.

The ROS checklist is a national tool for regional implementation. It indicates that arrangements should be 'in line with relevant guidance' and thus sets a national minimum standard where applicable. However, it does not specify the level or type of evidence required, nor in detail the assessment process to be adopted. Within parameters, there is flexibility, and regional teams have determined and documented their approaches to assessment, with differentiation between ICSs where appropriate to take account of local circumstances.

The ROS checklist is the key mechanism for reporting and assuring progress towards ICB establishment. System colleagues can download the checklist to undertake a self-assessment, RAG rating their current and projected (June 2022) positions ['projected' option removed from final assessment] against the different elements, and supplying a supporting commentary. Individual system self-assessments should be submitted to regional teams.

In June 2022 (see ICB Establishment Timeline for dates) each designate ICB chief executive and their relevant NHS England & NHS Improvement regional director will be asked to co-sign a 'Readiness to Operate Statement' (ROS). This will be a high-level statement to confirm that:

- all legally required and operationally critical elements are in place ready for the establishment of the Integrated Care Board (ICB) as a statutory body on 1 July 2022; and
 - arrangements are in place for the ICB to fulfil its role within the wider ICS, including establishing the Integrated Care Partnership (ICP) with the relevant local authority/ies.
- Once completed in June 2022, the checklist should be appended to the signed ROS.

The ROS checklist will be the key mechanism for reporting and assuring progress towards ICB establishment.

There will be a joint assessment of progress against each element of the checklist between all systems and the relevant NHS England and NHS Improvement regional team. Assessments at the end of Q2 and Q3 have been completed, and the assessment for Q4 2021/22 will take place in March / April. There will be a final assessment and each ICB's ROS will need to be signed off in June 2022.

Precise dates for submission of the ROS assessments are all outlined in the ICB Establishment Timeline.

Tab 2 includes the full checklist and the key points to note are as follows:

- column B provides an optional hierarchy allowing presentation as a high level summary (ie 12 core areas) or with all supporting elements
- the date of completion should be included at line 6 and as outlined above, and assessments at Q2, Q3, Q4 2021/22, with a final submission in June (noting that no projected position will be required for the final submission)
- column F seeks a current RAG rating based on the descriptions on the drop down list
- column G seeks a projected RAG rating based on the description on the drop down list
- column H provides a commentary column

Guidance in relation to the subjects covered in the ROS checklist is / will be available on the dedicated workspace for ICS Guidance on the FuturesNHS Platform: <https://future.nhs.uk/ICSGuidance/grouphome> on the FutureNHS Collaboration Platform

Version Control

The final draft of the ROS Checklist is contained in the guidance document and this working version is accessible via the Hub. Changes are not anticipated but if deemed necessary, strict version control will be applied. The version number and date of issue will be included below and any changes clearly identified

Current version number
Date of current version

V5
5/11/2022

Comments Regarding Versions Released

V1 was released on 18.08.21

V2 was released on 14.10.21 - no changes made to the content, the only change is in relation to the RAG rating methodology as outlined on the version control log

V3 was released on 03.12.21 - no changes made to the content, the only change is in relation to the RAG rating methodology as outlined on the version control log

V4 was released on 02.03.22 - most changes relate to the change in date for ICB establishment and a change in the narrative re prompt 9.1 - see changes in the version control log

V5 was released on 13.05.22 - no changes made to the content, the only change is in relation to the RAG rating methodology as outlined on the version control log

V4 V5 **Readiness to Operate Statement (ROS) Checklist - to prepare for legal establishment on 1 July 2022** V5
Please refer to the ROS Guidance before using this checklist

Name of ICB:	Shropshire, Telford and Wrekin ICS
Date:	20-May-22
Completed by:	Nicky O'Connor
Contact details:	

V4	Hierarchy	Ref	Description
	High Level Summary	1	Integrated care partnership (ICP): Initial ICP arrangements and principles agreed
V4	Supporting elements	1.1	Initial Integrated Care Partnership (ICP) arrangements agreed, including principles for operation from 1 July 2022, in line with relevant guidance
	High Level Summary	2	Integrated care board (ICB): Designate appointments to the Board of the ICB made and Board quorate in line with relevant guidance
V4	Supporting elements	2.1	Designate Chair appointed and ready to take up post on 1 April 2022
	Supporting elements	2.2	Designate Chief Executive appointed and ready to take up post on 1 April 2022
	Supporting elements	2.3	Designate Non-Executive Directors (minimum of two) appointed and ready to take up post on 1 April 2022
V4	Supporting elements	2.4	Designate Partner members appointed and ready to take up post [timing dependent on the Partner Member Regulations]
	Supporting elements	2.5	Other designate appointments made and postholders ready to take up post on 1 April 2022 (minimum additional Executive roles: finance; medical; nursing) to ensure quoracy of the ICB Board, according to its Constitution
	High Level Summary	3	System development plan, ICB constitution and governance arrangements: System Development Plan, ICB constitution and governance arrangements in place
	Supporting elements	3.1	System development plan (SDP) in place indicating how the ICB will work with its partners in the ICP from April 2022 to meet the needs of the population, with a focus on reducing health inequalities
V4	Supporting elements	3.2	ICB Constitution, including the Standing Orders and agreed ICB name, approved by NHS England before 1 July 2022, ready to be adopted on 1 July 2022 - in line with relevant guidance
V4	Supporting elements	3.3	ICB Scheme of Reservation and Delegation (SoRD) prepared and ready to be adopted on 1 July 2022
V4	Supporting elements	3.4	ICB Standing Financial Instructions (SFIs) prepared and ready to be adopted on 1 July 2022
V4	Supporting elements	3.5	ICB Governance Handbook (setting out the governance arrangements) prepared and ready to be adopted on 1 July 2022
V4	Supporting elements	3.6	ICB functions and decision map prepared and ready to be adopted on 1 July 2022 - including (where applicable) place boundaries, place-based leadership, and place-based governance arrangements (e.g. with Health and Wellbeing Boards); delegations (where appropriate); and any supra-ICB governance arrangements
V4	Supporting elements	3.7	Any joint commissioning arrangements for 2022/23 (including joint committees with local authorities, trusts / foundation trusts, other ICBs and NHS England and NHS Improvement) documented, ready to take effect on 1 July 2022
V4	Supporting elements	3.8	Schedules of delegation to be in place for 1 July 2022 where the ICB has agreed with NHS England and NHS Improvement to assume delegated responsibility for NHSEI commissioning functions in line with relevant guidance [For clarification purposes this relates to Pharmacy, Optometry and Dental commissioning function only]
V4	Supporting elements	3.9	Standards of business conduct policy prepared and ready to be adopted on 1 July 2022
V4	Supporting elements	3.10	Conflicts of interest policy prepared and ready to be adopted on 1 July 2022
	Supporting elements	3.11	Essential policies identified through risk assessment (eg commissioning [eg IVF commissioning], safeguarding, HR) and prepared
	High Level Summary	4	Provider partnerships: Provider partnership arrangements agreed
V4	Supporting elements	4.1	Provider partnership arrangements which will apply from 1 July 2022 agreed in line with relevant guidance. These include provider collaboratives, primary care networks and other collaborative arrangements
	High Level Summary	5	People and culture: People function ready for operation
	Supporting elements	5.1	Governance and delivery arrangements for people function agreed and ready for operation as set out in line with relevant guidance, and workforce and organisational development priorities identified in the system development plan
	High Level Summary	6	Quality, safety and EPRR: Quality, safety and EPRR systems and functions ready for operation
V4	Supporting elements	6.1	Quality and safety systems and function ready to take effect from 1 July 2022, including implementation of System Quality Groups in line with the National Quality Board's guidance
V4	Supporting elements	6.2	EPRR responsibilities clear and systems and function ready to operate from 1 July 2022 in line with relevant guidance
	High Level Summary	7	Clinical and care professional leadership: Model / arrangements prepared
	Supporting elements	7.1	ICB leadership model / arrangements prepared in line with relevant guidance
	High Level Summary	8	Working with people and communities: Public involvement and engagement strategy / policy
	Supporting elements	8.1	ICB public involvement and engagement strategy / policy prepared in line with relevant guidance
V4	High Level Summary	9	NHS oversight and ways of working: NHS oversight and ways of working between NHS England and NHS Improvement regional team and ICB
V4	Supporting elements	9.1	Arrangements for NHS oversight and the MOU to describe the agreed ways of working between the NHS England and NHS Improvement regional team and the ICB prepared, ready to take effect from 1 July 2022
	High Level Summary	10	Finance and planning: Planning for 2022/23 developed in line with national requirements and finance function and systems ready for operation
	Supporting elements	10.1	Planning for 2022/23 has been carried out in line with relevant guidance
V4	Supporting elements	10.2	Activities as outlined in the NHS SBS finance / ledger reconfiguration programme plan as due by 1 July 2022 have been delivered e.g. new bank account in place for the ICB, ICB able to make payments for goods and services, finance function ready to operate, etc.
	Supporting elements	10.3	Plan for ESR changes in place (if using IBM for a technical merge of ESR systems, technical slot booked)
	High Level Summary	11	Data, digital and information governance: Systems ready to operate and information governance activities on target
V4	Supporting elements	11.1	Activities outlined in the Organisation Data Service (ODS) reconfiguration toolkit as due by 1 July 2022 have been delivered
V4	Supporting elements	11.2	Activities outlined in the Information governance / data security and protection toolkit (DPST) (e.g. Caldicott Guardian, Information Asset Owner, Senior Information Risk Owner, records retention, etc.) as due by 1 July 2022 have been delivered
	High Level Summary	12	Transition from CCGs to ICBs: Equalities duties complied with, due diligence of people and property complete, consultation completed in line with TUPE requirements / COSoP guidance, staffing and property lists prepared and first day arrangements confirmed
	Supporting elements	12.1	Equalities duties
	Supporting elements	12.1.1	Evidence of compliance with the Public Sector Equalities Duty, and wider equalities duties, in the transfer and establishment process
	Supporting elements	12.2	People transfer
	Supporting elements	12.2.1	Consultation completed in line with TUPE requirements / COSoP guidance and staff list shared by sending CCG(s) to receiving ICB(s) (designate Chief Executive) - in line with relevant guidance [HR Framework and Due Diligence Guidance [tab 2.2 of the Due Diligence Checklist]]
	Supporting elements	12.2.2	CCG(s) staff due diligence completed and written assurance provided by the CCG's AO to the ICB's designate CE, with a copy to NHSEI's RD (where the AO and CE are the same person the written assurance should be provided to the NHSEI RD) - in line with relevant guidance [HR Framework and Due Diligence Guidance [tab 2.2 of the Due Diligence Checklist]]
	Supporting elements	12.3	Property transfer
	Supporting elements	12.3.1	CCG(s) due diligence completed on all property (assets and liabilities, including contracts e.g. with CSUs) in line with guidance; and written assurance provided by the CCG's AO to the ICB's designate CE, with a copy to NHSEI's RD (where the AO and CE are the same person the written assurance should be provided to the NHSEI RD). List of property and liabilities from sending CCG(s) to receiving ICB(s) produced - in line with relevant guidance (Due Diligence Guidance)
	Supporting elements	12.4	First day arrangements
	Supporting elements	12.4.1	Appropriate arrangements made in relation to NHS Resolution schemes (Clinical Negligence Scheme for Trusts, Liabilities to Third Parties Scheme and the Property Expenses Scheme) to provide indemnity in line with NHS Resolution guidance (when available)
	Supporting elements	12.4.2	First ICB Board meeting to note / approve (as appropriate): Constitution, governance handbook, appointments, key strategies, policies and delegation arrangements (covering both joint commissioning and formal delegations)
	Supporting elements	12.4.3	First day communications plan in place
	Supporting elements	12.4.4	ICB website in place

Final RAG Rating at June 2022
On target for delivery by 1 July (only to be used in exceptional circumstances)
On target for delivery by 1 July (only to be used in exceptional circumstances)
On target for delivery by 1 July (only to be used in exceptional circumstances)
Completed
Completed
Completed
On target for delivery by 1 July (only to be used in exceptional circumstances)
Completed
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On target for delivery by 1 July (only to be used in exceptional circumstances)
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On target for delivery by 1 July (only to be used in exceptional circumstances)
On target for delivery by 1 July (only to be used in exceptional circumstances)
Delivery is at risk but mitigation plan in place for delivery by 1 July
Delivery is at risk but mitigation plan in place for delivery by 1 July
Delivery is at risk but mitigation plan in place for delivery by 1 July
Delivery is at risk but mitigation plan in place for delivery by 1 July
On target for delivery by 1 July (only to be used in exceptional circumstances)
On target for delivery by 1 July (only to be used in exceptional circumstances)
On target for delivery by 1 July (only to be used in exceptional circumstances)
On target for delivery by 1 July (only to be used in exceptional circumstances)
Delivery is not achievable by 1 July
Delivery is at risk but mitigation plan in place for delivery by 1 July
On target for delivery by 1 July (only to be used in exceptional circumstances)
Completed
Completed
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On target for delivery by 1 July (only to be used in exceptional circumstances)
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Completed
Completed
Completed
Completed

Comments
ICP meeting booked for September SDP: Chapter 4.1 Governance
Governance handbook and ICP TORs are being drafted and will be submitted in line with revised ICB establishment timelines
SDP: Chapter 4.1 Governance and 4.3 People and Culture
Interim Chief Executive has commenced in post; intentions for the designate Chief Executive post will have been firmed up over the coming weeks All three NED posts have been appointed with NHSEI/ approval Evidence: announcement, see line 2.3 in the evidence log
The National model stipulates that the nomination processes must fulfil the requirements of being "jointly nominated"; details of this process are being set out in the Draft Constitution
Chief Financial and Chief Medical Officer have been appointed; Chief Nursing officer post is due for appointment in early April: all posts will start in line with revised ICB establishment timelines
SDP is this document - Chapters 4.1 Governance , 4.6 Place Development and 4.8 Commissioning
A refreshed SDP is attached to this ROS submission; further updates are being prepared for final submission on 10 June 2022
Draft constitution has been submitted and feedback has been received from NHSEI/; a further iteration has been included in evidence along with this submission. The updates reflect the feedback received and the most recent model constitution.
ICB Scheme of Reservation and Delegation (SoRD) has been prepared in line with the ICB draft constitution and has been included in this submission as part of the governance handbook ICB Standing Financial Instructions (SFIs) are being prepared and will be submitted in line with revised ICB establishment timeline on 20 May 2022 Evidence: see draft SFIs in line 3.4 of the evidence log The ICB governance handbook has been alongside the ICB constitution and is included in the evidence supporting this submission. The handbook will be further revisited and updated as the detail of the governance arrangements is further developed. An updated version of the functions and decisions map has been included in the evidence supporting this submission.
Conversations with neighbouring ICSs are continuing to discuss and reflect on the advantages and potential barriers associated with collaborative commissioning for a range of functions; key aim for this area is that any future collaborative commissioning arrangements would ensure delivery of efficiency of scale. An update to these conversations has been included with this submission as part of the SDP (relevant section of the SDP to be inserted here) The ICS is working with an NHSEI Link Person to liaise with regarding the level of NHSEI input and where this is most valuable. Work with partners will continue to progress our plans for July 2023 delegated functions. An outline plan with timelines has been included in an update to the SDP (relevant section of the SDP to be included here)
A standards of business conduct policy has been drafted as part of the governance handbook included in the evidence supporting this submission. A conflicts of interest policy has been drafted as part of the governance handbook included in the evidence supporting this submission. A programme of work is ongoing within the current CCG to refresh the policies that are currently in place. This has been risk assessed and prioritised. The programme will extend beyond 1st April 2022. Critical policies will be in place and work will be undertaken to ensure naming and other information is changed to reflect the move from CCG to ICS. SDP: Chapter 4.7 Provider Collaboratives
Principles of provider collaboration have been agreed; provider collaboration within the system reflects the small number of providers and therefore most provider collaborative discussions will occur at place; supra ICS collaborations already in existence SDP: Chapter 4.3 People and Culture
OD plan has been agreed by ICS People Board; Options paper included as part of evidence for this submission, TORs of reference for the people committee have been agreed;
SDP: Chapter 4.2 Quality
Meetings of the Quality & Performance Committee (QPC) are taking place monthly; operational assurance processes are arranged to allow the QPC to focus on strategic oversight of quality and safety across the system. The revised System Quality/ Quality Surveillance model will include strengthened arrangements with other learning partners. In addition, a System Patient Safety Group has been implemented with agreement on system priorities and the implementation of the NHS Patient Safety Strategy. The QPC feeds into the Integrated Care Board with subgroups and sub committees reporting into QPC. Local quality governance, implementing a structure and function have been set up in accordance with National Quality Board (NQB) and NHSEI published guidance as well as the needs of the system. Further NQB publication which will confirm the operating framework for System Quality Groups is expected. The system continues to work closely with NHSEI who co-chairs SOAG as part of the quality governance, particularly focussing on quality assurance. The requested ICB assurance template will be completed for submission in line with the workstream deadlines.
SDP: Chapter 4.11 Clinical, Care and Professional Leadership
A Clinical & Care Professional Leadership Framework and Engagement Strategy is currently being developed and will be progressed under the guidance of the newly appointed Chief Medical officer of STW ICS; updated drafts will be submitted in line with timelines agreed with the regional team. Actions that will be undertaken are as follows: Refresh and further development of document, internal circulation with CEOs and then further wider circulation with updates at each stage before the document is finalised and submitted. The document as included in the April submission for the ROS has been resubmitted.
SDP: Chapter 4.4 Working with People and Communities
Draft communication and engagement plan has been completed and included as evidence for this submission. The document will be approved by the ICB shadow board in advance of 27th May submission deadline and will be resubmitted at this point.
SDP: Chapter 4.10 Accountability and Oversight
Arrangements for system oversight have been outlined in SDP and the system MOU;
SDP: Chapter 4.9 Financial Allocations and Funding Flows
Preparation work in line with planning guidance has been completed in line with required timelines Evidence: see financial evidence in line 10.1, 10.2 and 10.3 of the evidence log
Full due diligence plan has been developed and reviewed by the Due Diligence panel; Monthly project boards with SBS have been undertaken. No significant risks currently identified Plan for ESR changes covered in detailed due diligence plan. Minimal action required as STW ICS does not require a technical merge Evidence: see line 10.3 in the evidence log SDP: Chapter 4.5 Data and Digital Standards and Requirements
Confirmed by region for October ROS submission and due diligence checkpoint in November that this action is not required for STW ICS
The DPST is completed and has been included in the evidence for this submission. Confirmation received that Shropshire, Telford and Wrekin has successfully submitted their 21/22 DSP Toolkit with a 'Standards Met' status on Friday 25th March 2022. Evidence - Confirmation email of DPST submission and full DPST tool kit in line 11.2 of the evidence log SDP: Chapter 5.1 Transitioning as an ICS
Equality Impact Assessment (EQIA) has been undertaken and is attached as evidence in line 12.1 of the evidence log Actions set out in the DD checklist. HR tab 2.1 action 2.1.3.4 are being progressed and monitored Equality Impact Assessment (EQIA) has been undertaken and is attached as evidence in line 12.1 of the evidence log
As set out in DD checklist tab 2.2 Relevant data is due to be produced in April 2022 followed by a checking and reconciliation exercise; data will be made available to the ICB on 1 June, the prescribed template is currently being tested on ESR with sample data. People Impact Assessment (PIA) Action 2.1.1.1 Has been completed and updated on a regular basis and EQIA Initial work completed (see above)
A full DD plan is in place that is tracked through due diligence checkpoints including independent review panels. Progress against the plan is regular reported back to both the Audit Committee of the CCG and the Audit and Risk Committee of the ICS. The checklist is updated in line with the checkpoints and any risks have been identified and mitigated. The most recent checklist has been included in the evidence pack for this submission.
A full DD plan is in place that is tracked through due diligence checkpoints including independent review panels. Progress against the plan is regular reported back to both the Audit Committee of the CCG and the Audit and Risk Committee of the ICS. The checklist is updated in line with the checkpoints and any risks have been identified and mitigated. The most recent checklist has been included in the evidence pack for this submission.
As set out in DD checklist Actions 1.7.4-7
A full DD plan is in place that is tracked through due diligence checkpoints including independent review panels. Progress against the plan is regular reported back to both the Audit Committee of the CCG and the Audit and Risk Committee of the ICS. The checklist is updated in line with the checkpoints and any risks have been identified and mitigated. The most recent checklist has been included in the evidence pack for this submission.
Confirmation on the continuation of the CCG's membership has been confirmed by NHS Resolution on 4 March 2022 Evidence: confirmation letter from NHS Resolutions in line 12.4.1 of the evidence log
The first ICB board meeting has been confirmed for 1 July 2022, further meeting arrangements were proposed in the ICB board meeting of 30 March 2022 and will be firmed up over the coming weeks
Draft communication and engagement plan is in development with the intention of being taken to the ICS board in April 2022 and completion by 20 May 2022 ICS Website is under development; a link to the site will be included in the final ROS submission

RAG Rating Guidance - See ICB Establishment Timeline for confirmation of all dates

RAG RATING FOR ALL LINES EXCLUDING 3.8

V2 V3 Final RAG rating (June 2022)

V4	R	Delivery is not achievable by 1 July
V5	A	Delivery is at risk but mitigation plan in place for delivery by 1 July
	G	On target for delivery by 1 July (only to be used in exceptional circumstances)
	C	Completed

RAG RATING FOR LINE 3.8 ONLY

V2 V3 Final RAG rating (June 2022)

V4	R	Delivery is not achievable by 1 July
V5	A	Delivery is at risk but mitigation plan in place for delivery by 1 July
	G	On target for delivery by 1 July (only to be used in exceptional circumstances)
	NA	Not applicable - applies to 3.8 only
	C	Completed

To guide assessment of what 'on target' means, refer to the systems' transition programme plans, which should be based on the NHSEI ICB Establishment Timeline.

NOTE THAT THAT THE GREEN OPTION SHOULD BE USED ONLY IN EXCEPTIONAL CIRCUMSTANCES IE WHERE IT IS ANTICIPATED THAT THE ACTION WILL BE COMPLETE BY 1 JULY 2022

VERSION CONTROL - LOG OF CHANGES

Date of Change	Version Change	Tab	Ref	Original Drafting	Revised Drafting	Comment Regarding Change
Version 1 released 18 August 2021						
Version 2 released 14 October 2021 - Changes shown below						
10/14/2021	V2	Introduction	Line 19	N/a	Comments Regarding Versions Released V1 was released on 18.08.21 V2 was released on 14.10.21 - no changes have been made to the content, the only change is in relation to the RAG rating methodology as outlined on the version control log	Added to provide confirmation of all versions released
10/14/2021	V2	ROS checklist	Current RAG rating	Current RAG rating (minimum requirement: Q2, Q3 2021/22, mid-February 2022 and final in March 2022) R - Not in place, not started or position unknown A - Progress made G - Completed and in place	Current RAG rating (minimum requirement: Q2, Q3 2021/22, mid-February 2022 and final in March 2022) R - Not on target, significant concerns A - Progress made, minor concerns G - On target, no concerns NS - Not possible to start C - Completed To guide assessment of what 'on target' means, refer to the systems' transition programme plans, which should be based on the NHSEI ICB Establishment Timeline.	Change to RAG rating options
10/14/2021	V2	ROS checklist	Projected RAG rating	Projected RAG rating at March 2022 (date to be confirmed and is likely to be between mid-March and 31/3/22) R - Delivery by March 2022 is not achievable or significant risk to delivery A - Delivery by March 2022 is at risk but mitigation plan in place G - On target for delivery by March 2022	Projected RAG rating at March 2022 (date to be confirmed and is likely to be between mid-March and 31/3/22) R - Delivery by March 2022 is not achievable A - Delivery by March 2022 is at risk but mitigation plan in place G - On target for delivery by March 2022 C - Completed	Change to RAG rating options
Version 3 released 3 December 2021 - Changes shown below						
12/3/2021	V3	Introduction	Line 19	Comments Regarding Versions Released V1 was released on 18.08.21 V2 was released on 14.10.21 - no changes have been made to the content, the only change is in relation to the RAG rating methodology as outlined on the version control log	Comments Regarding Versions Released V1 was released on 18.08.21 V2 was released on 14.10.21 - no changes made to the content, the only change is in relation to the RAG rating methodology as outlined on the version control log V3 was released on 03.12.21 - no changes made to the content, the only change is in relation to the RAG rating methodology as outlined on the version control log	Updated to reflect version control
12/3/2021	V3	ROS checklist	Current RAG rating	Current RAG rating (minimum requirement: Q2, Q3 2021/22, mid-February 2022 and final in March 2022) R - Not on target, significant concerns A - Progress made, minor concerns G - On target, no concerns NS - Not possible to start C - Completed To guide assessment of what 'on target' means, refer to the systems' transition programme plans, which should be based on the NHSEI ICB Establishment Timeline.	Current RAG rating (minimum requirement: 31 October 2021, 31 December 2021, 14 February 2022 and final in March 2022) R - Not on target, significant concerns A - Progress made, minor concerns G - On target, no concerns NA - Not applicable - applies to 3.8 only C - Completed To guide assessment of what 'on target' means, refer to the systems' transition programme plans, which should be based on the NHSEI ICB Establishment Timeline.	Change to RAG rating options. Not possible start has now been removed as work will now have started for all areas of the ROS. N/A option introduced for prompt 3.8 only.
12/3/2021	V3	ROS checklist	Projected RAG rating	Projected RAG rating at March 2022 (date to be confirmed and is likely to be between mid-March and 31/3/22) R - Delivery by March 2022 is not achievable or significant risk to delivery A - Delivery by March 2022 is at risk but mitigation plan in place G - On target for delivery by March 2022	Projected RAG rating at March 2022 (date to be confirmed and is likely to be between mid-March and 31/3/22) R - Delivery by March 2022 is not achievable A - Delivery by March 2022 is at risk but mitigation plan in place G - On target for delivery by March 2022 NA - Not applicable - applies to 3.8 only C - Completed	Change to RAG rating options. N/A option introduced for prompt 3.8 only.
Version 4 was prepared on 16 February 2022 (approved by the C&TSG) but not released and updated again on 2 March 2022 - Changes shown below						
2/16/2022	V4 16.02.22	Introduction	Line 7	The ROS checklist has been co-produced by NHS England and NHS Improvement teams, including the legal team, Integrated Care Systems (ICSs) and other stakeholders.	The ROS checklist has been co-produced by NHS England and NHS Improvement teams, including the legal team, Integrated Care Systems (ICSs) and other stakeholders. It was published via FutureNHS on 18 August 2021. It has been released as appendix B of the guidance document and also as a working Excel document with RAG rating drop-down options to enable systems to self-assess. The Excel document was revised and re-published on 14 October 2021 (V2) to take account of feedback that the RAG ratings needed to include options for 'not started' and 'completed', on 3 November 2021 (V3) to remove 'not started' and provide a 'N/A' option for prompt 3.8 and again on 16 February 2022 to reflect the change in the target date for ICB establishment. The ROS checklist is a national tool for regional implementation. It indicates that arrangements should be 'in line with relevant guidance' and thus sets a national minimum standard where applicable. However, it does not specify the level or type of evidence required, nor in detail the assessment process to be adopted. Within parameters, there is flexibility, and regional teams have determined and documented their approaches to assessment, with differentiation between ICSs where appropriate to take account of local circumstances. The ROS checklist is the key mechanism for reporting and assuring progress towards ICB establishment. System colleagues can download the checklist to undertake a self-assessment, RAG rating their current and projected (June 2022) positions against the different elements, and supplying a supporting commentary. Individual system self-assessments should be submitted to regional teams.	Extended description
2/16/2022	V4 16.02.22	Introduction	Line 8	In March 2022 (exact date TBC) each ICB chief executive designate and their relevant NHS England & NHS Improvement regional director will be asked to co-sign a 'Readiness to Operate Statement' (ROS). This will be a high-level statement to confirm that: <ul style="list-style-type: none">all legally required and operationally critical elements are in place ready for the establishment of the Integrated Care Board (ICB) as a statutory body on 1 April 2022; andarrangements are in place for the ICB to fulfil its role within the wider ICS, including establishing the Integrated Care Partnership (ICP) with the relevant local authority/ies. Once completed in March 2022, the checklist should be appended to the signed ROS.	In June 2022 (see ICB Establishment Timeline for dates) each designate ICB chief executive and their relevant NHS England & NHS Improvement regional director will be asked to co-sign a 'Readiness to Operate Statement' (ROS). This will be a high-level statement to confirm that: <ul style="list-style-type: none">all legally required and operationally critical elements are in place ready for the establishment of the Integrated Care Board (ICB) as a statutory body on 1 July 2022; andarrangements are in place for the ICB to fulfil its role within the wider ICS, including establishing the Integrated Care Partnership (ICP) with the relevant local authority/ies. Once completed in June 2022, the checklist should be appended to the signed ROS.	Changed date to respond to the new target date of 1 July 2022
2/16/2022	V4 16.02.22	Introduction	Line 9	The ROS checklist will be the key mechanism for reporting and assuring progress towards ICB establishment. There will be a joint review of progress against each element of the checklist between all systems and the relevant NHS England and NHS Improvement regional team at the end of Q2 and Q3 2021/22. ICSs will be asked to share their checklist with the regional team at these points, alongside their updated system development plans. There will be a final progress review in mid-February 2022 and each ICB's ROS will need to be signed off in March 2022 (deadline date to be confirmed).	The ROS checklist will be the key mechanism for reporting and assuring progress towards ICB establishment. There will be a joint assessment of progress against each element of the checklist between all systems and the relevant NHS England and NHS Improvement regional team. Assessments at the end of Q2 and Q3 have been completed, and the assessment for Q4 2021/22 will take place in March / April. There will be a final assessment and each ICB's ROS will need to be signed off in June 2022. Precise dates for submission of the ROS assessments are all outlined in the ICB Establishment Timeline.	Changed date to respond to the new target date of 1 July 2022
2/16/2022	V4 16.02.22	Introduction	Line 10	Tab 2 includes the full checklist and the key points to note are as follows: <ul style="list-style-type: none">column B provides an optional hierarchy allowing presentation as a high level summary (ie 12 core areas) or with all supporting elementsthe date of completion should be included at line 8 and as outlined above, it is expected that an assessment will be completed at Q2, Q3 2021/22, mid-February 2022, with a final submission in March (noting that no projected position will be required for the final submission)column F seeks a current RAG rating based on the descriptions on the drop down list.column G seeks a projected RAG rating based on the description on the drop down list.column H provides a commentary column.	Tab 2 includes the full checklist and the key points to note are as follows: <ul style="list-style-type: none">column B provides an optional hierarchy allowing presentation as a high level summary (ie 12 core areas) or with all supporting elementsthe date of completion should be included at line 8 and as outlined above, and assessments at Q2, Q3, Q4 2021/22, with a final submission in June (noting that no projected position will be required for the final submission)column F seeks a current RAG rating based on the descriptions on the drop down listcolumn G seeks a projected RAG rating based on the description on the drop down listcolumn H provides a commentary column	Changed date to respond to the new target date of 1 July 2022
2/16/2022	V4 16.02.22	ROS checklist	Cell G10	Projected RAG Rating at March 2022	Projected RAG Rating at June 2022	Changed date to respond to the new target date of 1 July 2022
2/16/2022	V4 16.02.22	ROS checklist	1.1, 3.2-3.10 incl, 4.1, 6.1, 6.2, 10.2, 11.1, 11.2	Date previously referred to 1 April 2022	Date now refers to 1 July 2022	Changed date to respond to the new target date of 1 July 2022 - for all prompts shown [note line 24 below which later included prompt 9.1]
2/16/2022	V4 16.02.22	ROS checklist	3.8	Schedules of delegation to be in place for 1 July 2022 where the ICB has agreed with NHS England and NHS Improvement to assume delegated responsibility for NHSEI commissioning functions in line with relevant guidance	Schedules of delegation to be in place for 1 July 2022 where the ICB has agreed with NHS England and NHS Improvement to assume delegated responsibility for NHSEI commissioning functions in line with relevant guidance [For clarification purposes this relates to Pharmacy, Optometry and Dental commissioning function only]	Clarified that this prompt relates to POD services only

