Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Appendices

MEETING
25 January 2023 14:00

PUBLISHED
20 January 2023

Agenda

Location	*Date*	*Owner*	*Time*
The Holiday Inn Telford	25/01/23		14:00

1. Blank

2. Follow up on Patient Story: New Dementia Model

3. ICB CEO Report

4. Integrated Care Strategy and Development of Joint Forward Plan

5. Progress with Big Ticket Item: HTP Update

6. ICS Performance Report

7. Transfer of POD Commissioning Services from NHSE to ICB: Approval of governance documents

8. Board Committee Minutes

   8.1. Quality and Performance Committee
   8.2. Finance Committee
   8.3. Strategy Committee
   8.4. Audit Committee
   8.5. Primary Care Commissioning Committee
   8.6. Integrated Delivery Committee

9. Other Minutes: Integrated Care Partnership

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ICB 25-01-053

Follow Up on Patient Story:

Implementation of New Dementia Model

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

January 2023

SHROPSHIRE, TELFORD AND WREKIN
INTEGRATED CARE BOARD

ICB
Our New Vision model for dementia assessment and post diagnosis support in Shropshire

People living with dementia and their unpaid carers are enabled to live the lives that they choose that enhances and preserves their wellbeing

THE VISION

Creating the best model for dementia care and support

Developed and co-designed by people living with dementia, unpaid carers and health and care professionals

The STW Health Economy Dementia Steering Group

People living with dementia and their unpaid carers are enabled to live the lives that they choose that enhances and preserves their wellbeing

What are we trying to fix?

- People living with dementia and their unpaid carers say they are largely unsupported by the current system

- They have told us how to fix it

Healthwatch Shropshire Research, 2019

People living with dementia and their unpaid carers are enabled to live the lives that they choose that enhances and preserves their wellbeing

Our Shared Purpose

Every person diagnosed with dementia or providing unpaid care will receive the support and care they need to live as well as they can.

Our guiding principle is that support will be provided equitably right across the health economy

People living with dementia and their unpaid carers are enabled to live the lives that they choose that enhances and preserves their wellbeing

The best model of dementia care 1

Referral & pre-assessment support - General Practice

Assessment & diagnosis - DASS

Post diagnosis support

Complex - Admiral Nurses

Other - Dementia Navigators - DASS

Pick your own
Dementia Support

Dementia UK
AdmiralNurses
Helping families face dementia

People living with dementia and their unpaid carers are enabled to live the lives that they choose that enhances and preserves their wellbeing

The best model of dementia care 2

A Living Plan - held by the person living with dementia/carer

Annual Reviews - General Practice

Community Peer Support Groups - Alz Soc Dementia Link workers

Carer respite entitlement - Adult Social Care

Pick your own
Dementia Support

People living with dementia and their unpaid carers are enabled to live the lives that they choose that enhances and preserves their wellbeing

The best model of dementia care - Win-Win

- Providing the support as and when needed
- Improved health and wellbeing (c 10,000 in STW)
- Improved staff recruitment & retention
- Better value for cost, meeting patient/carer needs
- less GP appts & hospital admissions
- delayed entry to care homes

People living with dementia and their unpaid carers are enabled to live the lives that they choose that enhances and preserves their wellbeing

Challenges to Implementation

- Major change to system working - as one team
- Workforce - new ways of working
- Rurality
- Demography & rising diagnosis numbers

People living with dementia and their unpaid carers are enabled to live the lives that they choose that enhances and preserves their wellbeing

Our Ask

- ICB Board level sponsorship
- System decision makers fully on board

People living with dementia and their unpaid carers are enabled to live the lives that they choose that enhances and preserves their wellbeing

Agenda Item

ICB 25-01-054

ICB CEO Report

From the office of Fran Steele
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Sent by email

Neil McKay, Chair
Simon Whitehouse, CEO
Shropshire, Telford and Wrekin ICB

13 December 2022

Dear Neil and Simon

Shropshire, Telford and Wrekin (STW) Quarterly System Review Meeting – 07 December 2022

Thank you to you and system colleagues for attending the Quarterly System Review Meeting (QSRM) on 07 December, chaired by Dale Bywater, Regional Director and for working with us to help finalise the agenda. This letter is intended to capture some of the key points from our discussions

1. Overview

The purpose of the meeting was to review the current areas of focus across the system, to discuss key challenges and to provide an update on the progress being made in relation to preventing ill health and reducing inequalities.

In terms of some of the positive progress being made we noted in particular that:

- there has been progress at SaTH towards delivering zero 104ww; whilst there have been some improvements at RJAH the position remains challenging
- Covid and flu vaccination has seen good results for the Core 20 plus 5 communities in particular
- maternity at SaTH is on a visible improvement journey with the "Saving Babies Lives" bundle now registering 100% and CNST compliance to be reported at the January 2023 Trust Board
- system Safeguarding is now rated as green and End of Life Care services continue to improve.

Areas of concern include provision of timely care for patients across elective care, cancer and access to primary care face to face appointments. It was also noted there has been a missed opportunity to deliver planned level of virtual ward capacity and occupancy. In addition, the financial position remains challenging and the drive to improve productivity and efficiency needs to remain a key focus.

2. Preventing Ill Health and Reducing Inequalities

It was helpful to have a comprehensive discussion on this issue, particularly the system's approach to governance in the absence of a system Health Inequalities Board. You explained that there is a system executive lead along with an operational lead and that all STW internal committees are required to consider the Health Inequalities (HI) agenda.

In terms of structure each of the system Places (Shropshire Integrated Place Partnership (SHIPP) and Telford & Wrekin Integrated Place Partnership (TWIPP)) have an established Place Partnership Board which reports HI issues to the system Population Health Board, Shropshire Council have developed the "Shropshire Plan", which is focussed on health inequalities, including 'breaking generational cycles'. You have found the Covid vaccination programme helpful in determining health inequalities eg high deprivation levels in Oswestry, which has become a focus for HI activity.

Financing the health inequalities agenda remains a challenge in view of the system's financial position. However, Place-based budgets are being developed and the STW finance team are joining Place meetings. You commented that you have found the financial tools useful.

Action QSRM20221207-01 System to share governance structure including reporting arrangements for Population Health Boards

3. Electives

Long waits

We noted that improvements for patient waiting times for both 104ww and 78ww have been made since the last QSRM, however there remains concerns regarding the number of 104ww at RJAH and 78ww at SaTH. We recognise that medical demand at SaTH is causing escalation into other patient areas and that is impacting inpatient elective and cancer activity but you continue to seek to create resilience where possible. In addition, the focus on retaining outpatient clinic activity remains high and you are looking to increase the number of theatre sessions taking place at RJAH. However, the overall recovery for ordinary electives in the system remains low at 69%.

Action QSRM20221207-02 System to review elective recovery and develop a plan to improve year end expectations

Cancer

We expressed concern about the 62-day backlog deterioration with an increasing number of patients having to wait longer than expected. In addition, the delivery of the faster diagnosis standard (FDS) is significantly below target. You explained that you are working to increase CT reporting capacity and are increasing the number of WLIs being proposed for colorectal services. In addition, MRI capacity is increasing week on week. You believe these initiatives will have a material impact on both standards and that reducing patient delays remains a high priority.

We also discussed issue of low uptake of FIT, an important step in the colorectal pathways in particular, you are out to procurement for a new provider for this programme with an ambition to rapidly improve the position in terms of uptake direct from GP surgeries.

We emphasised that a focus on FIT, OPA and diagnostics would have a further positive impact on the standards and for your patients and it was agreed these would continue to be a focus for the weekly escalation meetings in place with NHSE

4. Non electives

Urgent Care

We all acknowledged that the system is in a very challenged position across the urgent care pathway and that the number of ambulance handover delays continues to cause regional and national concern with a heightened risk of patient harm. We did not discuss this issue in detail given the system is part of the NHSE national escalation process with weekly oversight meetings in place.

However during the discussion we expressed concern that seven-day discharge delivery remains a significant issue for the system, with an example being given in relation to extremely low levels of weekend discharges. We discussed the importance of ensuring that 'out of hospital' approaches need to have clear and robust system oversight in place with more clarity about the additionality of action that can be taken, particularly in times of heightened escalation

It was helpful to note that the System Control Centre (SCC) is now operational, with tactical commanders in post, although the full workforce is not yet in place.

Action QSRM20221207-03 System to provide an update in terms of how the system wide OOH role is underpinned by a clear plan in terms of ongoing improvement as well as key actions to support periods of heightened escalation

Virtual Wards

Although there are patients allocated to virtual wards in the system this week, they are all step-up patients and in addition compared to other systems in the Midlands STW has lower levels of both capacity and occupancy. We understand there is a system trajectory to have capacity of 200 beds by end of March 2023 but current occupancy is well below this ambition and we all agreed that pace in the underpinning improvement activities is required

You believe there are two pieces of work which will move this forward. Firstly, clinical pathways to support transfer to virtual wards are progressing and expect to be signed off this week with a focus on step down activity in particular. Secondly the Regional Chief Pharmacist, Richard Seal, is working with the three clinical pharmacists in the system to resolve certain clinical governance issues which you also expect to be resolved by the end of this week.

Action QSRM20221207-04 System to confirm plans to increase virtual ward capacity and occupancy, especially for step down patients and the oversight approach to this work

5. CYP Transformation Programme

You acknowledged that the system has a risk to delivery against the children and young people ambitions. This was clearly disappointing to hear but you emphasised that in terms of governance for the programme, the Children's Partnership Board is reconvening next week and will consider how to inject pace into the plans given you believe the structures to support future delivery are in place.

6. Primary Care

You acknowledged that whilst good progress is being made in some areas the system has the second slowest recovery across the region in terms of getting back to face to face (F2F) patient appointments. However, you wanted to make us aware that although recovery has been slow, it is currently 5% ahead of levels in 2019/20. You are continuing to work on issues of primary care access and your primary care team has been asked to review the scale of variation across your geographical footprint to better understand areas of variation. In terms of the PCN Maturity Index you have found the self-assessment tool useful but feel that the PCNs are currently under selling themselves.

7. Quality and Nursing

Continuing Health Care (CHC)

We asked about the Q4 trajectory and whether there is a risk to delivery. You believe that the plan is on track but given the challenges you are having in terms of recruitment to clinical roles have a reliance on some agency staffing. You agreed to provide information on wait for assessment so that we have a clearer understanding of the current position

Action QSRM20221207-05 System to share current wait for CHC assessment

Child Deaths

There have been four child deaths which are under investigation, three of which are of 'looked after children' and we explored with you as to whether there is any learning to be taken forward on the back of this work. Your preliminary view is suggestion there are no obvious themes at this stage however the full thematic review needs completing and at that point full consideration will be given to any actions required

8. Finance

The system and regional NHSE colleagues met Julian Kelly, Deputy CEO and CFO, NHS England on 05 December to discuss system finances and expectations for the year-end financial position, so we agreed not to discuss finance in detail at this meeting. You confirmed you found the national meeting helpful. The key themes which are contributing to the financial position are:

- Lack of flow and prompt discharge of patients
- Workforce, particularly agency spend
- Poor productivity
- Clinical pathway maturity

We noted that you have articulated the problem as a system but that now is the time to effect delivery. Claire Skidmore as ICS CFO is leading this work and regrouping with CEO's to ensure momentum is maintained.

9. Leadership Capability and system governance

Chief People Officer (CPO)

You confirmed that there is an interim CPO in place with a specific focus is on agency spend. The recruitment of a substantive CPO is however progressing and NHSE will be kept included in this process

Provider Collaboratives

We noted that you see provider collaboratives as a key part of the next stage of system development and are exploring further options that may have greatest impact in STW. As part of this work you have been in discussions with a number of ICBs including North West London, Hereford and Worcester, Manchester and the Black Country. You expect these conversations to come to conclusion next month and are looking to pick up any good practice ideas to inform the next steps

10. Summary and Next Steps

In conclusion I would like to thank you and your system colleagues for what was a helpful and positive discussion. We will continue to work closely with you on areas of more challenged performance, especially around operational delivery and improving timely care for patients.

Yours sincerely,

Fran Steele
Director of Strategic Transformation, North Midlands

Cc Dale Bywater, Regional Director, NHSE Midlands

Integrated Care Board – January 23
West Midlands ICB Joint Arrangements - Office of the West Midlands

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1. Purpose:

1.1 This paper sets out the proposals agreed by the Six West Midlands ICBs for the formal establishment of a West Midlands Office and integrated staff hub.

1.2 Through at scale collaboration and distributive leadership these arrangements will be designed to add value and benefit to a shared set of functions and priorities agreed by all ICBs.

1.3 In addition the proposals would also finalise the arrangements for hosting and supporting the functions being delegated from NHSE/I to ICBs in the next few years.

2. Context and background

2.1 In September 22 WM ICBs agreed to put in place arrangements to assist with multi-ICB co-operation and collaboration on areas where working together could add benefit.

2.2 All ICBs took a paper to their Boards to establish a formal joint committee to oversee and make decisions around a range of areas including:

- Liaison with the West Midlands Combined Authority;
- Review of future CSU arrangements / contract renewal / efficiency opportunities;
- Shared arrangements for building intelligence capabilities and analysis – maximising the benefits of the existing Decision Support Network, working with East Midlands ICBs
- Mutual aid on elective and cancer recovery and waiting lists, collaboration between systems;
- Urgent and Emergency Care: looking at the interface with 111/999 arrangements, ambulance handover delays and the strategy on where people go/ conveyancing/ capacity distribution;
- Provider productivity and provider collaboration arrangements – sharing intelligence, capabilities and oversight;
- Workforce strategy: engagement on the HEE changes and new ways of working, standardising approaches across ICBs where appropriate;
- Overall oversight of creating a new relationship with NHSEI on performance functions, transfer of functions, NHSEI/ICS collaboration.

2.3 In addition the arrangements were used to plan for the delegation of some NHSE/I functions such as Pharmacy, Optometry & Dentistry (POD) from April 23 and Specialised Services from April 24.

2.4 Over the past few months this has mainly involved the co-ordination of the above projects (led by ICB CEOs) through a small amount of management resource to support.

2.5 In October 22 the CEOs felt that it was time to consider more robust plans and options for working together in order to coordinate the joint preparation for the delegation arrangements from NHSE/I and hosting of the staff .

But perhaps more importantly to consider the long term benefits and the opportunities to work at scale – both in the short term and in the future.

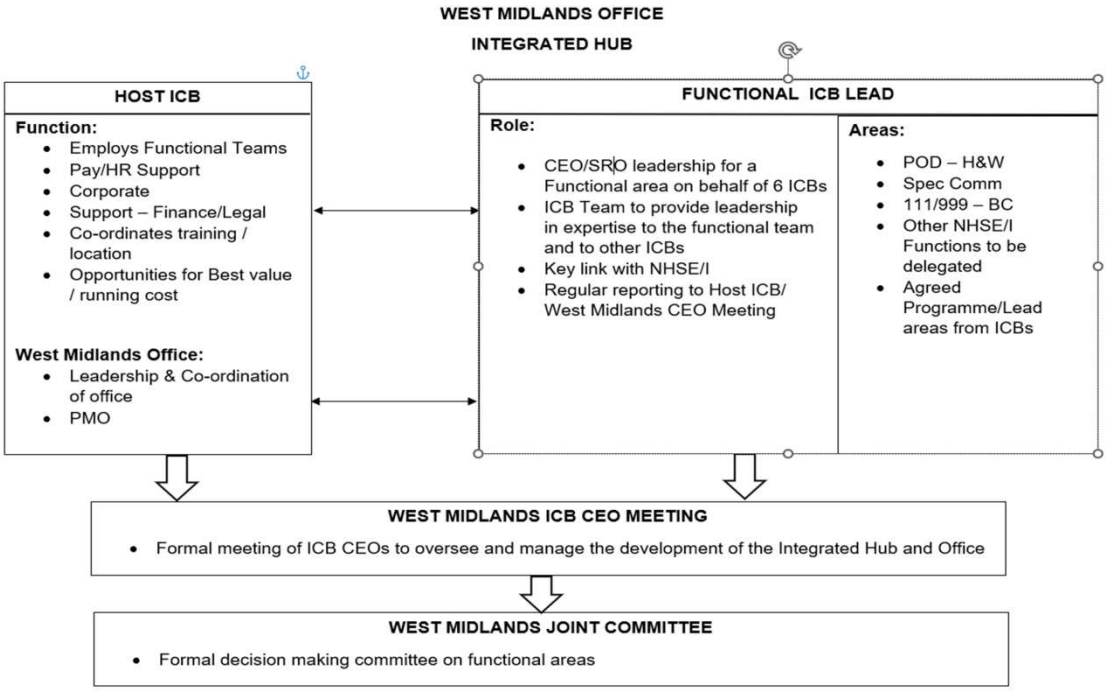
2.6 A number of options were considered and reviewed and there was consensus that the ICBs should plan for a wider more formal operating model to ensure they gained from the potential future opportunities for working and commissioning together.

2.7 Following discussion it was agreed that the West Midlands ICBs should establish a formal Office of the West Midlands with a dedicated Director supported by a single Integrated staff hub hosted by one ICB. Leadership and expertise across the work programme of the Office would be shared across all 6 ICBs.

3. West Midlands Office/Integrated Hub

3.1 The core purpose of the West Midlands Office will be :

- To commission a set of agreed functions/services at a West Midlands level through shared leadership and joint decision making
- To provide a vehicle for future delegated services from NHSE/I
- To identify shared priorities and goals through a clear work programme- short and long term
- To bring together in a single host ICB the employment of the shared teams and staff with leadership from the Office
- To develop distributive leadership and expertise across a range of functions /teams from each ICB
- To provide a single coherent voice for the West Midlands where appropriate
- To share learning and support improvement across all ICBs.



The above diagram sets out the key functions of the West Midlands Office and Integrated Hub. They include:

- **Host ICB**

  This will be a single ICB who will employ all shared teams agreed to be part of the integrated arrangements. The host will provide corporate support and HR/pay. It will ensure consistency of support and leadership which will come from the Lead Director for the West Midlands Office.

  The host ICB will not have any decision making authority for the functions and it is purely the housing of the staff and teams and accountability as the statutory ICB for the teams.

  It potentially will host pooled budgets on behalf of all 6 ICBs.

  It has been agreed collectively that BSol ICB will be the host ICB.

  In the first phase of the new arrangements BSol ICB will host and employ the West Midlands POD team currently employed through NHSE/I. (From April 23)

- **Functional ICB lead**

  Each ICB CEO and team will take on a responsibility for a particular function and will provide executive leadership and expertise to the hosted staff and to the other ICBs.

  They will also be the link to the NHSE/I teams on their particular function.

  This will ensure distributive leadership and ownership of the work of the Office of WM.

  In the first phase Hereford & Worcester ICB will be the functional lead for POD.

- **Director of West Midlands Office**

  It has been agreed there should be a dedicated Senior Executive Officer to oversee the work of the West Midlands Office including :

  - Providing leadership and support to the Integrated Hub and teams
  - Provide PMO and co-ordination of the work of the Office
  - Liaise and support ICBs/ICB CEO

  In the interim ICBs have agreed Alistair McIntyre (Director in Black Country) will take on this role whilst this is worked through and permanent arrangements are put in place.

- **Governance**

  A formal joint decision making committee has already been supported formally by ICB Boards.

  In addition the WM CEO will hold a monthly meeting to oversee the management and development of the Office.

  Further work will be carried out on future governance arrangements across the Integrated Hub/Office and functional lead role going forward.

- **Specialised Commissioning**

  The Specialised commissioning team are managed on a Midlands wide basis and will in future support both East and West Midlands arrangements as well as NHSE/I itself who will retain some commissioning responsibilities in this area from April 24.

  It has been agreed that BSol ICB will be the host for the Midlands NHSE/I team. Further work around distributive leadership across partners will be worked through in the next few months .

4. Next Steps

4.1 A multi ICB Task group led by Phil Johns CEO of Coventry & Warwickshire ICB will be established in January 23 to work through the detailed operating model and governance arrangements

4.2 In addition further work will be undertaken in consultation with all ICBs regarding the future priorities and work programme- both in the short term and long term.

4.3 This will also include close collaboration with NHSE/I who are working through their own future operating model and staff changes which may also have an implication of the work undertaken at a West Midlands level.

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5. Recommendation

5.1 The ICB is asked to note the work undertaken to establish the Office of the West Midlands and the next steps to agree the detailed operating model.

Annex one

West Midlands ICBs Joint Committee
Terms of Reference

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1. Joint Signatories:

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

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

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

2. Delegated functions and activities:

The Joint Committee has delegated authority from the ICB for the following:

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

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

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

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

2.5 Provision of a forum for collective discussion, agreement and decisions by the constituent members of the committee that is consistent with the delegated

limits of each ICB's standing financial orders. So enabling the ICBs to collaborate on areas of work and opportunities that arise.

2.6 Determination of the most appropriate commissioning governance and operation arrangements for any functions and services delegated to the committee by the six ICBs.

2.7 Determination of the most appropriate working group arrangements, reporting into the joint committee to enable the efficient and effective operation of the responsibilities that have been delegated to the committee by the six ICBs.

3. Accountability

3.1 The Joint Committee is accountable to the six ICB Boards.

3.2 Consequently, and to assist with public accountability, the minutes of the Joint Committee, which will include a record of all actions and decisions taken by the committee, will be reported to the ICB public Board meetings

4. Membership and Quoracy

4.1 The Joint Committee will include the following members:

- The six ICB CEOs
- Consideration may be given to other members being in attendance at the committee. For example:
  - The Senior Manager for the West Midlands ICB CEOs office
  - NHSEI Commissioning representative;
  - West Midlands Provider Collaborative representative;
  - West Midlands Public Health representative
  - Finance and Clinical representatives from the ICBs

4.2 If an ICB CEO cannot attend then they will send a representative with full authority to act on their behalf.

4.2 For decisions that are made in relation to section 1.5 then quoracy is not required as members are contributing based on their own limits of delegation.

4.3 Similarly for recommendations/and or proposals that are being submitted for approval by the ICBs, quoracy is not required.