STW ICB Constitution Appendix B

Agenda item 25-05.007



Shropshire, Telford
and Wrekin

NHS Shropshire, Telford and Wrekin Integrated Care Board CONSTITUTION

Version	Date effective from
Version 1	1 st July 2022

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1. Introduction

1.1 Background/ Foreword

Shropshire, Telford and Wrekin Integrated Care Board (ICB) was created as a statutory body on 1st July 2022 as part of our wider Integrated Care System (ICS).

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

Our ICS seeks to create a much more integrated system across Shropshire, Telford and Wrekin, working as a multi-organisational partnership both in terms of planning and commissioning services across our population, and in developing more integrated services on the ground.

Our partnership consists of the NHS (Shropshire, Telford and Wrekin ICB, The Shrewsbury and Telford Hospital NHS Trust, The Robert Jones Agnes Hunt Orthopaedic Hospital NHS Foundation Trust, Midlands Partnership NHS Foundation Trust, Shropshire Community Health NHS Trust and primary care/GPs), West Midlands Ambulance Service University NHS Foundation Trust, primary care through our Primary Care Networks (PCN), our local councils (Shropshire Council and Telford & Wrekin Council), along with the voluntary sector and other core partners involved in transforming the provision of health and care services across Shropshire, Telford and Wrekin for those we serve.

NHS England has set out the following as the four purposes of ICSs:

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

The ICB will lead the ICS and is the organisation with responsibility for NHS functions and budgets, supported by an Integrated Care Partnership (ICP); a statutory joint committee bringing together all system partners to produce a health and care strategy.

The ICB will use its resources and powers to achieve demonstrable progress on these aims, collaborating to tackle complex challenges, including:

- improving the health of children and young people

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

1.2 Name

- 1.2.1 The name of this Integrated Care Board is NHS Shropshire, Telford and Wrekin Integrated Care Board (“the ICB”).

1.3 Area Covered by the Integrated Care Board

- 1.3.1 The area covered by the ICB is aligned with the two unitary authorities; County of Shropshire and Borough of Telford and Wrekin, the County of Shropshire and Borough of Telford and Wrekin.

1.4 Statutory Framework

- 1.4.1 The ICB is established by order made by NHS England under powers in the 2006 Act.
- 1.4.2 The ICB is a statutory body with the general function of arranging for the provision of services for the purposes of the health service in England and is an NHS body for the purposes of the 2006 Act.
- 1.4.3 The main powers and duties of the ICB to commission certain health services are set out in sections 3 and 3A of the 2006 Act. These provisions are supplemented by other statutory powers and duties that apply to ICBs, as well as by regulations and directions (including, but not limited to, those made under the 2006 Act).
- 1.4.4 In accordance with section 14Z25(5) of and paragraph 1 of Schedule 1B to the 2006 Act, the ICB must have a Constitution, which must comply with the requirements set out in that Schedule. The ICB is required to publish its Constitution (section 14Z29). This Constitution is published at [\[add web address\]](#)
- 1.4.5 The ICB must act in a way that is consistent with its statutory functions, both powers and duties. Many of these statutory functions are set out in the 2006 Act, but there are also other specific pieces of legislation that apply to ICBs: examples include, but are not limited to, the Equality Act 2010 and the Children Acts. Some of the statutory functions that apply to ICBs take the form of general statutory duties, which the ICB must comply with when exercising its functions. These duties include but are not limited to:

- a) having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 2009 and section 14Z32 of the 2006 Act);
 - b) exercising its functions effectively, efficiently and economically (section 14Z33 of the 2006 Act);
 - c) duties in relation to children, including safeguarding, promoting welfare etc. (including the Children Acts 1989 and 2004, and the Children and Families Act 2014);
 - d) adult safeguarding and carers (the Care Act 2014);
 - e) equality, including the public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35);
 - f) information law, (for instance, data protection laws, such as the UK General Data Protection Regulation 2016/679 and Data Protection Act 2018, and the Freedom of Information Act 2000); and
 - g) provisions of the Civil Contingencies Act 2004
- 1.4.6 The ICB is subject to an annual assessment of its performance by NHS England, which is also required to publish a report containing a summary of the results of its assessment.
- 1.4.7 The performance assessment will assess how well the ICB has discharged its functions during that year and will, in particular, include an assessment of how well it has discharged its duties under—
- a) section 14Z34 (improvement in quality of services),
 - b) section 14Z35 (reducing inequalities),
 - c) section 14Z38 (obtaining appropriate advice),
 - d) section 14Z40 (duty in respect of research)
 - e) section 14Z43 (duty to have regard to effect of decisions)
 - f) section 14Z44 (public involvement and consultation),
 - g) sections 223GB to 223N (financial duties), and
 - h) section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).
- 1.4.8 NHS England has powers to obtain information from the ICB (section 14Z60 of the 2006 Act), and to intervene where it is satisfied that the

ICB is failing or has failed to discharge any of its functions, or that there is a significant risk that it will fail to do so (section 14Z61).

1.5 Status of this Constitution

- 1.5.1 The ICB was established on 1st July 2022 by [*name and reference of establishment order*], which made provision for its Constitution by reference to this document.
- 1.5.2 This Constitution must be reviewed and maintained in line with any agreements with, and requirements of, NHS England set out in writing at establishment.
- 1.5.3 Changes to this Constitution will not be implemented until, and are only effective from, the date of approval by NHS England.

1.6 Variation of this Constitution

- 1.6.1 In accordance with paragraph 15 of Schedule 1B to the 2006 Act, this Constitution may be varied in accordance with the procedure set out in this paragraph. The Constitution can only be varied in two circumstances:
- a) where the ICB applies to NHS England in accordance with NHS England's published procedure and that application is approved; and
 - b) where NHS England varies the Constitution of its own initiative, (other than on application by the ICB).
- 1.6.2 The procedure for proposal and agreement of variations to the Constitution is as follows:
- a) Any ICB Member may propose a variation to the Constitution of the ICB by submitting their proposal in writing to the Chief Executive, who will then consult with the Chair and at least two ordinary members of the ICB; one an independent non-executive member and one a partner member. The Chief Executive will present the proposed amendments in a report to the ICB, together with comments from those they have consulted with.
 - b) The ICB will make the decision to vary the Constitution and make an application to NHS England to accept the proposed amendments.
 - c) Proposed amendments to this Constitution will not be implemented until an application to NHS England for variation has been approved.

1.7 Related Documents

1.7.1 This Constitution is also supported by a number of documents which provide further details on how governance arrangements in the ICB will operate.

1.7.2 The following are appended to the Constitution and form part of it for the purpose of clause 1.6, and the ICB's legal duty to have a Constitution:

- a) **Standing orders**– which set out the arrangements and procedures to be used for meetings and the processes to appoint to the ICB committees.

1.7.3 The following do not form part of the Constitution but are required to be published:

- a) **The Scheme of Reservation and Delegation (SoRD)**– sets out those decisions that are reserved to the board of the ICB and those decisions that have been delegated in accordance with the powers of the ICB and which must be agreed in accordance with and be consistent with the Constitution. The SoRD identifies where, or to whom, functions and decisions have been delegated to.
- b) **Functions and Decision map**– a high-level structural chart that sets out which key decisions are delegated and taken by which part or parts of the system. The Functions and Decision map also includes decision-making responsibilities that are delegated to the ICB (for example, from NHS England).
- c) **Standing Financial Instructions**– which set out the arrangements for managing the ICB's financial affairs.
- d) **The ICB Governance Handbook**– This brings together all the ICB's governance documents so it is easy for interested people to navigate. It includes:
 - The above documents (a) to (c)
 - Terms of reference for all committees and sub-committees of the board that exercise ICB functions.
 - Delegation arrangements for all instances where ICB functions are delegated, in accordance with section 65Z5 of the 2006 Act, to another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one of those organisations in accordance with section 65Z6 of the 2006 Act.

- Terms of reference of any joint committee of the ICB and another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one of those organisations in accordance with section 65Z6 of the 2006 Act.
 - The up-to-date list of eligible providers of primary medical services under clause 3.6.2
- e) **Key policy documents**– which should also be included in the Governance Handbook or linked to it - including:
- Standards of Business Conduct Policy
 - Conflicts of interest policy and procedures
 - Framework and Principles for Public Involvement and Engagement

2. Composition of the Board of the ICB

2.1 Background

- 2.1.1 This part of the Constitution describes the membership of the Integrated Care Board. Further information about the criteria for the roles and how they are appointed is in section three.
- 2.1.2 Further information about the individuals who fulfil these roles can be found on our website [\[add link\].](#)
- 2.1.3 In accordance with paragraph 3 of Schedule 1B to the 2006 Act, the membership of the ICB (referred to in this Constitution as “the board”, and members of the ICB are referred to as “board Members”) consists of:
- a) a Chair
 - b) a Chief Executive
 - c) at least three Ordinary members
- 2.1.4 The membership of the ICB (the board) shall meet as a unitary board and shall be collectively accountable for the performance of the ICBs functions.
- 2.1.5 NHS England Policy, requires the ICB to appoint the following additional Ordinary Members:
- a) three executive members, namely:
 - ICB Chief Finance Officer
 - ICB Chief Medical Officer
 - ICB Chief Nursing Officer
 - b) at least two non-executive members.
- 2.1.6 The Ordinary Members also include at least three members who will bring knowledge and a perspective from their sectors. These members (known as “Partner Members”) are nominated by the following and appointed in accordance with the procedures set out in Section 3; below:
- Four NHS trusts and foundation trusts who provide services within the ICB’s area and are of a prescribed description;

- Two primary medical services (general practice) providers within the area of the ICB and are of a prescribed description;
- Two local authorities which are responsible for providing Social Care and whose areas coincide with or include the whole or any part of the ICB’s area.

While the Partner Members will bring knowledge and experience from their sector and will contribute the perspective of their sector to the decisions of the board, they are not to act as delegates of those sectors.

2.2 Board Membership

2.2.1 The ICB has eight Partner Members.

- a) Four from NHS Trust/Foundation Trusts
- b) Two bringing the perspective of primary medical services
- c) Two from local authorities

2.2.2 The ICB has also appointed the following further Ordinary Members to the board

- Chair
- Chief Executive
- ICB Chief Medical Officer
- ICB Chief Nursing Officer
- ICB Chief Finance Officer
- ICB Executive Director for Delivery and Transformation
- Four Non Executive Directors

2.2.3 The Board is therefore composed of the following members:

- Chair
- Chief Executive
- Four Partner member(s) NHS and Foundation Trusts
- Two Partner member(s) Primary medical services

- Two Partner member(s) Local Authorities
 - Four Non executive members
 - ICB Chief Finance Officer
 - ICB Chief Medical Officer
 - ICB Chief Nursing Officer
 - ICB Executive Director for Delivery and Transformation
- 2.2.4 The Chair will exercise their function to approve the appointment of the ordinary members with a view to ensuring that at least one of the ordinary board members will have the knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.
- 2.2.5 The board will keep under review the skills, knowledge and experience that it considers necessary for members of the board to possess (when taken together) in order for the board effectively to carry out its functions and will take such steps as it considers necessary to address or mitigate any shortcoming.
- 2.3 Regular Participants and Observers at Board Meetings**
- 2.3.1 The board may invite specified individuals to be Participants or Observers at its meetings in order to inform its decision making and the discharge of its functions as it sees fit.
- 2.3.2 Participants will receive advance copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the board meetings, or part(s) of a meeting, by the Chair. Any such person may be invited, at the discretion of the Chair, to ask questions and address the meeting but may not vote.
- a) Chair, The Midlands Partnership NHS Foundation Trust
 - b) Chair, The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
 - c) Chair, Shrewsbury and Telford Hospital NHS Trust
 - d) Chair, Shropshire Community Health NHS Trust
 - e) Leader Shropshire Council
 - f) Leader Telford and Wrekin Council

- g) ICB Executive Directors and Directors other than those outlined in 2.1.6 above.
- 2.3.3 Observers will receive advance copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the board meetings, or part(s) of a meeting, by the Chair. Any such person may not address the meeting and may not vote unless given permission from the Chair by exception.
- a) Chief Officer, Shropshire Healthwatch
 - b) Chair, Telford and Wrekin Healthwatch
 - c) Representative from local CVS
 - d) Representative from local CVS
- 2.3.4 Participants and / or observers may be asked to leave the meeting by the Chair in the event that the board passes a resolution to exclude the public as per the Standing Orders

3. Appointments Process for the Board

3.1 Eligibility Criteria for Board Membership:

- 3.1.1 Each member of the ICB must:
- a) comply with the criteria of the “fit and proper person test”
 - b) be willing to uphold the Seven Principles of Public Life (known as the Nolan Principles);
 - c) fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.2 Disqualification Criteria for Board Membership

- 3.2.1 A Member of Parliament.
- 3.2.2 A person whose appointment as a board member (“the candidate”) is considered by the person making the appointment as one which could reasonably be regarded as undermining the independence of the health service because of the candidate’s involvement with private healthcare sector or otherwise.
- 3.2.3 A person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted—
- a) in the United Kingdom of any offence; or

- b) outside the United Kingdom of an offence which, if committed in any part of the United Kingdom, would constitute a criminal offence in that part and, in either case, the final outcome of the proceedings was a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine.
- 3.2.4 A person who is subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order under Schedule 4A to the Insolvency Act 1986, sections 56A to 56K of the Bankruptcy (Scotland) Act 1985 or Schedule 2A to the Insolvency (Northern Ireland) Order 1989 (which relate to bankruptcy restrictions orders and undertakings).
- 3.2.5 A person who, has been dismissed, within the period of five years immediately preceding the date of the proposed appointment, otherwise than because of redundancy, from paid employment by any Health Service Body.
- 3.2.6 A person whose term of appointment as the chair, a member, a director or a governor of a Health Service Body, has been terminated on the grounds:
 - a) that it was not in the interests of or conducive to the good management of the Health Service Body or of the Health Service that the person should continue to hold that office;
 - b) that the person failed, without reasonable cause, to attend any meeting of that Health Service Body for three successive meetings;
 - c) that the person failed to declare a pecuniary interest or withdraw from consideration of any matter in respect of which that person had a pecuniary interest; or
 - d) of misbehaviour, misconduct or failure to carry out the person's duties.
- 3.2.7 A healthcare professional (within the meaning of section 14N of the 2006 Act) or other professional person who has at any time been subject to an investigation or proceedings, by anybody which regulates or licenses the profession concerned ("the regulatory body"), in connection with the person's fitness to practise or any alleged fraud, the final outcome of which was—
 - a) the person's suspension from a register held by the regulatory body, where that suspension has not been terminated;
 - b) the person's erasure from such a register, where the person has not been restored to the register;

- c) a decision by the regulatory body which had the effect of preventing the person from practising the profession in question, where that decision has not been superseded; or
 - d) a decision by the regulatory body which had the effect of imposing conditions on the person's practice of the profession in question, where those conditions have not been lifted.
- 3.2.8 A person who is subject to:
 - a) a disqualification order or disqualification undertaking under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002; or
 - b) an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual).
- 3.2.9 A person who has, at any time, been removed from the office of charity trustee or trustee for a charity by an order made by the Charity Commissioners for England and Wales, the Charity Commission, the Charity Commission for Northern Ireland or the High Court, on the grounds of misconduct or mismanagement in the administration of the charity for which the person was responsible, to which the person was privy, or which the person by their conduct contributed to or facilitated.
- 3.2.10 A person who has, at any time, been removed or is suspended from the management or control of anybody under—
 - a) section 7 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990(f) (powers of the Court of Session to deal with the management of charities); or
 - b) section 34(5) or of the Charities and Trustee Investment (Scotland) Act 2005 (powers of the Court of Session to deal with the management of charities).
- 3.3 Chair**
- 3.3.1 The ICB Chair is to be appointed by NHS England with the approval of the Secretary of State.
- 3.3.2 In addition to criteria specified at 3.1, this member must fulfil the following additional eligibility criteria:
 - a) the Chair will be independent.
- 3.3.3 Individuals will not be eligible if:
 - a) they hold a role in another health and care organisation within the ICB area;

- b) any of the disqualification criteria set out in 3.2; apply.
- 3.3.4 The term of office for the Chair on establishment of the ICB will be two years initially and then three years for subsequent appointments and the total number of terms a Chair may serve is three terms.

3.4 Chief Executive

- 3.4.1 The Chief Executive will be appointed by the Chair of the ICB in accordance with any guidance issued by NHS England.
- 3.4.2 The appointment will be subject to approval of NHS England in accordance with any procedure published by NHS England.
- 3.4.3 The Chief Executive must fulfil the following additional eligibility criteria:
- a) be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act;
- 3.4.4 Individuals will not be eligible if:
- a) any of the disqualification criteria set out in 3.2 apply;
 - b) subject to clause 3.4.3a), they hold any other employment or executive role;

3.5 Partner Member(s) — NHS Trusts and Foundation Trusts

- 3.5.1 These Partner Members are jointly nominated by the NHS trusts and/or FTs which provide services for the purposes of the health service within the ICB's area and meet the forward plan condition or (if the forward plan condition is not met) the level of services provided condition which are:
- a) Shrewsbury and Telford Hospital NHS Trust
 - b) Shropshire Community Health NHS Trust
 - c) The Midlands Partnership NHS Foundation Trust
 - d) The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
 - e) The West Midlands Ambulance Service University NHS Foundation Trust

- 3.5.2 These partner members must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:
- a) be an Executive Director of one of the NHS Trusts or FTs within the ICB's area;
 - b) They must bring the perspective of one of the following sectors:
 - (i) One bringing the perspective of an NHS Acute Trust
 - (ii) One bringing the perspective of an NHS specialist Trust
 - (iii) One bringing the perspective of an NHS Community Trust
 - (iv) One bringing the perspective, knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.
- 3.5.3 Individuals will not be eligible if:
- a) any of the disqualification criteria set out in 3.2 apply;
 - b) A conflict of interest is evident, as determined by the Chair or the selection panel, which results in the individual being unable to fulfil the role.
- 3.5.4 These members will be appointed by a panel composed of and determined by the Chair of the ICB with at least one other ICB member, supported by a suitably qualified and experienced HR and/or other adviser(s) and the appointment will be subject to the approval of the Chair.
- 3.5.5 The appointment process will be as follows:
- a) Joint Nomination:
 - when a vacancy arises, each eligible organisation listed at 3.5.1 will be invited to make one nomination per vacant role.
 - Eligible organisations may nominate individuals from their own organisation or another organisation
 - All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 5 working days being deemed to constitute agreement. If they do agree, the list will be put forward to step (b) below. If they do not the nomination process will be re-run until majority acceptance is reached on the nominations put forward.
 - b) Assessment, selection and appointment (subject to the approval of the Chair)

- The full list of nominees will be considered by a panel convened by the Chair
 - The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.5.2 and 3.5.3.
 - In the event that there is more than one suitable nominee the panel will select the most suitable for appointment.
- c) Chair's Approval
- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under (b) above.
- 3.5.6 The term of office for these Partner Members will be for two years.
- 3.5.7 There is no restriction as to the number of terms in total the same individual can be appointed, however after the completion of each term the individual will be subject to the process outlined in 3.5.5 above.
- 3.6 Partner Member - Providers of Primary Medical Services**
- 3.6.1 These Partner Members are jointly nominated by providers of primary medical services which hold a list of registered patients for the purposes of the health service within the ICB's area, that are primary medical services contract holders responsible for the provision of essential services, within core hours to a list of registered persons for whom the ICB has core responsibility.
- 3.6.2 The list of relevant providers of primary medical services for this purpose is published as part of the Governance Handbook. The list will be kept up to date but does not form part of this Constitution.
- 3.6.3 These members must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:
- a) An individual wishing to be considered in one of these roles must be an individual who is a registered General Practitioner registered with the regulatory body (GMC).
 - b) Each must be a current provider of general medical services working as either a; partner, shareholder, employee or contractor of a GP Practice that holds a contract with NHS England to provide primary medical Services to populations located in the geographical area coterminous with Shropshire, Telford and Wrekin ICB
 - c) One must provide Primary Medical Services to populations located in the geographical areas coterminous with Shropshire

Council’s boundary and one must provide Primary Medical Services to the population coterminous with Telford and Wrekin Council’s boundary.

d) Bring the perspective of primary medical services

3.6.4 Individuals will not be eligible if:

- a) any of the disqualification criteria set out in 3.2 apply;
- b) They are struck off by a relevant professional body
- c) They are not or are no longer a partner, shareholder, employee or contractor of a GP Practice holding a contract to provide Primary Medical Services to populations located in the geographical area coterminous with Shropshire, Telford and Wrekin ICB
- d) A conflict of interest is evident, as determined by the Chair or the selection panel, which results in the individual being unable to fulfil the role.

3.6.5 This member will be appointed by a selection panel composed of and determined by the Chair of the ICB including the CEO of the ICB and at least one other ICB member and supported by a suitably qualified and experienced HR and/or other adviser(s), and the appointment will be subject to the approval of the Chair.

3.6.6 The appointment process will be as follows:

- a) Joint Nomination:
 - when a vacancy arises, each eligible organisation listed at 3.6.1 and listed in the Governance Handbook will be invited to make two nominations per vacant role
 - The nomination of an individual must be seconded by one other eligible organisation.
 - Eligible organisations may nominate individuals from their own organisation or another organisation
 - All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 5 working days being deemed to constitute agreement. If they do agree, the list will be put forward to step (b) below. If they do not the nomination process will be re-run until majority acceptance is reached on the nominations put forward.
- b) Assessment, selection and appointment (subject to the approval of the Chair)

- The full list of nominees will be considered by a panel convened by the Chair
 - The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) via an interview process and will confirm that nominees meet the requirements set out in clause 3.6.3 and 3.6.4
 - In the event that there is more than one suitable nominee the panel will select the most suitable for appointment.
- c) Chair's Approval
- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under (b) above.
- 3.6.7 The term of office for this Partner Member will be for two years
- 3.6.8 There is no restriction as to the number of terms in total the same individual can be appointed, however after the completion of each term the individual will be subject to the selection process outlined in 3.6.5 above.
- 3.7 Partner Member(s) - local authorities**
- 3.7.1 These Partner Members are jointly nominated[*description to be inserted in accordance with the regulations*] by the local authorities whose areas coincide with or include the whole or any part of the ICB's area. Those local authorities are:
- a) Shropshire Council
 - b) Telford and Wrekin Council
- 3.7.2 These members will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:
- a) be the Chief Executive or hold a relevant Executive level role of one of the bodies listed at 0;
 - b) bring the perspective of delivering local authority social care services
- 3.7.3 Individuals will not be eligible if:
- a) any of the disqualification criteria set out in 3.2 apply;
- 3.7.4 This member will be appointed by a panel composed of and determined by the Chair of the ICB with at least one other ICB member, supported by a suitably qualified and experienced HR and/or

	other adviser(s) and the appointment will be subject to the approval of the Chair.
3.7.5	<p>The appointment process will be as follows:</p> <p>a) Joint Nomination:</p> <ul style="list-style-type: none"> • when a vacancy arises, each eligible organisation listed at 3.7.1 will be invited to make two nominations per vacant role. • Eligible organisations may nominate individuals from their own organisation or another organisation • All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 5 working days being deemed to constitute agreement. If they do agree, the list will be put forward to step (b) below. If they do not the nomination process will be re-run until majority acceptance is reached on the nominations put forward. <p>b) Assessment, selection and appointment (subject to the approval of the Chair)</p> <ul style="list-style-type: none"> • The full list of nominees will be considered by a panel convened by the Chair • The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.7.2 and 3.7.3 • In the event that there is more than one suitable nominee the panel will select the most suitable for appointment. <p>c) Chair's Approval</p> <ul style="list-style-type: none"> • The Chair will determine whether to approve the appointment of the most suitable nominee as identified under (b) above.
3.7.6	The term of office for this Partner Member will be for 2 years.
3.7.7	There is no restriction as to the number of terms in total the same individual can be appointed, however after the completion of each term the individual will be subject to the process outlined in 3.7.5 above.
3.8	ICB Chief Medical Officer
3.8.1	This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

- a) be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act;
- b) be a registered Medical Practitioner
- c) Meets the requirements as set out in the Chief Medical Officer person specification.
- 3.8.2 Individuals will not be eligible if:
- a) any of the disqualification criteria set out in 3.2 apply;
- b) They are struck off by a relevant professional body
- 3.8.3 This member will be appointed by a selection panel composed of and determined by the Chief Executive Officer of the ICB with at least one other ICB member, supported by a suitably qualified and experienced HR and/or other adviser(s) and the appointment will be subject to the approval of the Chair.
- 3.9 ICB Chief Nursing Officer**
- 3.9.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:
- a) be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act;
- b) be a registered Nurse;
- c) current valid registration with the Nursing and Midwifery Council;
- d) meets the requirements as set out in the Chief Nursing Officer person specification.
- 3.9.2 Individuals will not be eligible if:
- a) Any of the disqualification criteria set out in 3.2 apply;
- b) They are struck off by a relevant professional body
- 3.9.3 This member will be appointed by a selection panel composed of and determined by the Chief Executive Officer of the ICB with at least one other ICB member and supported by a suitably qualified and experienced HR and/or other adviser(s) the appointment will be subject to the approval of the Chair.