4.4 For decisions in relation to the collective delegation of functions and/or services then all ICB CEOs (or their designated representative) would need to be in attendance for the decision to be quorate. All decisions will also need to be made in accordance with the delegation agreement between NHSEI and the ICBs where this is appropriate.

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

5. Frequency of meetings

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

Annex Two

Joint Commissioning Framework

1. Joint Principles

1.1 The ICBs start from a shared principle of subsidiarity – so that joint arrangements will only be put in place where there is a clear demonstration of the added value that is being derived from the joint arrangement.

1.2 The joint arrangements will be expected to support the delivery of the NHS constitution, the triple aim, as well as the four purposes of the ICBs, namely:

1.2.1 Improving health outcomes;
1.2.2 Improving health inequalities;
1.2.3 Improving clinical effectiveness and/or value for money;
1.1.4 Supporting the wider economic impact of the ICBs.

1.3 Any joint functions overseen by the Joint Committee will be organised in such a way that it both:

1.3.1 Enables the delivery of expert capabilities at scale which would otherwise not be possible for the ICBs individually to undertake individually;
1.3.2 Operates efficiently and effectively;
1.3.3 Uses the best possible available (clinically led) intelligence to inform decision-making;
1.3.4 Is mindful of the ICBs public accountabilities and public opinion;
1.3.5 Has clear governance and lines of accountability back to the ICBs (and to NHSEI for delegated functions).

2 Commissioning Arrangements

2.1 When considering the joint commissioning arrangements you need to consider both the joint commissioning governance arrangements as well as the joint operational delivery arrangements.

2.1.4 The former covers how the ICBs make joint decisions and conduct joint performance and assurance arrangements on the services that they are commissioning together.
2.1.5 The latter covers the means by which the ICBs conduct the functions and activities that enables the commissioning to take place.

2.2 It is important not to confuse these two sets of arrangements. For example it would be possible for different ICBs to take the lead (in governance terms) for different services; but for the operational functions that support these arrangements to be hosted by one ICB.

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

3 Joint Commissioning Governance options:

3.1 Lead Commissioner Model

3.1.4 In this arrangement one ICB (or potentially NHSEI for Specialised Services) hosts the commissioning of the service(s) and therefore takes responsibility for the commissioning of those service(s) on behalf of the other members.

3.1.5 This includes providing the sub-governance arrangements (such as quality assurance, financial and contractual management oversight). Ordinarily such sub-governance arrangements would be incorporated into the lead commissioner's committees, such as quality and assurance committee and finance and performance committee. Through these arrangements the lead commissioner is then able to take full responsibility for the commissioning of the service(s).

3.1.6 The relevant outputs from the lead commissioner's assurance processes would be reported to the ICB joint committee by the lead commissioner. This then provides the mechanism to enable clear lines of accountability from the lead commissioner to the six ICBs.

3.1.7 Note: it would be possible for different services to be led by different ICBs (e.g. Primary Care arrangements by one ICB; Specialised Services by another; 111/999 by another) or for all to be led by one.

3.1.8 Such an arrangement would normally work well for the commissioning of a specific service from a single provider (such as 111/999).

3.1.9 Such an arrangement would normally be best supported by either a host provider or contracted provider model (see below).

3.2 Shared Commissioning Model

3.2.4 In this arrangement the six ICBs jointly share the responsibility for the commissioning of the service(s) so no individual ICB is leading on behalf of the others.

3.2.5 To enable this arrangement to work then there would need to be jointly organised sub-governance arrangements (such as joint quality assurance processed and joint financial management processes) which reports into the joint committee. This would therefore require the establishment of relevant joint working groups through which these joint processes would be conducted. These joint arrangements would be in place solely for the oversight of the shared services (i.e. they stand apart from any other governance arrangements in the ICBs).

3.2.6 The relevant outputs from the joint working groups would report in to the joint committee.

3.2.7 Such an arrangement would normally work well for activities that do not require substantial/complex oversight and/or are delivering shared functions as opposed to delivering front-line services (such as oversight of shared clinical networks).

3.3 Network Commissioning Model

3.3.4 In this arrangement the six ICBs take a distributed leadership and governance approach to the commissioning of a service. So ICBs will

make collective decisions on how a service is to be commissioned but then each ICB oversees the arrangements in their own system.

3.3.5 The sub-governance arrangements (such as quality assurance, financial and contractual management oversight) are undertaken by each ICB for their own local system. Note this may include acting on behalf of other ICBs where they are associates to the main ICB's contract.

3.3.6 The outputs, where relevant would be reported back by each ICB to the joint committee.

3.3.7 Such an arrangement would normally work well where you might want to make a joint policy decision but then enact it separately; or where you want to take the same approach to a service but it is provided by multiple organisations (i.e. in several ICSs) so it makes sense for the oversight to be incorporated into each ICB's existing arrangements rather than undertaken separately.

4 Joint operational delivery arrangements:

4.1 Hosted Model

4.1.4 In this arrangement the lead ICB take full responsibility for the function. Therefore the host ICB is accountable to the joint committee for all of the outputs and performance of this function.

4.1.5 This would include the employment of staff and the organisation of financial arrangements.

4.1.6 Consequently the staff would be working in accordance with the host ICB's HR policies and procedures; similarly the financial arrangements would follow the host ICBs SOs and SFIs.

4.2 Hosted (subcontracted) Model

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

4.3 Shared Model

4.3.4 In this arrangement the ICBs establish a shared resource/team that works to support shared arrangements across the ICBs.

4.3.5 You would still need there to be a single employer for the staff who are working in this shared team (and as such the team works in accordance with the host employers HR policies and procedures.

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

4.4 Shared (subcontracted) Model

4.4.4 It would similarly be possible for the shared model to be subcontracted from a 3rd party. In this instance the 6 ICBs would all agree the terms

of the 3rd party contract (through the Joint Committee) and each ICB would be a joint contract-holder with the 3rd party.

4.5 Distributed Model

4.5.4 In this arrangement the ICBs each take responsibility for the function in their own organisation but there is a collaborative arrangement whereby those functions work together for mutual benefit.

4.5.5 Each ICB employs their own staff working to their own HR policies, financial SOs and SFIs.

4.5.6 Each ICB makes a commitment to the others for their own individual contribution that they make to the collective effort.

Agenda Item

ICB 25-01-055

IC Strategy and Development of Joint Forward Plan

Shropshire, Telford and Wrekin

Integrated Care Partnership Strategy

Interim (December 2022- March 2023)

Final Approved V8.0

Telford & Wrekin Co-operative Council

Shropshire together

Integrated Care System
Shropshire, Telford and Wrekin

Contents

Executive summary

- The Shropshire, Telford and Wrekin ICP is responsible for the development of an Integrated Care Strategy, against which the ICB will reflect and respond in its development of the systems multi-year planning and commissioning response.
- It is acknowledged nationally, that in this first and short year of development, the Integrated Care Strategy will be considered an interim document, to allow more time to adequately shape the vision and assessment of need.
- The work, engagement and knowledge of the two STW Health and Wellbeing Boards will be consolidated as the foundation for further ICS development. We are not starting from a blank piece of paper, and neither are we concluding our activities to better understand the priorities for our system.
- The Health and Social Care Act outlines a statutory requirement for ICBs to undertake a 12 week consultation and engagement program with system stakeholders, to inform the development of a 5 year forward plan for STW by the end of March 2023.
- In progressing the engagement on the strategy development, STW ICB will include, amongst other priorities those identified in the interim ICS document and will continue to support its further development in partnership.

Introduction

- We know that more needs to be done to give everyone the very best start and every chance to live a long and healthy life. This includes working with partners in the wider economy to create good jobs and increase everyone's prosperity with investment in skills, housing, culture and infrastructure. To have the best chance of achieving this, we need to think and work differently with each other and with our communities.
- A greater emphasis on prevention is crucial, to improve the quality of people's lives and the time they spend in good health. We recognise that not everyone has an **equal** chance of a happy, healthy long life and therefore we need to do more to tackle inequalities, including health inequalities.
- As a Partnership we are embracing our communities and community partners in our conversations and are listening to what staff and local people have to say, so that everyone in Shropshire, Telford and Wrekin is part of our shared purpose.

How we will work and what is different

People First

- People are at the heart of everything we do
- Ensure community-centred co-production (with staff, partners, patients, carers, VCS and residents) underpins the development of services

Prevention and inequalities

- Act sooner to help people with preventable conditions
- Enable people to stay well and independent for longer by providing a greater emphasis on proactive prevention and self-care
- Tackle the wider determinants of health – homes, jobs, education
- Offer accessible, high quality health and care services, which are equitably targeted towards people in the greatest need

Subsidiarity

- Things should be done, services and decisions made at the level that is most relevant, effective and efficient
- These actions at every level work together to contribute to the overall ambition of the ICS.

Joint working

- Both in the way we commission and the way we deliver services, from shared funding, and collaboration to health and care teams designed around people and their lives.

Empowerment

- Enabling people to navigate our system when they need help. We will need every organisation to think harder about access, inclusion, cultural safety and health literacy in the services they provide.

Innovation, evidence and research

- Should be at the heart of our approach to the challenges we face and the opportunities to deliver
- Maximise innovation and digital opportunities
- Adopt an intelligence-led population health management approach

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

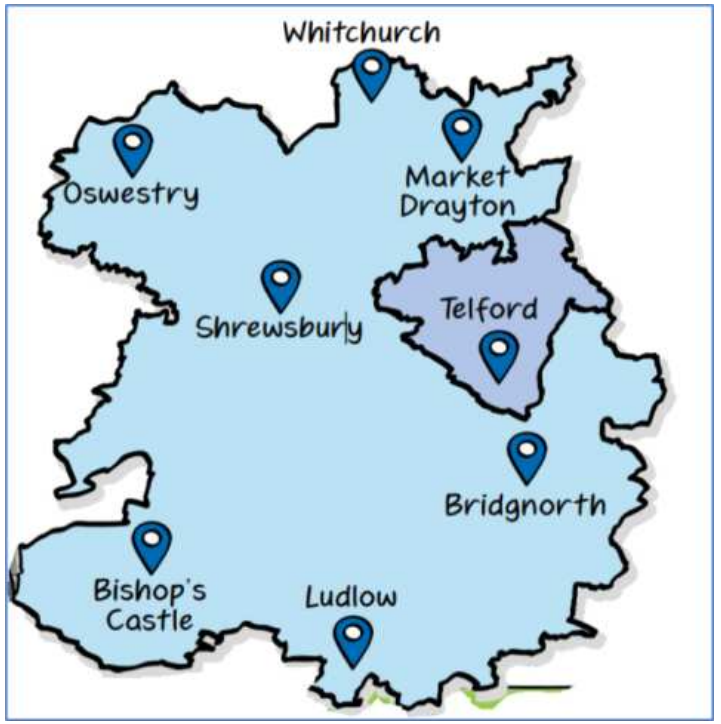
Overview of Our Integrated Care System

Chapter 1

Our system partners

Shropshire, Telford and Wrekin Integrated Care System includes the following partners:

- NHS Shropshire, Telford and Wrekin
- Shropshire Council (our Shropshire Place)
- Telford and Wrekin Council (our Telford and Wrekin Place)
- Shrewsbury and Telford NHS Trust (SaTH)
- Shropshire Community Health NHS Trust
- Robert Jones and Agnes Hunt Orthopaedic NHS FT
- Midlands Partnership NHS FT
- West Midlands Ambulance Service NHS FT
- Primary Care Networks – 8 PCN's (4 PCN's Telford and Wrekin, 4 PCN's Shropshire) and General Practice
- Community and Voluntary Sector organisations



We are an ambitious ICS and we want to make a real difference to the lives of local people.

We have previously engaged with our residents, patients, health and care staff, our local system partners and the voluntary, community and social enterprise (VCSE) sector and used this insight to develop ten pledges.

The pledges will be the golden thread through all the work we deliver.

Our ICS Pledges

1. We will improve **safety and quality.**

2. We will integrate services at **place and neighbourhood level.**

3. We will tackle the problems of **ill health, health inequalities and access to health care.**

4. We will deliver improvements in **mental health, learning disability and autism provision.**

5. We will support **economic regeneration** to help improve the **health and wellbeing of our population.**

6. We will respond to the threat of **climate change.**

7. We will strengthen our **leadership and governance.**

8. We will increase our **engagement and accountability.**

9. We will create a **financially sustainable system.**

10. We will make our ICS a **great place to work** so that we can attract and keep the **very best workforce.**

Our STW Integrated Care Partnership

- **Our Integrated Care Partnership (ICP),** is responsible for bringing together our system partners to develop a plan to address the broader public health, health and social care needs of our local populations and tackle health inequalities.
- Our ICP wants to make home and the community the hub of care and aims to ensure that services are personalised and seamless; empower patients; promote health; and prevent illness, where possible.
- The Integrated Care Partnership (ICP) provides a forum for NHS leaders and local authorities to come together, as equal partners, with key stakeholders from across the system and community.
- Together, the ICP is producing an integrated care strategy to improve health and care outcomes and experiences for the populations. This will be followed by a co-produced integrated 5 year plan to be in place by March 2023 which will inform the 'how' we deliver outcomes.

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Integrated Care Partnership Purpose and Vision

Chapter 2

Developing the ICP Mission and Vision

- Our ICP Vision and Mission statements are currently in draft as we co-produce, through a series of engagement events the further development of the ICP five year plan that supports out strategy document.
- Our partnership is developing the priorities from the two Health and Wellbeing boards across our places and listening to the voices of our partners and stakeholders as we develop our plan.
- Our partnership priorities need to be understood by our residents and all stakeholders.
- Our 5 year plan needs to underpin the delivery of our strategy. The plan needs to be developed by March 2023.

Integrated Care Strategy Vision and Objectives

We want everyone in Shropshire, Telford and Wrekin to have a great start in life and to live healthy, happy and fulfilled lives.

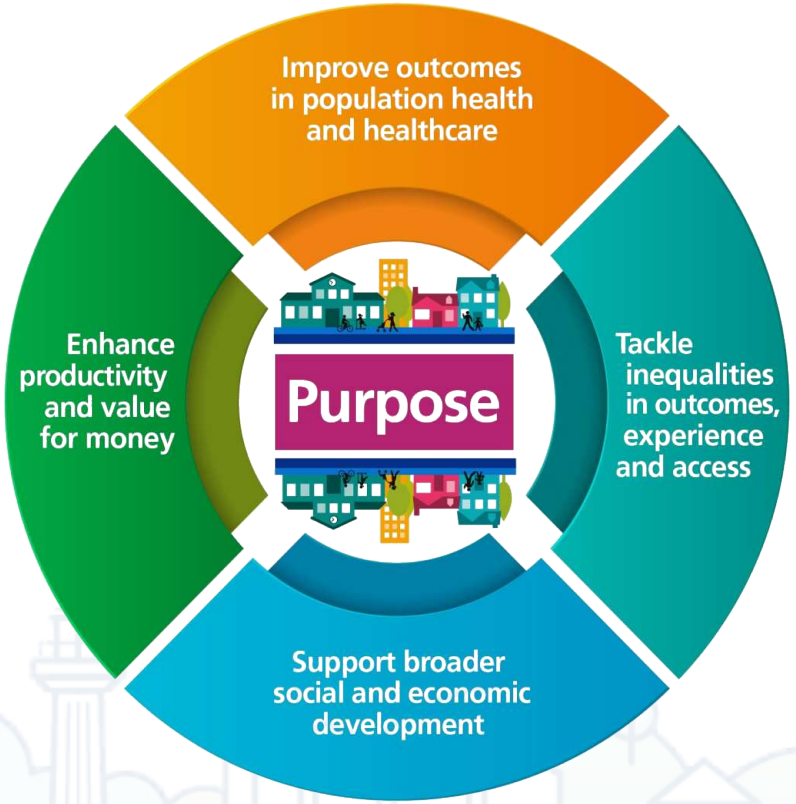
We will work together with our communities and partners to improve health and wellbeing by tackling health inequalities, encouraging self-care, transforming services and putting people at the heart of all we do.

Our ambition is to provide our communities across Shropshire, Telford and Wrekin with safe, high-quality services and the best possible experience from a health and care system that is joined up and accessible to all.

By transforming how and where we work, improving access to services and using our resources in the very best way for our communities, we will meet the needs of our population now and in the future.

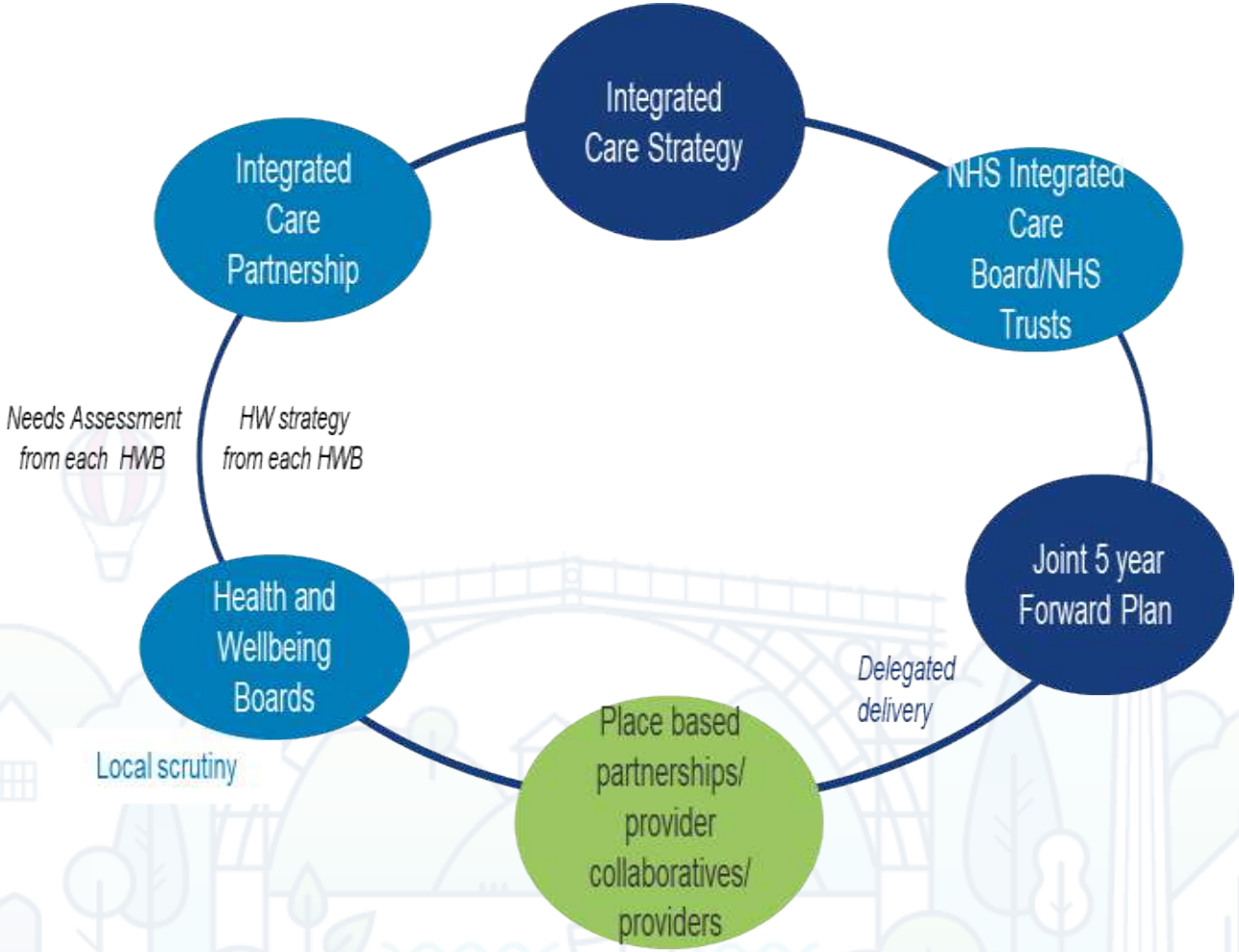
Joining up health and care is not new – a lot of work has already been done towards this and we will build on this work. This includes building on the positive joint working we saw in the system throughout the Covid 19 pandemic.

Our Four Strategic Objectives



Integrated Care Strategy: Cycle of development

This Integrated Care Strategy development through the ICP, is a key step in setting out the high level needs assessment and long term health and wellbeing priorities for Shropshire, Telford and Wrekin. A clear governance, planning and delivery cycle exists to support partnership working across the system. A comprehensive consultation and engagement process will wrap around this development cycle and support co-design.



Integrated Care Strategy Priorities

(from JSNA's to inform the HWB strategies and the interim integrated care plan)

Population Health Priorities

- Best start in life
- Healthy weight
- Mental wellbeing & Mental Health
- Preventable conditions – heart disease and cancer
- Reducing impact of drugs, alcohol and domestic abuse

Health Inequalities priorities

- Wider determinants:
  - homelessness
  - cost of living
- Inequity of access to preventative health care:
  - cancer
  - heart disease & screening
  - diabetes
  - Health Checks for SMI & LDA
  - vaccinations
  - preventative maternity care
- Deprivation and Rural Exclusion

Health and Care priorities

- Proactive approach to support independence
- Person – centred integrated within communities
- Best start to end of life (life course)
- Children and Young people physical and mental health and a focus on SEND
- Mental, physical and social needs supported holistically
- People empowered to live well in their communities
- Primary care access
- Urgent and Emergency care access
- Clinical priorities e.g. MSK, respiratory, diabetes

Integrated Care System
Shropshire, Telford and Wrekin

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Improve Outcomes in Population Health and Healthcare

Consolidating Knowledge and Findings

Chapter 3

Improve outcomes in population health and healthcare

Content:

- Joint Strategic Needs Assessments (JSNA)
- Population Health Intelligence
- Strategic Priorities
  - Health and Well Being Board Priorities
  - What our residents have told us
  - What our stakeholders have told us

Improve outcomes in population health and healthcare

- Each Health and Wellbeing Board has a statutory duty to publish a Joint Strategic Needs Assessment (JSNA) to inform the development of the Health and Wellbeing Strategies for each HWBB.
- Telford & Wrekin Health & Wellbeing Strategy refresh proposals have been developed based on JSNA intelligence and informed by engagement with residents as part of the development of the Vision 2023 - Building an Inclusive Borough – including circa 3,000 residents contributing through a telephone survey and focus groups in 2022 and also the residents survey in 2020 completed by circa 5,500 residents. Further engagement and community consultation on the proposed health & wellbeing refresh priorities is planned for February 2023.
- Shropshire Health and Wellbeing Strategy is being developed at a community level by engaging with the residents and local Town Councils using the data from the JSNA.
- The ICP has brought together the available intelligence from the HWBB strategies the system to inform the priorities for the interim Integrated Care strategy.
- The JSNAs and population health intelligence and the interim Integrated care Strategy should inform system partners about where there are areas of need, such as, health and social need, and the inequalities gaps in our communities.
- The interim Integrated Care Strategy will inform the development, with stakeholders through engagement into a five year plan to support the commissioning and provision of services and support that meet the needs of the population.