3.10 ICB Chief Finance Officer

3.10.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

- a) be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act;
- b) Qualified accountant with full membership and evidence of up-to-date continuing professional development.
- c) Meets the requirements as set out in the Chief Finance Officer person specification.

3.10.2 Individuals will not be eligible if:

- a) any of the disqualification criteria set out in 3.2 apply;
- b) They are struck off by their relevant professional body.

3.10.3 This member will be appointed by a selection panel composed of and determined by the Chief Executive Officer of the ICB with at least one other ICB member, supported by a suitably qualified and experienced HR and/or other adviser(s) and the appointment will be subject to the approval of the Chair.

3.11 Non-Executive Members

The ICB will appoint four Non-Executive Members.

- One Non- Executive Member will be appointed as a ‘Senior Independent Non-Executive Member’, to take a role in appraisal of the Chair. This role cannot be fulfilled by the Chair or the Chair of the Audit Committee.
- These members will be appointed by a selection panel composed of and determined by the Chair of the ICB with at least one other ICB member, supported by a suitably qualified and experienced HR and/or other adviser(s) and the appointment will be subject to the approval of the Chair.
- These members will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:
 - not be employee of the ICB or a person seconded to the ICB;
 - not hold a role in another health and care organisation in the ICS area;

- one shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Audit Committee;
- another should have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration Committee;
- Meet the requirements as set out in the Non-Executive Director Person Specification
- have the skill and ability to identify, assess and suggest strategies to manage conflicts of interest if they arise during ICB or committee meetings in line with the Conflicts of Interest Policy.
- Individuals will not be eligible if:
 - any of the disqualification criteria set out in 3.2 apply;
 - they hold a role in another health and care organisation within the ICB area;
 - A conflict of interest is evident, as determined by the Chair or selection panel, which results in the individual being unable to fulfil the role.
- The term of office for an Non-Executive Member will be three years and the total number of terms an individual may serve is three terms after which they will no longer be eligible for reappointment.
- Initial appointments may be for a shorter or longer period, in order to avoid all Non-Executive Members retiring at once and to support continuity of membership on the Board.
- Subject to satisfactory performance assessed through appraisal the Chair may approve the reappointment of an Non-Executive Member up to the maximum number of terms permitted for their role.

3.12 Executive Director of Delivery and Transformation

3.12.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

- a) be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 18(4)(b) of Schedule 1B to the 2006 Act;

- b) meets the requirements as set out in the Executive Director of Delivery and Transformation person specification.
- 3.12.2 Individuals will not be eligible if:
- a) any of the disqualification criteria set out in 3.2 apply;
- 3.12.3 This member will be appointed by a selection panel composed of and determined by the Chief Executive Officer of the ICB with at least one other ICB member, supported by a suitably qualified and experienced HR and/or other adviser(s) and the appointment will be subject to the approval of the Chair.
- 3.13 Board Members: Removal from Office.**
- 3.13.1 Arrangements for the removal from office of board members is subject to the term of appointment, and application of the relevant ICB policies and procedures.
- 3.13.2 With the exception of the Chair, and ex officio members, board members shall be removed from office if any of the following occurs:
- 3.13.3:
- a) If they no longer fulfil the requirements of their role or become ineligible for their role as set out in this Constitution, regulations or guidance;
 - b) If they fail to attend a minimum of 75% of the ICB meetings to which they are invited unless agreed with the Chair in extenuating circumstances
 - c) If they are deemed to not meet the expected standards of performance at their annual appraisal.
 - d) If they have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the honour and interest of the ICB and is likely to bring the ICB into disrepute. This includes but is not limited to dishonesty, misrepresentation (either knowingly or fraudulently); defamation of any member of the ICBS (being slander or libel); abuse of position, non-declaration of a known conflict of interest; seeking to manipulate a decision of the ICB in a manner that would ultimately be in favour of that member whether financially or otherwise.
 - e) Are deemed to have failed to uphold the Nolan Principles of Public Life
 - f) Are subject to disciplinary proceedings by a regulator or professional body.

- 3.13.4 Members may be suspended pending the outcome of an investigation into whether any of the matters in 3.13.2 apply.
- 3.13.5 Executive Directors (including the Chief Executive) will cease to be board members if their employment in their specified role ceases, regardless of the reason for termination of the employment.
- 3.13.6 The Chair of the ICB may be removed by NHS England, subject to the approval of the Secretary of State.
- 3.13.7 If NHS England is satisfied that the ICB is failing or has failed to discharge any of its functions, or that there is a significant risk that the ICB will fail to do so, it may:
- terminate the appointment of the ICB's Chief Executive; and
 - direct the chair of the ICB as to which individual to appoint as a replacement and on what terms.
- 3.14 Terms of Appointment of Board Members**
- 3.14.1 With the exception of the Chair, arrangements for remuneration and any allowances will be agreed by the Remuneration Committee, in line with the ICB remuneration policy and any other relevant policies published [say where] and any guidance issued by NHS England or other relevant body. Remuneration for Chairs will be set by NHS England. Remuneration for non-executive members will be set by a Remuneration Committee composed of the Chair, at least one executive ordinary member and at least one partner ordinary member of the Board.
- 3.14.2 Other terms of appointment will be determined by the Remuneration Committee.
- 3.14.3 Terms of appointment of the Chair will be determined by NHS England.
- 3.15 Specific arrangements for appointment of Ordinary Members made at establishment**
- 3.15.1 Individuals may be identified as "designate ordinary members" prior to the ICB being established.
- 3.15.2 Relevant nomination procedures for partner members in advance of establishment are deemed to be valid so long as they are undertaken in full and in accordance with the provisions of 3.5-3.7
- 3.15.3 Any appointment and assessment processes undertaken in advance of establishment to identify designate ordinary members should follow, as far as possible, the processes set out in section 3.5-3.12 of

this Constitution. However, a modified process, agreed by the Chair, will be considered valid.

3.15.4 On the day of establishment, a committee consisting of the Chair, Chief Executive and [one other] will appoint the ordinary members who are expected to be all individuals who have been identified as designate appointees pre ICB establishment and the Chair will approve those appointments.

3.15.5 For the avoidance of doubt, this clause is valid only in relation to the appointments of the initial ordinary members and all appointments post establishment will be made in accordance with clauses 3.5 to 3.12

4 Arrangements for the Exercise of our Functions.

4.1 Good Governance

- 4.1.1
- The ICB will, at all times, observe generally accepted principles of good governance. This includes the Nolan Principles of Public Life and any governance guidance issued by NHS England.
- 4.1.2
- The ICB has agreed a code of conduct and behaviours which sets out the expected behaviours that members of the board and its committees will uphold whilst undertaking ICB business. It also includes a set of principles that will guide decision making in the ICB. The ICB Standards of Business Conduct Policy is published in the Governance Handbook.

4.2 General

- 4.2.1
- The ICB will:

a) comply with all relevant laws, including but not limited to the 2006 Act and the duties prescribed within it and any relevant regulations;

b) comply with directions issued by the Secretary of State for Health and Social Care;

c) comply with directions issued by NHS England;

d) have regard to statutory guidance, including that issued by NHS England;

e) take account, as appropriate, of other documents, advice and guidance issued by relevant authorities, including that issued by NHS England; and

f) respond to reports and recommendations made by local Healthwatch organisations within the ICB area.
- 4.2.2
- The ICB will develop and implement the necessary systems and processes to comply with 0–f) above, documenting them as necessary in this Constitution, its Governance Handbook, and other relevant policies and procedures as appropriate.
- 4.3 Authority to Act
- 4.3.1
- The ICB is accountable for exercising its statutory functions and may grant authority to act on its behalf to:

a) any of its members or employees;

b) a committee or sub-committee of the ICB.

4.3.2 Under section 65Z5 of the 2006 Act, the ICB may arrange with another ICB, an NHS trust, NHS foundation trust, NHS England, a local authority, combined authority or any other body prescribed in Regulations for the ICB's functions to be exercised by or jointly with that other body or for the functions of that other body to be exercised by or jointly with the ICB. Where the ICB and other body enters such arrangements, they may also arrange for the functions in question to be exercised by a joint committee of theirs and/or for the establishment of a pooled fund to fund those functions (section 65Z6). In addition, under section 75 of the 2006 Act, the ICB may enter partnership arrangements with a local authority under which the local authority exercises specified ICB functions or the ICB exercises specified local authority functions, or the ICB and local authority establish a pooled fund.

4.3.3 Where arrangements are made under section 65Z5 or section 75 of the 2006 Act, the Board must authorise the arrangement, which must be described as appropriate in the SoRD.

4.4 Scheme of Reservation and Delegation

4.4.1 The ICB has agreed a scheme of reservation and delegation (SoRD) which is published in full [add where].

4.4.2 Only the board may agree the SoRD, and amendments to the SoRD may only be approved by the board.

4.4.3 The SoRD sets out:

- a) those functions that are reserved to the board;
- b) those functions that have been delegated to an individual or to committees and sub committees;
- c) those functions delegated to another body, or to be exercised jointly with another body, under section 65Z5 and 65Z6 of the 2006 Act.

4.4.4 The ICB remains accountable for all its functions, including those that it has delegated. All those with delegated authority are accountable to the board for the exercise of their delegated functions.

4.5 Functions and Decision Map

4.5.1 The ICB has prepared a Functions and Decision Map which sets out, at a high level, its key functions and how it exercises them in accordance with the SoRD.

4.5.2 The Functions and Decision Map is published [add web address].

4.5.3 The map includes:

- a) Key functions reserved to the board of the ICB;
- b) Commissioning functions delegated to committees and individuals;
- c) Commissioning functions delegated under section 65Z5 and 65Z6 of the 2006 Act to be exercised by, or with, another ICB, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body;
- d) functions delegated to the ICB (for example, from NHS England).

4.6 Committees and Sub-Committees

- 4.6.1 The ICB may appoint committees and arrange for its functions to be exercised by such committees. Each committee may appoint sub-committees and arrange for the functions exercisable by the committee to be exercised by those sub-committees.
- 4.6.2 All committees and sub-committees are listed in the SoRD.
- 4.6.3 Each committee and sub-committee established by the ICB operates under terms of reference agreed by the Board. All terms of reference are published in the Governance Handbook.
- 4.6.4 The board remains accountable for all functions, including those that it has delegated to committees and sub-committees and, therefore, appropriate reporting and assurance arrangements are in place and documented in terms of reference. All committees and sub-committees that fulfil delegated functions of the ICB, will be required to:
 - a) The Chair of the Committee or Sub Committee will prepare reports from the Committee or sub Committee which have delegated decision making will be presented to the ICB or in the case of a sub-committee to its parent committee at its next scheduled meeting. The reports will include the main items discussed and any delegated decisions made by the Committee or sub Committee.
 - b) Have the terms of reference of the Committee or sub Committee approved by the ICB or by the parent Committee if a sub committee and must be aligned with the Scheme of Reservation and Delegation.
 - c) Membership of Committees must be specified by the ICB.

- 4.6.5 Any committee or sub-committee established in accordance with clause 0 may consist of or include persons who are not ICB Members or employees.
- 4.6.6 All members of committees and sub committees that exercise the ICB commissioning functions will be approved by the Chair. The Chair will not approve an individual to such a committee or sub committee if they consider that the appointment could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.
- 4.6.7 All members of committees and sub-committees are required to act in accordance with this Constitution, including the Standing Orders, as well as the SFIs and any other relevant ICB policy.
- 4.6.8 The following committees will be maintained:
- a) Audit Committee:** This committee is accountable to the board and provides an independent and objective view of the ICB's compliance with its statutory responsibilities. The committee is responsible for arranging appropriate internal and external audit.
- The Audit Committee will be chaired by a Non-Executive Member (other than the Chair of the ICB) who has the qualifications, expertise or experience to enable them to express credible opinions on finance and audit matters.
- b) Remuneration Committee:** This committee is accountable to the board for matters relating to remuneration, fees and other allowances (including pension schemes) for employees and other individuals who provide services to the ICB.
- The Remuneration Committee will be chaired by a Non-Executive Member other than the Chair or the Chair of Audit Committee.
- 4.6.9 The terms of reference for each of the above committees are published in the Governance Handbook.
- 4.6.10 The board has also established a number of other committees to assist it with the discharge of its functions. These committees are set out in the SoRD and further information about these committees, including terms of reference, are published in the Governance Handbook.
- 4.7 Delegations made under section 65Z5 of the 2006 Act**
- 4.7.1 As per 0, the ICB may arrange for any functions exercisable by it to be exercised by or jointly with any one or more other relevant bodies (another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body).

- 4.7.2 All delegations made under these arrangements are set out in the ICB Scheme of Reservation and Delegation and included in the Functions and Decision Map.
- 4.7.3 Each delegation made under section 65Z5 of the Act will be set out in a delegation arrangement which sets out the terms of the delegation. This may, for joint arrangements, include establishing and maintaining a pooled fund. The power to approve delegation arrangements made under this provision will be reserved to the board.
- 4.7.4 The board remains accountable for all the ICB's functions, including those that it has delegated and, therefore, appropriate reporting and assurance mechanisms are in place as part of agreeing terms of a delegation and these are detailed in the delegation arrangements, summaries of which will be published in the Governance Handbook.
- 4.7.5 In addition to any formal joint working mechanisms, the ICB may enter into strategic or other transformation discussions with its partner organisations on an informal basis.

5 Procedures for Making Decisions

5.1 Standing Orders

5.1.1 The ICB has agreed a set of Standing Orders which describe the processes that are employed to undertake its business. They include procedures for:

- a) conducting the business of the ICB;
- b) the procedures to be followed during meetings; and
- c) the process to delegate functions.

5.1.2 The Standing Orders apply to all committees and sub-committees of the ICB, unless specified otherwise in terms of reference which have been agreed by the board.

5.1.3 A full copy of the Standing Orders is included in Appendix 2: and form part of this Constitution.

5.2 Standing Financial Instructions (SFIs)

5.2.1 The ICB has agreed a set of SFIs which include the delegated limits of financial authority set out in the SoRD.

5.2.2 A copy of the SFIs is published as part of the Governance Handbook [specify where].

6

Arrangements for Conflict of Interest Management and Standards of Business Conduct

6.1

Conflicts of Interest

- 6.1.1
- As required by section 14Z30 of the 2006 Act, the ICB has made arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the ICB will be taken and seen to be taken without being unduly influenced by external or private interest, and do not (and do not risk appearing to) affect the integrity of the ICB’s decision-making processes.
- 6.1.2
- The ICB has agreed policies and procedures for the identification and management of conflicts of interest **[which are published on the website]**.
- 6.1.3
- All board, committee and sub-committee members, and employees of the ICB will comply with the ICB policy on conflicts of interest in line with their terms of office and/or employment. This will include but not be limited to declaring all interests on a register that will be maintained by the ICB.
- 6.1.4
- All delegation arrangements made by the ICB under Section 65Z5 of the 2006 Act will include a requirement for transparent identification and management of interests and any potential conflicts, in accordance with suitable policies and procedures comparable with those of the ICB.
- 6.1.5
- Where an individual, including any individual directly involved with the business or decision making of the ICB and not otherwise covered by one of the categories above, has an interest or becomes aware of an interest which could lead to a conflict of interests in the event of the ICB considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Constitution, and the Conflicts of Interest Policy and the Standards of Business Conduct Policy.
- 6.1.6
- The ICB has appointed the Audit Chair to be the Conflicts of Interest Guardian. In collaboration with the ICB’s governance lead, their role is to:

 - a) act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest;
 - b) be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest;

- c) support the rigorous application of conflict of interest principles and policies;
- d) provide independent advice and judgement to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation;
- e) provide advice on minimising the risks of conflicts of interest.

6.2

Principles

6.2.1

In discharging its functions, the ICB will abide by the following principles:

- a) Decision-making must be geared towards meeting the statutory duties of ICBs at all times including the triple aim and achieving the four principles:
 - improve population health and healthcare;
 - tackle unequal access, experience and outcomes;
 - enhance productivity and value for money; and
 - ensure the NHS supports broader social and economic development.

Any individual involved in decisions relating to ICB functions must be acting clearly in the interests of the ICB and of the public, rather than furthering direct or indirect financial, personal, professional or organisational interests.

- b) ICBs have been created to give statutory NHS providers, local authority and primary medical services (general practice) nominees a role in decision-making. These individuals will be expected to act in accordance with the first principle, and it should not be assumed that they are personally or professionally conflicted just by virtue of being an employee, director, partner or otherwise holding a position with one of these organisations.
- c) The personal and professional interests of all ICB board members, ICB committee members and ICB staff who are involved in decision taking need to be declared, recorded and managed appropriately. Declarations must be made as soon as practicable after the person becomes aware of the conflict or potential conflict and, in any event, within 28 days of the person becoming aware. This includes being clear and specific about the nature of any interest, and about the nature of any conflict that may arise regarding a particular decision.
- d) Actions to mitigate conflicts of interest should be proportionate and should seek to preserve the spirit of collective decision-

making wherever possible. Mitigation should take account of a range of factors including the impact that the perception of an unsound decision might have, and the risks and benefits of having a particular individual involved in making the decision.

- e) ICBs should clearly distinguish between those individuals who should be involved in formal decision taking, and those whose input informs decisions, including shaping the ICB's understanding of how best to meet patients' needs and deliver care for their populations. The way conflicts of interest are managed should reflect this distinction.
- f) As is already established practice in the NHS, where decisions are being taken as part of a formal competitive procurement of services, any individual who is associated with an organisation that has a vested interest in the procurement should recuse themselves from the process.
- g) The way conflicts of interest are declared and managed should contribute to a culture of transparency about how decisions are made.

6.3 Declaring and Registering Interests

6.3.1 The ICB maintains registers of the interests of:

- a) members of the ICB;
- b) members of the board's committees and sub-committees;
- c) its employees.

6.3.2 In accordance with section 14Z30(2) of the 2006 Act, registers of interest are **[published on the ICB website/add where]**.

6.3.3 All relevant persons as per 0 and 0 must declare any conflict or potential conflict of interest relating to decisions to be made in the exercise of the ICB's commissioning functions.

6.3.4 Declarations should be made as soon as reasonably practicable after the person becomes aware of the conflict or potential conflict and, in any event, within 28 days. This could include interests an individual is pursuing. Interests will also be declared on appointment and during relevant discussion in meetings.

6.3.5 All declarations will be entered in the registers as per 0.

6.3.6 The ICB will ensure that, as a matter of course, declarations of interest are made and confirmed or updated at least annually.

- 6.3.7 Interests (including gifts and hospitality) of decision-making staff will remain on the public register for a minimum of six months. In addition, the ICB will retain a record of historic interests and offers/receipt of gifts and hospitality for a minimum of six years after the date on which it expired. The ICB's published register of interests states that historic interests are retained by the ICB for the specified timeframe and details of whom to contact to submit a request for this information.
- 6.3.8 Activities funded in whole or in part by third parties who may have an interest in ICB business, such as sponsored events, posts and research will be managed in accordance with the ICB policy to ensure transparency and that any potential for conflicts of interest are well-managed.

6.4 Standards of Business Conduct

- 6.4.1 Board members, employees, committee and sub-committee members of the ICB will at all times comply with this Constitution and be aware of their responsibilities as outlined in it. They should:
- a) act in good faith and in the interests of the ICB;
 - b) follow the Seven Principles of Public Life set out by the Committee on Standards in Public Life (the Nolan Principles);
 - c) comply with the ICB Standards of Business Conduct Policy and any requirements set out in the policy for managing conflicts of interest.
- 6.4.2 Individuals contracted to work on behalf of the ICB, or otherwise providing services or facilities to the ICB, will be made aware of their obligation to declare conflicts or potential conflicts of interest. This requirement will be written into their contract for services and is also outlined in the ICB's Standards of Business Conduct Policy.

7 Arrangements for ensuring Accountability and Transparency

- 7.1.1 The ICB will demonstrate its accountability to local people, stakeholders and NHS England in a number of ways, including by upholding the requirement for transparency in accordance with paragraph 11(2) of Schedule 1B to the 2006 Act.

7.2 Principles

- 7.2.1 The ICB:
- a) will submit itself to appropriate scrutiny from the public about the decisions and actions it takes; and

b) ensure there will be transparency about the decisions and actions that the ICB takes, such as to promote confidence between the ICB and its staff, patients and the public.

7.3 Meetings and publications

- 7.3.1 Board meetings and committees composed entirely of board members or which include all board members undertaking public functions will be held in public, except where a resolution is agreed to exclude the public on the grounds that it is believed to not be in the public interest.
- 7.3.2 Papers and minutes of all meetings held in public will be published.
- 7.3.3 Annual accounts will be externally audited and published.
- 7.3.4 A clear complaints process will be published.
- 7.3.5 The ICB will comply with the Freedom of Information Act 2000 and with the Information Commissioner Office requirements regarding the publication of information relating to the ICB.
- 7.3.6 Information will be provided to NHS England as required.
- 7.3.7 The Constitution and Governance Handbook will be published as well as other key documents, including but not limited to:

a) Conflicts of Interest policy and procedures

b) Registers of interests

c) Standards of Business Conduct Policy

d) Framework and Principles for Public Involvement and Engagement

e) Scheme of Reservation and Delegation

f) Functions and Decisions Map

g) Standing Financial Instructions
- 7.3.8 The ICB will publish, with our partner NHS trusts and NHS foundation trusts, a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years. The plan will explain how the ICB proposes to discharge its duties under:

• sections 14Z34 to 14Z45 (general duties of integrated care boards), and

• sections 223GB and 223N (financial duties).

And

- proposed steps to implement the Shropshire and Telford and Wrekin joint local health and wellbeing strategies.

7.4 Scrutiny and Decision Making

7.4.1 At least three Non-Executive Members will be appointed to the board, including the Chair; and all of the Board and committee members will comply with the Nolan Principles of Public Life and meet the criteria described in the Fit and Proper Person Test.

7.4.2 Healthcare services will be arranged in a transparent way, and decisions around who provides services will be made in the best interests of patients, taxpayers and the population, in line with the rules set out in the NHS Provider Selection Regime.

7.4.3 The ICB will comply with the requirements of the NHS Provider Selection Regime including:

- a) ensuring that there are internal decision-making structures that will allow for decisions around arranging healthcare services to be made in line with the NHS Provider Selection Regime;
- b) this includes ensuring that there are appropriate governance structures that will deal with any challenges that may follow decisions about provider selection;
- c) evidence that the ICB has properly exercised its responsibilities for arranging healthcare services set out in the NHS Provider Selection Regime;
- d) this will include publishing ICB intentions for arranging services in advance, publishing contracts awarded and keeping records of decision making; and
- e) ensure that local audit arrangements will be capable of auditing the decisions made under the NHS Provider Selection Regime

7.4.4 The ICB will comply with local authority health overview and scrutiny requirements.

7.5 Annual Report

7.5.1 The ICB will publish an annual report in accordance with any guidance published by NHS England and which sets out how it has discharged its functions and fulfilled its duties in the previous financial year. An annual report must in particular:

- a) explain how the ICB has discharged its duties under section 14Z34 to 14Z45 and 14Z49 (general duties of integrated care boards);
- b) review the extent to which the ICB has exercised its functions in accordance with the plans published under section 14Z52 (forward plan) and section 14Z56 (capital resource use plan);
- c) review the extent to which the ICB has exercised its functions consistently with NHS England's views set out in the latest statement published under section 13SA(1) (views about how functions relating to inequalities information should be exercised), and
- d) review any steps that the ICB has taken to implement any joint local health and wellbeing strategy to which it was required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007

8 Arrangements for Determining the Terms and Conditions of Employees.

- 8.1.1 The ICB may appoint employees, pay them remuneration and allowances as it determines, and appoint staff on such terms and conditions as it determines.
- 8.1.2 The board has established a Remuneration Committee, which is chaired by a Non-Executive Member other than the Chair or Audit Chair.
- 8.1.3 The membership of the Remuneration Committee is determined by the board. No employees may be a member of the Remuneration Committee, but the board ensures that the Remuneration Committee has access to appropriate advice by allowing it to:
 - a) seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the committee) within its remit as outlined in these terms of reference;
 - b) 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 the ICB for obtaining legal or professional advice.

- 8.1.4 The board may appoint independent members or advisers to the Remuneration Committee who are not members of the Board.
- 8.1.5 No individual member of Remuneration Committee should be present during any discussion relating to:
- any aspect of their own pay;
 - any aspect of the pay of others when it has an impact on them.
- 8.1.6 The main purpose of the Remuneration Committee is to exercise the functions of the ICB regarding remuneration included in paragraphs 18 to 20 of Schedule 1B to the 2006 Act. The terms of reference agreed by the Board are published [say where].
- 8.1.7 The duties of the Remuneration Committee include:
- a) setting the ICB pay policy (or equivalent) and standard terms and conditions;
 - b) making arrangements to pay employees such remuneration and allowances as it may determine;
 - c) set remuneration and allowances for members of the board;
 - d) set any allowances for members of committees or sub-committees of the ICB who are not members of the board; and
 - f) any other relevant duties.
- 8.1.8 The ICB may make arrangements for a person to be seconded to serve as a member of the ICB's staff.

9 Arrangements for Public Involvement

- 9.1.1 In line with section 14Z454(2) of the 2006 Act the ICB has made arrangements to secure that individuals to whom services which are, or are to be, provided pursuant to arrangements made by the ICB in the exercise of its functions, and their carers and representatives, are involved (whether by being consulted or provided with information or in other ways) in:
- a) the planning of the commissioning arrangements by the Integrated Care Board;
 - b) the development and consideration of proposals by the ICB;
 - c) for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals

(at the point when the service is received by them), or the range of health services available to them; and

d) decisions of the ICB affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

9.1.2 In line with section 14Z54 of the 2006 Act the ICB has made the following arrangements to consult its population on its system plan:

- a) Through a process of genuine co-production with local communities, stakeholders and staff, the ICB will establish a clear strategic purpose and develop a strategy to deliver that purpose.
- b) The ICB will deliver a series of public engagement and involvement activities with its communities and staff on the strategic development of the ICB in two stages; firstly to develop the ICB strategic purpose and secondly to develop the ICB long-term strategy. Citizens, patients, carers, services users, stakeholders and staff will be invited to get involved in the development of proposals to transform the way health and care are delivered in Shropshire, Telford and Wrekin.
- c) Comprehensive and meaningful engagement will ensure local services are more responsive to people’s physical, emotional, social and cultural needs. In both stages the ICB will take active steps to strengthen public, patient and carers’ voice at place and system levels. In particular, the activities will focus on groups who are seldom heard and have the greatest health inequalities to ensure they are not excluded from the dialogue.

9.1.3 The ICB has adopted the ten principles set out by NHS England for working with people and communities:

- a) Put the voices of people and communities at the centre of decision making and governance, at every level of the ICS;
- b) Start engagement early when developing plans and feed back to people and communities how it has influenced activities and decisions;
- c) Understand your community’s needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect;
- d) Build relationships with excluded groups – especially those affected by inequalities;
- e) Work with Healthwatch and the voluntary, community and social enterprise sector as key partners;

- f) Provide clear and accessible public information about vision, plans and progress to build understanding and trust;
 - g) Use community development approaches that empower people and communities, making connections to social action;
 - h) Use co-production, insight and engagement to achieve accountable health and care services;
 - i) Co-produce and redesign services and tackle system priorities in partnership with people and communities; and
 - j) Learn from what works and build on the assets of all partners in the ICS – networks, relationships, activity in local places.
- 9.1.4 In addition, to reduce inequalities the ICB will need to draw on the knowledge of the local authorities, VCSE sector and other partners with experience and expertise in this regard. The VCSE sector is an important partner in the ICS and ICP and plays a key role in improving health, wellbeing and care outcomes. The ICB have established a Memorandum of Understanding (MOU) with the VCSE sector to further strengthen its place-based working. The MOU sets out key principles and commitments of the ICB, ICP and VCSE sector working together.
- 9.1.5 These principles will be used when developing and maintaining arrangements for engaging with people and communities.