The intelligence in this section shows the key themes and headlines from the JSNAs and the population health priorities for our places and our system.

STW - Demographic & socio-economic headlines

Telford & Wrekin

- Fastest population growth in the West Midlands (2011-2021 = 11.4% growth). 2nd fastest growth nationally in 65+ population (35.7%)
- Population changing - becoming more diverse & ageing (median age now same as WMs at 39.6 years)
- 27% Telford & Wrekin residents live 20% most deprived areas in England – circa 45,100 people (= NHSE CORE20) significantly higher than the England average and just over a fifth (21%) of children and young people are living in poverty
- Life expectancy at birth & at age 65 for men and women significantly worse than England average and there are significant inequalities gaps

Shropshire

- 139,000 households - predicted to increase 28% by 2043
- 23% of the population +65 years (18.5% England Age)
- 26% increase in LAC 2019/20 to 2020/21
- 44,969 people are 30 minutes or more by public transport to the closest GP
- An estimated 3,740 people are currently living in care home settings in Shropshire, with this figure likely to increase in the future
- The relatively affluent county masks pockets of deprivation, growing food poverty, health inequalities and rural isolation, with the county overall having a low earning rate

STW Area

- Total Population in 2020 506, 737 (Shropshire 325,415 Telford 181,322)
- Male 49.5 % Female 50.5%
- Across a total Area 3,487 sq km
- Average Annual Births 4,600 and Deaths 4,920
- Shropshire is predominately 66% rural (101 people/sq km) Telford and Wrekin is predominantly urban (620 people/sq km)
- By 2043 there will be an estimated 589,330 people in STW - 30% will be over 65 (currently 21%)
- There are over 155 care homes in the area with more than 4,320 beds
- Across STW there are 88,000 people with a long term limiting illness (18%)

Population Health Priorities

Using evidence from our JSNAs and our two Health & Wellbeing Strategies the following shared priorities emerged:

- Give every child the best start in life (including healthy pregnancy)
- Encourage healthier lifestyles with a priority focus on unhealthy weight
- Improve people's mental wellbeing and mental health
- Reduce the impact of drugs, alcohol and domestic abuse on our communities

STW JSNAs – Key Headlines

- Trends show that overall life expectancy for males and females has stalled and inequalities are clear across both Places. Life expectancy at birth for both males and females is significantly worse than the England average in Telford & Wrekin and significantly better than the national average in Shropshire
- The inequalities gap in life expectancy (between the most deprived and least deprived areas within each local authority):
  - for men is 7.3 years in Telford & Wrekin, compared to 7.2 years in Shropshire
  - for women is 4.1 years in Telford & Wrekin, compared to 5 years in Shropshire
- The gap in life expectancy is driven by mortality from cardiovascular disease, followed by cancers
- Early death rates from preventable cardiovascular disease and cancer in Telford & Wrekin are significantly worse than the England average, and this contributes to the reduced life expectancy picture
- Excess weight is the most significant lifestyle risk factor in the population with the level of adult excess weight in both Telford & Wrekin and Shropshire are significantly higher than the England average
- The level of alcohol related-hospital admissions in Telford & Wrekin are also significantly higher than the England average
- Adult smoking rates in routine and manual groups in both Shropshire and Telford & Wrekin are a key driver of inequalities
- Smoking in pregnancy is a particular issue for Shropshire and Telford & Wrekin, with levels of maternal smoking at birth significantly worse than England overall, the highest levels are seen amongst younger mothers and those living in deprived communities
- Unhealthy weight in children & young people in Telford & Wrekin are also worse than the national average
- Mental Health is a key cause of poor health amongst our communities and levels of poor mental health in children and younger people is increasing. The physical health of adults with Serious Mental Illness is also a cause for concern with both Shropshire and Telford & Wrekin having high rates of excess mortality in this group compared to the national average

Deprivation, ethnicity & access to services

Deprivation

- Shropshire is a relatively affluent county which masks pockets of high deprivation, growing food poverty, and rural isolation.
- More than 1 in 4 people in Telford and Wrekin live in the 20% most deprived areas nationally and some communities within the most deprived in the country.

Ethnicity

- In Shropshire, in 2011 there were approximately 14,000 people (5.6%) from BAME and other minority ethnic groups. Data suggests this has increased particularly in Eastern European populations.
- In Telford and Wrekin 10.5 % of the population from BAME and other minority ethnic groups, however more recent estimates, including the school census and midyear estimates suggest the percentage is closer to 17%.

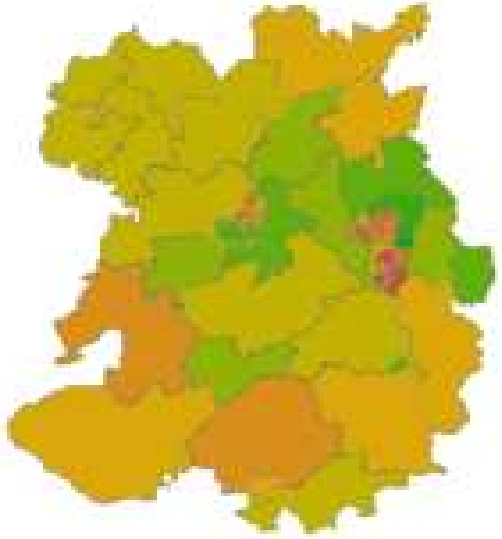
Access

- The access domain highlights significant areas of Shropshire, Telford and Wrekin that have the lowest level of access to key services including GP services, post office and education

Cost of Living

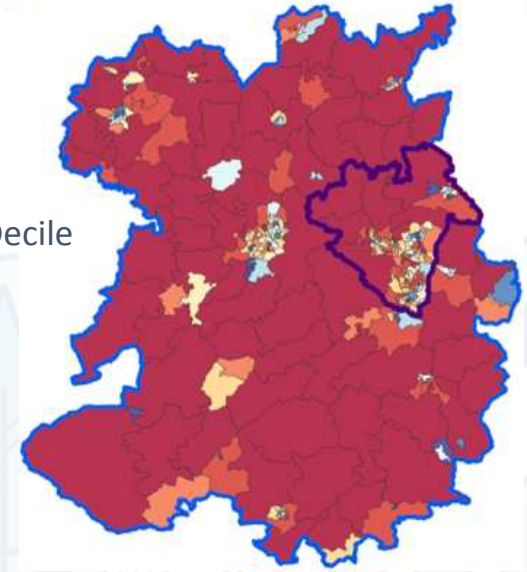
- The Cost of Living Vulnerability Index is 1,203 for Shropshire and 1,348 for Telford and Wrekin – both in the highest quartile of local authorities nationally

Deprivation - IMD 2019 Decile



Ethnicity - % BAME 2011 Census

Access - IMD 2019 Decile



Wider determinants of health

Public Health Outcomes Framework Indicator	Period	Telford & Wrekin	Shropshire
Children in relative low income families (under 16s)	2020/21	21.4	16.8
School readiness: percentage of children achieving a good level of development at the end of reception	2018/19	71.3	72.6
School readiness: percentage of children achieving the expected level of development in the phonics screening check in Year 1	2018/19	83.5	80.9
First time entrants to the youth justice system	2021	108.9	64.2
16-17 year olds not in education, employment of training (NEET) or whose activity is not known	2020	7.4	10.3
Adults with a learning disability who live in stable and appropriate accommodation	2020/21	77.8	85.6
Adults in contact with secondary mental health services who live in stable and appropriate accommodation	2020/21	59.0	71.0
Gap in the employment rate between those with a long-term health condition and the overall employment rate	2020/21	11.8	16.3
Gap in the employment rate for those with a learning disability and the overall employment rate	2020/21	70.2	70.8
Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate	2020/21	63.9	67.4
Percentage of people aged 16-64 in employment	2020/21	72.9	76.4
Sickness absence – the percentage pf employees who had at least one day off in the previous week	2018-20	1.7	1.6
Sickness absence – the percentage of working days lost due to sickness absence	2018-20	1.0	0.7
Violent crime – hospital admissions for violence (including sexual violence)	2018/19-20/21	27.8	20.0
Homelessness – households owed a duty under the Homelessness Reduction Act	2020/21	12.3	7.9
Social Isolation: percentage of adult social care users who have as much social contact as they would like (18+ yrs)	2019/20	40.8	51.4
Social Isolation: percentage of adult carers who have as much social contact as they would like (18+ yrs)	2018/19	36.0	35.4

Population Health Outcomes

	Public Health Outcomes Framework Indicator	Telford & Wrekin	Shropshire	NHSE health inequalities & prevention priorities
Overarching	Life expectancy at birth (males)	78.2	80.2	• Overarching Health Inequalities Outcomes
	Life expectancy at birth (females)	81.9	83.7	
	Healthy life expectancy at birth (males)	57.6	62.8	
	Healthy life expectancy at birth (females)	60.3	67.1	
	Life expectancy at 65 (males)	18.0	19.3	
	Life expectancy at 65 (females)	20.2	21.5	
Maternity & Early Years	Teenage pregnancy	16.8	11.5	• HI 5 key clinical areas: maternity • LTP NHS prevention priority health weight
	Obesity in early pregnancy	29.5	24.1	
	Baby's first feed breastmilk	63.8	70.8	
	Smoking at time of delivery	14.3	11.0	
	Children overweight (including obese) – reception	26.1	22.6	
	Children overweight (including obese) – year 6	40.0	29.7	

Population Health Outcomes

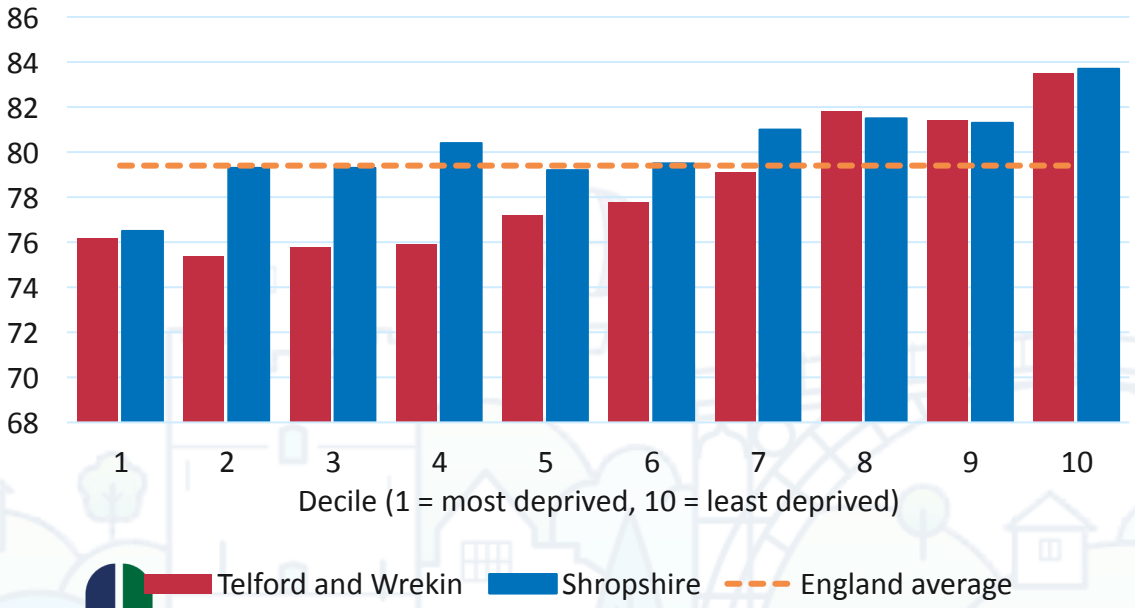
	Public Health Outcomes Framework Indicator	Telford & Wrekin	Shropshire	NHSE health inequalities & prevention priorities
Prevention	Adults classified as overweight or obese	70.6	68.0	• HI 5 key clinical areas: hypertension case finding • LTP accelerate diabetes & CVD prevention programmes • LTP NHS prevention priority healthy weight
	Diabetes diagnosis rate (estimate)	85.6	71.4	
	Early mortality from preventable CVD	38.4	24.8	
	Early diagnosis cancer (stages 1 and 2)	50.3	53.3	• HI 5 key clinical areas: early cancer diagnosis
	Cancer screening coverage – cervical cancer	74.4	76.8	
	Cancer screening coverage – bowel cancer	65.1	69.4	
	Early mortality from preventable cancers	66.2	38.7	
	Early mortality from preventable respiratory disease	18.6	12.6	• HI 5 key clinical areas: chronic respiratory disease
	Flu vaccination coverage – at risk individuals	55.5	60.6	
	Early mortality in adults with severe mental illness	134.4	89.0	• HI 5 key clinical areas: severe mental illness
	Excess mortality in adults with severe mental illness	475.4	477.6	
	Emergency hospital admissions for self harm	182.4	146.8	
	Admissions for alcohol related conditions	512	460	• LTP NHS prevention priority: alcohol care team
	Early mortality from preventable liver disease	19.6	14.7	
	Smoking attributable mortality	246.1	173.7	• LTP NHS prevention priority: NHS tobacco dependency programme
	Smoking attributable hospital admissions	1,944	1,475	
	Smoking prevalence routine & manual occupations	21.4	25.6	

Inequality in Life Expectancy

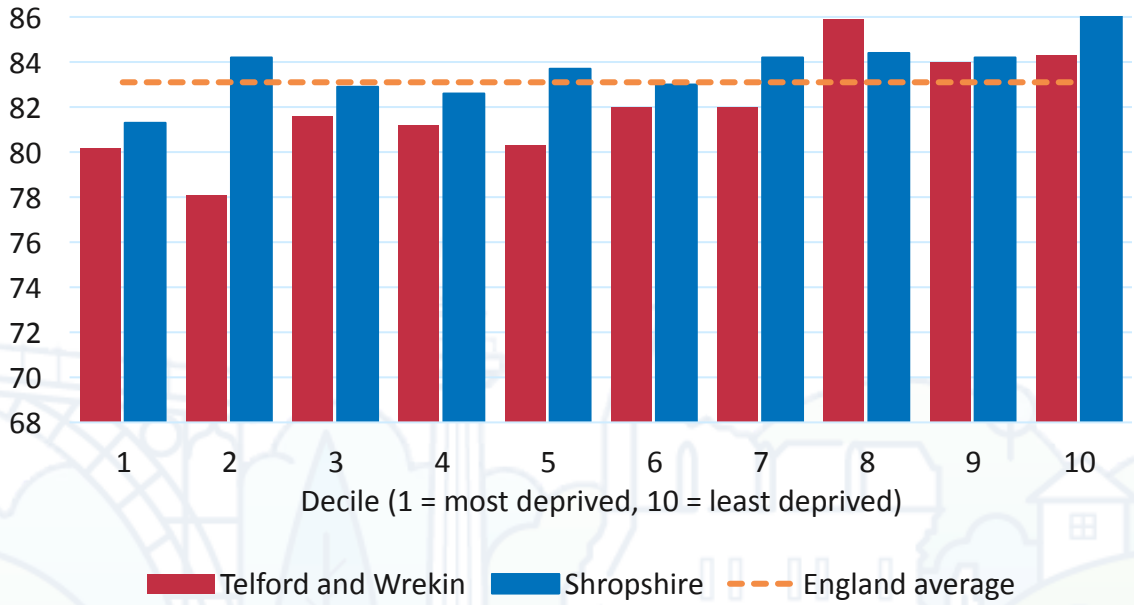
In both Shropshire and Telford and Wrekin life expectancy at birth is lower in the most deprived areas than in the least deprived areas and there are clearly inequalities gaps.

However life expectancy at birth in the most deprived parts of Telford and Wrekin is considerably lower than the national average and most deprived parts of Shropshire.

Life expectancy at birth by deprivation decile 2018-20 (male)



Life expectancy at birth by deprivation decile 2018-20 (female)



What our residents have told us

As an ICS we understand the importance of developing our health and care services based on the views of our local population, alongside the evidence on population health.

Our residents have said they wanted 'A person-centred approach to our care,' and this is central to all the work we are doing.

People are at the heart of everything we do and by delivering joined up services in both the acute and community settings we can give everyone the best start in life, creating healthier communities and helping people to age well.

The top 10 statements from all respondents for the Shropshire, Telford & Wrekin questionnaire which described the measures were the most **important to our residents**:

- 1. "Professionals that listen to me when I speak to them about my concerns"
- 2. "Access to the help and treatment I need when I want it"
- 3. "I want to be able to stay in my own home for as long as is it is safe to do so"
- 4. "I want my family and me to feel supported at the end of life"
- 5. "Choosing the right treatment is a joint decision between me and the relevant health and care professional"
- 6. "I want there to be convenient ways for me to travel to health and care services when I need to"
- 7. "Easy access to the information I need to help me make decisions about my health and care"
- 8. "Having the knowledge to help me to do what I can to prevent ill health"
- 9. "Communications are timely"
- 10. "I have to consider my options and make choices that are right for me

What our residents have told us

Those who had long term conditions told us to focus on:

- Getting help and communications
- Impact of having more than one conditions
- Waiting Times
- Access to ongoing care and support
- Transport and Travel

When asked what our residents would do to, to be supported to live a healthier life? What can services do to provide you with better care and support? What would make it easier for you to take control of your health and wellbeing?

People told us that a number of things are important and should be priorities:

1. Access and timely intervention e.g. local services that people know about, that are available when people need them (including 24 hour) and that they can get to easily, including services that can help people to live healthy lives such as affordable gyms and social groups
2. Tackling isolation and loneliness e.g. Making sure socially isolated people know what support is available to them and how to access it, including homeless people and people who do not have a named GP or relationship with services
3. Consistent and reliable information and education for all ages e.g. reducing confusion by giving clear and consistent information that can be trusted, including information about services such as available appointments and giving people a single point of contact to improve consistency, including appropriate signposting and offering information and advice (e.g. advice about medication)
4. Services working together, including information sharing and a flexible approach to working e.g. ensuring staff know what other services are out there and talking to each other, improved referral processes, social services and the NHS working together
5. Building strong communities and investment in local people e.g. supporting and promoting local groups to enable and encourage people to get together, e.g. walking groups, dementia groups

What our stakeholders have told us

Together with the views of our partners, clinicians, staff and service users we can identify what is working well, what can be improved and what is important to them. This will enable us to plan, design and deliver health and social care services that are right for our local population of Shropshire, Telford & Wrekin.

Our clinical priorities identified through the HWBB consultations and engagement:

- Cancer
- Cardiac
- Respiratory
- Urgent and Emergency Care
- Diabetes
- Orthopaedics
- Mental Health

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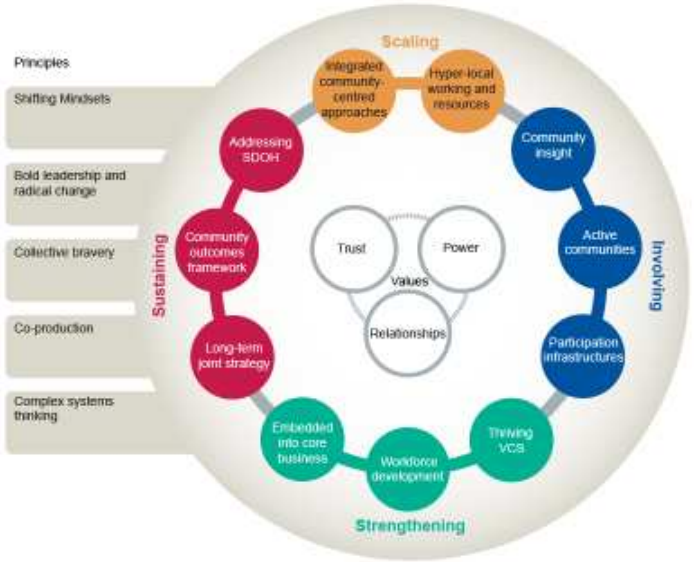
Tackle Inequalities in Outcomes, Experience and Access

Consolidation of Knowledge and Findings

Chapter 4

Tackling inequalities – approach

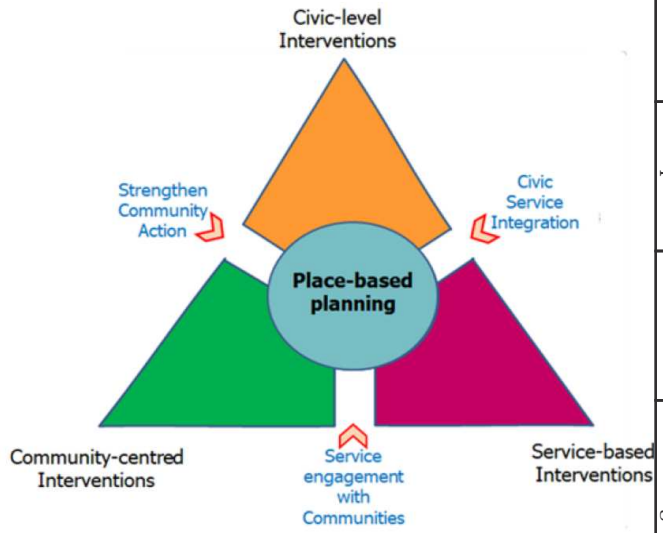


Community focused co-production

Place-based system wide

Intelligence-led

Equitable targeting



Intelligence-led population health management, including equity profiling for inclusion groups

Narrow the gap in service and support uptake and outcomes by proactively targeting people in inclusion based on equity profiling and engagement insight

Telford & Wrekin Co-operative Council

Shropshire together

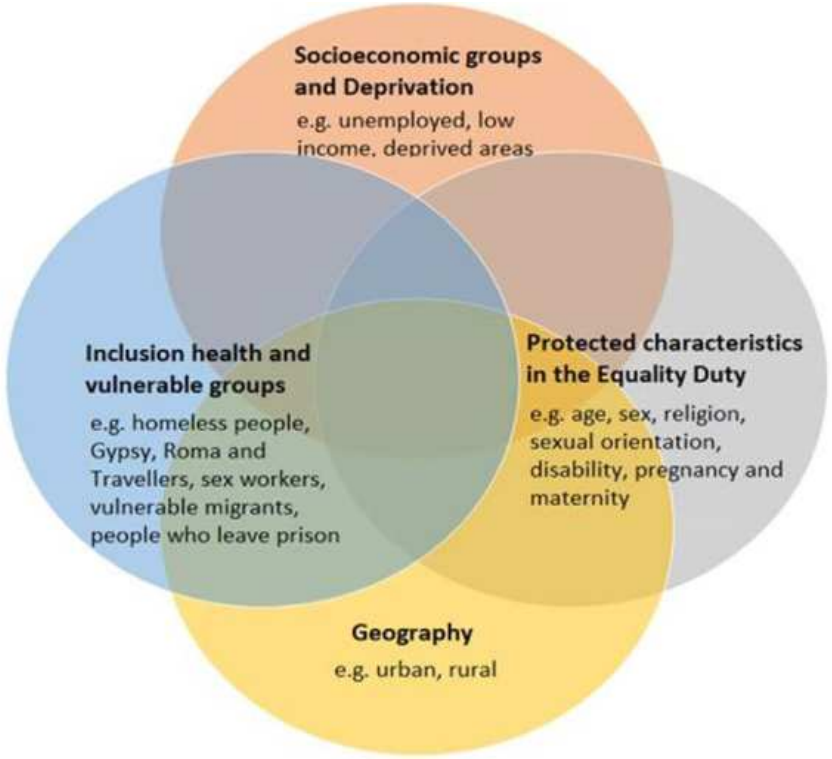
Integrated Care System
Shropshire, Telford and Wrekin

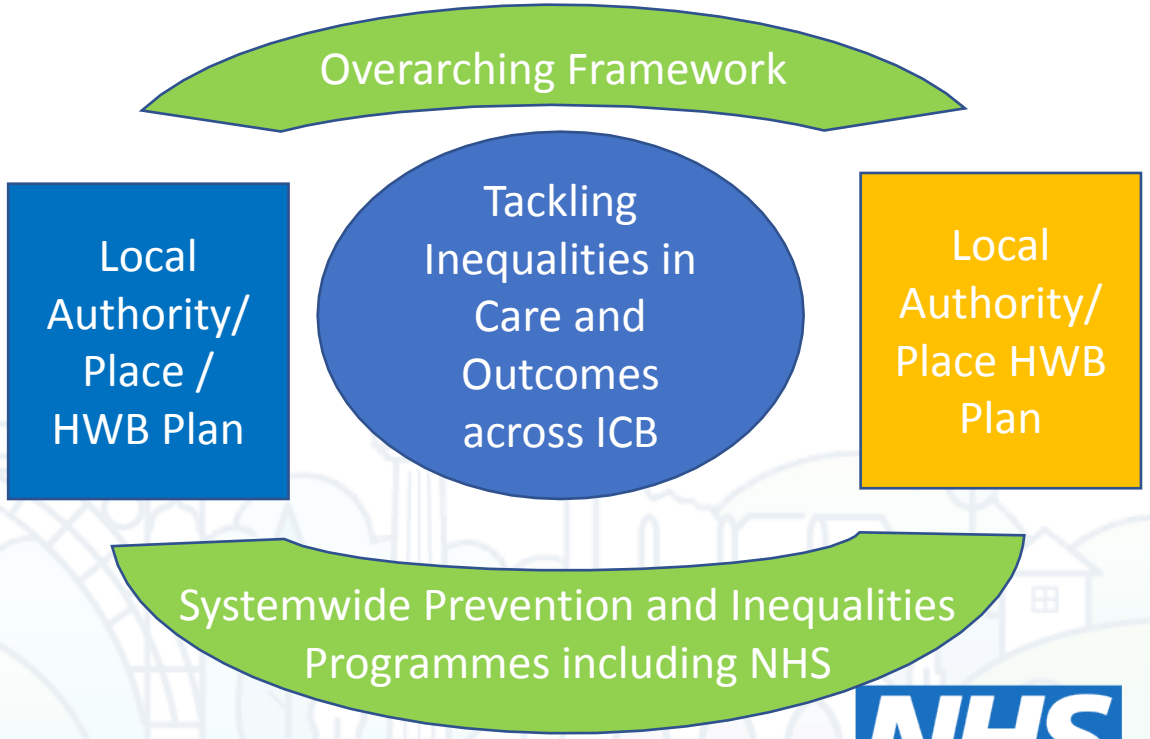
Inequalities and Health Inequalities

Health inequalities are unfair, systematic and avoidable differences in health.

Inequalities in the wider determinants of health (such as housing, education and access to green space) translate into health inequalities.

Therefore, action to reduce health inequalities requires action to improve outcomes across all the factors that influence our health. Approx 10% of our health is impacted by the healthcare we receive.





Tackling inequalities – inclusion groups

Clear focus where outcomes are poorest for people and families who are:

- from black and minority ethnic groups
- living in deprived communities, including rural deprived
- affected by alcohol and other drugs
- victims and survivors of domestic abuse
- experiencing poor emotional and mental health
- living with physical, learning disabilities and autism
- within Equality Act protected characteristic groups
- at risk of exploitation
- LGBTQ+
- service personnel and veterans
- looked after children and care leavers
- asylum seekers and refugees

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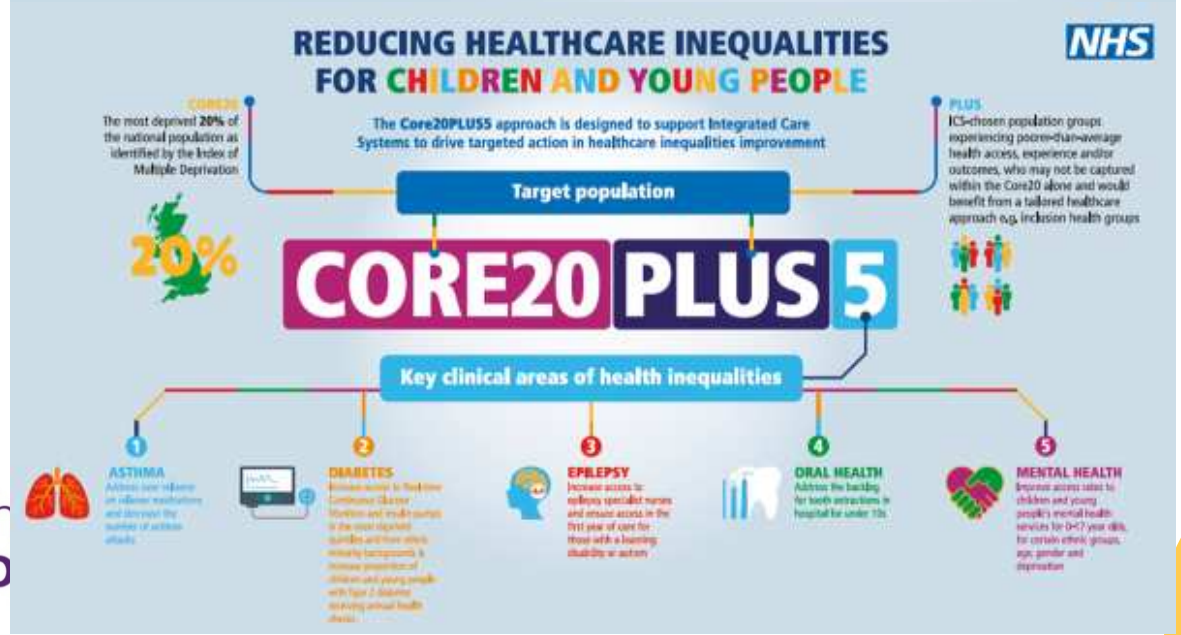
Integrated Care System
Shropshire, Telford and Wrekin

Tackling inequalities - overview

Wider determinants cost of living crisis, housing, employment

Inclusive, connected, healthy & sustainable communities



Healthy behaviours & lifestyles strengthening prevention

Best start in life for every child

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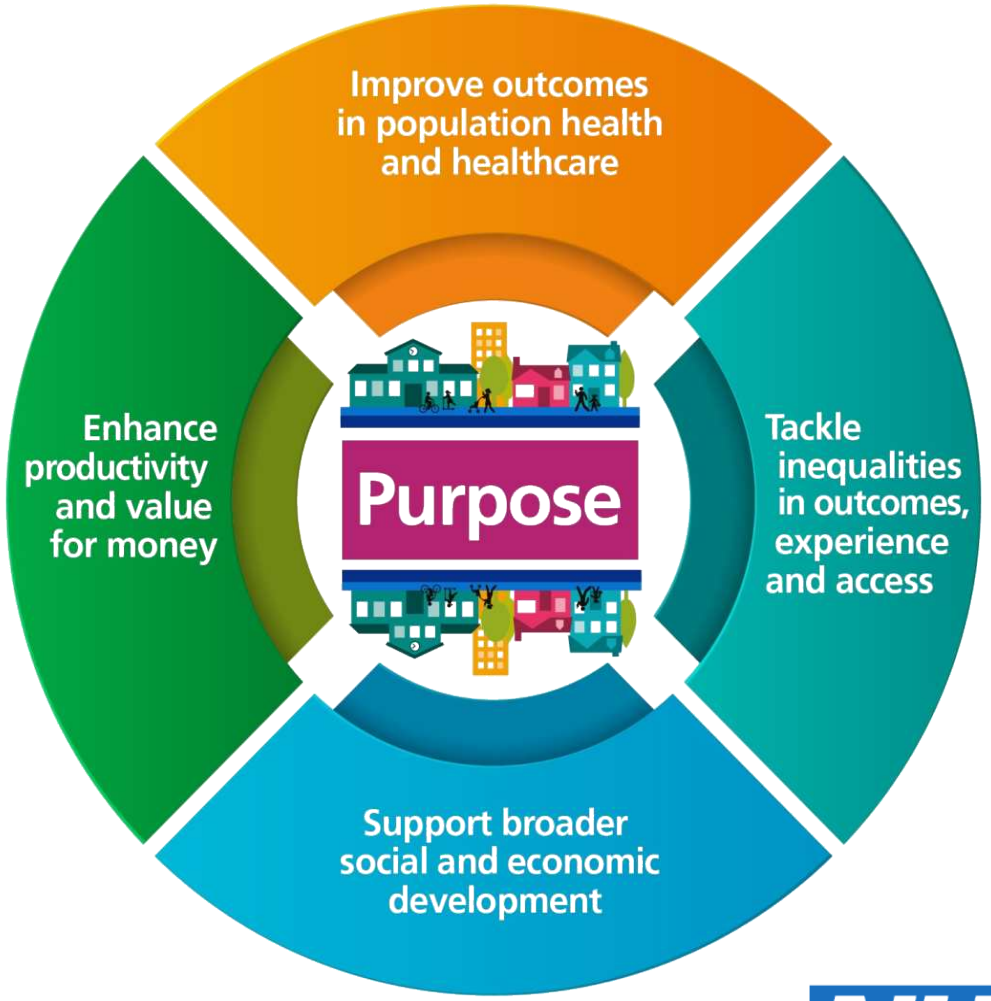
Health Inequalities

Health inequalities are widening, our partnership needs to focus on the root causes of health inequalities, the wider determinants, and address inequity of access to services for those most in need. We need to understand the multiple barriers people can face in accessing our services more fully.

We therefore commit to accelerate, targeted collaborative local action to reduce health inequalities, by the following priorities:

- Tackling the wider determinants of health
    - homelessness, healthy homes, poverty & cost of living, positive work and employment
    - Giving every child the best start in life – to influence a range of outcomes throughout people's lives
    - Improving equity of access to healthcare for those living in our most deprived areas, including rurally excluded as well as other forms of exclusion (for example Core20 plus 5 programme and a focus on healthcare preventable diseases)
    - for adults this includes hypertension, early cancer diagnosis, health checks for SMI and LDA, vaccinations, continuity of carer in maternity.
    - For children this includes epilepsy, diabetes and asthma



Telford & Wrekin Health and Wellbeing Proposed Priorities

INTEGRATION PRIORITIES

	START WELL	LIVE WELL	AGE WELL
Population health & prevention	excess weight and obesity		
	mental & emotional health		
	impact of alcohol and other drugs		
	preventable diseases (e.g. CVD, diabetes, cancer, respiratory)		
Inequalities	Marmot Borough		
	cost of living crisis		
	barriers to access (transport & digital)		
	domestic abuse, alcohol, drugs and dual diagnosis		
	healthcare inequalities (NHS restoration/CORE20PLUS5)		
	homelessness, affordable housing & specialist accommodation		
Health & care	• healthy and safe pregnancy • parents/carers empowered to care for & nurture their children	• Community Mental Health Services Transformation	• proactive prevention to maximise independence • control, choice & flexibility in care and support
	strong integrated model of community-centred care (e.g. local care programme)		
	integrated primary care in the heart of our communities		
Enablers	population health management → workforce → sustainability of resources		

Shropshire Inequality Plan

Wider Determinants	Healthy Lifestyles	Healthy places	Integrated Health and Care
Marmot: (i) Create fair employment (ii) Ensure healthy living standard	Marmot: (iii) CYP and adults – maximise capability and control (iv.a) strengthen Ill-health prevention (lifestyles)	Marmot: (i)v Create healthy and sustainable places and communities	Marmot: (vi) Give every child the best start in life (iv.b) strengthen Ill-health prevention (transformation/disease programmes)
Inequalities Work Programmes			
Embed Health in all polices	Smoking/tobacco dependency	Air Pollution	Restore NHS services inclusively
Housing – affordable/specialist/supported	Healthy weight	Planning	Rurality
Economy and skills	Physical Activity	Culture & Leisure	Mitigate Digital Exclusion
Workforce		Licensing	Datasets complete
Education incl. SEND		Food Insecurity	Strengthen leadership & accountability
Early Years			Population Health Management
Virtual School			Personalisation/ Personalised Care
Post 16			COVID and flu vaccination
SEND			Annual health checks for people with LD/SMI
Transport			Continuity of Carer (Maternity)
			Chronic Respiratory Disease
Social Inclusion Groups	**Social Inclusion Groups (Continued)**	**PCN Health Inequality Plans**	Early Cancer Diagnosis
Domestic Abuse	Drug and Alcohol Misuse		Hypertension Case-Finding
Exploitation	Looked After Children		Diabetes
Homelessness	Ethnic Minority Groups		Children & Young People
Learning Disability	Prisoners and their families		Trauma Informed Workforce
Autism			Healthy Start
Gypsy and traveller families			Oral Health
Asylum seekers/ refugees			Best Start in Life
Unpaid Carers			Children/Families in Need
Physical disabilities			Complex Need
LGBTQ+			Mental Health (MH Transformation Plan)
Services personnel & (families & veterans)			Suicide Prevention
			Social Prescribing
			Integrated Impact Assessment (IIA

Shropshire Joint Health and Wellbeing Strategy priorities 2022-2027

Strategic Priorities Long-term aims and how we will achieve them	Key areas of focus Identified areas of health and wellbeing need in Shropshire
Joined up working	Workforce
Working with and building strong and vibrant communities	Healthy Weight and Physical Activity
Improving Population Health	Children & Young People incl. Trauma and ACEs (All-age)
Reducing Inequalities	Mental Health

Other – These form part of the Key Priorities			
Social Prescribing	Drugs and Alcohol	Smoking in Pregnancy	Housing
Suicide Prevention	Food Poverty	Killed and Seriously Injured on Roads	Air Quality
Exploitation			

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Shropshire, Telford and Wrekin

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Support broader social and economic development

Chapter 5

Support broader social and economic development

As our Partnership develops the 5 year plan we need to take into account broader system working. Other programmes need to demonstrate how they will deliver against the integrated care strategy.

This includes:

- Local Planning and regeneration
- Climate and green planning
- Hospital Transformation Programme
- Local Care Integration Programme

Enabling strategies need to support the integrated care strategy within the 5 year plan

- Workforce
- Digital
- Communications and Engagement
- Population Health Management

Enablers

Workforce:

- Our local people plan outlines and supports our system response.
  - Looking after our people
  - Belonging in STW
  - New ways of working and delivering care
  - Growing for the future
  - Focus on Nursing and Health Care Support Workers (HCSW)

Communication and Engagement:

- Communication and Engagement Plan
- The STW 5 year Plan is the "*How*" element of delivering the ICP's Strategy and its priorities. Partnership workshops are planned to inform the consultation plan narrative, approach, methods, and key questions
- Equalities Involvement Committee will guide and advise on inclusion of protected groups and seldom heard voices
- Ongoing dialogue will be supported by developing a citizens panel, working local involvement networks, VCSE, Healthwatch, and NHS/LA enabling workstreams

Digital:

- Our ICS Digital Strategy continues to develop.
  - Shared Care Record
  - Care Delivery systems
  - Remote monitoring
  - Population analysis
  - Artificial intelligence

Population Health Management (PHM):

- Development of a PHM Strategy to ensure accurate data, insights, and evidence to support system decision making
  - Development of an engine room
  - Grow analytical skills and capacity
  - Delivery of systemwide work programme
  - Ongoing development of JSNAs as foundation

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Enhance productivity and value for money

Chapter 6

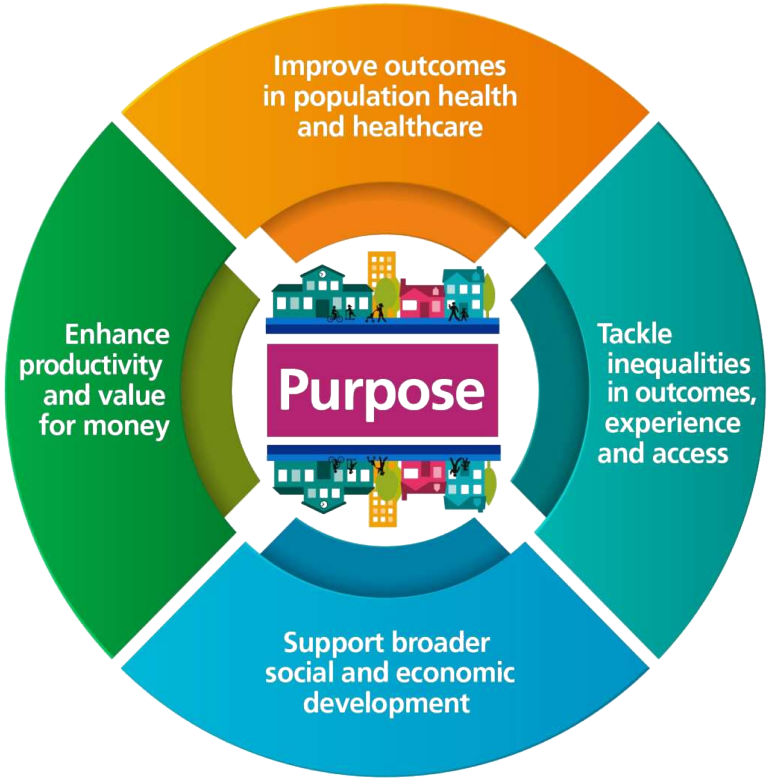
Enhance productivity and value for money

Our ICP will consider whether needs could be better met through arrangements such as the pooling of budgets, under Section 75 of the NHS Act 2006. Section 75 is a key tool to enable integration and will be part of delivery of the integrated care strategy.

The term “left shift” is used to describe a strategic direction that supports more care being provided in lower cost out of hospital settings (ideally at home) and prevention. The underlying premise is that acute care is often likely to be the most costly care setting and can become the default option where services that have the potential to prevent patients requiring acute care are not optimal in either capacity, capability or delivery.

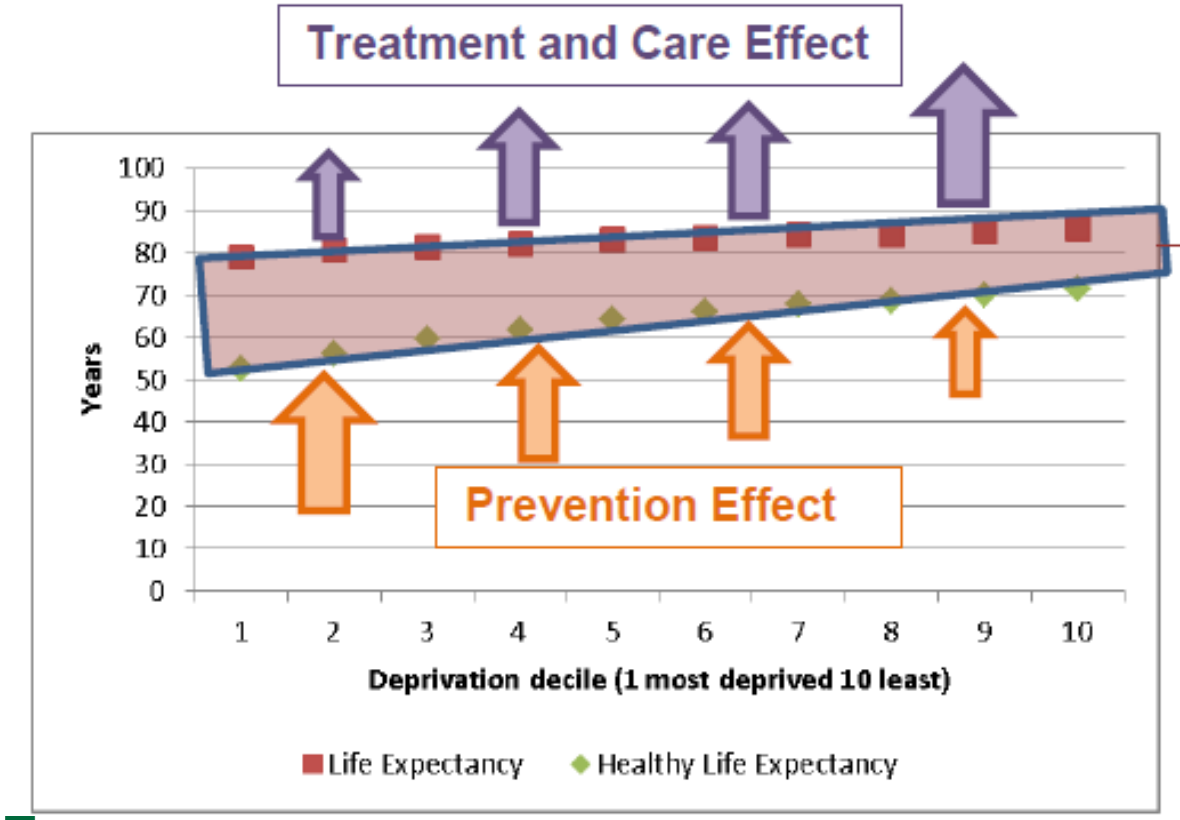
The point prevalence audit recorded that just under 20% of patients in acute care on the day of the audit could have been treated appropriately in “left-shift” settings such as community hospitals, care homes or in their own homes with additional primary care and social care support. However, this work needs to be further analysed and described in the 5 year plan to ensure that appropriate integrated primary and community services are being developed to support the ‘left shift’. ‘Left shift’ also applies to prevention and early support services that sit below primary, community and social care.