Appendix 1: Definitions of Terms Used in This Constitution

2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022.
Area	The geographical area that the ICB has responsibility for, as defined in part 2 of this Constitution.
Committee	A committee created and appointed by the ICB board.
Executive Member of the ICB	Those roles on the ICB that are appointed by the ICB under an employment contract and include the Chief Executive Officer, ICB Chief Finance Officer, ICB Chief Medical Officer, ICB Chief Nursing Officer
Functions and Decisions Map	High level description of where decision making on the functions of the ICB is undertaken under delegation by committees, joint committees and individuals.
Health Service Body	Health Service Body as defined by section 9(4) of the NHS Act 2006 or (b) NHS Foundation Trusts
ICB board	Members of the ICB.
ICB Chief Finance Officer	This role is the Chief Finance Officer for NHS Shropshire, Telford and Wrekin Integrated Care Board
ICB Chief Medical Officer	This role is the Chief Medical Officer for NHS Shropshire, Telford and Wrekin Integrated Care Board
ICB Chief Nursing Officer	This role is the Chief Nursing Officer for NHS Shropshire, Telford and Wrekin Integrated Care Board
Non-Executive Members	These roles are ordinary members of the ICB who are independent from the ICB and therefore are neither an employee or a contractor.

Integrated Care Partnership	The joint committee for the ICB's area established by the ICB and each responsible local authority whose area coincides with or falls wholly or partly within the ICB's area.
NHS England	The operational name for the National Health Service Commissioning Board
Ordinary Member	The Board of the ICB will have a Chair and a Chief Executive plus other members. All other members of the Board are referred to as Ordinary Members.
Partner Member of the ICB	<p>Some of the Ordinary Members will also be Partner Members. Partner Members bring knowledge and a perspective from their sectors and are appointed in accordance with the procedures set out in Section 3 having been nominated by the following:</p> <ul style="list-style-type: none"> • NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description. • The primary medical services (general practice) providers within the area of the ICB and are of a prescribed description <p>The local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area</p>
Place-Based Partnership	Place-based partnerships are collaborative arrangements responsible for arranging and delivering health and care services in a locality or community. They involve the Integrated Care Board, local government and providers of health and care services, including the voluntary, community and social enterprise sector, people and communities, as well as primary care provider leadership, represented by

	Primary Care Network clinical directors or other relevant primary care leaders.
Sub-Committee	A committee created and appointed by and reporting to a committee.

Appendix 2: Standing Orders

1. Introduction

- 1.1 These Standing Orders have been drawn up to regulate the proceedings of NHS Shropshire, Telford and Wrekin Integrated Care Board so that the ICB can fulfil its obligations as set out largely in the 2006 Act (as amended). They form part of the ICB's Constitution.

2. Amendment and review

- 2.1 The Standing Orders are effective from 1st July 2022.
- 2.2 Standing Orders will be reviewed on an annual basis or sooner if required.
- 2.3 Amendments to these Standing Orders will be made as per clause 1.6.2 in the Constitution.
- 2.4 All changes to these Standing Orders will require an application to NHS England for variation to the ICB Constitution and will not be implemented until the Constitution has been approved.

3. Interpretation, application and compliance

- 3.1 Except as otherwise provided, words and expressions used in these Standing Orders shall have the same meaning as those in the main body of the ICB Constitution and as per the definitions in Appendix 1.
- 3.2 These Standing Orders apply to all meetings of the Board, including its committees and sub-committees unless otherwise stated. All references to Board are inclusive of committees and sub-committees unless otherwise stated.
- 3.3 All members of the Board, members of committees and sub-committees and all employees, should be aware of the Standing Orders and comply with them. Failure to comply may be regarded as a disciplinary matter.
- 3.4 In the case of conflicting interpretation of the Standing Orders, the Chair, supported with advice from the Director of Corporate Affairs will provide a settled view which shall be final.
- 3.5 All members of the Board, its committees and sub-committees and all employees have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.
- 3.6 If, for any reason, these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported

to the next formal meeting of the Board for action or ratification and the Audit Committee for review.

4. Meetings of the Integrated Care Board

4.1 Calling Board Meetings

4.1.1 Meetings of the Board of the ICB shall be held at regular intervals at such times and places as the ICB may determine.

4.1.2 In normal circumstances, each member of the Board will be given not less than one month’s notice in writing of any meeting to be held. However:

- a) The Chair may call a meeting at any time by giving not less than seven calendar days’ notice in writing.
- b) One third of the members of the Board may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the Board members signing the requisition may call a meeting by giving not less than fourteen calendar days’ notice in writing to all members of the Board specifying the matters to be considered at the meeting.
- c) In emergency situations the Chair may call a meeting with two days’ notice by setting out the reason for the urgency and the decision to be taken.

4.1.3 A public notice of the time and place of meetings to be held in public and how to access the meeting shall be given by posting it at the offices of the ICB body and electronically at least three clear days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened.

4.1.4 The agenda and papers for meetings to be held in public will be published electronically in advance of the meeting excluding, if thought fit, any item likely to be addressed in part of a meeting is not likely to be open to the public.

4.2 Chair of a meeting

4.2.1 The Chair of the ICB shall preside over meetings of the Board. If the Chair of a meeting is absent or is disqualified from participating by a conflict of interest, the Deputy Chair will preside. If the Deputy Chair is not in attendance or is also disqualified from participating by a conflict of interest then the remaining Board members will nominate one of their number to preside by a majority vote.

- 4.2.2 If the Chair of a meeting is absent, or is disqualified from participating by a conflict of interest, and there is no Deputy Chair appointed the remaining committee members will nominate one of their number to preside by a majority vote.
- 4.2.3 The Deputy Chair will be appointed by the ICB Board from the Non-Executive Members of the ICB Board, but may not be the same individual who is appointed as the Audit Committee Chair.
- 4.2.4 The Board shall appoint a Chair to all committees and sub-committees that it has established. The appointed committee or sub-committee Chair will preside over the relevant meeting. Terms of reference for committees and sub-committees will specify arrangements for occasions when the appointed Chair is absent.
- 4.3 **Agenda, supporting papers and business to be transacted**
- 4.3.1 The agenda for each meeting will be drawn up and agreed by the Chair of the meeting.
- 4.3.2 Except where the emergency provisions apply, supporting papers for all items must be submitted at least seven calendar days before the meeting takes place. The agenda and supporting papers will be circulated to all members of the Board at least five days before the meeting.
- 4.3.3 Agendas and papers for meetings open to the public, including details about meeting dates, times and venues, will be published on the ICB's website at [\[insert link\]](#).
- 4.4 **Petitions**
- 4.4.1 Where a valid petition has been received by the ICB it shall be included as an item for the agenda of the next meeting of the Board, in accordance with the ICB policy as published in the Governance Handbook.
- 4.5 **Nominated Deputies**
- 4.5.1 With the permission of the person presiding over the meeting, the Executive Directors may nominate a deputy to attend a meeting of the Board that they are unable to attend. The deputy may speak at the meeting but not vote on their behalf and will not count towards the quorum.
- 4.5.2 A deputy should be nominated according to availability on the day of a meeting or according to the agenda items under discussion; and would not necessarily have to be the same nominated deputy for the duration of the term of office of the Executive Director. Provided they

- are appropriately experienced and that this is confirmed with the ICB Chair in advance of the meeting.
- 4.5.3 The decision of person presiding over the meeting regarding authorisation of nominated deputies is final.
- 4.6 **Virtual attendance at meetings**
- 4.6.1 The Board of the ICB and its committees and sub-committees may meet virtually using telephone, video and other electronic means when necessary, unless the terms of reference prohibit this.
- 4.7 **Quorum**
- 4.7.1 The quorum for meetings of the Board will be 50% of the total membership, including:
- a) Either the Chief Executive or the Chief Finance Officer
 - b) Either The Chief Medical Officer or the Chief Nursing Officer
 - c) At least one independent Non Executive member
 - d) At least one Partner Member
- 4.7.2 For the sake of clarity:
- a) No person can act in more than one capacity when determining the quorum.
 - b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum.
- 4.7.3 For all committees and sub-committees, the details of the quorum for these meetings and status of deputies are set out in the appropriate terms of reference.
- 4.8 **Vacancies and defects in appointment**
- 4.8.1 The validity of any act of the ICB will not affected by any vacancy among members or by any defect in the appointment of any member.
- 4.8.2 In the event of vacancy or defect in appointment the quorum will be calculated using the total number of members who are properly appointed.

4.9 Decision making

4.9.1 The ICB has agreed to use a collective model of decision making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working though difficult issues where appropriate.

4.9.2 Generally it is expected that decisions of the ICB will be reached by consensus. Should this not be possible then a vote will be required. The process for voting, which should be considered a last resort, is set out below:

- a) All members of the Board who are present at the meeting will be eligible to cast one vote each.
- b) In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote, but this does not preclude anyone attending by teleconference or other virtual mechanism from participating in the meeting, including exercising their right to vote if eligible to do so.
- c) For the sake of clarity, any additional Participants and Observers (as detailed within section 2.3 of the Constitution) will not have voting rights.
- d) A resolution will be passed if more votes are cast for the resolution than against it.
- e) If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote.
- f) Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

Disputes

4.9.3 Where helpful the Board may draw on third-party support to assist them in resolving any disputes, such as peer review or support from NHS England.

Urgent decisions

4.9.4 In the case of urgent decisions and extraordinary circumstances, every attempt will be made for the Board to meet virtually. Where this is not possible the following will apply.

4.9.5 The powers which are reserved or delegated to the Board, may for an urgent decision be exercised by the Chair and Chief Executive (or relevant lead director in the case of committees)

- subject to every effort having been made to consult with as many members as possible in the given circumstances.
- 4.9.6 The exercise of such powers shall be reported to the next formal meeting of the Board for formal ratification and the Audit Committee for oversight.
- 4.10 Minutes**
- 4.10.1 The names and roles of all members present shall be recorded in the minutes of the meetings.
- 4.10.2 The minutes of a meeting shall be drawn up and submitted for agreement at the next meeting where they shall be signed by the person presiding at it.
- 4.10.3 No discussion shall take place upon the minutes except upon their accuracy or where the person presiding over the meeting considers discussion appropriate.
- 4.10.4 Where providing a record of a meeting held in public, the minutes shall be made available to the public.
- 4.11 Admission of public and the press**
- 4.11.1 In accordance with Public Bodies (Admission to Meetings) Act 1960, all meetings of the Board and all meetings of committees which are comprised of entirely Board members or all Board members, at which, public functions are exercised will be open to the public.
- 4.11.2 The Board may resolve to exclude the public from a meeting or part of a meeting where it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.
- 4.11.3 The person presiding over the meeting shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the board's business shall be conducted without interruption and disruption.
- 4.11.4 As permitted by Section 1(8) Public Bodies (Admissions to Meetings) Act 1960 (as amended from time to time) the public may be excluded from a meeting to suppress or prevent disorderly conduct or behaviour.

- 4.11.5 Matters to be dealt with by a meeting following the exclusion of representatives of the press and other members of the public shall be confidential to the members of the Board.

5. Suspension of Standing Orders

- 5.1 In exceptional circumstances, except where it would contravene any statutory provision or any direction made by the Secretary of State for Health and Social Care or NHS England, any part of these Standing Orders may be suspended by the Chair in discussion with at least two other members.
- 5.2 A decision to suspend Standing Orders together with the reasons for doing so shall be recorded in the minutes of the meeting.
- 5.3 A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Audit Committee for review of the reasonableness of the decision to suspend Standing Orders.

6. Use of seal and authorisation of documents.

- 6.1 The ICB will use a seal for executing documents where necessary. The following individuals or officers are authorised to authenticate its use by their signature. A single signature from the following will be required.
- a) the Chief Executive;
 - b) the Chair of the ICB;
 - c) the ICB Chief Finance Officer.
- 6.2 The following individuals are authorised to execute a document on behalf of the ICB by their signature. A single signature from the following will be required.
- a) the Chief Executive;
 - b) the Chair of the ICB;
 - c) the ICB Chief Finance Officer.

STW ICS Green Plan
Agenda item 25-05.008

Shropshire Telford & Wrekin Integrated Care System

Green Plan

2022-2025



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Welcome

Our activities as a species on Earth are having a profound impact on the environment with **irrevocable consequences** -

biodiversity loss and mass extinction, plastics in our food chain, acidification of our seas and climate change that will bring about frequent and often disastrous weather events. We must therefore maintain momentum in minimising our contribution to carbon in the atmosphere, products that persist in nature, and the destruction of other species due to loss of natural habitats. Extreme weather events and infectious diseases are now a very real and tangible part of our lives. Human activities have already set in motion these occurrences and therefore, we must adapt.

The UK typically experiences 10 severe storms per annum, and some of the most severe heatwaves experienced over the last 60 years have been in the last ten years or so (Kendon, et. al, 2021). These incidents will clearly have an impact on our communities' health and wellbeing - be it through heatwaves, flooding, or storms. Moreover, the buildings and infrastructure we use to provide care must do so throughout these events, enabling the business that our clinical and support services colleagues deliver to continue uninterrupted — particularly because of the impact that major incidents have on our service delivery.

We must, then, adapt our services to ensure that we mitigate for emerging risks brought about by climate change and loss in biodiversity.

The Shropshire, Telford and Wrekin Integrated Care System (STW ICS) has thus far reached significant milestones in its journey to realising Net Zero. We must ensure that we speed up our efforts now, in a joined-up approach, to meet targets set out by NHSEI in the document Delivering a Net Zero NHS (2020). We are fortunate enough to be situated in one of the most beautiful areas of the UK, and because of this are reminded daily how precious our world is, and that we must take responsibility for caring for the environment we live and work in.

This document is a representation of our system's organisations, the STW ICS, three-year plans to do just that.



It is not the strongest,
nor the most intelligent
of species that survives,
but the one that is most
adaptable to change.

Charles Darwin (1808–1882)

naturalist, biologist and geologist, born in Shrewsbury

Introduction

Shropshire, Telford and Wrekin Sustainable Transformation Partnership (STP) became an **Integrated Care System (ICS)** from 1st April 2021.

In an integrated care system, NHS organisations, in partnership with local authorities and other partners, take collective responsibility for managing resources, delivering NHS care, and improving the health of the population they serve.

Our ICS footprint covers 1,347sq miles, but is one of the smallest in terms of population, covering around 500,000 people. We have one Clinical Commissioning Group covering the area of Shropshire, Telford & Wrekin. The CCG is responsible for buying NHS services for local people. We have two acute hospitals, sited less than 20 miles apart, with services delivered by one acute trust, Shrewsbury and Telford NHS Trust (SaTH). There is also a specialist orthopaedic hospital, Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJA), which provides elective orthopaedic surgery, sited in the northwest of the county. Additional providers include a community trust (SCHT), a mental health trust (MPFT) which covers Shropshire and Staffordshire, and the region is served by the West Midlands Ambulance Service University NHS Foundation Trust (WMAS). In summary, our ICS System partnership consists of;

- NHS Shropshire, Telford and Wrekin Clinical Commissioning Group,
- The Shrewsbury and Telford Hospital NHS Trust -SaTH
- The Robert Jones Agnes Hunt Orthopaedic Hospital NHS Foundation Trust -RJA
- Midlands Partnership NHS Foundation Trust -MPFT
- Shropshire Community Health NHS Trust -SCHT
- Shropshire Council- SC
- Telford and Wrekin Council - TW

- The Primary Care Network including GPs
- West Midlands Ambulance Service - WMAS
- The voluntary sector and other core partners involved in transforming the provision of health and care services across Shropshire, Telford and Wrekin for those we serve.

The ICS has two unitary authorities: Shropshire Council and Telford & Wrekin Council. The area covered by Shropshire Council is 3,197 square kilometres, or 1,234 square miles. This is 91.7% of the ceremonial county of Shropshire, with the remainder being covered by Telford & Wrekin Council. The footprint has a number of towns, but no major cities. Shropshire has an estimated population of around 310,000 and Telford & Wrekin has an estimated population (for the borough) of around 170,000. Of these, around 150,000 live in Telford itself, making it the largest town within the ICS and it is one of the fastest-growing towns in the United Kingdom. In the Shropshire Council area, Shrewsbury is the largest town with a population of 70,600 with the second largest being Oswestry with a population of just 16,600.

Our ICS area is one of a handful that borders Wales and provides some hospital services for people from the Welsh health system who are external to the ICS footprint. Some residents of mid-Wales therefore rely on the services at SaTH and RJA.

Each organisation within the ICS currently has their own Green Plan, with their own specific Action Plan. This document outlines the achievements already made, our ambition as a system, and how we aim to achieve these ambitions. We see our journey to net zero as a collaboration of the organisations in our system to approach with a broader view of delivering care to our communities.

In October 2020, NHS England published ‘Delivering a Net-Zero National Health Service’, a report that details the scale of the environmental problems faced by the NHS and the country. This report sets ambitious targets requiring all NHS Organisations to become Net zero by 2040 for the NHS Carbon Footprint and by 2045 for the NHS Carbon Footprint Plus. The document is a milestone for NHS Organisations in that they now have key targets to achieve by the 2030s and 2040s.

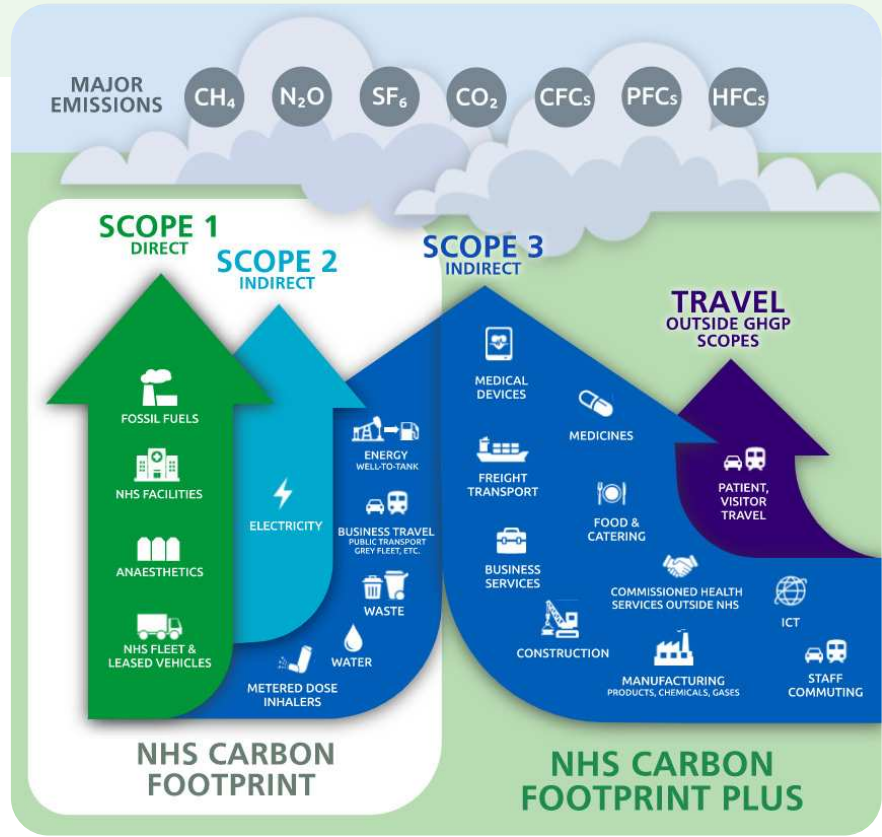
Both Telford and Wrekin, and Shropshire Councils have a target to be 100% net zero carbon by 2030

The NHS aims to provide health and high-quality care for all, now and for future generations. This requires a resilient NHS, currently responding to the health emergency that COVID-19 has brought, protecting patients, our staff, and the public. The NHS also needs to respond to the health emergency that climate change brings, which will need to be embedded into everything we do now and in the future.

Clearly, there will be financial investment required across the system. We aim to return on these investments over the lifetime of the output projects, or where this is not possible, for them to be cost-neutral. This may not always be possible so we must be careful in how we initiate projects and consider the benefits they provide in a holistic approach.

The two key net zero targets for the NHS set in the ‘Net Zero’ (NHSEI, 2020) paper:

- 1 100% by 2040 for the NHS Carbon Footprint, with an ambition for an 80% reduction (compared with a 1990 baseline) by 2028 to 2032
- 2 100% by 2045 for the NHS Carbon Footprint Plus (see below), with an ambition for an 80% reduction (compared with a 1990 baseline) by 2036 to 2039.



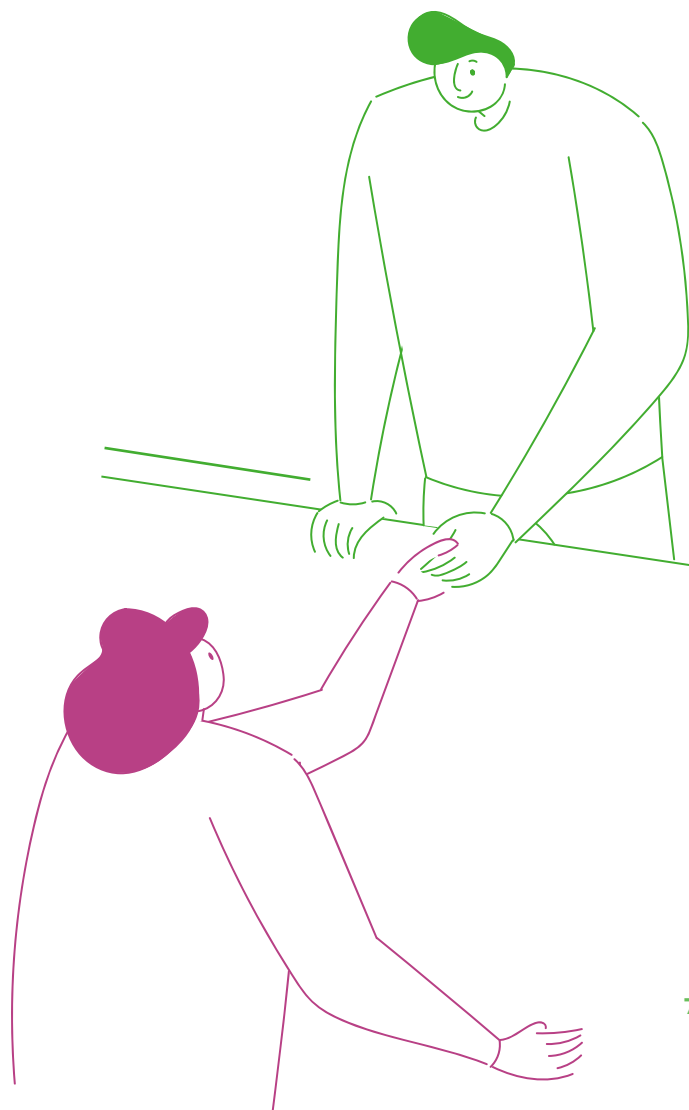
Integrated Care System Vision

We will **work together** with the people of Shropshire, Telford & Wrekin to develop innovative, safe and high-quality services, attracting and retaining the best staff to deliver world class care that meets our current, and future, rural and urban needs.

We will support people — in their own communities — to live healthy and independent lives, helping them to stay well for as long as possible. Creating partnerships to find solutions that work better for the people we serve and those who provide care.

As the world faces up to a climate emergency, we are committed to delivering an internationally recognised system known for its environmentally friendly services that make the best use of our resources. We want this journey to net zero carbon to provide population health benefits to our communities and staff throughout the process and capitalise on financial benefits where possible.

Our journey is towards local sustainability while being sensitive to global sustainability and delivering on net zero. Our approach will be one of collaboration between our member organisations to ensure we achieve our targets comprehensively and systematically together in good time, realising all of the benefits that come with it environmentally and in terms of health and service provision.



Key Milestones — Our progress so far

Our journey to **net zero** has already started at our organisational levels. Our key milestones are:

An overall system reduction in reliance on fossil fuels of circa **1,066,000 kWh** for PV arrays

Achieved by the installation of renewable on site energy

Around **£2.98**_m saved from reduction in journeys

Adapted our sites to accommodate local wildlife

Achieved by

- Installing swift and bat boxes
- Sited beehives on some of our hospital sites
- Encouraged a diverse range of plants and fauna in our green spaces.

Achieved and quantified by MPFT:

- moving outpatients clinics to telephone/video calls, delivering over **80,000** virtual consultations
- adapting agile (hybrid) working for our colleagues
- planning our services better

Completely eliminated Desflurane from our clinical practices

Achieved by adopting alternative methods such as less environmentally harmful anaesthetic gases and **Total Intravenous Anaesthetics (TIVA)**

Each metric outlined in the document covers more of the achievements we have made in further detail.

Diverting around 440 tonnes of waste from landfill each year

Achieved by RJAHS in the period April 2020 — March 2021, 100% of RJAHS waste was diverted from landfill = saving of 440 tonnes waste, breakdown below:

Area	Weight (tonnes)
Incineration (Clinical) Waste Volume	102.49
Alternative Treatment (Clinical) Waste Volume	76.05
Offensive Waste Volume	119.87
Recycling Waste Volume	53.07
Domestic Waste Volume	78.20
Food Waste Volume	14.39

Achieved by

- segregation of waste
- collaborating with waste partners to adopt practices that make energy from waste

The Next Three Years and Beyond

The next three years will be fundamental in **building collaboration** and establishing early investment to maximise benefits later.

There are many early interventions we must address, but establishing our benchmarks is a priority. To do this, we aim to determine the overall system carbon footprint from scopes 1 & 2 emissions by April 1st, 2023, with scope 3 emissions later in 2023. We will also review waste metrics, travel and medicines. This will give us a point of reference in which to measure our progress. Some organisations within the system have already completed a carbon foot-printing assessment, so we intend to complete a joint exercise for those who have not, to capitalise on economies of scale.

Adopting a collaborative approach to both the actions at organisational and system levels will ensure we maximise benefits and realise any financial saving opportunities. It will also provide consistency in reporting and some resilience in terms of team member movement.

Therefore, our key actions are to identify opportunities in the system where we can share learning, optimise efficiencies, and capitalise on collaborative working.

To do this, we will:

1. Establish our system baseline positions
2. Ensure that we have the right people delivering our net zero agenda
3. Consider how we can deliver care in a sustainable, balanced way

4. Harness digital technologies to approach a multifaceted challenge of delivering quality care outcomes, improving the quality of our care and diagnostics, reducing waste, and optimising our building services
5. Encourage our communities to avoid contributing to our carbon output
6. Focus on our supply chain’s commitments to achieving net zero
7. Develop decarbonisation plans, continuing our transition to renewable energy, and in the interim making every kilowatt of fossil fuel energy count
8. Adopt practices to avoid creating waste that persists in nature, and recycling those we cannot.
9. Adapting our services to meet the challenges of climate change and extreme weather events
10. Encourage biodiversity at our properties



Our Green Plan structure follows the NHS England Guidance:



This structure will form the basis of our strategy. Each subheading discusses the progress made so far (and our baselines, where applicable), our key targets, timeframe and how we intend to achieve this. We also feel that it is important to include Biodiversity under its own subheading because a broad and diverse environment locally, nationally and internationally is central to tackling the key issues addressed in this document.