However, a move to left shift will not happen by default without a conscious effort by the system to support doing something different and recognising that costs and benefits of change will not fall consistently across the system.



The Left Shift – preventive approach

- **Closing the Care and Quality Gap** *"To narrow the gap between the best and the worst whilst raising the quality bar for everyone"*
- **Closing the Health Gap** *"We are living longer lives but we are not living healthier lives. The overwhelming majority of ill health and premature death in this country is due to diseases that could be prevented"*



Focusing on Prevention/early intervention;

- Reduces/preventing demand
- Delays health and care service need
- Delivers better Outcomes by extending Healthy Life Expectancy
- Reduces inequalities

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Performance Monitoring and Scrutiny

Chapter 7

Performance monitoring and scrutiny

- High level outcomes for the system are broadly agreed but may develop during further consultation and co-production
- Interim Integrated Care Strategy will be further developed with residents, partners and stakeholders and a five year system plan for delivery will be in place by March 2023.
- Delivery of the five year plan will be overseen by the Integrated Care Board and developed closely with the ICP
- Scrutiny of the high level strategy and the subsequent five year plan will be overseen by the Joint Health Overview and Scrutiny Committee

Outcome Focus – potential high level outcomes

The health of our population will be improve through a focus on....	Our Outcomes
The health of our RESIDENTS	1. We will increase healthy life expectancy across STW and narrow the gap between different population groups 2. We will reduce early deaths from preventable causes – cardiovascular and respiratory conditions, cancers and liver disease – focussing on those communities which currently have the poorest outcomes 3. We will improve life expectancy of those with Serious Mental Illness 4. We will increase the proportion of people in STW with a healthy weight 5. We will improve self-reported mental wellbeing 6. We will reduce the number of children & young people who self-harm 7. We will reduce alcohol related hospital admissions 8. We will reduce the proportion of pregnant women who smoke 9. We will lower the burden and minimise the impact of infectious disease in all population groups
The health of our SERVICES	1. We will increase the proportion of our residents who report that they are able to find information about health and care services easily 2. We will increase the proportion of our residents who report that they are able to access the services they need, when they need them 3. We will increase the proportion of our residents who report that their health and care is delivered through joined up services as close to home as possible

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Outcome Focus – potential high level outcomes

The health of our population will be improve through a focus on....	Our Outcomes
The health of our STAFF	1. We will improve our ability to attract, recruit and retain our staff 2. We will improve staff training and development opportunities across all our partners 3. We will improve self-reported health and wellbeing amongst our staff 4. We will increase Equality and Diversity workforce measures in all organisations
The health of our COMMUNITIES	1. We will reduce the impact of poverty on our communities 2. We will reduce levels of domestic violence and abuse 3. We will reduce the impact of alcohol on our communities 4. We will reduce the impact of Adverse Childhood Experiences (ACEs) on our communities 5. We will reduce the number of young people not in education, training or employment 6. We will increase the number of our residents describing their community as a healthy, safe and positive place to live
The health and wellbeing of our ENVIRONMENT	1. We will increase the proportion of energy used by the estates of our partner organisations from renewable sources 2. We will reduce the total carbon footprint generated through travel of patients using our services 3. We will increase the use of active travel, public transport and other sustainable transport by our staff, service users and communities

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Next steps

- Work continues to develop the Interim Integrated Care Strategy into a high level assessment of the systems challenges, needs and priorities, with broader stakeholder input.
- A comprehensive engagement plan has been drafted to guide our next step approach, reach and methodology and will be launched in January 2023 and run for 8 - 12 weeks.
- Key lines of enquiry with stakeholders, patients and the public will sense check the feedback received to date; check if the priorities are the right areas to focus on.
- *By listening* to our stakeholders, and public *and reflecting their feedback in our strategic and operational plans will enable a local ownership and buy in to change moving forward*.
- In conjunction with the engagement program, the ICB will start to shape the 5 year system plan, for completion March 2023 and the ICB commissioning response, ensuring to utilise the knowledge to date from the interim ICS document.

Outline strategy and plan development timeline

Strategy development & Five Year plan engagement set up – Sept to Dec 2022

- ICP and ICB review existing data and outputs and agree strategy & plan development approach
- Develop the Integrated Care Strategy
- ICP sign off draft strategy
- Submit strategy to NHS E
- Begin planning for the broad public engagement to inform the Joint Five Year Plan and strategy
- Map engagement & comms gaps & key groups
- Warm up and engage partners on 'Big Conversation' and plan development

Comms & engagement – Dec – late Feb 2023

- Begin engagement for Joint Five Year Plan and strategy
- Launch STW 'Big health and care Conversation' engagement (8 weeks)
- Provide regular updates to ICP & ICB and other key groups and partner stakeholders
- Engagement with key system partner staff and groups with specific roles in the plan development and drafting (e.g. ICP, JOSC, H&WBBs,)
- Begin drafting plan informed by engagement feedback

Late Feb 2023 to mid March 2023

- Progress drafting the plan informed by engagement outputs
- Share strategy and plan with stakeholders for comments and input
- Continue engaging ICP, ICB, key system groups and partners
- Conclude the Big Conversation engagement and feedback 'you said, we've incorporated'
- Prepare final strategy and plan for sign off

Sign off – End of March 2023

- Strategy and plan signed off by ICB
- Submit to plan NHS E
- Share with key stakeholders and partners

Appendix 2: Summary of the guidance on developing the Joint Forward Plan (JFP)

See full guidance document: Guidance on developing the Joint Forward Plan

The guidance, published on 23 December 2022, supports integrated care boards (ICBs) and their partner NHS trusts and foundation trusts to develop their first 5-year joint forward plans (JFPs) with system partners. The plans must meet specific statutory requirements.

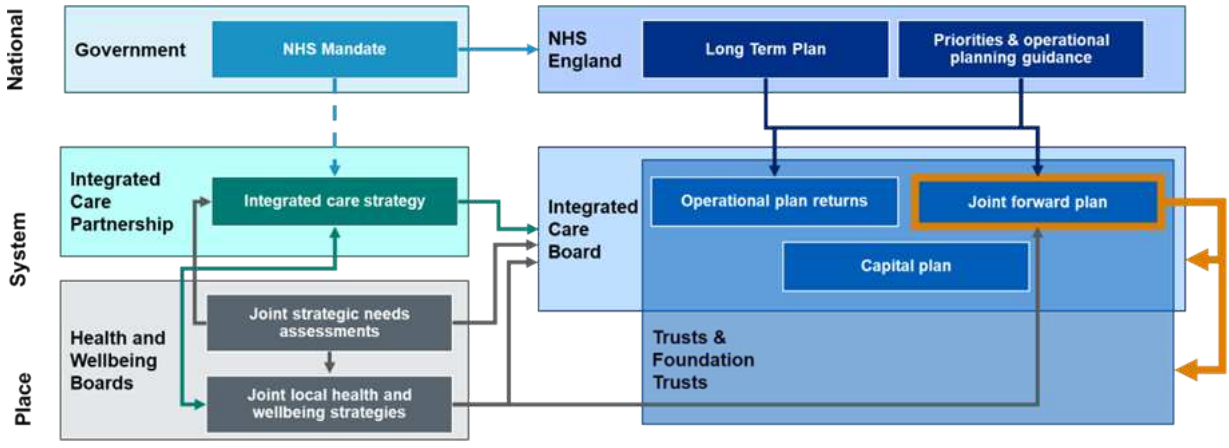
Key points:

- As a minimum, the JFP should describe how the ICB and its partner trusts intend to arrange and/or provide NHS services to meet their population's physical and mental health needs. This should include the delivery of universal NHS commitments, address ICSs' four core purposes and meet legal requirements

- JFP Principles
    - Principle 1: Fully aligned with the wider system partnership's ambitions.
    - Principle 2: Supporting subsidiarity by building on existing local strategies and plans as well as reflecting the universal NHS commitments.
    - Principle 3: Delivery focused, including specific objectives, trajectories and milestones as appropriate.

- Relationship with NHS planning - ICBs and their partner trusts will continue to separately submit specific operational and financial information as part of the nationally co-ordinated NHS planning

- Legislative framework
    - Statutory framework (not including interaction with wider system partners) relating to the JFP



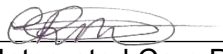
- Supporting resources and advice from NHS England are offered and early engagement is recommended

- Consultation: close engagement with partners will be essential to the development of JFPs

- Action required of integrated care boards (ICBs) and their partner trusts

Deliverable and activities set out in the guidance	How will required activities be met by STW ICS	Timeline
ICBs to prepare a first Joint Forward Plan (JFP)	Coordinated work for the JFP, led by the Strategic Director, has commenced across the ICS	before the start of the financial year 2023/23 – i.e. by 1 April
Publication and sharing of final JFP	NHS England is to specify that the date for publishing and sharing the final plan with NHS England, their integrated care partnerships (ICPs) and Health and Well-being Boards (HWBs)	Anticipated to be 30 June 2023
Consultation process on a draft JFP	The consultation process has commenced, further details are set out in the 'Joint Forward Plan Development – Engagement Approach Paper' submitted to this committee for the meeting on 19 January 2023	producing a version by 31 March finalised in time for publication and sharing by 30 June
ICBs and their partner trusts must consult with those for whom the ICB has core responsibility. A draft JFP should be shared with the relevant ICP and NHS England	Consultation has commenced and will continue in line with the 'Joint Forward Plan Development – Engagement Approach' Draft JFP will be shared as per guidance and timeline requested by NHSE; the Strategy Director will submit papers and join meetings of ICB, ICP, the Health and Wellbeing boards and relevant local authority scrutiny committees	Ongoing between January and June 2023; a detailed timetable is in development
ICBs and their partner trusts must involve relevant HWBs in preparing or revising the JFP.	Draft JFP will be shared as per guidance and timeline requested by NHSE; the Strategy Director will submit papers and join meetings of ICB, ICP, the Health and Wellbeing boards and relevant local authority scrutiny committees	As per guidelines from NHSE
ICBs and their partner trusts should agree processes for finalising and signing off the JFP. the final version must be published JFPs must be reviewed and updated;	Relevant sign off processes will be agreed through governance arrangements.	In development 30 June 2023 (tbc by NHSE) before the start of each financial year

Integrated Care Board

Agenda Item no.	**ICB 25-01-055 Appendix 3**
Meeting date:	25 January 2023
Paper title	STW Integrated Care Strategy and Joint Forward Plan Development – Engagement Approach Paper 'Shropshire, Telford and Wrekin health and wellbeing conversation'
Paper presented by:	Edna Boampong, Director of Communications and Engagement, NHS STW
Paper approved by:	Nicola Dymond, Director of Strategy and Integration, NHS STW
Paper prepared by:	Edna Boampong, Director of Communications and Engagement
Signature:	
Committee/Advisory Group paper previously presented:	Integrated Care Partnership (ICP) – 15th December 2022

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

Previous considerations:	**None identified.**

1.0 Executive summary and points for discussion

NHS guidance and aspects of the Health and Care Act 2022 are prescriptive about the process for and engagement expectations around the development of the Joint Forward Plan. In addition, health and care organisations have a duty to engage with the public about any plans, proposals or decisions that are likely to impact on services provided. This paper sets out our intention for NHS STW to fulfil this legal duty to involve and consult.

The purpose of this report is to outline a proposal for public involvement and engagement activity, 'Shropshire, Telford and Wrekin's health and wellbeing conversation', to take place from February 2023 through to May 2023 to inform the system's Joint Forward Plan development

Which of the ICB Pledges does this report align with?

Improving safety and quality	
Integrating services at place and neighbourhood level	
Tackling the problems of ill health, health inequalities and access to health care	
Delivering improvements in Mental Health and Learning Disability/Autism provision	
Economic regeneration	
Climate change	
Leadership and Governance	
Enhanced engagement and accountability	X
Creating system sustainability	

Workforce	

2.0 Recommendation(s)

The Board is asked to:

- **Note the content of the paper;**
- **Provide ideas and suggestions for additional engagement which may not be detailed in the paper;**
- **Agree the outline approach and timeline; and**
- **Provide suggestions on how best to engage and brief key partners to ensure they have the tools to support this activity and be part of the conversation.**

3.Does the report provide assurance or mitigate any of the strategic threats or significant risks in the Board Assurance Framework? If yes, please detail

N/A

4.Appendices

N/A

5. What are the implications for:

Shropshire, Telford and Wrekin's Residents and Communities	No implications
Quality and Safety	No implications
Equality, Diversity, and Inclusion	No implications
Finances and Use of Resources	No implications
Regulation and Legal Requirements	NHS guidance and aspects of the Health and Care Act 2022 are prescriptive about the process for and engagement expectations around the development of the Joint Forward Plan.
Conflicts of Interest	No implications
Data Protection	No implications
Transformation and Innovation	No implications
Environmental and Climate Change	No implications
Future Decisions and Policy Making	No implications
Citizen and Stakeholder Engagement	Health and care organisations have a duty to engage with the public about any plans, proposals or decisions that are likely to impact on services provided

Request of Paper:	The Board is asked to:	**Action approved at Board:**	

	• Note the content of the paper; • Provide ideas and suggestions for additional engagement which may not be detailed in the paper; • Agree the outline approach and timeline; and • Provide suggestions on how best to engage and brief key partners to ensure they have the tools to support this activity and be part of the conversation.		
		If unable to approve, action required:	
Signature:		**Date:**	

Table of Contents

1.0 Purpose

The purpose of this report is to outline a proposal for public engagement and involvement activity, ***'Shropshire, Telford and Wrekin health and wellbeing conversation',*** to take place from February 2023 through to May 2023 to inform and support the development of the Shropshire Telford and Wrekin ICS Integrated Care Strategy and Joint Forward Plan.

This paper provides an overview of the approach and methods that will be implemented within the above period which will deliver a robust, equitable and inclusive engagement programme. This will help further shape the interim Integrated Care Strategy, inform the development of the Joint Forward Plan and underpin any future formal consultation processes which may need to take place at a later date.

The ICS design framework sets out ten principles to use when developing their arrangements for working with people and communities. We have used these principles to develop our system-wide strategy for involving people and communities, building on our existing relationships, good practice and networks.

2.0 Context and background

The NHS Long Term Plan (2020) describes a vision for health and care service which are fit for the 21st century. This vision empowers people, their families and carers to take more control over their own health, care and treatment supported by easy access to integrated holistic care, in settings closer to where people live and organised to effectively support people with multiple conditions.

To achieve this vision will require NHS organisations to develop new models of care and plans to ensure:

- Individuals are taking greater responsibility for their own health
- We are better at preventing and managing demand
- We are designing patient-centred services and finding innovative ways of delivering outcomes for a society that lives longer and expects more
- We are maximising the value of our health and social care spend

As the Shropshire, Telford and Wrekin (STW) ICS develops there is a need to establish a clear strategic purpose and develop a plan to deliver that purpose. Doing so is one of the most important tasks of the next few months for our new Integrated Care System.

Like every Integrated Care System, over the next few months we must produce an interim Integrated Care Strategy and detailed plan that will establish how we will work together to improve health, care and wellbeing for the people of Shropshire, Telford and Wrekin.

The strategy is the 'what' and the plan is the 'how'. The two are linked and both have a five year timeframe, though to be reviewed annually, and will play a key role in shaping the future of health, care and wellbeing in Shropshire, Telford and Wrekin over the next five years.

The Integrated Care Strategy will set a bold vision for what we want to achieve through greater partnership and collaboration with the aim of delivering more joined-up, preventative, and person-centred care for our population. Developing the strategy is the responsibility of the Integrated Care Partnership (ICP). It is largely a data driven document, that must be built on the health and wellbeing strategies in place as well as Joint Strategic Needs Assessments (JSNA) data and have regard to the Health and Care Act requirements, national policy and guidance.

The Joint Forward Plan will provide the operational detail around how the strategy's vision can and will be realised. Developing the plan is the responsibility of the Integrated Care Board.

In line with our values, we will build the Forward plan through a process of genuine co-production with our local communities, stakeholders and our staff. The Health and Care Act 2022 and NHS E guidance set clear expectations around engagement and involvement with key stakeholders to inform the development of the plan.

We do not start from scratch; there has been significant engagement in the past which we want to acknowledge and build on. The establishment of the ICS is an opportunity to deepen and strengthen our historical approach.

We have previously engaged with our residents, patients, health and care staff, our local system partners and the voluntary, community and social enterprise (VCSE) sector and used this insight to develop ten pledges. These pledges will be the golden thread through all the work we deliver. Through pledge number eight, *Enhanced engagement and accountability*, we have committed to increase our engagement, involvement and communication with stakeholders, politicians and the public.

We aim to develop a strategy and plan for our system, built by the people in our system – both working in partnership with the organisations that provide the services that keep us healthy, happy and well, and with people living in Shropshire, Telford and Wrekin who access these services.

3.0 Objectives

The overarching strategic objectives of the engagement activity are to work collaboratively with all partners across the STW system to support and inform the further development of the Integrated Care Strategy and the Joint Forward Plan for the system, to ensure they reflect the needs and views of our people, and to:

1. Raise awareness around health and wellbeing with a particular focus on being well and keeping well;
2. Discuss with the public, stakeholders and staff their ambition for health and care services locally;
3. Encourage STW citizens to consider what part they can play to manage their own health and care – promoting self-care and resilience;
4. Create a movement in which citizens in Shropshire, Telford and Wrekin are motivated to become involved with deciding what future services will look like;
5. Provide early opportunities for active, open, dialogue to allow residents, service users, carers and wider stakeholders to input to and be involved in ICS strategic purpose and the design and delivery of health and care services;
6. Increase understanding of the 'case for change' and enable people to be part of that change;
7. Test terminology and plans to ensure the language we use is understandable and will resonate with the public; and
8. Engage with groups protected by equality legislation to ensure their views are heard and that issues of equality are considered.

4.0 Proposed approach

Comprehensive and meaningful engagement will ensure our services are more responsive to people's physical, emotional, social and cultural needs. We will take active steps to strengthen public, patient and carers' voice at place and system levels. In particular, we will focus on groups who are seldom heard and have the greatest health inequalities to ensure they are not excluded from the dialogue.

We recognise that to reduce inequalities we will need to draw on the knowledge of the local authorities, VCSE and other partners with experience and expertise in this regard. The VCSE sector is an important partner in our system and plays a key role in improving health, wellbeing and care outcomes due to their reach and connection with communities. We will also work closely with Healthwatch, as a health and social care champion, to hear people's voices, to find out what matters to them and ensure their views help shape our plans

Our engagement will be done, loosely, in two stages. The first stage is focused on validating our interim Integrated Care Strategy and agreeing our strategic intention. The second phase of our engagement work will be focused more on delivery to help shape and inform the development of our Joint Forward Plan.

4.1 Stage one – Agreeing Our Strategic Intention (January 2023)

The interim Integrated Care Strategy will articulate the strategic purpose and priorities for the ICS, what we are trying to achieve and the overarching strategy to deliver that purpose. The interim Integrated Care Strategy will build on the existing strategies and data from the health and wellbeing strategies and JSNAs.

Once the interim Integrated Care Strategy has been developed, the engagement in this stage will focus on decision makers and internal partners, primary and secondary care clinicians across the ICS. With our partners, we will aim to agree our strategic direction for the next five years, our commissioning intentions, our strategic objectives, how we will get there, what we will spend and how we will monitor and measure that we are realising our vision.

Inevitably, these conversations will involve some difficult choices on what we prioritise within our financial envelope, what we do first and what we defer. Choices about what we should do more of and what we should stop doing. And most importantly, how can we do better.

The output of this engagement will support with the further development of the interim Integrated Care Strategy, built around a succinct statement of the strategic intention for the ICS. It will enable us to establish an overarching framework, setting out the key elements and themes that we will develop further over the coming months to inform our Joint Forward Plan and transformation programmes.

4.2 Stage two – Development of Joint Forward Plan (February – June 2023)

The second phase of our engagement work will be focused more on delivery to help shape the development of our Joint Forward Plan.

We want to hear people's views as part of an ongoing process that will help to inform the plan including ideas for the way services in STW should be configured and provided in the future.

In stage two we will conduct a *Shropshire, Telford and Wrekin health and wellbeing conversation* programme of engagement with our communities, staff and partners in conversations about the details of our plans.

In these conversations we will share the initial Integrated Care Strategy for context to frame the conversations and an outline of the Joint Forward Plan. We will ensure that the conversations are realistic by setting out the real-world constraints we are working within. We will ask (indicative questions):

- Is it clear what our strategy / plans are trying to achieve?
  - Have we focused on the right things?
  - Do you agree these are the things that would support and enable you and your family to live healthier and happier lives over the next five years?
  - If not, how can they be improved? What does good look like?
- What matters the most to you, your families and your communities?
  - What do you need to keep you healthy and happy?
- What are the things that would make the biggest difference to improve experience of local health and care services?
- Are you willing to travel further for '*better*' specialist care?
- Would a better digital infrastructure support you to access health and care services more easily and keep you well?
  - What is the right balance between digital and face-to-face consultations / appointments?

The output of these conversations we will be fed into the Joint Forward Plan, setting out how we intend to deliver our strategic priorities set out in the Integrated Care Strategy over the next five years.

5.0 Methods

It is essential the engagement activity is accessible and as visible as possible, using all established methods of communication and engagement such as printed materials in a range of formats, online and face-to-face contact through a variety of meetings and events, as well as embarking on new channels of digital engagement. Partnerships will be formed with VCSE organisations, Healthwatch and local media organisations to maximise reach and raise awareness about the activity. Activity will be tailored to ensure it is appropriate for the local population and specific protected characteristics and audiences.

The aim is to achieve 25,000 meaningful interactions with as much of the adult population in STW. Our population in STW is approximately 500,000; a target of 25,000 interactions will mean that we have interacted with approximately 5% of our population (recognising there will be some element of double counting with analysing responses).

The primary objective is face-to-face interactions with citizens (virtually or in person) - talking to them about what matters to them and their loved ones and asking them what they can do to make a difference to their health and wellbeing, with the aim of gently trying to change expectations.

New technology and social media will be used to communicate and engage with citizens, therefore a portion of the 25,000 interactions will be secondary interactions e.g. people visiting the STW website, sharing online content, taking and reading literature about the campaign etc.

The STW ICS Comms and Engagement Team will work closely and collaboratively with all partner comms teams to ensure this activity aligns and complements other engagement activity taking place in the system.

5.1 Big conversation survey

An online survey will be developed to support the 'Conversation', enabling us to capture qualitative and quantitative data and will be available at engagement activity on iPads. We will seek to get as many people

as possible to complete a survey as well as capture important demographic data and data for future engagement and follow up.

5.2 STW citizen pledges

A large part of the 'conversation' will be emphasising the need for people to take more personal responsibility for their own health and wellbeing and promoting community resilience.

Citizens will be given information about pressures that exist in the system and the small things they can do to improve things e.g. the impact of attending A&E for a non-emergency, benefits of accessing their local pharmacy versus a GP.

We will use this opportunity to socialise the STW pledges. The public will also be asked to suggest some pledges, things they can do to improve their own wellbeing or changes to the way they currently use health and care services which could help address some of the challenges faced in the system.

5.3 Community outreach - road shows

A number of roadshows will be held throughout STW to provide an opportunity for the public to find out more about our plans and to have their say.

In order to encourage citizens to complete surveys, provide feedback, pledges and contact details for further engagement and follow up, they will be incentivised with the opportunity to win a prize that will support healthy lifestyles.

A community engagement team will conduct on-street / opportunistic engagement at prime locations in communities (e.g. Supermarkets, GP practices and outpatient clinics). Street teams will focus on areas of high deprivation and target groups of people who would not normally contribute to engagement activity.

5.4 Stakeholder engagement

A series of stakeholder engagement sessions will take place throughout the period, including primary care, hospital clinicians, councillors, MPs, VCSE colleagues and Healthwatch to ensure they have an opportunity to be part of the 'conversation' and the design process and are sighted early on our priorities and proposals.

Stakeholders will be provided with opportunities to:

- Input and share ideas about how they / their organisations can contribute to local delivery
- Describe what they would like to see in the health and care system over the next five years – *what will things look like in five years time?*
- Identify ways we can transform / plan / commission services differently to increase access and reduce inequalities.

5.5 Establishing a citizen panel/people network

We will recruit a system-wide citizen panel; a community or network of local residents enabling us to gather public views and opinions on a wide variety of topics, allowing members of the public to get involved in shaping the future of local health and care services. The panel will form a large, representative group of local residents who are able and willing to offer their opinion and be consulted on a wide range of local issues.

Done right, they enable:

- Transparent Demographic Profiling
- Responsive and innovative feedback mechanisms

- An inclusive and broad respondent base, beyond the reach of some of our conventional methodologies

5.6 Engagement with community groups

We will attend a number of existing community groups and meetings to engage with protected characteristics and equality groups. The format of the engagement activity will depend on the demographics and needs of the group. The aim of this engagement will be to gain insight into the experiences of marginalised groups to support improving access and reducing inequality.

5.7 Deliberative events/ citizen jury

Deliberative events will provide good evidence that the ICS has heard and considered alternative arguments to any proposals, allowing a more detailed discussion with the public and stakeholders. Participants will be recruited from a range of socio-economic groups across STW (mainly people from lower socio-economic groups) to take part in a citizen jury.

Members of the public will hear evidence from a range of clinicians, residents and health professionals around the Case for Change, along with planned proposals. Through independent facilitation participants will be able to deliberate the evidence and provide recommendations around the proposals. This evidence will then be presented to clinicians and representatives from the ICS and form part of the qualitative evaluation.

5.8 PR and media engagement

A proactive PR campaign will be launched as the engagement activity goes live, a content / editorial plan will be developed to showcase good news stories, case studies and updates about the 'conversation' and raise the profile of STW ICS. A well-executed PR campaign will enable us to reach a large audience without the expensive cost of traditional advertising and marketing and increase viability of the ICS and the engagement exercise.

5.9 Digital activity

In order to ensure maximum reach the digital campaign will be varied and wide ranging. The digital campaign will consist of a mixture of interactive website content, social media sharing and interaction, consistent and frequent e-newsletters to staff in all partner organisations, using their existing channels. Photo and video content generated during the outreach activity will also be shared on social media.

The Communications and Engagement Team will work with partner organisations to maximise the reach and impact of the social media engagement, by utilising the considerable collective reach of all partners.

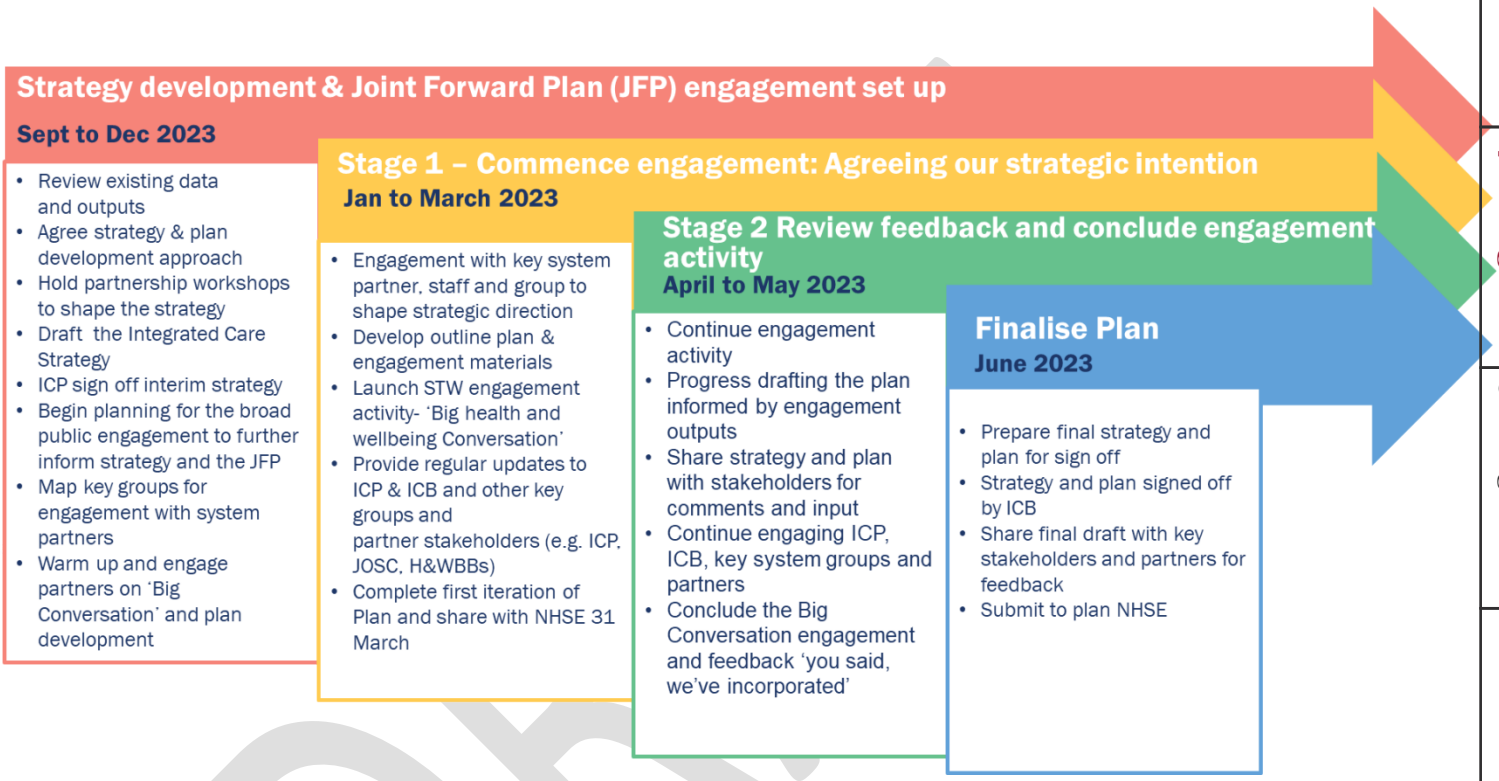
6.0 Benefits

The intention is our long-term strategy and plan for the system will be a live document so there will be a commitment to have ongoing dialogue. Some elements of our plans may require full public consultation but more importantly, plans will continue to evolve. We will develop processes for ongoing and continuous engagement to refine our strategies and plans over the coming years.

This proposal, in part, is to demonstrate our commitment to pledge eight 'Enhanced engagement and accountability', however it is also a mechanism for facilitating the other pledges. The benefits of this approach include:

- Establishing and maintain a relationship with the population based on collaboration, transparency and trust;
- The creation of an accountability mechanism, i.e. a document / product / report that refers back to 'what you told us' … 'so we did' (or if we didn't then it was for the following reasons);
- Preparation of the ground for difficult commissioning decisions; and
- A proactive way of setting out objective facts rather than responding to subjective preferences.

7.0 Indicative timeline



Agenda Item

ICB 25-01-056

Progress with Big Ticket Item

HTP Update

The Shrewsbury and Telford Hospital NHS Trust

Hospitals Transformation Programme

Update for Integrated Care Board

25th January 2023

Partnering
Ambitious
Caring
Trusted

Content

- ICS Context
- Key drivers
- Programme Governance
- Progress
- Next steps

HTP is a key part of wider ICS ambitions

Integrated Care System
Shropshire, Telford and Wrekin

NHS
The Shrewsbury and Telford Hospital NHS Trust

- The Hospitals Transformation Programme is one part of our overarching aim to improve health and wellbeing across Shropshire, Telford and Wrekin.

- Alongside transforming our acute hospital services, we are working with partners across the integrated health and care system to improve access to GP services and deliver better services in the community.

- Our wider plans involve all of our health and care system partners working together:
  - in a more joined-up way,
  - using our resources in the very best way for our communities
  - ensuring health and care services meet the needs of our population, now and in the future.

This winter again shows that long-term we need this new way of working, delivering two thriving hospitals and maximising the resources available.

The bigger picture for our patients and communities

Integrated Care System
Shropshire, Telford and Wrekin

NHS
The Shrewsbury and Telford Hospital NHS Trust

We want all residents in Shropshire, Telford & Wrekin and mid Wales to live healthier, longer lives. We are committed to tackling health inequalities and helping people to stay independent and well

To realise our ambition, we have established two principal programmes that will drive the transformation of health and care services for our communities

The Local Care Programme (transforming services in our local communities)

- Establishing a range of community-based services, closer to home (and in home), whilst also placing greater emphasis on prevention and self-care, helping our population to live healthy and independent lives in their normal place of residence for as long as possible
- This programme will also focus on improving integration across our partner organisations including GPs, community services, community mental health services, adult social care, care homes, home care services and voluntary organisations

The Hospitals Transformation Programme (transforming services across our acute hospital sites)

- Putting in place the core components of the acute service reconfiguration agreed as part of the Future Fit consultation, helping us to address our most pressing clinical challenges, and establish solid and sustainable foundations upon which to make further improvements.
- Key benefits include: Enhanced emergency care services, Dedicated planned care services that support the needs of our population, a much better environment for patients, families and staff, and Improved integration of services for local people.

Improving care for everyone

Integrated Care System
Shropshire, Telford and Wrekin

NHS
The Shrewsbury and Telford Hospital
NHS Trust

HTP will enable us to make a step change in improving the quality of services we provide for patients and our day-to-day experience as a team

A new model of care addressing our most pressing challenges, including duplicated & fragmented services and ageing infrastructure

Creating a far better and more collaborative working environment through better clinical adjacencies and simpler patient pathways

More joined-up services allowing us to work seamlessly with our health and social care partners as one integrated system

HOSPITALS TRANSFORMATION PROGRAMME

HIGHER QUALITY, SAFER CARE

IMPROVED OUTCOMES

BETTER ACCESS

A GREAT PLACE TO WORK

Two thriving hospital sites

Integrated Care System
Shropshire, Telford and Wrekin

NHS
The Shrewsbury and Telford Hospital NHS Trust

Excellent care, in the right place, at the right time, from the right people

Dedicated Emergency Department with immediate access to medical and surgical specialities

- Timely access to the right specialist consultants
- Eliminate 12-hour breaches and reduced ambulance waiting times
- Shorter hospital stays

Ring-fenced planned care capacity supporting the needs of our population

- Fewer procedures cancelled
- Improved cancer waiting times
- Resilient to peaks in emergency demand

Improved environment for patients, families and staff

- Modern, well-designed facilities
- A better experience of care
- Positive impact on staff experience

Integrated services for local people

- Simpler and more effective patient pathways
- Working seamlessly with our health and social care partners
- Alleviating the burden on Primary Care caused by planned care delays

HOSPITALS TRANSFORMATION PROGRAMME

HIGHER QUALITY, SAFER CARE | IMPROVED OUTCOMES | BETTER ACCESS | A GREAT PLACE TO WORK

Better experience for all residents

Integrated Care System
Shropshire, Telford and Wrekin

NHS
The Shrewsbury and Telford Hospital NHS Trust

Better outcomes for their emergency care

- Earlier access to specialist consultants
- Improved access to multidisciplinary teams
- Medical and surgical specialities immediately available to the emergency department

Better outcomes for their planned care

- Improved access to planned care with fewer cancellations and delays
- Enhanced access to rehabilitation
- Improved surgical outcomes and fewer complications

Safer, cleaner, brighter facilities

- More access to daylight in new facilities, supporting recovery and wellbeing
- Facilities that are easier to maintain and clean
- A more collaborative professional and teaching environment

More effective and efficient services on both sites

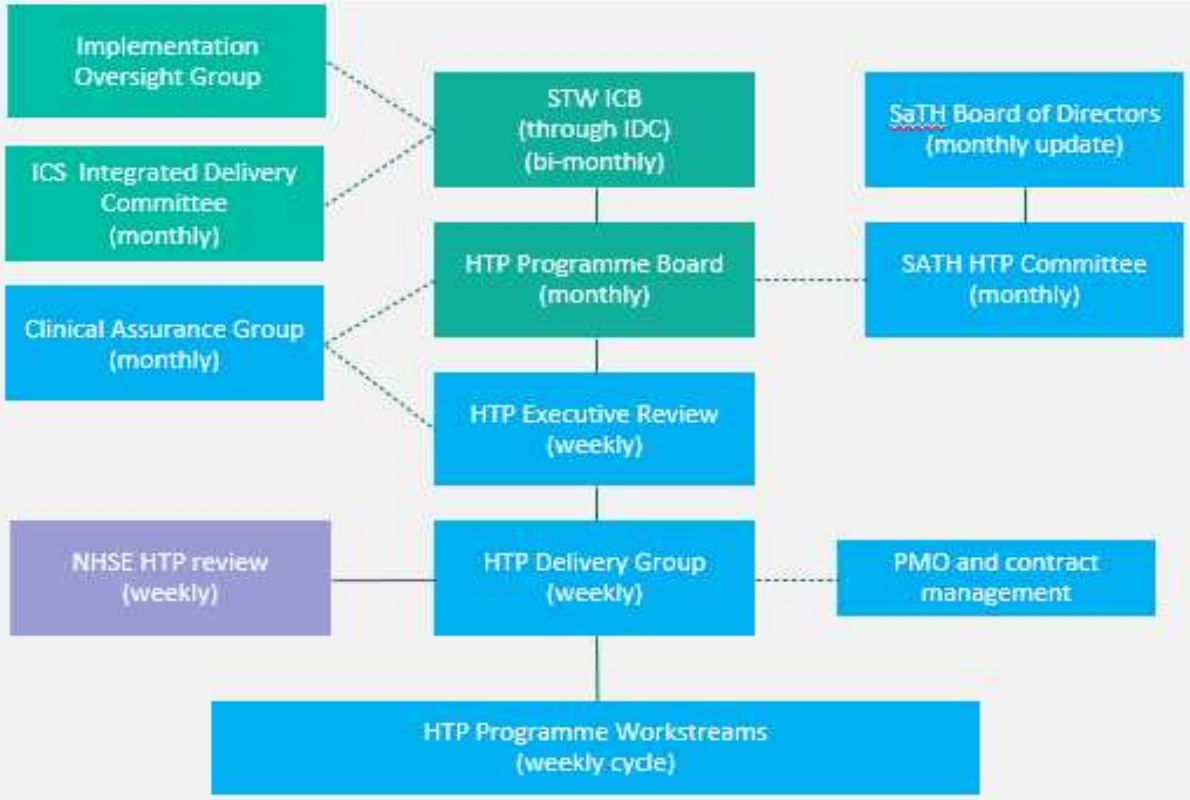
- Separation of patient flows for emergency and planned care – leading to better outcomes and improved resilience
- Integrated service approach, end to end patient management
- Reduction in overall clinical risk to patients

Making the most of both sites

Integrated Care System
Shropshire, Telford and Wrekin

NHS
The Shrewsbury and Telford Hospital NHS Trust

Rigorous governance framework



Notes:

- ICS commissioned programme
- SATH is lead provider and hosts the HTP Programme Team
- ICS and other system partners are represented across the governance framework
- HTP Committee comprises Non-Executive and Executive members of SATH
- HTP Programme Board comprises executive members from ICS, Shropcomm, RJAH, MPFT and Powys THB
- Alignment of HTP with Local Care Programme is achieved at HTP Delivery Group, HTP and LCP Programme Boards and at the ICS Integrated Delivery Committee
- Clinical leadership at the forefront of design

Independent assurance is provided through key assurance committees and groups

SATH/HTP governance arrangements

ICS/System-wide governance arrangements

Progress and next steps

The Shrewsbury and Telford Hospital NHS Trust

Integrated Care System
Shropshire, Telford and Wrekin

Progress so far

Integrated Care System
Shropshire, Telford and Wrekin

NHS
The Shrewsbury and Telford Hospital NHS Trust

- End August 2022 – DHSC/NHSE Joint Investment Committee confirmed approval of the **Strategic Outline Case (SOC)**
- September 2022: work started to develop the **Outline Business Case (OBC)** – more detailed work in all sections. A significant task, to develop detailed plans/designs (targeting approval in **Summer 2023**)
- When OBC has been approved, progress to the third / final approval stage – **Full Business Case (FBC)** (targeting approval in **Autumn 2023**)
- Following approval, we will begin to implement the changes to the Princess Royal Hospital and the Royal Shrewsbury Hospital sites that will deliver the new clinical model of care. We need to use allocated capital resources in the best possible way, especially with rising inflation, to deliver the highest value for our residents and our patients.
- Clinical leadership and expertise is at the heart of the design of the pathways, model of care and estate developments. There will also be continued engagement with staff and communities throughout each stage.

Targeted timeline

Integrated Care System
Shropshire, Telford and Wrekin

NHS
The Shrewsbury and Telford Hospital NHS Trust

Strategic Outline Case approved by the Department for Health and Social Care

Create our **Outline Business Case** - greater detail including clinical model and architect designs:

- Detailed pathway design
- Detailed architectural designs
- Procurement and commercial approaches described
- Planning permission sought

Create **Full Business Case** including:

- Treasury approval
- Procurement routes established
- Contracts can be signed
- Transition into delivery

Implement HTP and our agreed clinical model

Continued involvement

Integrated Care System
Shropshire, Telford and Wrekin

NHS
The Shrewsbury and Telford Hospital NHS Trust

We will work to ensure all our stakeholders are informed and involved in the development of our detailed plans.