Leadership & Workforce

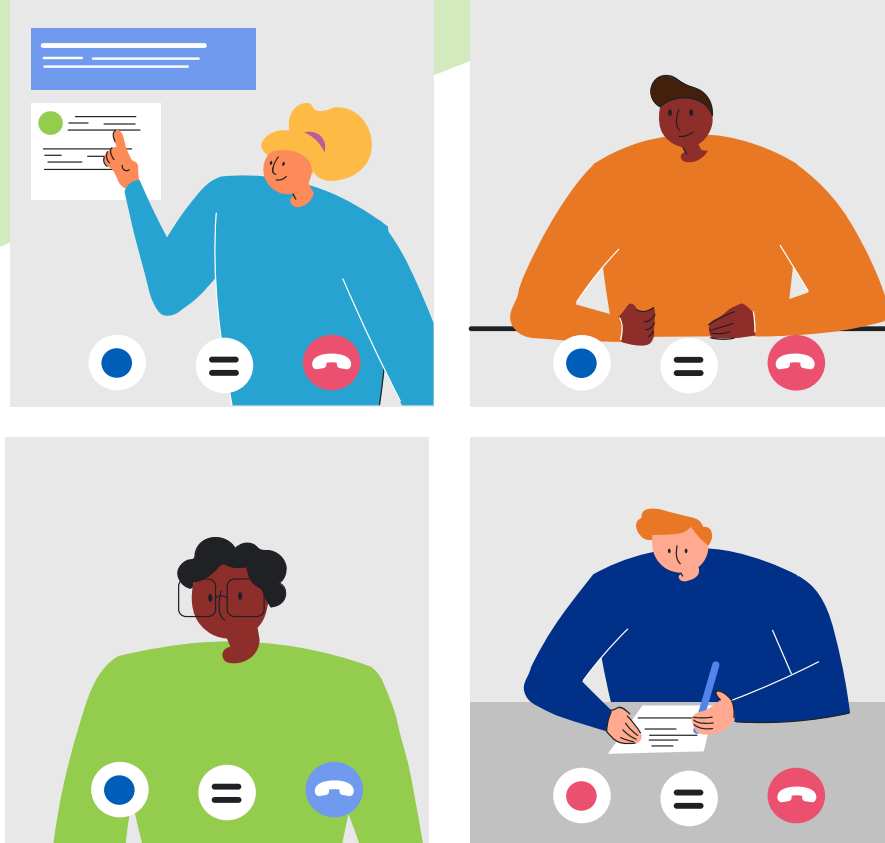
Our people are central to delivering our care services **sustainably**.

Currently, many of the organisations in our system manage sustainability through various roles such as sustainability managers, energy managers or waste managers (or a combination of these). Whilst we already have excellent examples of collaboration and governance through the ICS Climate Change Working Group, there are opportunities to focus the co-ordination of collaborative working to drive efficiencies between the organisations - both environmentally and financially.

All our staff have a responsibility for contributing to achieving net zero, and can help by:

- Where practical, and meeting the service needs, work from home wherever possible
- Use greener methods of transportation such as 'active travel', and where this is not possible, use public transportation and carpools
- Minimise waste, reuse if safe to do so and use recycling facilities provided
- Holding local sustainability working groups
- Challenge colleagues where socially and sustainably responsible behaviours need improvement
- Increase awareness by discussing with colleagues and teams
- Sensible use of technology to enable remote working and drive efficiencies — for example, embracing the use of electronic devices for delivering services in the community or holding a MS Teams meeting rather than traveling to meet face-to-face.
- Raising sustainability awareness to our colleagues, service users and communities by participating in campaigns, Sustainability Days, Sustainability Competitions, and so on.
- Collaboration with schools and nurseries to promote sustainability as part of their curriculums; providing advice and help with planning activities to teachers, administrators, business managers.

Sensible use of technology to enable remote working and drive efficiencies.



As job descriptions throughout the whole workforce are reviewed and refreshed on a routine basis, we must ensure that sustainability & waste management are highlighted as an essential requirement to the day-to-day responsibilities of each colleague, expecting sustainability as ‘business as usual’ facet of our work practices.

Our ICS board lead for sustainability is Shropshire Council’s Chief Executive.

In 2022 we will look to identify a Sustainability Lead for the ICS — a person accountable to the board lead and responsible for providing support to the respective organisations within the ICS, holding those organisations to account and ensuring that their respective action plans are being addressed in the agreed timeframes.

Some of the organisations in our system already have colleagues in senior leadership positions who have completed carbon literacy training. This training is a formally recognised certificate which we intend to roll out for senior leaders in the whole system using a train-the-trainer model, capitalising on collaboration, to improve our understanding of how we can tackle our emissions by changing behaviours and embedding carbon performance in our service delivery. A by-product of this training would encourage and identify climate and carbon champions in all service areas.

Collaborative Opportunities

1. Individual and System Baseline Carbon Footprinting (we have a stronger position for negotiation through economies of scale)
2. Introduce a network of Net Zero Carbon Champions (staff, service users and members of the public)
3. Improvement in comms by sharing regular cross-system sustainability-related information, such as benchmarks and how colleagues can change behaviours to have a collective impact on our carbon footprint
4. Share training to provide consistent approaches, and capitalise on economies of scale

We will recognise the fantastic work and milestones achieved by our colleagues throughout the system through nominations at national level sustainability awards and at local levels through internal nominations for individual recognition.



Sustainable Models of Care

Delivering the best care is our business — it's what we do. As a system we have huge opportunity to organise our services in such a way that patient care improves whilst we **make carbon efficiencies.**

We must consider the location of our services to suit — utilising existing buildings, collaborating on projects that improve care across our membership and ensuring we have the right services in the right places.

We are harnessing technologies to reduce the need to invite patients to sites, often through 'virtual' consultations. For example, MPFT has completed over 80,000 of these appointments since March 2020 — demonstrating an estimated £3m saved in travel. There is therefore much opportunity for the system, where it is clinically safe to do so, to adopt this approach.

In 2015, NICE published guidelines on medicines optimisation, advising that the environmental impact of each bed day is 63.7kg of CO₂e, 0.6m³ of direct fresh water used (98.6 m³ of indirect freshwater use) and 8.15kg of waste produced. From 1,271 (700 SaTH, 174 RJA, 24 Ludlow, 25 Bridgnorth, 348 MPFT) bed spaces in the system, this translates to a total of 81tCO₂e, 762.6m³ direct fresh water, 125,321m³ indirect fresh water and 10,359kg of waste (per day).

We must encourage our patients to live balanced, healthy lifestyles, and geographically we must provide this care that is accessible for all engaging in active travel. The **#TogetherWeMove** movement is a charity-led initiative encouraging active travel, exercise and the benefits that come with this.

There are also opportunities to signpost patients, staff and service users to energy efficiency advice outlets, such as Beat the Cold and Keep Shropshire Warm.

Collaborative Opportunities

Align individual digital technology to offer Care Closer to Home to reduce bed days

Partner to develop and deliver the Shropshire Joint Health and Wellbeing Strategy, specifically: -

- reducing stigma of mental illness
- reduce inequalities that are the cause of ill health
- influence planning decisions regarding fast food takeaways and green spaces
- support people as they are discharged from hospital
- promote the health, wellbeing and social change needed to improve health in Shropshire

Signposting to energy efficiency advice to patients, staff, public, financial help with energy bills, improve their health and wellbeing, etc. directly or via charities (e.g. Beat the Cold, Keep Shropshire Warm **#WeMoveTogether**).

There are further opportunities to embed carbon reduction into the services that are commissioned from health through the PH grant

All Shropshire Council commissioned activity will seek to identify opportunities to reduce carbon admissions; including locality-based models of care, reducing the need for paper and moving to digital solutions, incentivise sustainable transport solutions. The same is true for Telford and Wrekin Council; increasing its environmental evaluation criteria weightings to encourage suppliers to use sustainable practices and to reduce carbon emissions in the supply chain. This is an opportunity for the NHS organisations in the system to both support and adopt best practices.

The development of a new Wellbeing Centre in Shrewsbury will provide opportunities to introduce innovative ways of working and delivering health care, including related green initiatives. There are further opportunities to embed carbon reduction into the services that are commissioned from health through the PH grant — the commissioned services are primarily from ShropCom— Drugs and Alcohol (DAT), School Nursing, Health Visiting, health checks commissioned from primary care, and some weight management programmes commissioned from SaTH. Building this integration into our zero-carbon journey will enable us to adapt as we need to and expedite the carbon reductions.





Digital Transformation

With the advent of SARs-CoV-2 and the subsequent COVID-19 pandemic, our **organisations had to adapt** to continue to provide services whilst protecting patients and staff.

To do so, our IT teams worked around the clock to enable more colleagues to work from home or working remotely to provide services where this did not impact business needs - as discussed in the Sustainable Models of Care chapter, for example, assisting with moving to online consultations.

This inadvertently reduced our carbon footprint significantly, within the space of just a few weeks. There is now real opportunity to further drive down our key carbon emissions through harnessing digital infrastructure, particularly in delivering patient care but also as colleagues return to site.

We are building resilience in the event of major incidents, outbreaks, and enabling colleagues to perform flexibly and efficiently by improving communications — for example, pivoting to VOIP telephones and integrating telephone services with Microsoft Teams. Digital exclusion, the term used for inequalities in access to digital technology, is a barrier to providing care in our communities; particularly with respect to our ambition to provide 25% of outpatient activity and we will aim to review progress with this in mind and exploring options to support our communities to overcome this.

Collaborative Opportunities

Enable ability for staff to work from other stakeholders locations if closer to home or patients

Encouraging staff across the system to use Ecosia to contribute to biodiversity around the world.

Joint booking systems for clinical and non-clinical spaces



Collaboration between council and NHS organisations may also benefit our services; particularly where we share building spaces, whereby staff can work from nearest office space throughout the entire system. A joint space booking system is currently being investigated to cover the entire system both for non-clinical and clinical space. Councils also have a role to play in working with NHS partners in the system to develop and enhance digital solutions to support people to live safe and well at home, to ensure the right care, at the right time in the right place in needed and care is not being overprescribed.

Electronic Patient Records (EPR)

The recent NHS Long Term Plan has an expectation that all services should have met ‘a level of core digitalisation by 2024’. The move to EHRs supports this as well as helping with compliance with the General Data Protection Regulation (GDPR) as well as the visibility of patients notes improves care. WMAS and SCHAT are already using an electronic system, RJAH are implementing for go live in 12 months, SATH in 18 months.



There is an opportunity for all organisations to adopt Ecosia

Ecosia

The free-to-use search engine that donates approximately 80% of its profits to fund tree planting projects around the world.

University College London Hospital (UCLH) have recently rolled this out and provided a case study. In the first full month (February 2022) of Ecosia being used trust wide UCLH has funded the planting of 2,238 trees. UCLH employs 11,000 staff, which is a tree planting rate of: $2238/11000 = 0.203$ trees funded per staff per week. Although the exact rate of tree planting will vary between organisations, this gives an approximation for potential tree planting impact. If the system adopts this approach, the number of trees planted could reach close to 84,000 per year ($34,345 \text{ staff} \times 0.203 \times 12 = 83,664$)

Work From Home and Agile (Hybrid) Working

The Covid-19 crisis has kickstarted a movement to agile (hybrid) working, and where service delivery is not impacted there are clear benefits to continuing this model:

- Improved wellbeing for staff due to reduced commuting, better work-life balance, local emissions reductions and so on.
- Reduction in carbon from commuting, less local pollution, improved access to parking for site visitors,
- Reduction in utilities usage, such as water, electricity and gas on site

Improving building services monitoring and control

Adopting the latest technologies in Building Management Systems (BMS) will provide significant and often direct carbon emissions at local level. Although frameworks exist for service providers in this industry, there is real opportunity to collaborate on maintenance contracts where similar systems are being employed across multiple sites, and to support transition to improved equipment. Organisations can link and pool expertise through peer meetings to ensure that benefits of BMS systems are being maximised.

Work underway, by Shropshire Council, to help staff with insulations and loan scheme for solar and battery installation in their homes.

It is important to note that Ecosia does allow for ‘carbon offsetting’, so the carbon sequestered from tree’s planted cannot be used in any official carbon accounting. Nor does NHSEI encourage tree planting as a route to net zero, rather, this method will be a tool for us to contribute to biodiversity in some of the most environmentally important areas across the globe — South America, Africa, Europe and East Asia.



Journeys, Transport and Active Travel

Business Travel and Staff Commuting are one of the major contributors to Trust Scope 3 emissions. Trusts are tasked with **outlining plans to reduce the carbon emissions** arising from Travel and Transport.

Fig 3: Greenhouse gas emissions by sector, 2019, by proportion (BEIS, 2020)

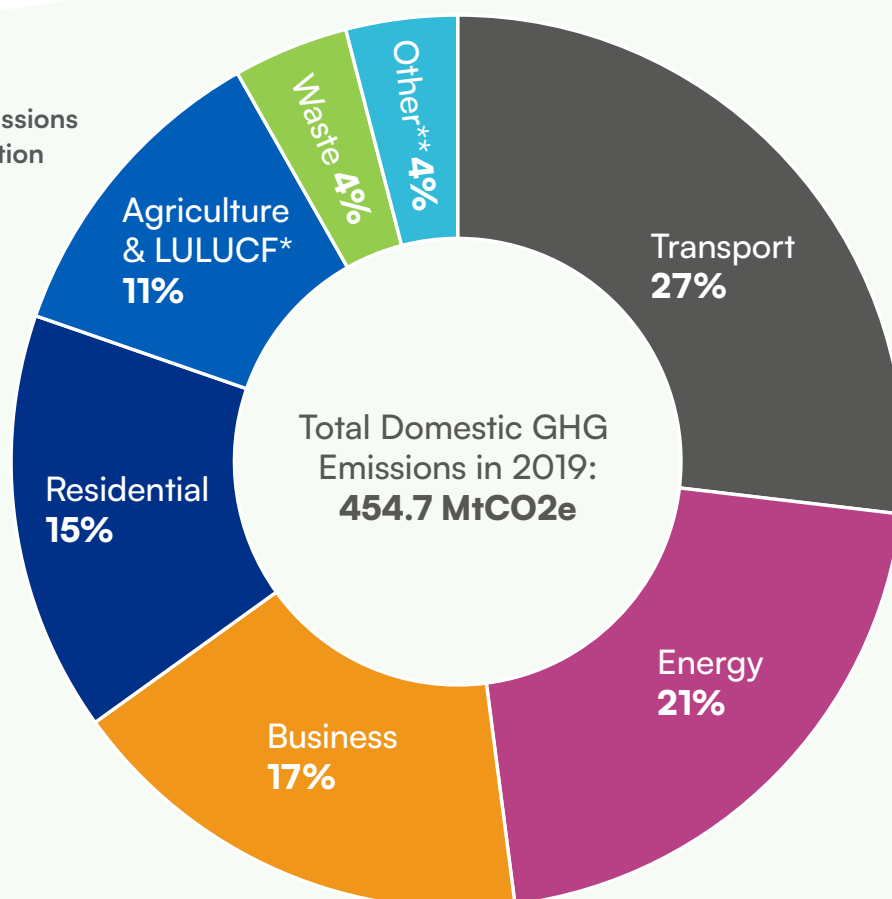
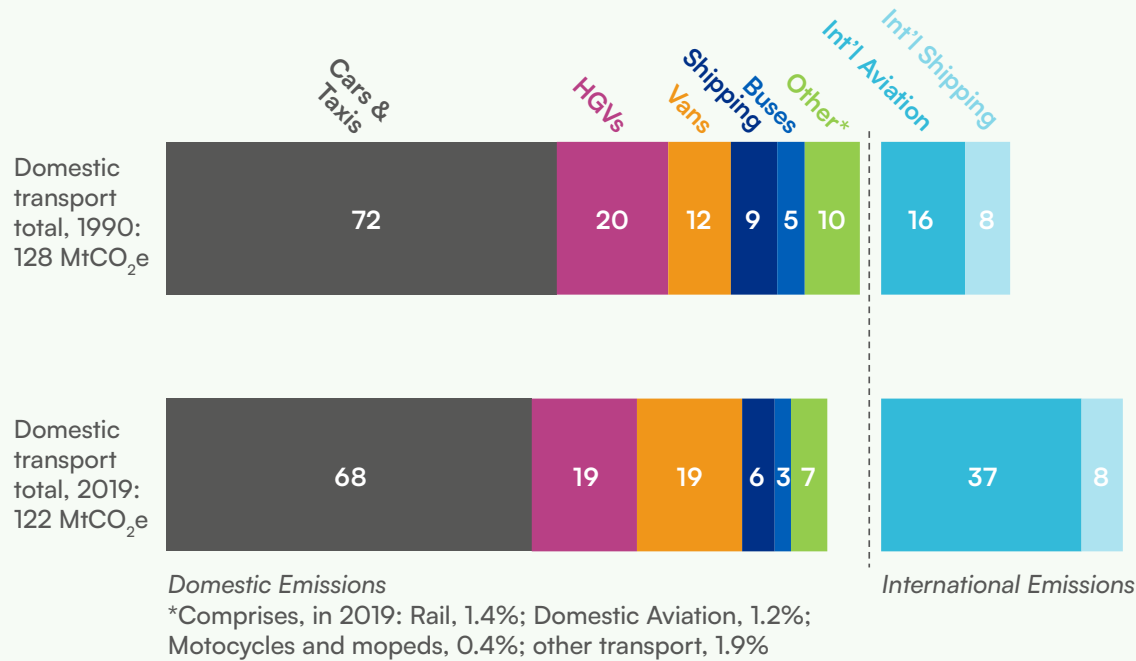


Fig 4: Greenhouse gas emissions by transport mode, 1990 and 2019 (ENVO201)



Source: www.gov.uk/government/statistics/transport-and-environment-statistics-autumn-2021/transport-and-environment-statistics-autumn-2021

The NHSi Greener NHS Fleet Data Collection tool can be completed by all non-ambulance NHS provider Trusts and was created to enable reporting on fleet carbon emissions and to understand the vehicle landscape to support planning for the necessary transition to zero emissions vehicles.

This uses vehicle registration numbers (VRNs) to look up emissions data. Understand operated vehicles and how these may be replaced.

Organisations will need to identify a named individual who will complete and submit the return on their behalf. Multiple people can respond for each organisation.

After identifying the responsible individual, they should:

1. Register for OKTA:
<https://apps.model.nhs.uk/register>
2. Register for the data collection:
<https://forms.office.com/r/PUq5Bre4rz>
3. Start collating the data required
4. Access and submit to the DCF portal:
<https://dcfdatacollections.improvement.nhs.uk>

Data collection portal opens: Friday 1st April 2022
 Data collection portal closes: Tuesday 24th May 2021

Investing in low emission fleet and reviewing the organisations transport of goods, patient transport, work patterns and location of services are also beneficial. For example, Telford & Wrekin Council are looking to implement an optimum flexible working pattern to reduce the carbon impact of staff travel and enable reduction in required office space as well as developing a Corporate Travel Plan to minimise car travel between offices.

The current process of renewing the Local Transport Plan (LTP4) for Shropshire will provide opportunities to generate co-benefits for both health and carbon performance.

Shropshire Council health and transport colleagues are working together to improve the health impact of the new Shropshire LTP, along with the LCWIP — Local Walking and Cycling Infrastructure Plan and the Bus Strategy. The actions will increase access to public and active travel and help to mitigate any negative health impacts.

Additional effort and investment is required to:

- Reducing barriers to using active travel
- Reduce Business Milage
- Develop and appraise Travel Plans to assess progress and quantify emissions saved
- Replace fleet with low emission (LEV/ULEV/ZLEV) alternatives

Travel plans can make a real contribution towards encouraging and promoting alternatives to the car.

Organisation can utilize the Clean Air Hospital Framework — a free resource available to help clean up their air.

This is a self-assessment tool designed to benchmark and shows areas to improve air quality across sites and in the local community.

The framework is focused on seven key areas:

1. Travel
2. Procurement and supply chain
3. Construction
4. Energy
5. Local air quality
6. Communication and training
7. Hospital outreach and leadership

Increasing ‘Active Travel’ and use of public transport are some of the interventions which some of the organisations in the ICS have already underway. For example, improvements to availability of shower facilities and increased cycle storage, as well as improving footpaths and lighting and introducing salary sacrifice schemes for cycle purchase or season tickets. Not only improving staff fitness but improving site emissions. SATH have, to date, 38 electronic vehicles on lease (another 19 on order) and 60 bicycle purchases via salary sacrifice.

Car sharing just once a week will help to reduce the amount of traffic on our roads, improve the local environment and our health. Similarly, walking once a week has obvious health benefits and helps to reduce the amount of traffic on our roads.

There are currently two Air Quality Management Areas (AQMAs) in the Shropshire Council area, in Shrewsbury and Bridgnorth, where action is required to address poor air quality. Traffic management measures and new infrastructure, together with support for a move to ULEV transport options are likely to result in a reduction of particles and other more harmful emissions

Telford & Wrekin Council are implementing discounts available from Arriva and West Midlands Trains to staff. Arriva also offers discount on monthly season tickets to NHS Staff

Staff commuting contributes to Trust Scope 3 emissions, therefore, any action taken now will begin to reduce our contributions.

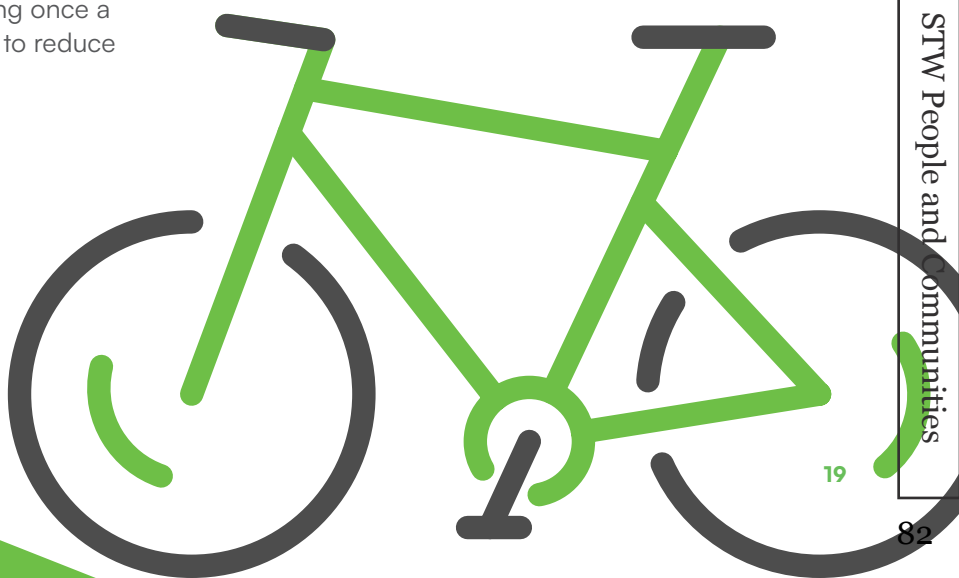
Currently SaTH have 60 bikes purchased under salary sacrifice, a bicycle user group and cycle champion promoting the service and benefits amongst staff.

Collaborative Opportunities

Develop a system-wide Green Travel Plan which will in turn influence organisations’ Green Travel Plan — focusing active travel, business travel and grey fleet

Manage the combined Non-patient transport service contract (due to start Mar22)

Set up regular meeting between key staff from each stakeholder to share ideas, developments and successes.





Estates (Hard Facilities Management)

NHS England's guidance, **Estates 'Net Zero' Carbon Delivery Plan**, advises a four-step approach to decarbonising estates.

Taking this holistic approach will enable organisations in our system to make easier, quicker wins in the short term, gradually building to net zero. Our Estate has a significant role in reducing our Scope 1 emissions and organisations within our system have made huge progress with reducing our direct emissions burden by installing photovoltaic (PV) solar panels, replacing lighting for LEDs, replacing boilers and associated equipment with ultra-efficient alternatives, improving installation to buildings and pipework, and for indirect (scope 2) emissions, switched to REGO energy from the national grid (electricity supplied to the grid from renewable energy sources). We have achieved electrical savings of at least 1,066,000 kWh/annum through the installation of PV solar panels, protecting future finances from expected grid cost inflation and price rises from the supply crisis.

Some examples of the efforts so far include:

- The installation of photovoltaic (PV) solar panels to many buildings,
- Replacing boilers with ultra-efficient equipment; for example, RJA have been able to reduce their gas consumption by up to 1.8mWh per year,
- Installing LED lights across multiple sites,
- Improving the insulation, or U-Value, of our buildings so that it takes less energy to reach required temperatures,
- All our organisations will purchase only renewable (REGO) electricity from the national grid by April 2022,
- Replacing antiquated Building Management Systems (BMS) with smarter controls

We're taking responsible measures to not only reduce our carbon emissions, but to realise financial benefits using the philosophy that less kWh used means less money spent - making every kilowatt count. We're also pro-actively accessing public grants and funding available such as the Public Sector Decarbonisation Scheme (PSDS); for example, Shropshire Council are implementing low carbon heating and lighting through this funding on one site to reduce energy use by over 65% and carbon emissions by 15 tonnes per year. Similarly, Telford and Wrekin Council are initiating an air source heat pump and thermal upgrade, saving 115 tonnes CO₂e.



Our Estate has a significant role in reducing Scope 1 emissions

The four-step approach to decarbonise the NHS estate by 2040
(Source: Estates 'Net Zero' Carbon Delivery Plan, NHSEI)



Includes indicative numbers to illustrate the scale of the challenge to decarbonise the NHS estate by 2040. These are not actuals.

The above infographic, published in the NHSE ‘Estates ‘Net Zero’ Carbon Delivery Plan, estimates that every £1 million invested across the NHS in the actions listed will deliver a 1.33ktCO₂e saving per year. The cumulative capital costs of these investments would be offset by equal revenue savings over only 3.8 years. By generating a proportion of the energy we consume at our sites, we are protecting our finances against inflationary and market price rises of importable utilities. There is opportunity to collaborate on large scale projects between our organisations and a key action is to explore the development of a PV farm on Shropshire Council land near to RJAH.

There are other exciting and potentially ground-breaking opportunities for the system to adopt emerging technologies that could see a reduction of direct and indirect carbon emissions in the near-to-medium-term. We will explore these opportunities and some member organisations may lead case studies with a view to adapting infrastructure at other sites.

The NHS organisations in our system collectively consumed over

116,000,000 kWh

We intend to collaborate between our organisations at a local level; sharing building space, day services are being reviewed with view to offer building-based services to a wider group across all ages. This space utilisation will in some cases reduce the burden on capital budgets and have an impact on carbon output, as well as reducing our consumption of building products which further contribute to climate change.

The NHS organisations in our system collectively consumed over 116,000,000 kWh (NHSEI, 2021) in natural gas in the year 2020-21. These scope 1 emissions are a key challenge that we will aim to reduce over the next three years.

However, we are already mitigating and reducing our reliance on grid energy by utilising Combined Heating and Power (CHP) technology to use fossil fuels in the most ethical way:

- Approximately 13,800,000 kWh electrical generation from CHP across all NHS sites in the system
- Approximately 13,900,000 kWh thermal energy generation from CHP across all NHS sites in the system.
- Approximately 18,600,000 kWh grid energy consumed across all NHS sites in the system in 2020-21, but our organisations are transitioning to on-site generation. Some examples of this are:
 - RJAH generate around 440,000 kWh pa
 - Telford & Wrekin Council produce a combined 498,000 kWh from PV solar arrays across multiple sites
 - MPFT generate around 128,000 kWh pa

Source: NHSE ERIC Data Collection, 2021

Collaborative Opportunities

Share benefits of installation of EV charging points through joint tender exercises

Give early warning to peers on grants, loans and other schemes that may benefit our reduction of scope 1 emissions

Share benefits of adopting emerging technologies and offer unique access to case studies.

Explore feasibility of shared power generation and consumption from PV farms, district heat networks and other renewable technologies.