- **Internally in SATH (clinical and non-clinical teams):** Ongoing workshops, briefings, roadshows and physical presence across our hospitals

- **Our system colleagues across Shropshire, Telford & Wrekin and partner organisations (GPs, ambulances, community care, Powys):** Attending briefings, providing updates, joining existing and planned engagement forums

- **Patients, public and the community (including seldom heard groups):** We will utilise existing mechanisms wherever possible, including existing patient, carer and public forums across Shropshire, Telford & Wrekin, as well as developing bespoke focus groups directly linked to each of our workstreams

Summary of Key Points

Integrated Care System
Shropshire, Telford and Wrekin

NHS
The Shrewsbury and Telford Hospital NHS Trust

1. **This investment will improve care for everyone**
   - Planned care services will be available throughout the year leading to fewer cancellations and delays for operations
   - Improved emergency care services will be delivered from a new, purpose-built Emergency Department, meaning that patients will be seen more quickly, with shorter stays and faster ambulance handover times
   - Enhanced 24/7 urgent care services will be available on both sites and be delivered through a new A&E Local Model in Telford staffed by a team of health, care and community specialists
2. **Our plans will deliver two thriving hospital sites**
   - We will continue to invest heavily in both of our sites e.g. new £24m planned care hub in Telford will upgrade facilities for local population, fully aligned with the HTP
3. **We cannot continue as we are**
   - Our patients regularly experience delays in accessing the right specialist teams (as a result of configuration)
   - It is vital that our facilities support modern healthcare practices (e.g. inadequate size and configuration of our EDs)
   - Currently face significant ambulance handover delays and patient delays (emergency, urgent and planned care)
   - These changes are a critical part of our integrated health and care system response
4. **We must put the available funding to good use**
   - We are facing a challenging national fiscal situation
   - A significant amount of funding has been allocated to improve our services – we must put it to good use

Thank you

The Shrewsbury and Telford Hospital NHS Trust

Integrated Care System
Shropshire, Telford and Wrekin

Agenda Item

ICB 25-01-057

ICS Performance Report

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Integrated Performance Report

Appendix A - Data Pack

25th January 2023

Content

UEC Core Metrics

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

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

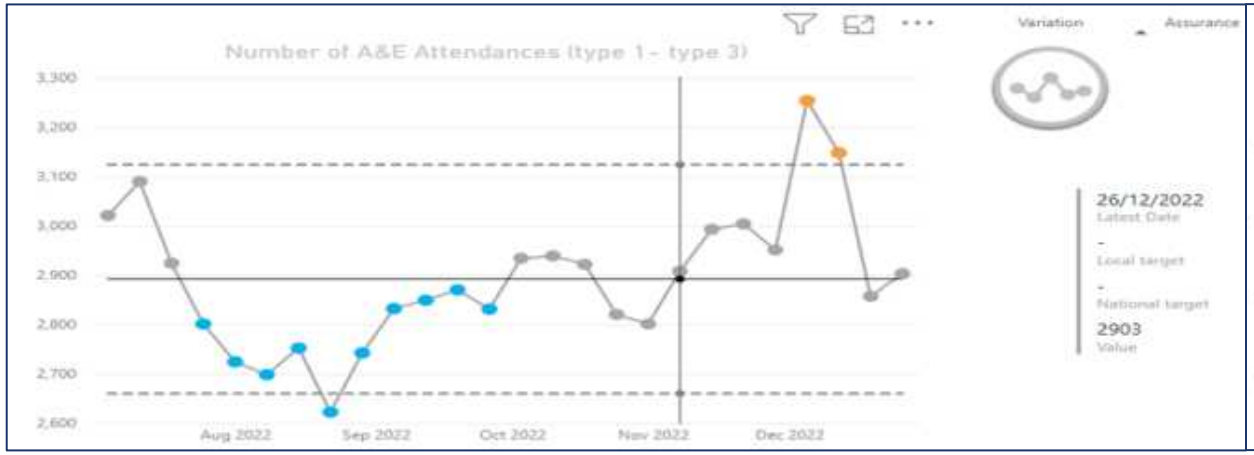
The 2 RED highlighted metrics are not currently captured. Clinically Ready to Proceed will be captured once the new Patient Administration System (PAS) is implemented at SaTH (plan July 23)

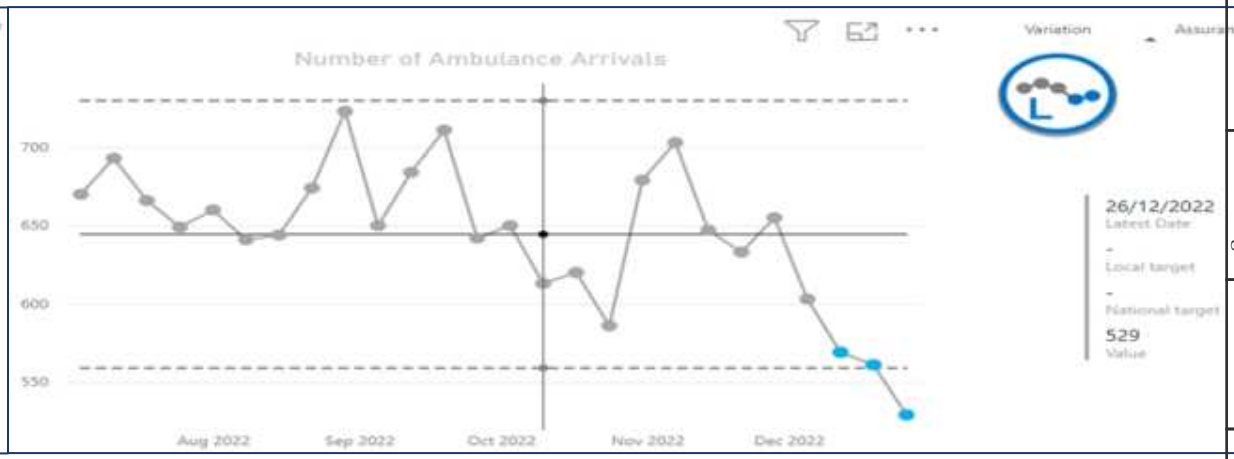
Critical Time Standards criteria has not yet been set nationally

Urgent and Emergency care data

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

Setting the scene: Demand data



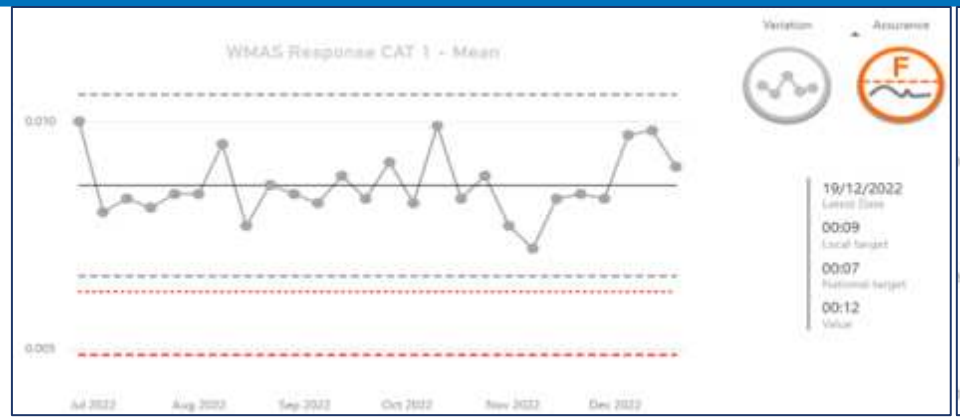


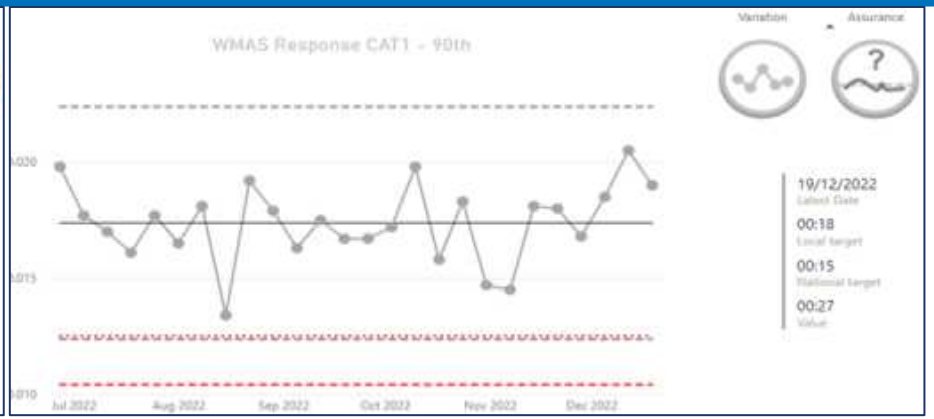
Number of A&E attendances peaked in early December with the increase in Strep A type infections, Covid and Flu.

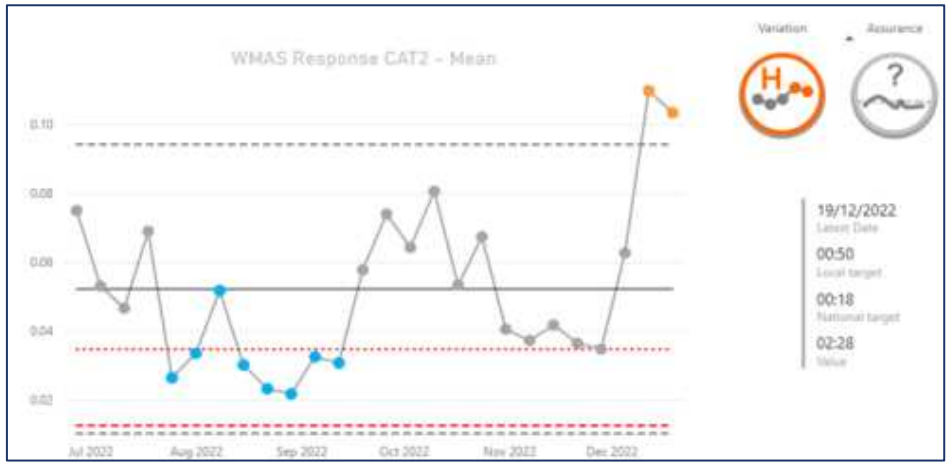
Total SaTH attendances (2022/23) are reporting a YTD increase of just 0.4% (compared to 2021/22), with unheralded attendances reporting a YTD variance of 11% increase compared to 21/22. However, the pressure felt during December reports a increase of 37% in unheralded attendances compared to Dec 21/22

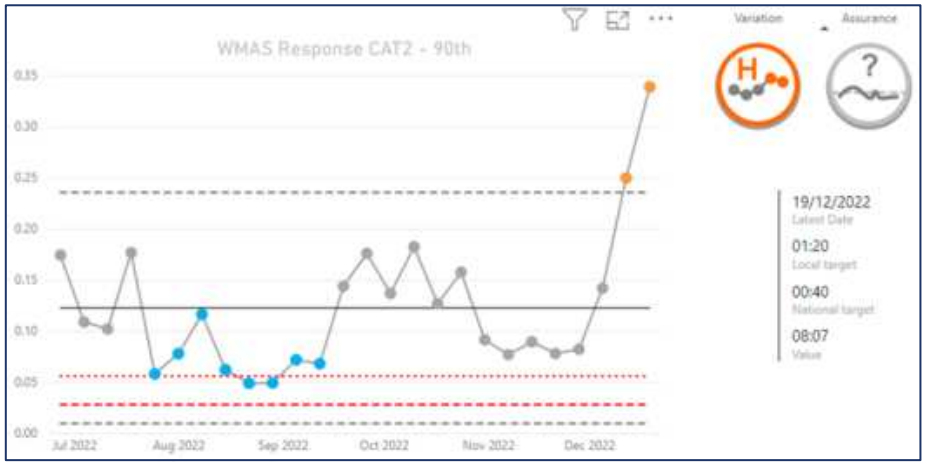
Ambulance arrivals continued to reduce through December. Industrial action on 21/12 also impacted on number of ambulances attending site.
December 22 reported -19% (-581) ambulance arrivals compared to Dec 21

UEC Dashboard Latest – Core Metrics cont. Ambulance response times









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

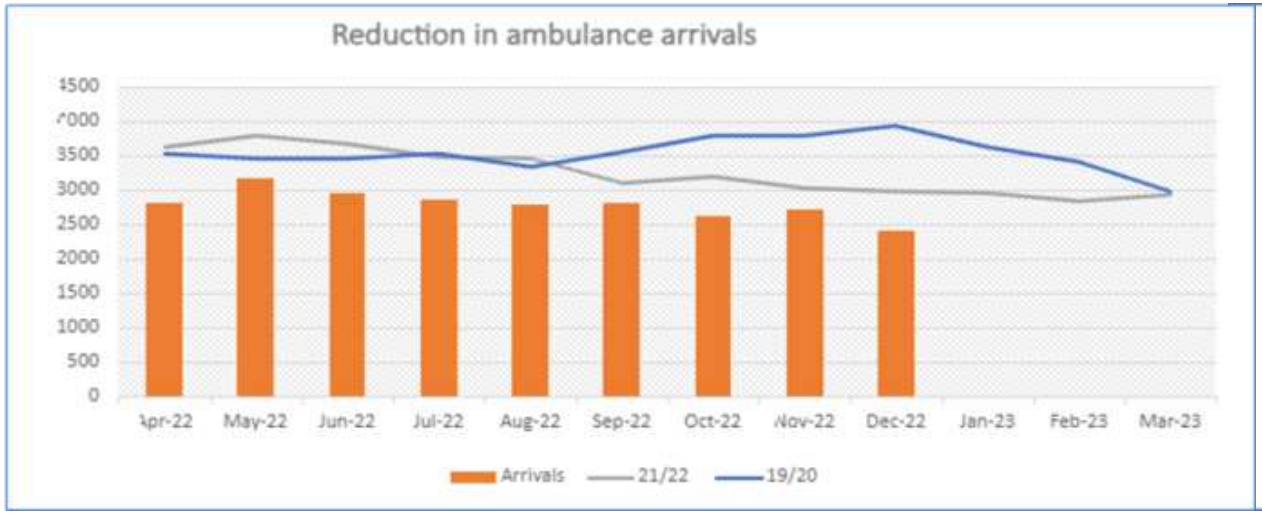
Cat 1 response time shows an increase during the later part of December. Variation is similar to figures reported across the region.

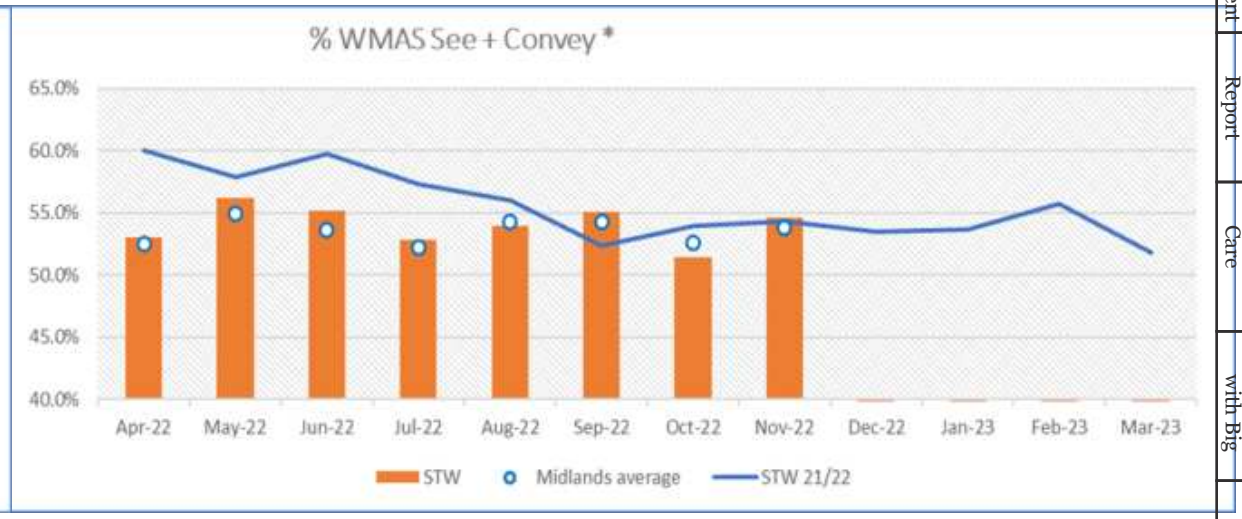
We must recognise that the geographic make up of Shropshire will lead to slightly increased average response times where incidents are in a rural location

Cat 2 times have declined significantly with the latest week (w.c. 19th Dec) reporting 2hr 28, impacted by the handover delays caused at providers.

UEC Dashboard Narrative:
During the last few months the service has been under immense challenge with levels of extreme demand; the call stack at times has exceeded 500 calls. In order to maintain patient safety some calls that may have been waiting a lot longer than usual were increased to a higher category call depending on the length of time in the call stack which may explain the spike in Cat 1 and 2 calls seen in June. STW along with Shropdoc and Shropcom partners now have twice daily stack review calls of Cat 3 and 4 with WMAS. Shropdoc are leading on this on behalf of the system. Data reporting is available but needs triangulating with other UEC data – being progressed by the BI team. Initial analysis shows that the Stack Review calls are having a positive impact in identifying alternative pathways other than ED. Calls are taking place 7 days a week.

UEC Dashboard Latest –WMAS



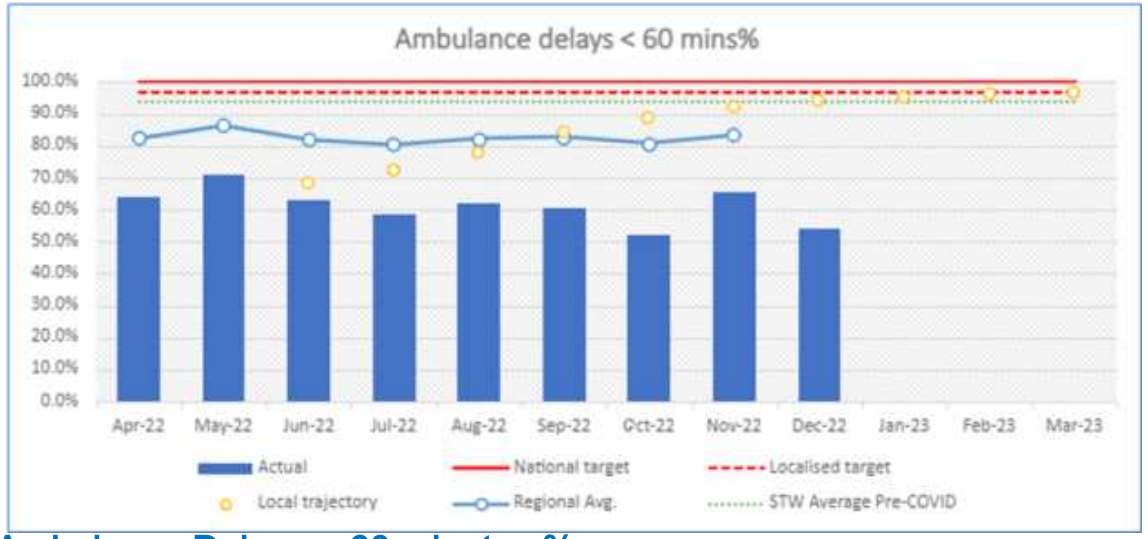


Ambulance arrivals at SaTH reported a decrease in December: YTD compared with 21/22 reports -17.1% (-5183 ambulances).
The strike period did report a reduction in Cat 2 arrivals in December.

No national target is set for conveyances as each case is based on clinical need.
Latest known data (November 22) suggest a small increase locally and regionally. Figures reported for STW are in line with region.
Early suggestion of a reduction in conveyance rate for December – again impacted by the industrial action where 35% conveyance was reported.

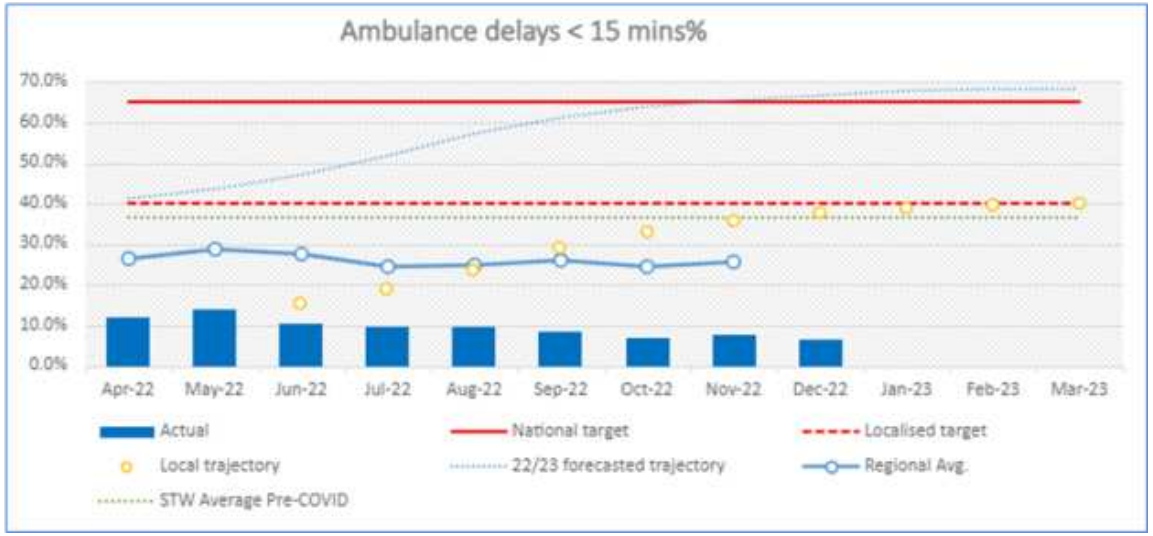
UEC Dashboard Latest – Core Metrics

Ambulance Handover delays



Ambulance Delays < 60 minutes %

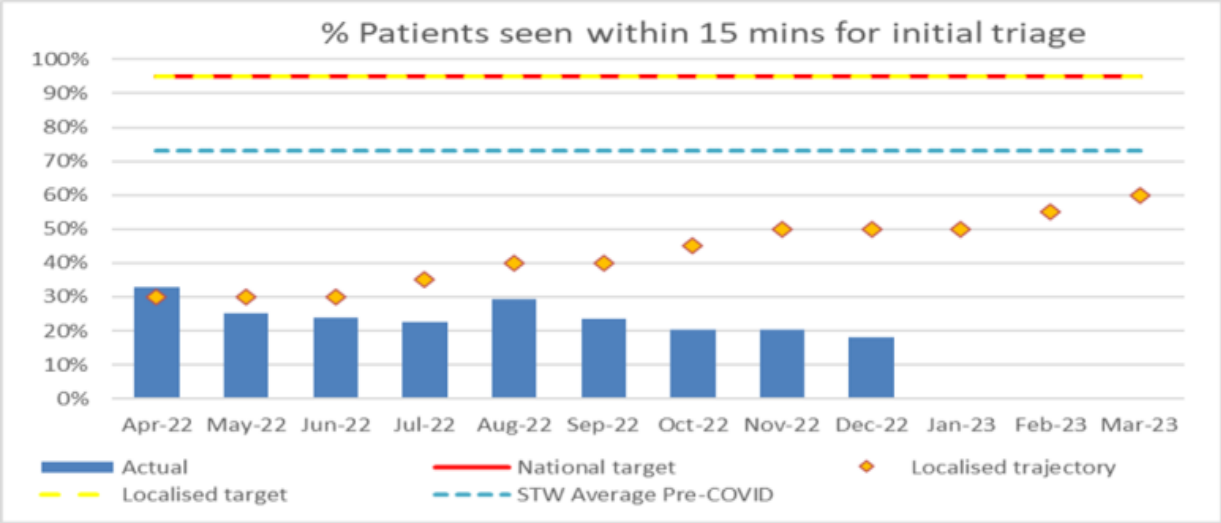
December handovers at PRH and RSH are reporting a reduced performance of 54.0% (decreased from 65.4% in November).
STW reports a -42% variance to the improvement trajectory, despite the drop in ambulance arrivals.
The latest figure for the region is 83.5%. STW therefore reporting a variance of -21% to the regional average. Pre-Covid, STW reported an average of 94%. Work to address this is currently underway with the development of RSH ED, the acute floor redevelopment and the Next Patient model.