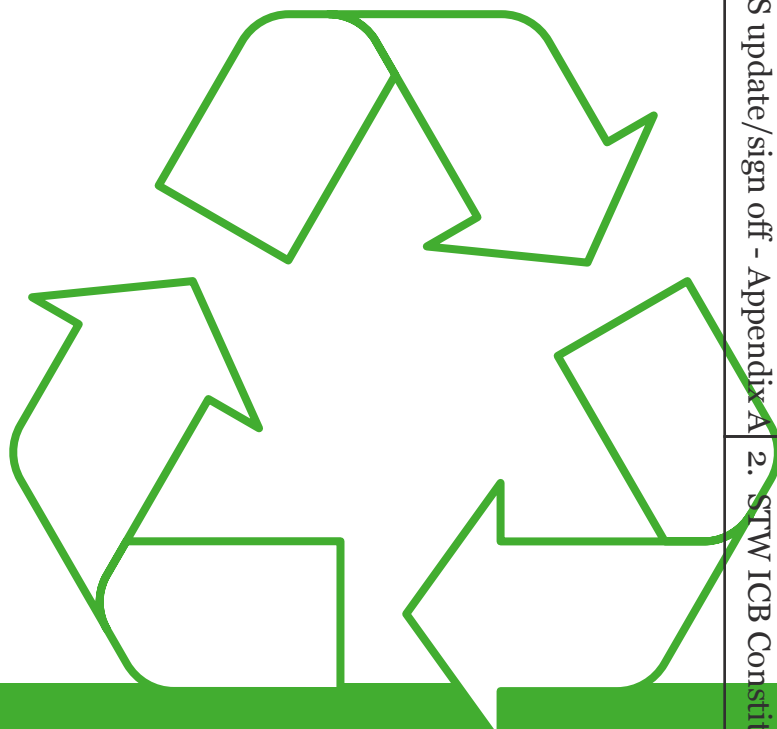
Facilities (Soft Facilities Management)

In our current economy, we take materials from the Earth, make products from them, and eventually throw them away as waste — the process is linear. In a circular economy, by contrast, **we stop waste being produced in the first place.** The world’s economy is only 9% circular. We must be bolder about saving resources.



As the area the sites depend on to maintain a pleasant, healthy and safe working environment are instrumental in the day-to-day operations it is a key priority that we work to reduce waste as well as air & water pollution to improve local environments.

WMAS have already made some major benefits from changing their cleaning to a single multi use, low packaging product as well as successfully piloting & beginning to roll out Domestic Waste recycling in its office locations. RJAH regularly divert 100% of domestic & clinical waste from landfill.



Waste

The management of healthcare waste is an essential part of ensuring that healthcare activities do not pose a risk or potential risk of infection and are securely managed. UK-wide guidance provides a framework for best practice waste management.

The management of waste in the NHS falls into 3 main categories:

Domestic — generated as a result of the ordinary day-to-day activities

Clinical (including sharps) — waste produced from healthcare that may pose a risk of infection, e.g. swabs, bandages, dressings; or may prove hazardous, for example medicines.

Offensive — non-infectious but may be unpleasant to anyone who encounters it e.g. nappies, feminine hygiene products, used but uncontaminated PPE.

WMAS has undertaken a survey for the implementation of recycling processes for the control and segregation of domestic waste. Following which they plan to introduce recycling at all sites across the Trust to fall in line with the successful introduction of Mixed Recycling at the Erdington Hub.

The initial trial of introducing Mixed Recycling at one of our major Hubs has resulted in the sites waste production being at 50% recycling, which is a 6,000kg saving in CO2e,

MPFT no longer purchase single use plastic stirrers and straws and are looking into alternatives to single use plastics in catering & reduce use of cups, cutlery, gloves & aprons in other areas.

Collaborative Opportunities

Set up quarterly meeting between facilities managers from each stakeholder to share ideas, developments & successes.

Share ways to improve waste management practices & improve specifications for tendering

Develop or update organisations Food & Drink Strategy - starting with aims to improve staff & patient nutrition & hydration as well as ways to reduce carbon

Combined procurement for provision of food & drink & use of local supply chains

Combined procurement of environmentally friendly catering items (e.g. takeaway containers, cups & cutlery)

Upon renewal of MPFT waste contracts requirements will be reviewed to ensure more efficient recycling of waste & are investigating using re-usable sharps and pharmaceutical boxes/bins. As well as displaying “bring your own bottle” notices and the introduction of bespoke MPFT water bottles and reusable bamboo cups.

SATH, RJAH & SCHAT utilize the same contracts meaning 98% of domestic waste is incinerated & converted into electricity for homes near the plant in Shrewsbury. Clinical & offensive waste is either safely processed & sent to energy recovery (by a third party) or burnt. SATH also use reusable sharps containers.



Medicines

Medicine optimisation as well as safe & effective use in health & social care can contribute to Scope 3 emission reductions.

Progress so far against key national targets:

Anaesthetic Gases

Measures already taken by all the ICS members have successfully eliminated the use of Desflurane.

Inhalers

Carbon emissions from inhalers have been assessed as responsible for approximately 3% of all NHS carbon emissions. The majority of emissions come from the propellant contained in pressurised metered dose inhalers (pMDIs). pMDIs contain propellants known as hydrofluorocarbons (HFCs), powerful greenhouse gases, which are used to deliver the medicine rather than the medicine itself.

Source: NHS England and NHS Improvement. *Delivering a 'Net Zero' National Health Service*. Published October 2020. & NICE. *Inhalers for asthma (patient decision aid)*. Published 23 May 2019. Last updated 01 Sept 2020.

pMDIs account for 71.6% of all inhaler device types prescribed in England, 68.8% in Wales and 66.6% in Scotland Source - NHSBSA Apr-Jun 21.

The NHS England Long Term Plan published in January 2019, outlined the national targets of reducing the carbon footprint of health and social care in line with the Climate Change Act targets of 51% by 2025.

Many people will be able to achieve the same benefit from DPIs. DPIs have lower average estimated carbon footprints of 20 g CO₂e per dose (two puffs) compared O₂ to pMDIs which are estimated at 500 g CO₂e per dose (two puffs).

The Shropshire, Telford and Wrekin Health Economy Formulary review is) already well underway updating the respiratory section to produce a green inhaler formulary to provide guidance to all prescribers and to support PCNs to deliver the IIF targets in a cost-effective manner. The draft formulary is currently with specialist consultation to ensure there are no clinical gaps before approval and launch.

There are key national targets which the ICS is working towards:

1. The IIF ES-01 has a target for pMDI prescriptions as a percentage of all non-salbutamol inhaler prescriptions issued to patients aged 12 years or over on or after 1 October 2021 (range: 35% to 44%). This aims to reward increased prescribing of DPIs and SMI where clinically appropriate with a target of 25% of non-salbutamol inhalers prescribed will be pMDIs by 2023/24.
2. The IIF ES-02 indicators has a target for the mean carbon emissions per salbutamol inhaler prescribed on or after 1 October 2021. This aims to reduce the mean propellant carbon intensity of salbutamol inhalers prescribed in England to 11.1 kg per salbutamol inhaler prescribed by 2023/24

Shropshire, Telford and Wrekin Current Performance

Commissioner Benchmarking	Total Items	Carbon footprint per inhaler kgCO2e	Total carbon footprint gCO2e (K = thousands)	Carbon footprint per 1,000 patients gCO2e (K = thousands)
NHS Shropshire, Telford and Wrekin CCG	46,645	25.1	1,651,348K	3,177K

Currently STW CCG prescribes 55.66% on non-salbutamol inhalers as pMDI, ranking 57th/133 CCGs or health boards in England and Wales. Target is 25%

	pMDI (excluding salbutamol)		DPI & SM I (excluding salbutamol)		Grand Total
Commissioner Benchmarking	Total Items	% of Total Items	Total Items	% of total Items	Total Items
NHS Shropshire, Telford and Wrekin CCG	36,619	55.66%	29,177	44.34%	65,796

Source: Medicines Management, Shropshire, Telford and Wrekin CCG

Local Authority transport measures can influence air quality &Shropshire Council are acting to improve air quality through the air quality strategy and through reduction of emissions in the Local Transport Plan 4 (<https://shropshire.gov.uk/roads-and-highways/local-transport-plan-ltp4/>). This can lead to reduction in the numbers of asthma cases diagnosed and to reduction in the number of asthma attacks.

Other actions in our progress include:

- Monitoring how local prescribing data on the inhaler carbon footprint compares to the national data using the PrescQIPP inhaler carbon footprint data tool and visual data pack to and identify where local improvements can be made to ensure timely progress is being made.
- Optimising prescribing to improve both patient outcomes and reduce carbon impact of inhaler choices by;
 - Reviewing patients regularly; demonstrating, checking and improving inhaler technique.
 - Discussing lower carbon footprint inhalers during reviews or when a change in treatment is clinically necessary.
 - Ensuring newly initiated treatments have a low carbon impact and switching existing therapies to lower carbon impact options where clinically appropriate
 - Reducing SABA overuse and increasing the percentage of patients on the Quality and Outcomes Framework (QOF) Asthma Register who were regularly prescribed an inhaled corticosteroid over the previous 12 months (target for IIF RESP-01 indicator in PCN DES is range 71% to 90%)
- Increase use of leukotriene receptor antagonists where clinically appropriate
- Wherever possible use combination inhalers for patients on dual or triple inhaled therapy.

Support prescribers through education in lowering inhaler carbon footprint, sharing data, reviewing respiratory prescribing guidelines to include lower carbon footprint inhalers, and how to optimise prescribing ensuring lower carbon footprint inhaler options are included in medicines formularies and ensure stock availability with suppliers.

Reduce waste through encouraging patients to; return their used or unwanted inhalers to a pharmacy (for either recycling where available, or environmentally safe disposal); to look after their inhalers and not over-order & increasing the use of re-usable inhalers.

Other opportunities for medicine optimisation include reductions in Polypharmacy (most defined as the use of five or more medications daily by an individual) could decrease the risk of avoidable hospital admissions.

Avoidable medicines-related admissions to hospitals may equate to nearly 2 million bed days in England per year (*Source: Environmental impact report: Medicines optimisation Implementing the NICE guideline on medicines optimisation (NG5)*)

We also need to begin to discuss with suppliers to assess and reduce blister pack carbon footprint and recycling opportunities. For example, the Association of the British Pharmaceutical Industry tool can be used to provide a quick approximation of the carbon impacts

www.abpi.org.uk/r-d-manufacturing/abpi-blister-pack-carbon-footprint-tool

Avoidable medicines-related admissions to hospitals may equate to nearly 2 million bed days in England per year





Supply Chain & Procurement

Over 60% of the total NHS Carbon Footprint sits within the supply chain, therefore, **suppliers and procurement will play a pivotal role in reducing our emissions.**

To ensure a better quality of life now and for future generations, we need to look seriously at the way we use the earth's resources, operate our businesses and live our lives. A sustainable approach recognises the broader impacts of our actions and aims to minimise any adverse effects.

Sustainable procurement requires taking environmental and social factors into account in purchasing decisions. For example, looking at what products are made of, where they come from, and who has made them and, therefore, minimising the environmental and social impacts of the purchases we make.

MPFT are looking to increase sustainable procurement principles within their procurement, collaborating with other NHS Trusts and other organisations to improve knowledge and understanding of sustainable procurement and to seek shared opportunities and benefits, consolidate orders to reduce deliveries, improve stock rotation to avoid product expiry.

Collaborative Opportunities

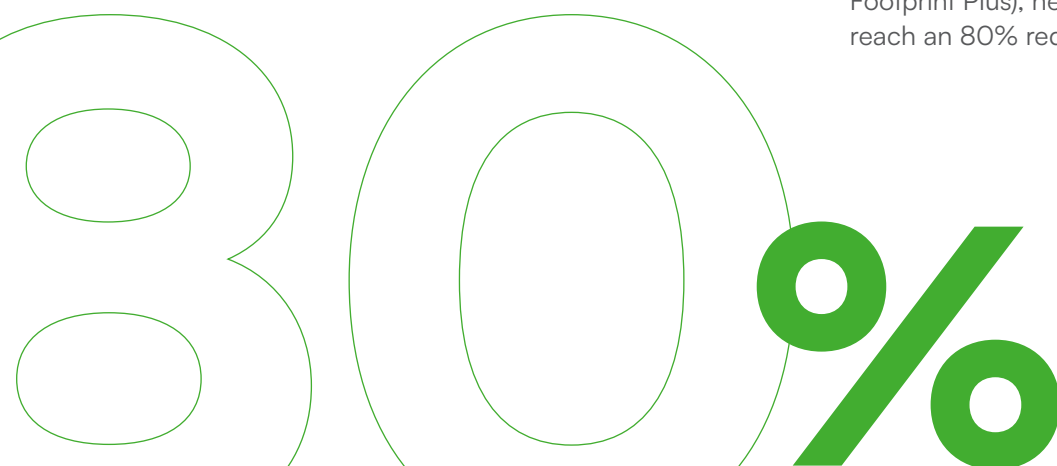
Set up quarterly meeting between procurement team members from each stakeholder to share ideas, developments and successes

Develop ICS Procurement Workplan for projects which would benefit from joint working

Engage and work with local suppliers, where possible within current rules, to reduce delivery miles

In January 2020, a Greener NHS which sets out a path to a 'net zero' NHS and as a result the below targets have been set:

- for the emissions we control directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032
- for the emissions we can influence (our NHS Carbon Footprint Plus), net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039



We must demonstrate leadership in sustainable procurement and will work with our supply chains to achieve this by addressing specific aspects of sustainable procurement such as:

- Reducing fossil fuel usage to minimise climate change
- Reducing usage of hazardous materials
- Reducing waste
- Ensuring fair pay and working conditions through the supply chain
- Reducing use of transport
- Reducing the use of Single Use Plastics
- Move to working with suppliers to minimise packaging, use reusable containers for deliveries and manufacture using renewable energy

A more sustainable product can be described as:

- Fit for purpose and providing value for money
- Energy and resource efficient
- Reusable and recyclable or durable, easily repairable or upgraded
- Ethically sourced (i.e. Wasn't made in a socially irresponsible way)
- Doesn't deplete natural, non-renewable resources
- The production, distribution, and/or consumption uses as little energy as possible and minimizes/responsibly disposes of waste.

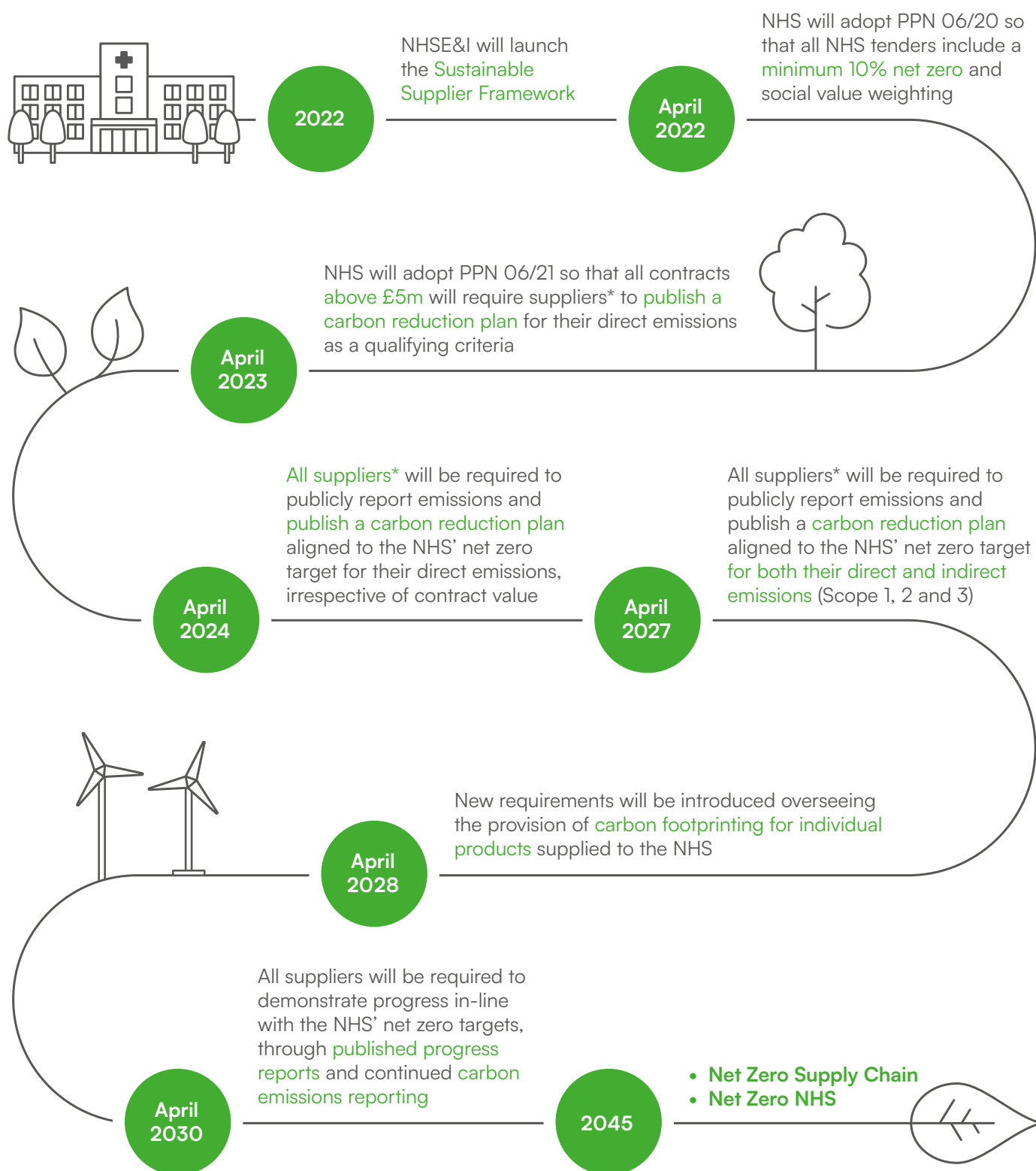
The benefits of moving to an ICS model

The shift to the ICS way of working will provide the foundation for scale procurement across the NHS with significant monetary and non-monetary benefits, achieved through unlocking efficiencies and improving operational performance across the system.

Improved resilience	C-19 taught us that working together is essential to mitigate risk. Working together across the ICS and at greater scale (where appropriate) provides greater protection from supply failures, price increases and quality defects
Reduced total cost	The ICS represents a publicised and policy driven way of driving 'at scale' procurement delivery; enabling greater efficiency and effectiveness through the potential to standardise and reduced repetition
Greater value	The ICS enables us to demonstrate social and financial value across organisational boundaries to drive better outcomes for our patients
Better supplier management	Working closer together helps leverage scale and value attained through our supplier base through a single voice for categories
Optimised workforce	The ICS enables us to make best use of our collective resource through reduction in duplicated activities and access more diverse roles across the system
Improved capability	Working together frees up capacity to give us time to develop and leverage specific skills and expertise
Great careers	ICS provides a great platform for career growth with a more diverse set of challenges and opportunities across the commercial life cycle.
Empowered culture	The ICS provides an opportunity to fundamentally change and shape the way we work across the system and into the future

Source: NHSEI Commercial Directorate procurement Target Operating Model "ICS Based Procurement Guidance" January 2021 <https://future.nhs.uk/PTOMHub/view?objectId=122643621>

Building Net Zero into NHS procurement



*To account for the specific barriers that Small & Medium Enterprises and Voluntary, Community & Social Enterprises encounter, a two-year grace period on the requirements leading up to the 2030 deadline, by which point we expect all suppliers to have matched or exceeded our ambition for net zero.



Food & Nutrition

“It is estimated that food and catering services in the NHS accounts for approximately **6% the NHS’ Carbon Footprint Plus**” — *Source NHS England Greener NHS website*

Members need to consider ways to reduce the carbon emissions from the food made, processed and served within our organisations. Members currently have various solutions, but it is essential work on reducing overall food waste and ensuring provision of healthier and seasonal menus. Making menus seasonal and adaptable can save money as buying items in season is more cost effective.

Challenging the amount of food waste and reducing the carbon emissions of the food consumed as well as changing to healthier items can have a large impact.

Collaborative Opportunities

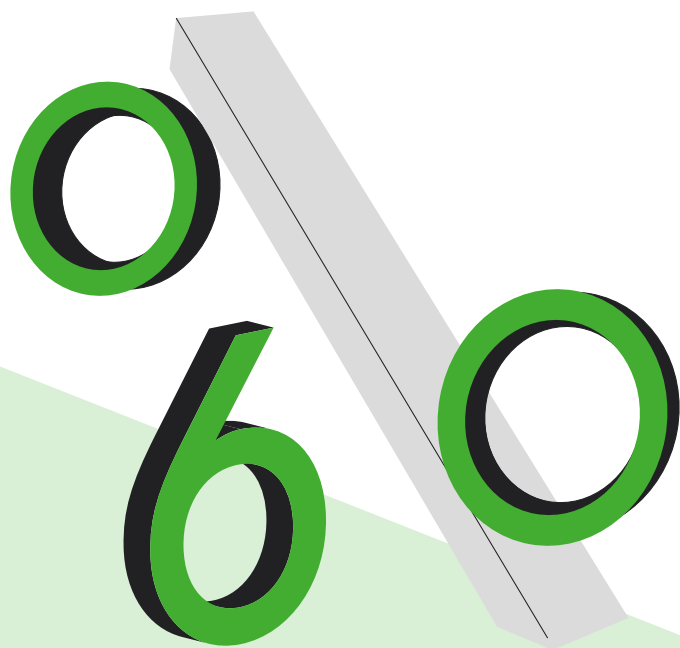
Set up quarterly meeting between catering staff and dieticians from each stakeholder to share ideas, developments and successes

Look to award joint contracts to enable utilisation of fresh food sourced locally, where applicable

Share strategies to minimise food waste

ICS members to join the Shropshire Good Food Partnership and Marches good food group

MPFT have a 4 year plan to provide healthier eating for whole hospital community, achieve Soil Association Food for Life Catering MARC - bronze standard, introduce on the day ordering to reduce waste. Food provided in in-patient wards will be purchased and produced in sustainable way. As well as looking to re- instating greenhouse and plots to grow in hospital gardens/health centres, community outside space etc.



Shropshire Good Food Partnership are working across Shropshire taking a food systems approach to improve sustainability, amongst other objectives, in the local food system. Engagement by ICS partners with the local food system is an opportunity to reduce food miles and to engage with producers who are using sustainable forms of food production.

Food production is responsible for one-quarter of the world’s greenhouse gas emissions.

UK Agriculture contributed 10 per cent to total greenhouse gas emissions in 2018, including 70% of nitrous oxide emissions, (generated by synthetic fertilizer use), and nearly half of total methane emissions.

Greenhouse gas emissions across the food supply chain:



Source: <https://ourworldindata.org/food-choice-vs-eating-local>

It is also important to utilize each patient contact to promote healthy and sustainable lives, inc. diet and exercise options.



Biodiversity

Biological diversity, or biodiversity can be described as **“the variety of life on Earth,** it includes all organisms, species, and populations; the genetic variation among these; and their complex assemblages of communities and ecosystems.” (Benn, 2010)

Biodiversity is incredibly important for sustaining life on the planet; the interdependency we have with the species of flora, fauna, animals, birds, insects and micro-organisms is vital in sustaining our existence through absorbing carbon and regulating environmental change such as climate and disease, providing renewable sustenance at all levels of the food chain, and balancing species population.

It is important, then, that the activities we carry out in providing the services we are commissioned to deliver do not negatively impact our local, national and worldwide ecosystems.

What are we doing to sustain biodiversity?

There are great examples of encouraging biodiversity in our Integrated Care System. SaTH are collaborating with local beekeepers to provide hives at the Shrewsbury site, as well as bat boxes and Swift boxes to divert such creatures away from buildings whilst providing space for them to live, in addition to planted trees and improved gardens and courtyards with native plants to attract pollinators. RJAH are planting 100 trees across the site around the Captain Sir Tom Moore Path of Positivity, an area for patients (including those bed-bound) and staff to enjoy the local wildlife.

In 2021, TWC gave away 14,525 free trees to residents and organisations in Telford and Wrekin as part of our Trees4TW project.

Collaborative Opportunities

Share funding models / share information on available grants for investment in surveys introduction of habitats

Work together develop or update organisations ICS Green Space Strategy

What will we do now?

Look to ensure any impact of development is replaced e.g. trees, wild areas or hedges removed are replaced nearby.

As discussed in Digital Transformation, by adopting Ecosia as our default search engine, we are indirectly contributing the planting of trees and in turn promoting biodiverse habitats in areas outside of Shropshire, Telford and Wrekin.

We will ensure that the local habitats of our native species are considered during capital works to ensure that any works we complete have a positive impact on local wildlife.

We will adopt methods already employed by some organisations in the system to provide beehives, bat and swift boxes where appropriate and plant trees and plant species in our green spaces.

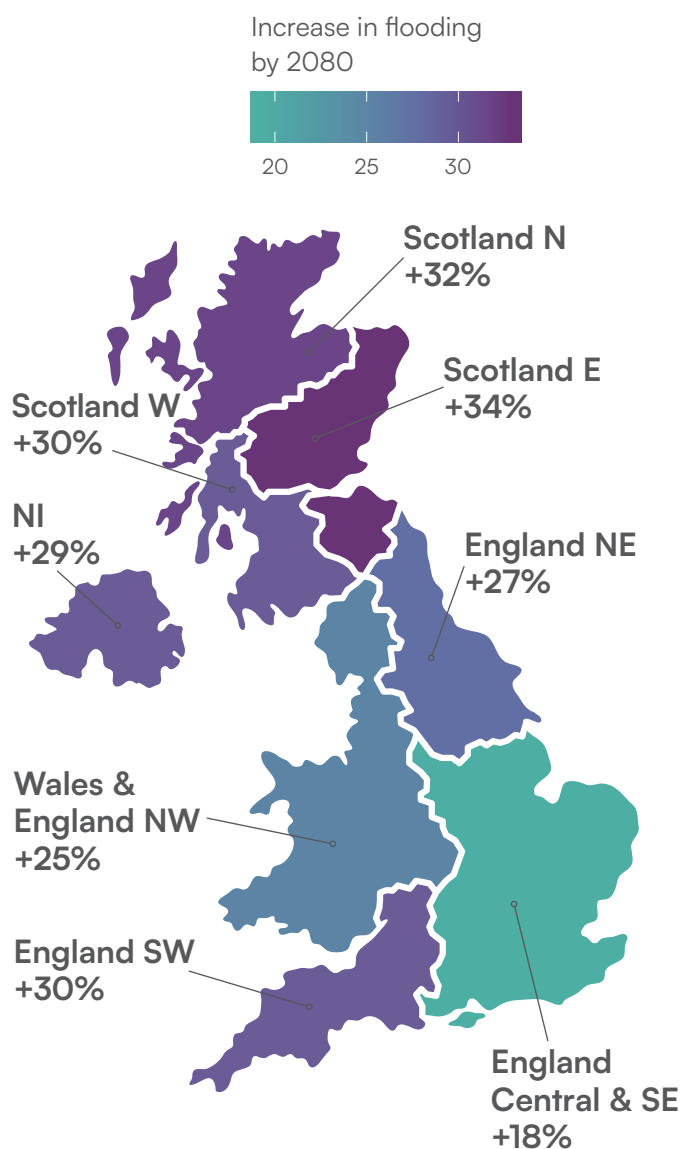


Adaptation

The care we provide must be **consistent throughout major incidents** such as wildfires, floods, heatwaves, droughts and infectious diseases.

Sustained extremes in weather and climate are likely to become the status quo in the UK, and varied sources and data indicate that:

- Wildfires are likely to increase 14% by 2030, 30% by the end of 2050 and 50% by the end of the century (UNEP, 20)
- Flooding will increase by 15-35% by 2080, with Shropshire, Telford and Wrekin likely to experience an increase of around 25% (figure, left) (Visser-Quinn, 2021)
- Heatwave frequency, length and average temperatures are significantly increasing -their average length more than doubling — increasing from 5.3 days in 1961-90 to over 13 days in the decade 2008-2017 (Met Office, 2018)
- Sustained droughts are more common. From September 2010 to March 2012 many parts of England experienced the driest 18 months for over 100 years (Environment Agency, 2017)
- The emergence of SARS-CoV-2 and subsequent Covid-19 crisis in 2020 set a precedent for future outbreaks and how the country will address subsequent variants and other pandemics.



Source: Heriot-Watt University



Although it is unrealistic to expect a service to continue in the event of localised flooding or incidents that incapacitate certain service delivery for some organisations, there may be opportunity to provide contingency, support or mutual aid from the wider system. Preparedness for infectious disease outbreaks is not covered in detail this document, although it is recommended that there be a systematic approach to building resilience to future pandemics and infectious disease outbreaks - for example, the mutual aid between NHS organisations in the system during the Covid-19 pandemic.

How we adapt now to the climate crisis will have significant influence on the investments required later, so it would be prudent to intervene at an early stage. The Department of Health publication for resilience in estate planning (HBN 00-07) offers guidance and all our NHS organisations should adopt this approach when producing Estates Plans. Some of the guidance is transferrable for council estates planning, and other documents such as the CIBSE guidance suite is relevant and applicable.

Collaborative Opportunities

Shared working spaces and agile (hybrid) working to generate carbon and climate resilience benefits

Mutual aid

A co-ordinated Clinical Strategy

A co-ordinated Estates Strategy

Action Plan

The action plan developed below outlines **collective goals** not only at system level, but at organisation level with the support from the ICS.

The target dates and completion of the actions will be monitored by the ICS Climate Change Working Group and assurances/escalations will be provided to ICS Board. Executive leads are to be agreed for each area over the next 12 months.

Leadership & Workforce			
Action	What resource is needed?	How will we measure our progress?	Target date
Explore options for a Sustainability Lead for the ICS	1 WTE to be banded	Once postholder is in role	April 2022
Establish a baseline carbon footprint	Funds for external consultancy to deliver	System-wide carbon footprint figure	March 2023
Make carbon literacy training available for senior leaders, expecting at least one from each organisation to have completed by April 2023	Funds for training provider to deliver training	Once one senior leader from each organisation has completed the training	April 2023
Green Plan to be reviewed and actions measured within 12 months, with a view to amend accordingly	Central co-ordination/Climate Change Working Group to review	Updated version of Green Plan to be published April 2023	April 2023
Develop benchmarks on system performance to demonstrate assurance and/or areas for further development	Central co-ordination/Climate Change Working Group to review	Quarterly benchmark reporting to Climate Change Working Group	October 2022
Ensure that sustainability behaviours are considered when reviewing job descriptions	Communications and engagement with human resources/people services	Job descriptions updated to include sustainability behaviours	April 2023

Sustainable Models of Care

Action	What resource is needed?	How will we measure our progress?	Target Date
Where outpatient attendances are clinically necessary, at least 25% of outpatient activity should be delivered remotely	ICT equipment and training, engagement with clinical teams	All outpatients services delivering ≥25% of activity	April 2023

Digital Transformation

Action	What resource is needed?	How will we measure our progress?	Target Date
Organisations encouraged to adopt Ecosia as their default internet search engine	Engagement with IT departments to add Ecosia as an extension to MS Edge	IT departments to provide collective data (against UCLH data benchmark)	October 2022
Promote the option of agile (hybrid) working where there is no negative impact on service delivery	Engagement with IT departments, it is anticipated that no significant extra equipment be required as those that could work from home did so during the covid-19 crisis and were provided with equipment then	IT departments to provide collective data (against benchmarks during covid-19 crisis)	April 2023

Travel & Transport

Action	What resource is needed?	How will we measure our progress?	Target Date
Organisations will need to identify a named individual who will complete and submit the return NHSEI Greener Fleet Data Collection tool	Time and named individual	Successful and routine return of data to NHSEI	April 2022
ICS to develop a system Green Travel Plan, ensuring a hierarchy of travel starting with active travel	Central co-ordination, climate change working group for peer support	Document to be published April 2023	April 2023
Ensure that, for new (fleet) purchases and (fleet) lease arrangements, the system (and organisations) solely purchases and leases cars that are ultra-low emissions vehicles (ULEVs) or zero emissions vehicles (ZEVs)	It is anticipated that this transition will occur when existing contracts are renewed, so those organisations still in contract by April 2023 will aim to move to ULEVs/ZEVs once those contracts end. Electric Vehicle (EV) charging infrastructure will be required at base sites	All contracts transitioned at their end	April 2023

Estates			
Action	What resource is needed?	How will we measure our progress?	Target Date
NHS Organisations to ensure they procure only REGO energy from grid as soon as their existing contracts allow	Small cost pressures to utilities (typically less than £2/mWh additional)	All organisations to confirm at Climate Change Working Group	April 2022
Organisations to commit to invest in on-site renewable energy, insulation, and energy efficient technologies (such as LED lights) as part of their Estates Strategies	Capital commitment during schemes, although there would be an expectation of ROI	Sustainable technologies specified in all organisations' Estates Strategies	April 2025
Where possible, invest in emerging renewable technologies	Capital investment where there is attractive ROI	Successful completion of projects	April 2025
As a minimum, adopt BREEAM as a benchmark for constructing sustainable buildings, with a shared design benchmark to follow on from the work from Shropshire Council	Could be absorbed in capital projects	Successful BREEAM validation on capital projects	April 2023
Develop a heat decarbonisation plan for the system	External consultancy and central co-ordination, climate change working group for peer support	Document to be published October 2023	October 2023
Replace any habitat removed during developments	Could be absorbed in capital projects	External verification	April 2023
Facilities			
Action	What resource is needed?	How will we measure our progress?	Target Date
Explore options to appoint a system waste manager	1 WTE to be banded	Once postholder is in role	October 2022
Organisations to assess waste management practices against better-performing peers and adopt where reasonably practicable (i.e. segregation)	System Waste Manager to co-ordinate	Quarterly benchmarking to climate change working group	April 2023
Organisations to aim to divert 100% household waste from landfill	Review contracts and amend when renewing, where applicable	Quarterly benchmarking to climate change working group	April 2023
Organisations to sign up to the single use plastic pledge (catering)	Cost pressure to some catering budgets — opportunities to collaborate on procurement	All organisations to confirm through the climate change working group	April 2023

Facilities (continued)

Action	What resource is needed?	How will we measure our progress?	Target Date
Reduce food waste through smarter working (i.e. patient ordering strategies, management of stock, etc)	Could be pursued through existing catering structures	Quarterly benchmarking to climate change working group	April 2024
Adopt, where clinically safe to do so, environmentally friendly domestic cleaning chemicals	Could be pursued through existing procurement structures	Organisations to report through climate change working group	April 2023

Medicines

Action	What resource is needed?	How will we measure our progress?	Target Date
Organisations to encourage use of low-carbon alternatives to inhalers and similar environmentally harmful medicines (where it is clinically safe to do so)	Continue specialist consultation before launch of green inhaler formulary	All organisations to confirm via the climate change working group	April 2023
Organisations to consult with their clinicians to agree alternatives to environmentally harmful anaesthetic gases such as Sevoflurane, Isoflurane and Nitrous Oxide	Engagement clinicians and Medicines Managements teams	All organisations to confirm via the climate change working group	April 2024

Supply Chain & Procurement

Action	What resource is needed?	How will we measure our progress?	Target Date
Adopt PPN 06/20 so that all NHS tenders include a minimum 10% net zero and social value weighting on contracts >£5m per annum	Add to pre market engagement process	An NHS wide TOMs (Themes, Outcomes and Measures) reporting portal is being developed	April 2022
Procurement staff to complete training on Social Value in tenders	Staff time, although free training available via: www.govcommercialcollege.co.uk	Staff appraisals	December 2022
Ensure process/contract for reuse of Walking Aids is in place	Introduction of process and minimal ongoing staff resource to prepare for reissue	Reduction in expenditure	March 2023
Ensure reusable surgical instruments have been investigated and implemented as appropriate	Validating and introducing process by clinicians / H&S	Reduction on expenditure	March 2023
Review procurement procedures to embed awareness of sustainable in procurement processes	Amend with regular reviews	Processes embedded	December 2023

Supply Chain & Procurement (continued)

Action	What resource is needed?	How will we measure our progress?	Target Date
Ensure the whole life cycle impacts of the procurement	Include in pricing exercise and evaluation	Expenditure better managed	December 2023
Begin to communicate NHS Net Zero targets for Scope 3	Carry out via contract management	Awareness improved	March 2024
Promote the value of human rights and equality within our supply chain	Carry out via contract management	Awareness improved	March 2024
All suppliers will be required to publicly report emissions and publish a Carbon Reduction Plan for their direct emissions and social value included in the evaluation and award, irrespective of contract value. *SME and Voluntary Sector have a 2-year grace period to adhere to this	National requirements	Awareness improved	April 2024

Food & Nutrition

Action	What resource is needed?	How will we measure our progress?	Target Date
Organisations to expand plant-based menu options, reduce meat-based menu options and hold 'meat-free' days regularly	Amend menus, there may be a need for new suppliers/ contracts	Use of meat-based items	April 2023
Organisations to employ seasonal menus to enable provision of fresh food sourced locally	Amend menus, may be a need for new suppliers/contracts	Use of more fresh produce	April 2023
Organisations to attain sustainable catering accreditation (i.e. Soil Association Food for Life Catering MARC)	Tie commitment and small cost pressure for validations, in house awareness and inspection	MARC Accreditation	April 2025
Organisations to develop a strategy to minimise food waste	Co-ordination and peer review via climate change working group	Quarterly benchmarking to climate change working group	April 2024

Biodiversity

Action	What resource is needed?	How will we measure our progress?	Target Date
Organisations to consider the impact of capital estates projects on local wildlife and ensure neutral or positive impact by developing green spaces in proximity to the works	Could be absorbed in capital projects	External verification	April 2023
Organisations to 'rewild' green spaces by planting diverse range of trees and plant species	External funding, for example the Queen's Green Canopy	Organisations to report via climate change working group	April 2025
Develop an ICS Green Space Strategy	Central co-ordination/ Climate Change Working Group to review	Document to be published September 2023	September 2023

Adaptation

Action	What resource is needed?	How will we measure our progress?	Target Date
Ensure our NHS organisations consider HBN 00-07 when developing Estates' Strategies	Engagement with Estates teams	HBN 00-07 to be specified in Estates strategies	April 2023
Organisations to ensure contingency plans are in place in the event of adverse weather and major incidents to provide business continuity, staff and patient safety and care provision	Engagement with whole organisations to ensure comprehensive and joined-up approach	Organisations to escalate concerns via climate change working group	April 2022

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Acronyms

Acronym	Definition
CO2e	CO2e accounts for carbon dioxide and other gases such as methane and nitrous oxide
DPI	Dry Powder Inhaler
EPR	Electronic Patient Records
GHG	Greenhouse Gases
ICB	Integrated Care Board
ICS	Integrated Care System
MPFT	Midlands Partnership NHS Foundation Trust
MS	Microsoft
NICE	National Institute for Clinical Excellence
pMDIs	Pressurised Metered Dose Inhalers
PV	PhotoVoltaic (Solar panels that convert the Sun's energy into useful electrical power)
QIPP	Quality, Innovation, Productivity and Prevention
REGO	Renewable Energy Guarantees of Origin
RJAH	The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
ROI	Return on Investment
SATH	The Shrewsbury & Telford Hospital
SC	Shropshire Council
SCHT	Shropshire Community Health NHS Trust
SM	Salmeterol
STW CCG	Shropshire, Telford & Wrekin Clinical Commissioning Group
TW	Telford & Wrekin Council
WMS	West Midlands Ambulance Service

Further Information

If you have a general enquiry about Shropshire, Telford & Wrekin Integrated Care System(ICS), please email **stw.stp@nhs.net**

Visit us online **www.stwics.org.uk**

Our partnership is made up of the following organisations:



STW People and Communities Involvement

Agenda item 25-05.009



Strategy



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The purpose of the document

This strategy explains how the newly formed NHS Shropshire, Telford and Wrekin (NHS STW) intends to involve people and communities. We are an organisation bringing together providers and commissioners of NHS services with local authorities and other local partners to plan, co-ordinate and deliver health and care services.

We see the formation of NHS STW as an exciting opportunity to really strengthen our connections and work with local people of all ages and our local communities – to us that means groups of people living in the same place or having a particular characteristic in common – as well as building on our existing relationships, networks and activities.

To be a strong and effective organisation, we need a deep awareness of all our communities and the people living within them. Understanding their diverse hopes, needs and experiences will be essential in enabling us to tackle health inequalities and the other challenges all health and care systems face.

This strategy will help us to make sure we establish a shared approach to hearing the needs, experiences and wishes of local people, learning from them, and ensuring they inform our priorities and key decisions about health and care services.

In this document, we describe our approach and our methods to ensure we are putting the people of Shropshire, Telford and Wrekin at the heart of everything we do.

The overarching responsibility for approval and monitoring of this strategy is with the NHS STW Board.

In developing this document, we have taken national guidance into account and, our intention is to further refine its content and our approach to involvement over time with input from our partners and the communities we serve.

Background and context

ICS overview

NHS STW is part of the Shropshire, Telford and Wrekin Integrated Care System (ICS). ICSs embody a new way of working which brings together all the health and care organisations in a particular local area, to work together more closely.

An ICS is responsible for looking after and delivering all the health and care services in the area it covers. Each ICS is made up of an integrated care board and an integrated care partnership, working together:

- an **integrated care board (ICB)** – an organisation bringing together providers and commissioners of NHS services with local authorities and other local partners to plan, co-ordinate and commission health and care services. In our area, this organisation is called **NHS Shropshire, Telford and Wrekin (NHS STW)**
- an **integrated care partnership (ICP)** – a wider set of system partners to develop a plan to address the broader health, public health and social care needs of the local population.

These new arrangements empower us to deliver more joined-up health and care services, improve population health and reduce health inequalities. The term ‘health inequalities’ generally refers to differences in the status of people’s health. It can also refer to differences in the care people receive and the opportunities they have to lead healthy lives.

Much of our work will be completed over smaller geographies (‘places’) which mirror the footprint of our local authorities – Shropshire Council and Telford and Wrekin Council – and through teams delivering services in even smaller areas (‘neighbourhoods’).

We follow the ethos of ‘Think Local, Act Personal’. This means we are committed to working with the people in our communities and, through their insight, deliver care that meets their current and future needs and wishes. Together, we are on an exciting journey to provide compassionate, well-designed services that make a positive difference to our local communities.

Partners in our ICS include:

- NHS Shropshire, Telford and Wrekin (the organisation that holds responsibility for planning NHS services, including those previously planned by NHS Shropshire, Telford and Wrekin Clinical Commissioning Group)
- The Shrewsbury and Telford Hospital NHS Trust – which includes the Princess Royal Hospital in Telford and the Royal Shrewsbury Hospital in Shrewsbury
- The Robert Jones Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
- Midlands Partnership NHS Foundation Trust
- Shropshire Community Health NHS Trust
- 51 GP practices
- Shropshire Council
- Telford and Wrekin Council
- Healthwatch Shropshire and Healthwatch Telford and Wrekin
- Voluntary, community and social enterprise (VCSE) organisations.

Our vision

Our vision is for us all to work together with our population to develop safe and high-quality services – supporting people to live healthy and independent lives and to stay well for as long as possible.

*An ambitious ICS, we want to make a real difference to the lives of local people. To guide our work, we are committed to delivering on **10 key pledges**. One of these pledges is enhanced engagement and accountability – increasing our engagement, involvement and communication with stakeholders, politicians and the public.*

Our communities

Shropshire, Telford and Wrekin is a highly diverse area, from the agricultural villages of the Shropshire Hills to the urban landscapes of Telford town.

Population^{1,2,3}

Our growing population includes many younger people but as people are living longer, we also have an increasing number of older residents.

We know people's health and wellbeing is impacted by many factors – their homes, income, opportunities for education and employment, and access to public services.



Telford and Wrekin:

181,000

Shropshire:

325,000

18% of people in Shropshire, Telford and Wrekin live with a long-term illness



Long-term conditions⁴

18% of people in Shropshire, Telford and Wrekin live with a long-term illness.

¹ ONS Mid 2020 population estimates

² <https://shropshire.gov.uk/information-intelligence-and-insight/facts-and-figures/shropshire-snapshots/population/>

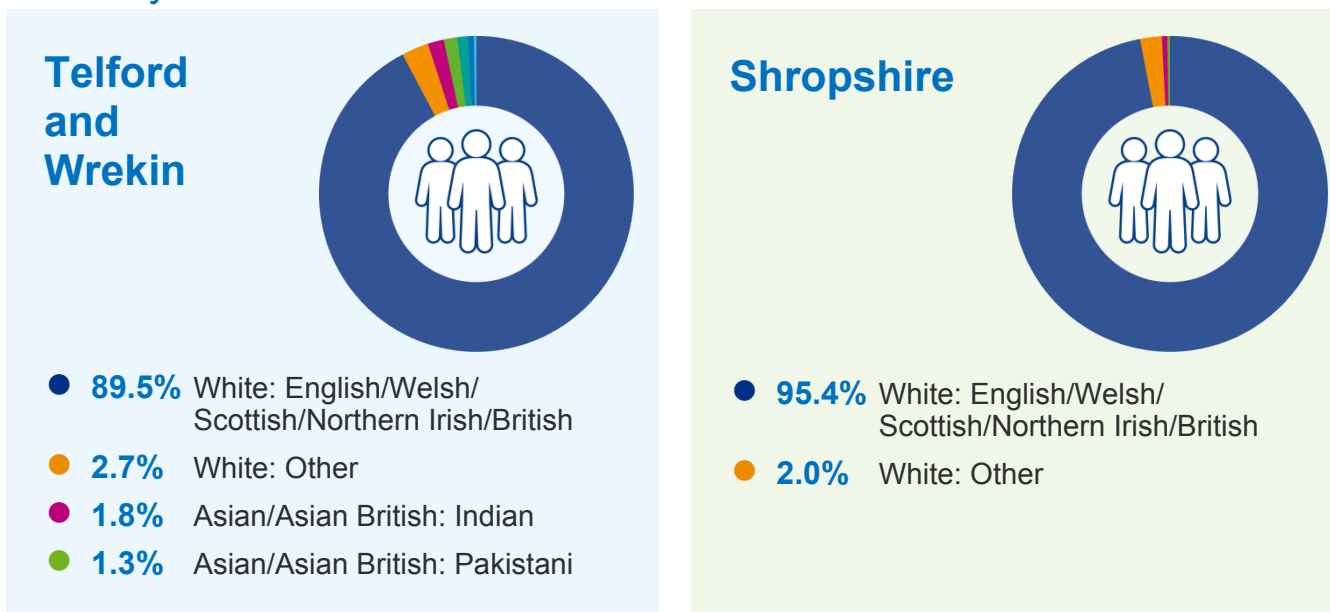
³ Shropshire, Telford and Wrekin ICS Annual Review

⁴ Shropshire CCG and Telford and Wrekin CCG Annual Report Summary 2020/21

Deprivation⁵

- In Telford and Wrekin, around 30% of local authorities in England have higher levels of deprivation than Telford and Wrekin (99th out of 317), although 18 areas in the borough fall within the 10% most deprived boroughs nationally
- Shropshire has overall average deprivation (165th out of 317 local authority areas), with rural areas being mostly of higher affluence with hidden pockets of deprivation. Two areas within the more urban setting of Shrewsbury fall within the 10% most deprived boroughs nationally.

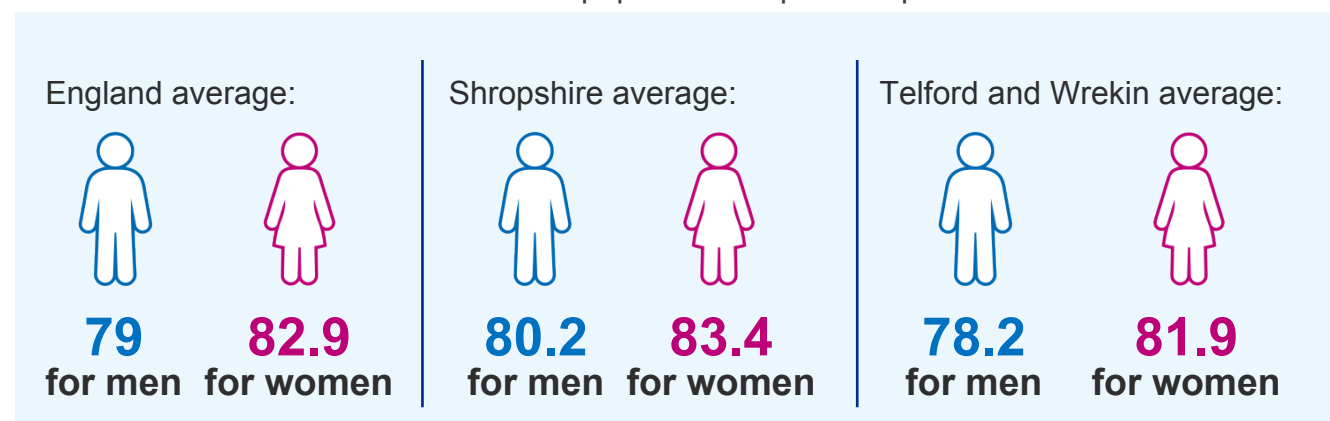
Ethnicity



We also have smaller numbers of people from a range of other ethnicities within our communities across both Shropshire, Telford and Wrekin, including White: Irish, Asian/Asian British: Chinese; Mixed/multiple: White and Asian; British: Bangladeshi; and Other: Arab.

Life expectancy⁶

There is a large variation in life expectancy across our area, so understanding the health conditions that are more common in our population helps us to prioritise our efforts.



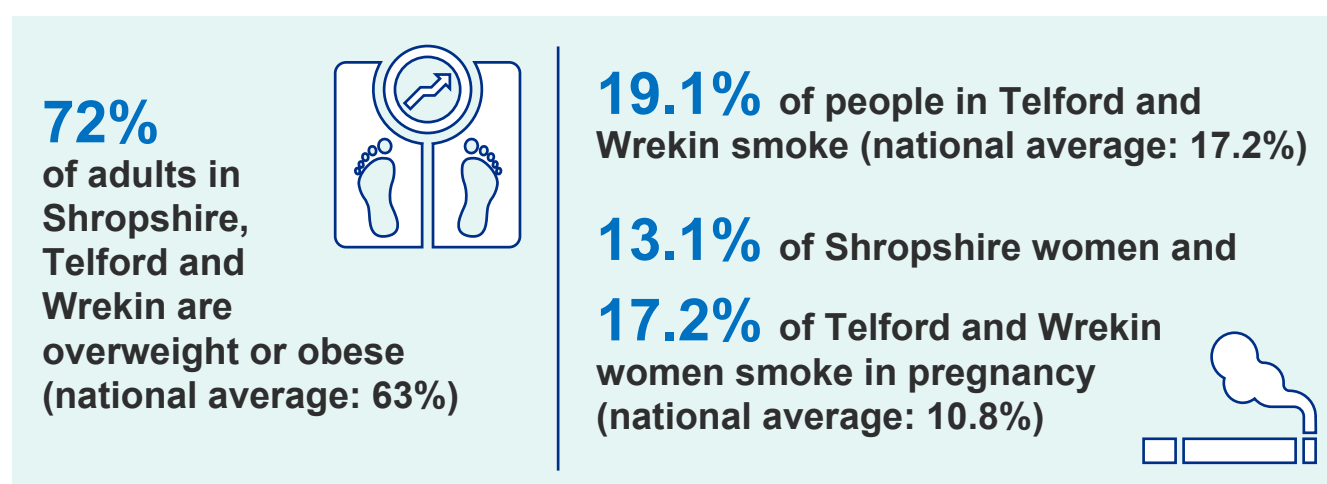
⁵ 2019 Indices of Deprivation

⁶ 2020 Office for National Statistics figures, as reported in Shropshire Star:

<https://www.shropshirestar.com/news/health/2021/09/30/life-expectancy-for-shropshire-men-falls/>

- **Cardiovascular disease** is the most common cause of death in Shropshire (around 35% of all deaths each year)⁷
- Higher-than-national-average hospital admissions in Telford and Wrekin for **coronary heart disease and stroke**⁸
- Deaths from **coronary heart disease**⁹:
 - Telford and Wrekin: 42 in 100,000 each year
 - Shropshire: 34 in 100,000 each year
- An estimated one in four people have a **mental health disorder**¹⁰.

We know helping people to make healthier lifestyle choices and improve their overall health reduces their risk of certain health conditions.



⁷ Shropshire CCG Annual Report 2020/21

⁸ Telford and Wrekin Council JSNA: <https://www.telford.gov.uk/factsandfigures>

⁹ 2019 BHF Report, as reported in Shropshire Star:

<https://www.shropshirestar.com/news/health/2019/05/21/hundreds-under-75-die-from-stroke-and-heart-disease-in-shropshire>

¹⁰ Shropshire CCG and Telford and Wrekin CCG Annual Report Summary 2020/21

What do we mean by involvement?

Communication and involvement

‘Communication’ can be defined as what to say and who to say it to, while ‘involvement’ is about actively gathering and listening to people’s input. Communication can happen without involvement, but involvement cannot happen without communication.

NHS England defines involvement as: “Enabling people to voice their views, needs and wishes, and to contribute to plans, proposals and decisions about services...Different approaches will be appropriate, depending on the nature of the commissioning activity and the needs of different groups of people.”

Health and care organisations have a duty to involve the public in any plans, proposals or decisions that are likely to impact on services provided. This is the right way to ensure our services meet the needs and hopes of people living in Shropshire, Telford and Wrekin. We are committed to this approach for involving our local people and communities.

As public sector organisations, the approach we take to involving local people must be appropriate and proportionate to each piece of work including spending public money wisely.

What is a ‘formal consultation’?

‘Formal consultation’ describes the statutory requirement for NHS bodies to consult with local authority health overview and scrutiny committees (HOSCs), the public and stakeholders when considering a proposal for a substantial development or change of a service.

Consultations help to gather information and shape decisions to be made around proposed service changes. The information gathered from the consultation process gives those making the decisions an insight into the feelings and needs of local people to help inform what steps to take next.

Formal consultation is not needed for every service change – the HOSC will take a view on whether a formal consultation is required or if a local involvement programme is appropriate.

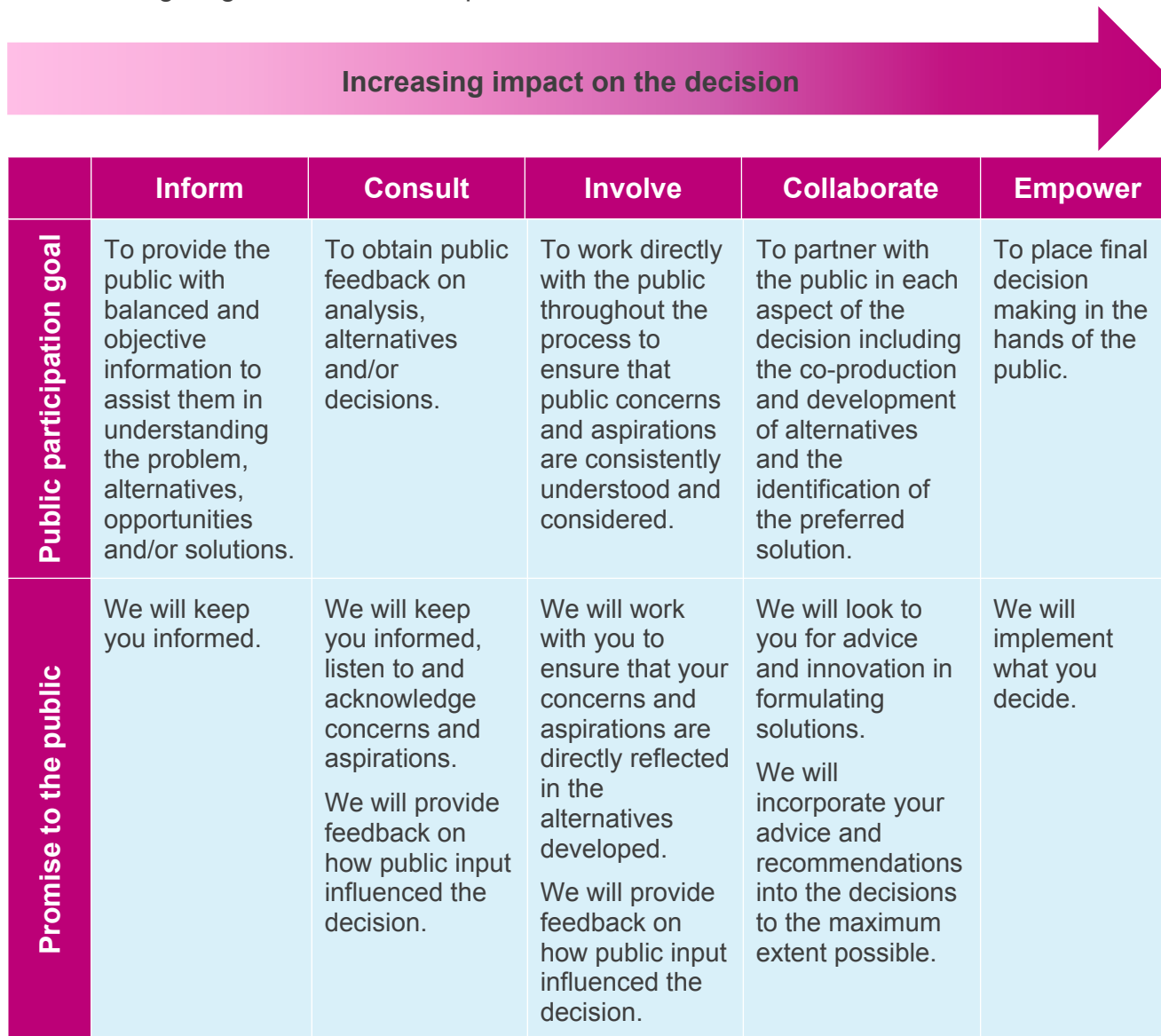
Before carrying out any formal consultation, we will follow the [Gunning principles](#). These principles are good to apply to any consultation process to ensure the consultation is fair and meaningful:

1. Consultation must be at a time when proposals are still at a formative stage
2. There is sufficient information provided to give ‘intelligent consideration’
3. Adequate time is given for consideration and response
4. The responses to the consultation are conscientiously taken into account before a decision is made

Spectrum of Public Participation

The [International Association for Public Participation](#) (IAP2)'s Spectrum of Public Participation¹¹ was designed to assist with the selection of the level of participation that defines the public's role in any public participation process. The Spectrum is used internationally, and is found in public participation plans around the world.

The following diagram has been adapted from their model:



¹¹ © IAP2 International Federation 2018. All rights reserved. 20181112_v1

Source: https://cdn.ymaws.com/www.iap2.org/resource/resmgr/pillars/Spectrum_8.5x11_Print.pdf

Developing our approach to involvement – our journey so far

We have already made significant steps in developing our approach to involving people and communities but recognise that our approach will be refined over time with further input from our partners and the communities we serve.

The COVID-19 pandemic strengthened the way we work together with partners and communities. It harnessed and strengthened relationships driven by a shared purpose with a focus on health inequalities.

We have built on this collaborative approach by setting out our ambition to work more closely with the voluntary, community and social enterprise sector (VCSE) and sharing good practice examples of involving people so we can bring this learning into our shared strategy.

Involving the VCSE sector

We have more than 2,000 registered VCSE organisations and over 1,800 small, unregistered community groups and organisations in Shropshire, Telford and Wrekin. With many focused on health and wellbeing, we value their considerable resource, knowledge and community connections which helps us to understand, reach and involve with our diverse population.

We began an open conversation on our future relationship with the VCSE sector during a workshop in May 2021. A key part of the event was the development of a Memorandum of Understanding (MOU) that sets out our shared ambitions and commitment to:

- Improving health outcomes and reducing health inequalities for local people
- Getting the most value for our money and focusing on interventions that make a major difference
- Building successful partnerships to enable health improvements and create healthier communities
- Engaging and involving people and communities in the transformation of health and social care
- Increasing mutual learning and continuous professional development
- Working together effectively to create better services and provide greater support.

[The MOU was signed in October 2021 and can be viewed on our website.](#)

We are now in the process of developing a VCSE Alliance with our system partners that will be meaningfully connected into our ICS to enable inclusivity and closer working with the VCSE as a strategic partner. The overall objective of the VCSE Alliance will be to:

- Enable the sector and the ICS to work together in a coordinated way and ensure a robust mechanism for representation and feed-back building on the connections already established between the sector and the two local authorities
- Provide the ICS with a single route of contact and involvement with the sector and links to communities

- Better position the VCSE sector in the ICS and enable it to contribute to the design and delivery of integrated care and have a positive influence on health priorities, support population growth or reduce inequalities
- Develop and support active two-way communication and feedback mechanisms between the NHS and VCSE sector at system, place and neighbourhood levels, ensuring the influence of the VCSE sector is amplified
- Ensure the VCSE Alliance is inclusive – representing organisations of all sizes and diverse communities, including those with [protected characteristics](#) or those who experience health inequalities
- Ensure the VCSE has a leading role within the prevention agenda
- The Alliance will be responsible for scrutinising strategies/plans and avoiding unintentionally disadvantaging or discrimination.

Making involvement and co-production business as usual

In September 2021, we hosted a workshop to demonstrate our commitment to involving people in local decision-making. The event was open to anyone from the VCSE sector, health and care sector, as well as interested members of the public keen to work with us in shaping how we involve people, communities, organisations in the development of health and care services.

Approximately 55 people attended this virtual event, contributing a number of key themes and sharing local examples of where involvement is already working well. These have helped both to build our understanding of good practice and the existing frameworks for involvement, and to agree on how we develop a more consistent approach to involvement with various stakeholders across Shropshire, Telford and Wrekin.

There are a number of existing frameworks created and adopted by partners which will inform further development of our system approach to involvement and underpin specific areas of activity. For example:

[Think Local Act Personal \(TLAP\) – Making it Real Framework](#)

[The Shropshire Parent and Carer Council \(PACC\) ‘Bench’ co-production model](#)

[Parents Opening Doors Telford Participation Handbook](#)

[Maternity Voices Partnership toolkit](#)

Developing our Strategy for Involving People and Communities

At a workshop in March 2022, over 70 people from across our system, including representatives from the VCSE, local authorities and the NHS came together to help shape this strategy. At the same time, we engaged with our communities to better understand how they want to be involved in the work of the ICS.

We have listened to what people have told us is needed to develop a culture of meaningful involvement for our ICS and incorporated it into our approach as set out in this document.

We know there is more work to be done to refine our approach which will continue to evolve with the input of all partners and our people and communities as the ICS develops.



Our vision and principles

Our vision: 'To create a culture of inclusion and involvement throughout our ICS so people and communities are able and enthusiastic about contributing in a meaningful way to help develop services that improve the lives of our whole population.'

We will ensure all our involvement activities are geared towards having a positive impact on people's lives.

The strategy sets out our ambition and commitment for embedding a culture of involvement within our ICS.

It places a system-wide focus on encouraging a creative, positive and welcoming environment where people can contribute in a meaningful way and acts as the platform for further work to plan how we will put our principles and approach to involvement into practice.

Our principles have been developed and shaped from the rich conversations which took place in our three workshops.

They have been informed by the knowledge and experience of the diverse range of people who attended, including those with lived experience of using our services and those for whom involvement is already embedded into their working practices. We have ensured they align with and build on the ten principles set out in the [national guidance](#) but reflect our collective local aspirations.

[ICONS TO BE INCLUDED FOR EACH OF THE PRINCIPLES]

Our principles:

1. Seek out, listen, and respond to the needs, experiences, and wishes of our communities to improve our health and care services
2. Ensure people are involved within everything we do as an ICS – from an individual's care, to service design and making decisions about health and care priorities
3. Relationships between our communities and health and care organisations are based on equal partnerships, trust, and mutual respect
4. Use existing and new knowledge about our communities to understand their needs, experiences and wishes for their health and care by developing methods for gaining people's insights
5. Involve people early and clearly explain the purpose of the involvement opportunities
6. Reach out to and involve groups and individuals who are often seldom heard by working with community partners and organisations
7. Make sure the communications and the ways people can get involved are clear and accessible
8. Record what people say and let them know what happened as a result
9. Ensure staff understand the importance of involving people in their work, and have the skills and resources they need to do it
10. Learn from when involvement is done well and when it could be improved.

Our shared principles are underpinned by a set of standards which we have included in a toolkit to support our staff to involve people in their work [\(link to toolkit\)](#).

These principles and standards will help us to clearly communicate the reasons and objectives for involving people. They will ensure our stakeholders recognise the value of being involved, and also support us to effectively monitor the impact of our involvement.

1. ROS update/sign off - Appendix A
2. STW ICB Constitution- Appendix
3. STW ICS Green Plan
4. STW People and

Tackling health and care challenges and reducing inequalities

ICSs are required to tackle the health and care challenges within their local areas. The organisations that are part of the ICS are increasingly working together and sharing their knowledge, expertise and resources to find solutions to local health and care challenges. Engaging with the public and stakeholders gives the ICS valuable information which helps to address these health and care issues.

COVID-19 has given fresh momentum to tackling health inequalities and supporting broader social and economic development. The power of our ICS comes from our ability to influence beyond health and social care, we can also influence the wider factors that have such a fundamental effect on tackling inequalities, such as access to employment, education and housing.

Paying particular attention to hearing from people who have difficulty accessing services and have poorer experiences and outcomes – understanding their needs, barriers, aspirations – will enable us to work together to reduce inequalities.

We will work with our partners and use all of our networks to reach our diverse communities, for example building on the relationships established through the pandemic including with local businesses, faith and community groups, and educational settings.

Our VCSE partners will be vital in this work of improving population health, and we also intend to use [population health management \(PHM\)](#) to better understand local needs. PHM is a way of working to help understand current health and care needs and predict what local people will need in the future. It uses historical and current data to understand what factors are driving poor outcomes in different population groups.

It is important to us that we listen, respond, and make every effort to involve individuals from all [protected characteristic](#) groups. It is also important we listen to other seldom-heard groups such as condition-specific groups, homeless people, or people living in deprivation to make sure we reach a diverse range of people to give them the opportunity to share their views.

We have set out a number of [pledges](#) which demonstrate our commitment to racial equality, diversity and inclusion within which involvement plays a key factor. These include:

- Ensuring diverse representation on key groups, boards and in decision-making processes
- Encouraging staff to positively challenge when they see a lack of diversity and call out inappropriate behaviour or discrimination
- Actively engaging with people from marginalised and seldom-heard groups, ensuring we include them in our work.

By committing to these pledges, we will ensure we involve all members of our local population to find out how we can improve their experiences of health and care in Shropshire Telford and Wrekin.

We will use our integrated impact assessment process to help us understand which groups may need to be specifically targeted for a programme of work. We will also be informed by

the Shropshire and Telford & Wrekin Joint Strategic Needs Assessments and evidence on health inequalities.

All our involvement activity will be equality monitored, to help us better understand how representative it is. Using this data can help understand if the reach is appropriate, and if new approaches are needed to address gaps. Once complete, the data can be analysed to understand if all groups share the same views, experiences, and access. This analysis can identify themes and areas to be explored to address inequalities.

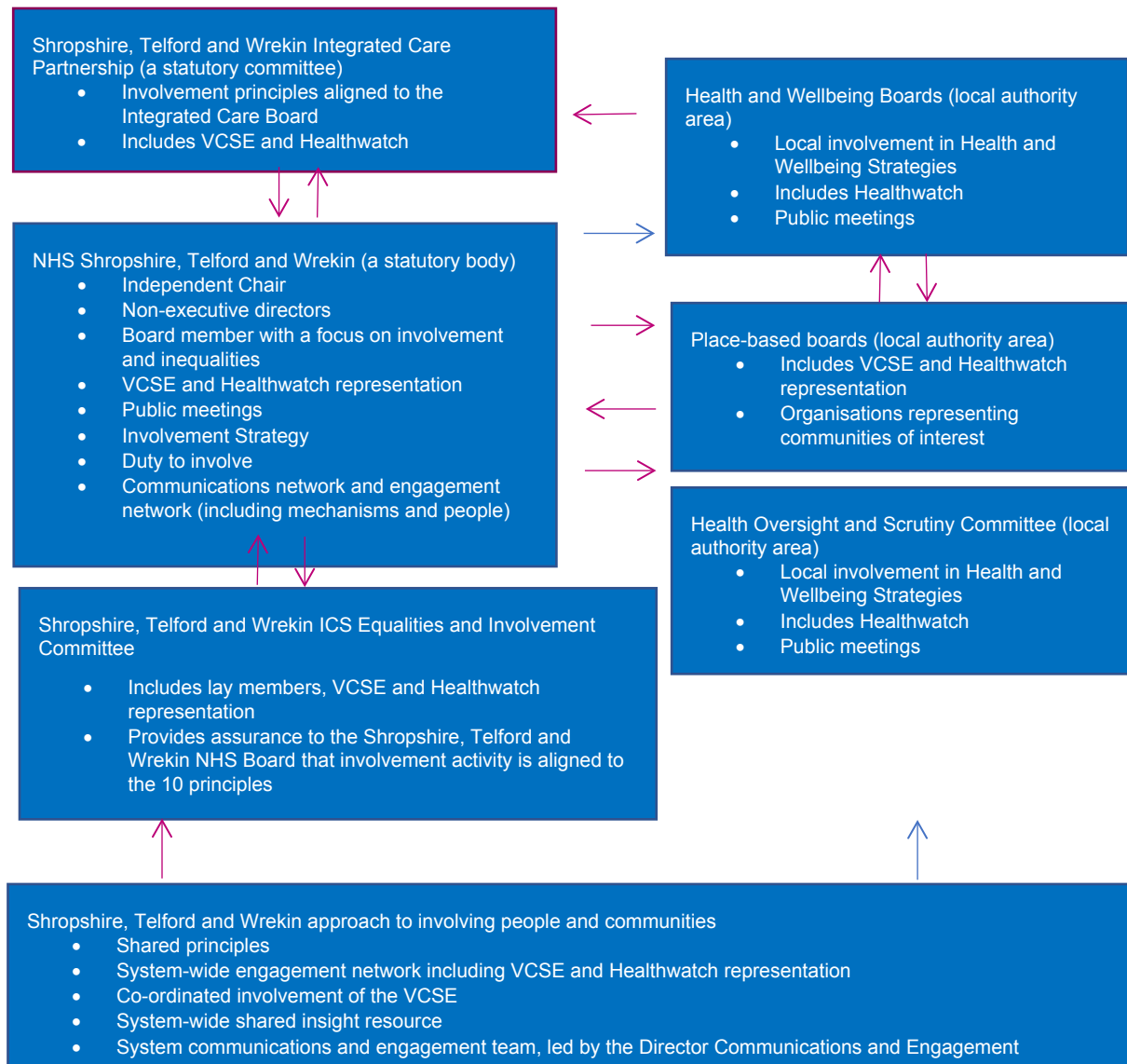
We also need to ask and be aware of what stops people from getting involved, and collectively think about the solutions to overcoming these barriers.

1. ROS update/sign off - Appendix A
2. STW ICB Constitution- Appendix
3. STW ICS Green Plan
4. STW People and

Embedding involvement in governance

The infographic below sets out how involving people and communities is embedded in the governance of our system:

[INFOGRAPHIC BELOW TO BE DESIGNED]



From 1 July 2022 the new organisation, NHS Shropshire, Telford and Wrekin (NHS STW), will take over from NHS Shropshire, Telford and Wrekin Clinical Commissioning Group (which will cease to exist) to become responsible for allocating, and accounting for NHS resources. It will oversee a plan for NHS services across the county including how we involve people and communities.

This statutory body is a new type of organisation, governed by partners from across the system and focused on collaboration as a means of driving improved outcomes for people in our communities and reducing inequalities, at a local and system-wide level.

NHS STW will delegate budgets to our two local 'Place-based Partnerships' (Shropshire, and Telford & Wrekin), so they can determine how the money is spent in order to meet people's needs and wishes. Local places work with their health and wellbeing boards to develop plans that work for local people.

NHS STW is responsible for agreeing the strategy for our health and care system and strengthens joint working arrangements between the NHS, councils, care providers, hospices, Healthwatch, the voluntary, community and social enterprise sector. It brings together elected members, executive and non-executives and independent co-opted members in one decision making process.

This new organisation is also influenced by the voice of local people. It includes representation from both Healthwatch and a board member whose role it is to ensure we maintain a strong commitment to listening to the public's views and aspirations.

How we make decisions

Shropshire, Telford and Wrekin Integrated Care Partnership

The integrated care partnership (ICP) operates as a statutory committee. It is made up of partners from across the local area, including VCSE organisations and independent healthcare providers, as well as representatives from NHS STW. One of the key roles of the partnership is to assess the health, public health and social care needs of the area it serves, and to produce an Integrated Care Strategy to address them. This, in turn, will direct NHS STW planning of health services and the local authorities' planning of social care services.

NHS Shropshire, Telford and Wrekin Board

NHS Shropshire, Telford and Wrekin Board will agree and oversee a plan to deliver the Integrated Care Strategy and will be responsible for allocating, and accounting for NHS resources.

Place-based partnerships

The two Health and Wellbeing Boards (Shropshire, and Telford and Wrekin) agree a health and wellbeing strategy for each place. These place-based strategies are based on what is most important to local people. Most of the decisions about spending and services will be made by committees in our local place-based partnerships.

Health Overview and Scrutiny Committees

Health Overview and Scrutiny Committees (HOSC) are local authority committees with the powers to review and scrutinise health and care services. The aim of HOSC is to make decision-making processes more transparent, accountable, and inclusive.

All their work is underpinned by the following values and behaviours:

- to provide a constructive 'critical friend' challenge
- to amplify the voices and concerns of the public
- to drive improvement in public services.

We have good working relationships with local and joint OSCs and provide regular updates both in written format and by attending meetings. We take their role of 'critical friend' very seriously – they are an important part of the way we work.

Assuring Equality and Involvement Committee

Our Assuring Equality and Involvement Committee includes a number of members of the public and partners from across the system. It acts as a 'critical friend' to review and advise on plans to involve people and communities across all our work programmes, with a particular focus on ensuring we are addressing and reducing inequalities.

This committee is chaired by a member of the NHS Shropshire, Telford and Wrekin board who has responsibility for involvement and equalities. The committee reports directly into the **XXX** and **Director of Communications and Engagement**, who holds formal responsibility for ensuring involvement guidance is adhered to and good practice is consistent.

Methods and channels for involvement

We are committed to providing opportunities for everyone to contribute and help shape our plans and services. We shall be inclusive of the range and diversity of voices and ensure we include a balance from across Shropshire, Telford and Wrekin. This will be achieved through a variety of methods:

Community outreach

To involve local people effectively and make sure we are reaching our diverse population and those most seldom heard, we must physically get out into communities, attending local events and groups, holding focus groups, reaching out to people through our services and working closely with our VCSE and community leaders.

Sometimes varied approaches are needed to reach into different communities, so we adapt our activity depending on who we are aiming to involve and value the knowledge and insight from our VCSE and partners to support this.

Insight

Insight from people using our services can provide rich intelligence that other performance data cannot, such as their experience of a service, whether there are any barriers to accessing a service, or their views about a potential change to a service.

We will continue to capture people's experiences and views through different methods such as surveys and patient feedback. People will be given a choice of different formats to ensure these opportunities to get involved are accessible and appropriate to those we are seeking to hear from.

We will use insight derived from what people tell us to: improve the quality of our services; design better services and pathways based on people's experiences; plan services around people's health and care needs; and understand our communities and the place that health plays in their everyday lives.

Working as a local health and care system offers an excellent opportunity to combine our insight across pathways of care to provide us with a more holistic understanding of people's lives, experiences and needs.

An involvement and insight network

We have established a system-wide involvement and insight network to map out and identify the existing involvement infrastructure such as which stakeholders, partners, groups and communities we currently involve with. The network will identify any gaps or groups that are under-represented and seek to build relationships and connections to encourage their involvement.

In addition, the involvement network will support the co-ordination of future involvement opportunities, share good practice, and manage relationships with local people and communities.

Involvement at 'Place'

We will grow and develop place-based networks, to increase reach and active involvement across our diverse communities, making sure we work with people and our partners to develop collaborative solutions to issues and barriers that are identified.

An insight library

We are developing a Shropshire, Telford and Wrekin insight library to host intelligence and insight about communities produced by all partners. This will be accessible to all partners across the ICS to help improve and inform future involvement activities.

Having a central place for this information will help us identify emerging themes and avoid duplicating involvement activities.

Experts by Experience

Experts by experience are people that work with organisations very closely, who have personal experience of using, or caring for someone who uses health or care services. Sometimes in the health sector we refer to experts by experience as patient representatives.

Across our health and care system, experts by experience sit on various boards, project groups and work streams, or work directly in co-production with organisations that provide them with the support and platform to share their experiences and shape the services they use.

Examples

- **Making It Real Boards** – Shropshire Council and Telford and Wrekin Council have established Making It Real Boards which are made up of people who use adult services or who are interested in the development of Adult Social Care (ASC). The Boards work in co-production with council leaders, making recommendations on how different service areas can improve and develop, with the aim of seeing services progress towards more person-centred, community-based support.
- **Shropshire Parents and Carer Council and Parents Opening Doors Telford** – Both these organisations support and empower parents and carers of children with a disability or additional need, to enable them to be actively involved in the design and delivery of the services they use, through the sharing of their experience and knowledge of their family's needs.
- **Shropshire, Telford and Wrekin Maternity Voices Partnership** – The MVP is an independent team made up of women and their families; commissioners (who plan, buy and monitor services); and providers (who deliver services such as midwives and doctors). This team of people work in partnership to design and improve maternity care together.

Meetings held in public

We are committed to working in an open and transparent way and want to make sure people can learn about all the work of the health and care system. This includes holding meetings in public and live streaming.

Website and digital (online tools)

Our website is an important tool to inform our various stakeholders about our plans, activities, and opportunities to transform the health and care across Shropshire, Telford and Wrekin.

We keep our website up to date and publish all our current and previous involvement activity, clearly setting out all the ways for people to get involved – including meetings,

events, consultations and surveys. We use our website to share news and plans that affect current and future services.

Our new website to support the work of the ICS has been developed through involvement with people from our communities, our staff and partners. The look, feel and content has been informed by what they have told us is important to them.

We use social media and other digital platforms to provide opportunities for genuine, open, honest, and transparent involvement with all stakeholders, giving them a chance to participate and influence the work we do. Digital exclusion is very real, and affects many of our most disadvantaged communities.

We will therefore make sure this is not the only route to involvement, and we will make arrangements to reach groups and communities to hear their views.

Staff involvement

We are committed to staff involvement and recognise many of our staff are also members of our communities. We will continue to hold our very well attended all staff ‘huddles’ and distribute bi-weekly written briefings. We are also in the process of developing a new intranet to support our staff involvement activity.

Political involvement

Local MPs and councillors represent the interests of our local population, they have significant reach into our communities, and people often raise their experiences of health and care services with them.

We are therefore committed to making sure we inform, involve, and consult with Health and Wellbeing Boards, the local authority Overview and Scrutiny Committees, and MPs in each area about our plans and make sure we hear what their constituents are telling them. We keep them updated via regular written briefings, face-to-face meetings, and updates and attendance at appropriate Committees and Boards

Continuous feedback

As a system, we want to enable people to share their experiences of our services at any time, not only when we are seeking to review or develop a specific service or strategy. We promote these everyday channels, including via our Patient Advice and Liaison Service (PALS), both Healthwatch, and our Maternity Voices Partnership, through our website and other communication tools.

We use the insight captured through these channels to identify and learn from common experiences of our services, what is working well and what can be improved.

Roles and responsibilities

We believe good involvement is everyone's business not just a handful of people with 'involvement' or 'engagement' in their job title. However, there are some specific roles within our health and care system that are key to ensuring good involvement happens.

Role of senior leadership

The senior leadership is committed to ensuring we seek out and listen to the people and communities in Shropshire, Telford and Wrekin.

As well as championing the importance of involvement, our leaders are critical to ensuring adequate resources are committed, including time and funding, to enable it to happen. They also have a really important role in being visible to our communities, encouraging people to get involved, and ensuring transparency about the way decisions are made.

Role of senior responsible officer

The Director for Communications and Engagement is a member of NHS STW senior leadership team and works directly with the board members to not only champion and drive involvement but ensure it is embedded in the system. This role is critical to realising our vision and approach and ensuring involvement is discussed at the top table.

Role of engagement practitioners

NHS Shropshire, Telford and Wrekin has a core Communications and Engagement team led by the Director of Communications and Engagement. This team provides advice, guidance and support to programme leaders to help them properly involve people and communities in the development and design of services.

Engagement leads within each of the organisations work together to co-ordinate involvement activity and make the best use of the relationships and connections with our communities.

Role of programme leads

Involvement is not the sole responsibility of the Communications and Engagement team – programme leads have a fundamental responsibility for ensuring they involve people and communities in their work. It is their role to lead and plan involvement and ensure adequate resource is committed, including time and budget, to carry out any involvement activity to support their work. Any involvement work of these programmes should be planned and coordinated with expertise from the engagement leads.

Training is essential to support programme leads to plan and undertake good involvement. We are developing a system resource for our programme leads as well as wider workforce to support them with involvement. This resource will include case studies from programme leads sharing their own experiences of involvement to highlight good practice but also some of the challenges they faced and how they managed to overcome them.

Role of Healthwatch

Healthwatch Shropshire and Healthwatch Telford and Wrekin have been effective partners in contributing to the development of our communication and involvement approach. Their role

is to challenge the partnership on areas of concern and to hold the partnership to account if we don't follow the principles of involvement.

They also provide a voice and a channel for our communities through which to share their experiences of health and care services and ensure they are heard by the NHS STW Board.

Role of the VCSE and community partners

VCSE organisations improve health outcomes and tackle health inequalities not only by delivering services but also by shaping their design and advocating for, representing and amplifying the voice of service users, patients and carers, particularly those experiencing the poorest health.

The VCSE and our community partners are often closer to our communities and hold trusted relationships with some of our most vulnerable or marginalised members of society.

We are committed to positive involvement with the VCSE sector so that their knowledge, expertise and networks are utilised and protected, for the benefit of the whole community. Where possible we will look to provide financial support to our partners in the VCSE to undertake involvement with our communities in order to capture insight to help develop services.

Working closely with voluntary and community colleagues, we are committed to building on our MOU with the VCSE by appointing a VCSE partnership coordinator. This will ensure there are clear points of connections in place between the system and VCSE to facilitate and support effective two-way involvement.

Reviewing and evaluating involvement activity

We are committed to continually reviewing how we involve people and communities to check that the purpose of the involvement is being achieved and is having a real impact on our local health and care landscape. We must assure ourselves and our communities that it is making a positive difference to the services we design and deliver, and ultimately the lives of the people we serve.

Informed by the conversations we have had with our partners and communities to design our approach and principles, we have developed a toolkit (add link to toolkit) which includes a set of standards to help shape and measure the effectiveness of our involvement activity:

[ICONS TO BE INCLUDED FOR EACH OF THE STANDARDS]

- **Purpose** – clearly set out the purpose and what the involvement activity hopes to achieve
- **Be clear**– be clear about the scope of the involvement activity and what can be changed and what can't. When changes can't be made, explain why
- **Identify** – complete an Integrated Impact Assessment to identify who is likely to be impacted and needs to be involved
- **Involve** – involve the people and organisations who have an interest in/be impacted by the focus of the involvement and work with people you seek to involve to help design your approach to ensure it is inclusive and appropriate.
- **Collaborate** – work with others where appropriate to avoid duplication of involvement and explore existing intelligence
- **Plan** – agree the purpose, scope, required resources and timescale of the involvement and the actions to be taken
- **Methods** – agree and use methods of involvement that are fit for purpose and relevant to the target audience

- **Communicate** – communicate the ways and opportunities to involve and update regularly on your progress
- **Reach out** – attend existing meetings/groups/spaces and go to where people are rather than expect people to come to you, making a particular effort in reaching diverse communities and those who are seldom heard
- **Support** – identify and overcome any barriers to involvement and support people to involve
- **Embed the learning** – ensure involvement feeds into service development
- **Feedback** – feed back the results of the involvement to the wider community and those who undertook the involvement in a timely manner
- **Monitor and evaluate** – monitor and evaluate whether the involvement is achieving its purpose and keep a record of those who have been involved.

We will further strengthen our ability to review our involvement by co-producing, with partners, people, and communities, a system approach to evaluation through the development of an Evaluation Framework Tool.

Providing feedback to people and communities

Collecting the views and opinions of our local people and communities is one part of the involvement process and we understand it doesn't stop there. We must provide feedback to those who have participated in our involvement process but also our wider population.

It is essential for us to feed back on the outcome of people's involvement and provide an overview of 'you said, we heard, we did' to build confidence in our decision-making processes. We publish updates on our website and share through our social media channels, but also ask people how they would like to receive feedback and ensure it is timely. Feedback also needs to include the decision-making process and clearly explain the reason for the decision taken.