Ambulance Delays < 15 minutes %

December 15-minute handovers at PRH and RSH reduced to 6.5%. Down from 7.4% in November. STW therefore reporting a variance of -79% to trajectory.
Pre-Covid STW reported an average of 37%
Regional average during November reported 25.7%

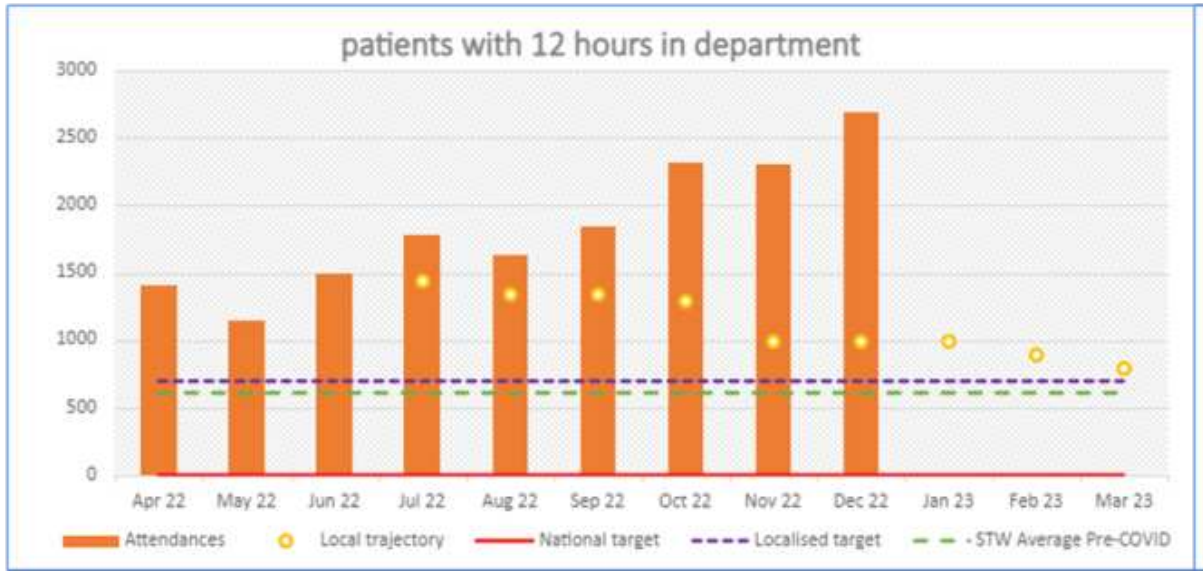
UEC Dashboard Latest – 15 min initial assessment

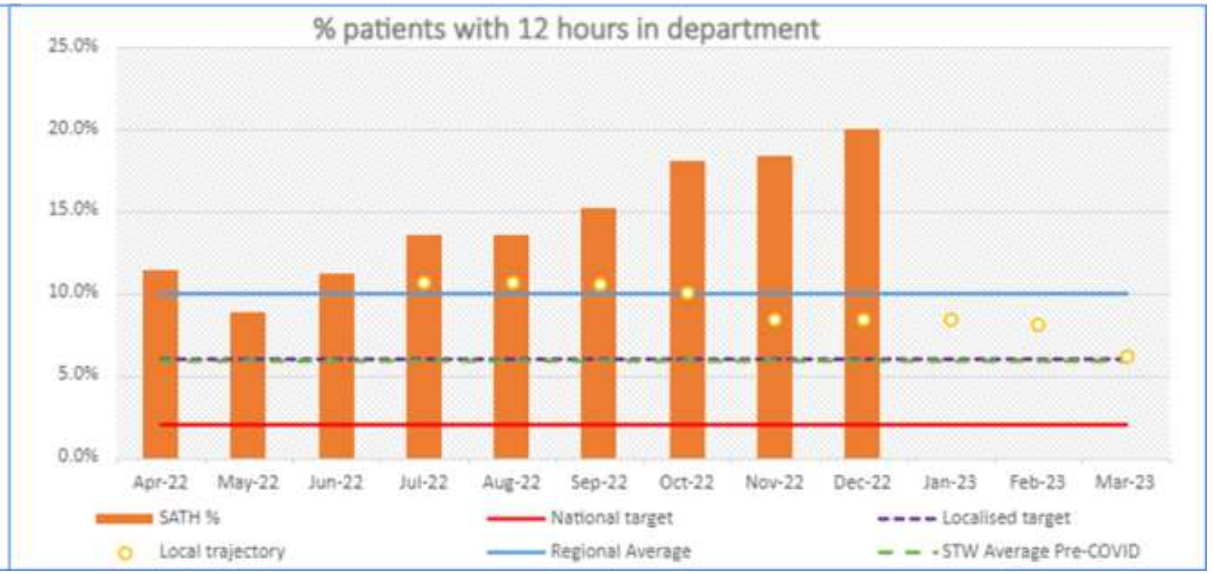


Performance reduced in December achieving 18%, down from 20% in November.
Regional average is reported at 50%
STW is 61% away from the regional average
SaTH reported an average of 73% pre-covid.

Week commencing 26/12/2022, 18.2% of people were seen within 15 minutes for initial assessment.
Performance continues to be very low for this metric.
Continued pressure for space in ED, requirement to isolate patients due to Flu and Covid and staff shortages due to sickness, are all contributing to this position.

UEC Dashboard Latest – 12 hour patient

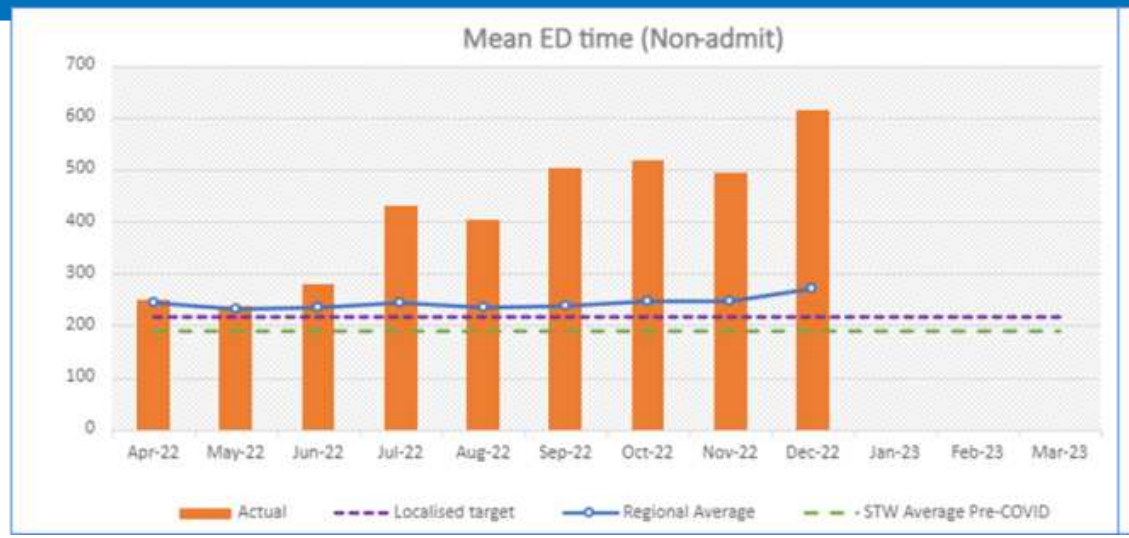


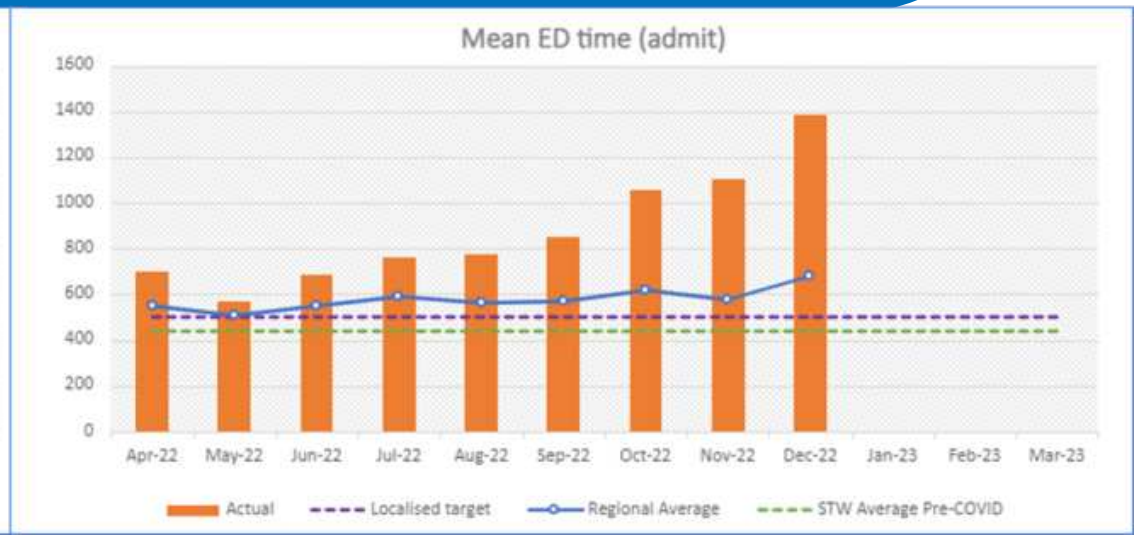


December reported 20% of total attendances incurring 12+ hours in ED. Trajectory was set for 8.4% during December.
This reported a total of 2691 cases incurring 12 hours + in department.

The immediate regional systems report an average of 10%.
With the department developments of the Acute floor and redesign due to progress from September to November, the trajectory is to achieve pre-Covid performance of 8.5% as a result of the changes, moving towards the pre-Covid performance of 5.9% after winter.

UEC Dashboard Latest – Core Metrics cont.
Mean time in ED





Non-Admitted

The STW average pre-Covid reports 190 minutes, with the regional average of 225 minutes. During December, STW reported average of 615mins for Non-admitted attendances. Mean Time in ED for non-admitted patients had a further increase at the beginning of December and has stayed at this new level throughout December. Capacity to see patients in ED due to the number of people waiting for beds has limited the space to see non-admitted patients. Significant shortfall in staffing within the ENP workforce and in the UTC provider continues which is increasing time to assessment and treatment.

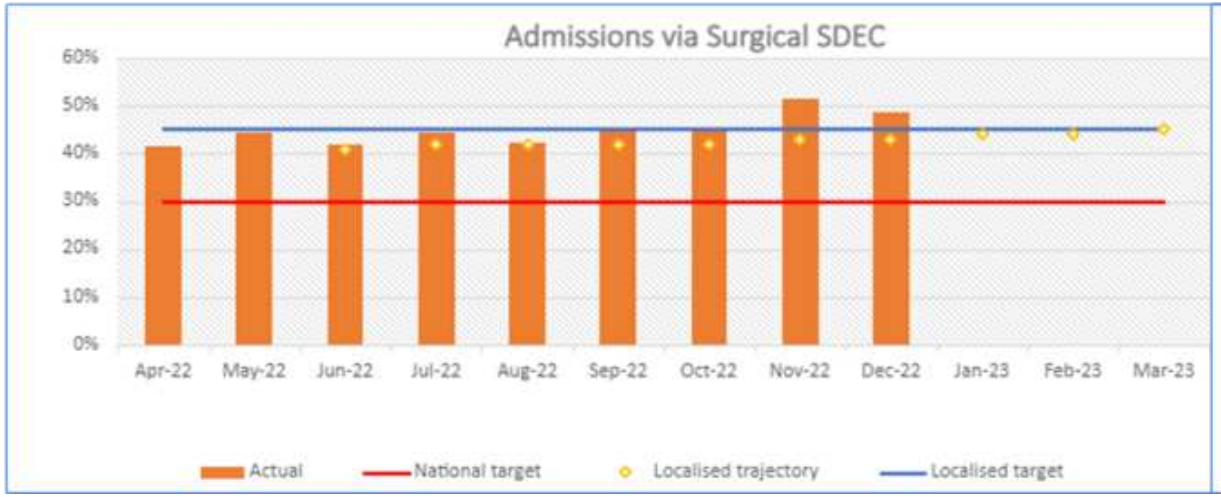
Admitted

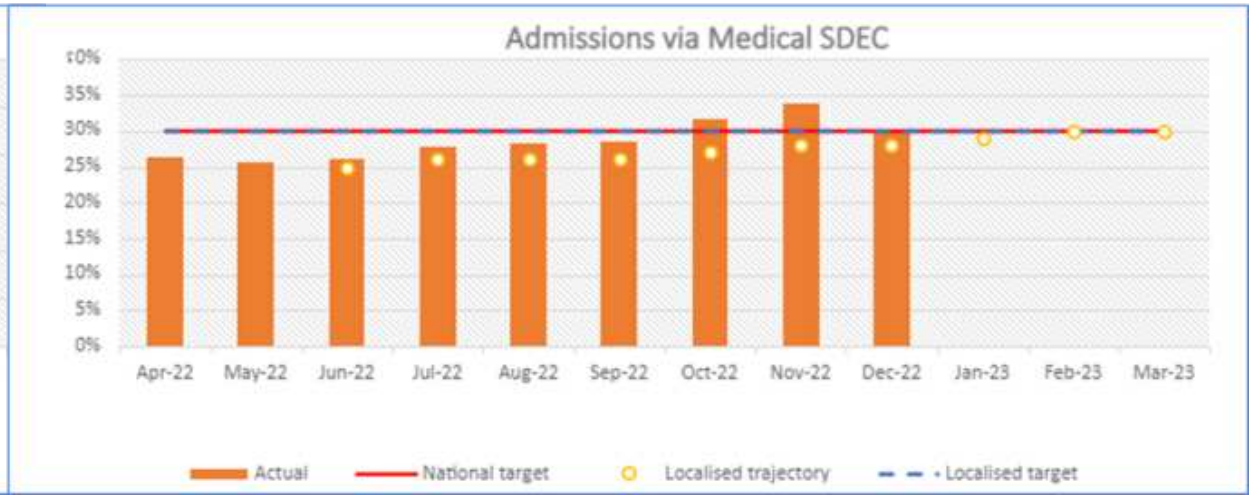
The mean has increased further during December to 1384 mins. During 22/23 STW has reported an average of 698 mins. The localised target is set at 500 mins, with regional average reporting 495. STW during December were 147% higher than localised target.

Mean times in ED for admitted patients have risen again through December, despite the ongoing work around Next Patient model. The acute floor opened mid-December, and we are working through processes to pull patients referred to acute medicine into the AMA for clerking - this should improve the position through the latter end of January as processes become established. The ongoing bed gap and increased number of MFFD patients is contributing to limited flow and waits for beds in ED.

UEC Dashboard – additional supporting metrics

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

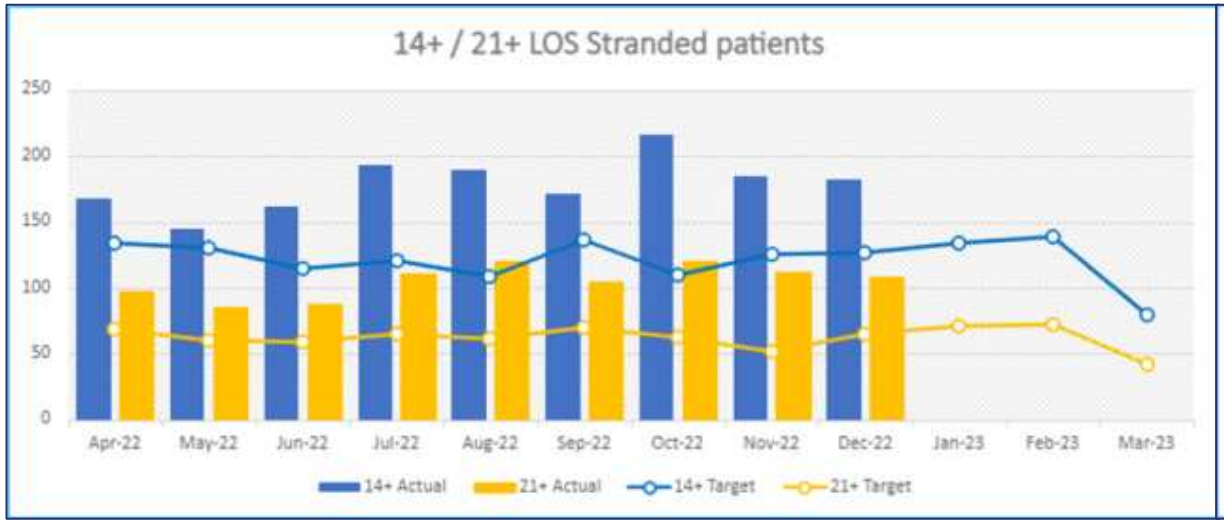


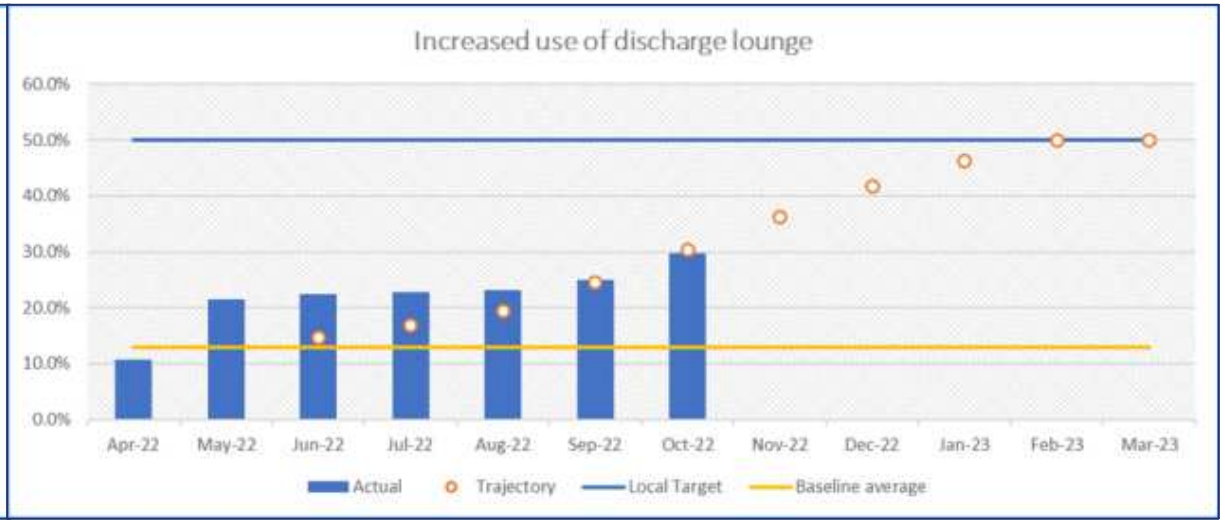


The surgical SDEC continues to report achievement of our local stretch target during December, reporting 49%.

The Medical SDEC has reduced during December reporting 30% and now achieving the 30% national target. The acute floor opened mid-December and we are working through processes to pull patients referred to acute medicine into the AMA for clerking - this should improve this position through the latter end of January as these processes become established. The ongoing bed gap and the increased number of MFFD patients is contributing to limited flow and waits for beds in ED

UEC Dashboard – Length of stay



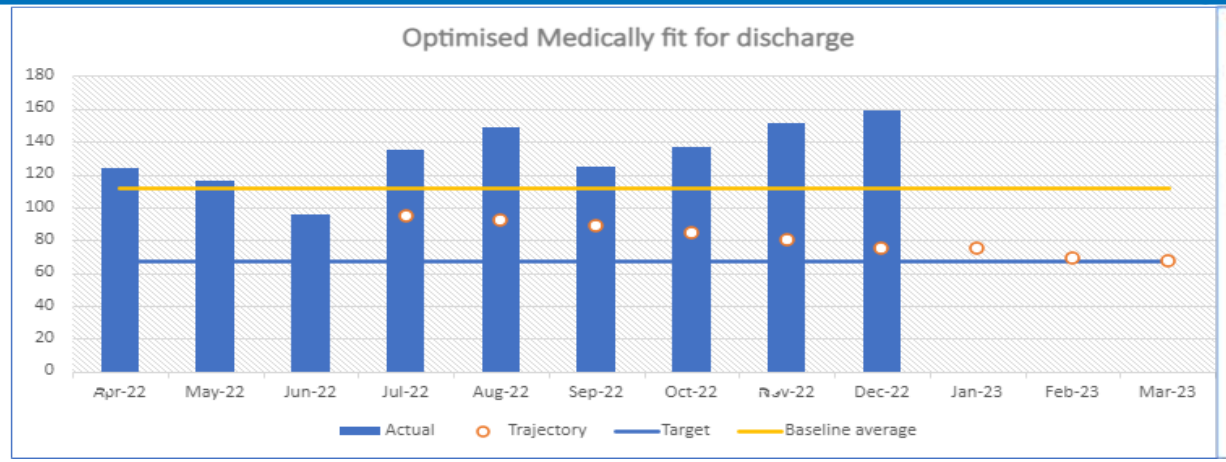


The chart above shows the number of patients at month end fitting into 14+ and 21+ LOS. The lines represent the target figures reported for the same month last year 19/20 (Pre-COVID).

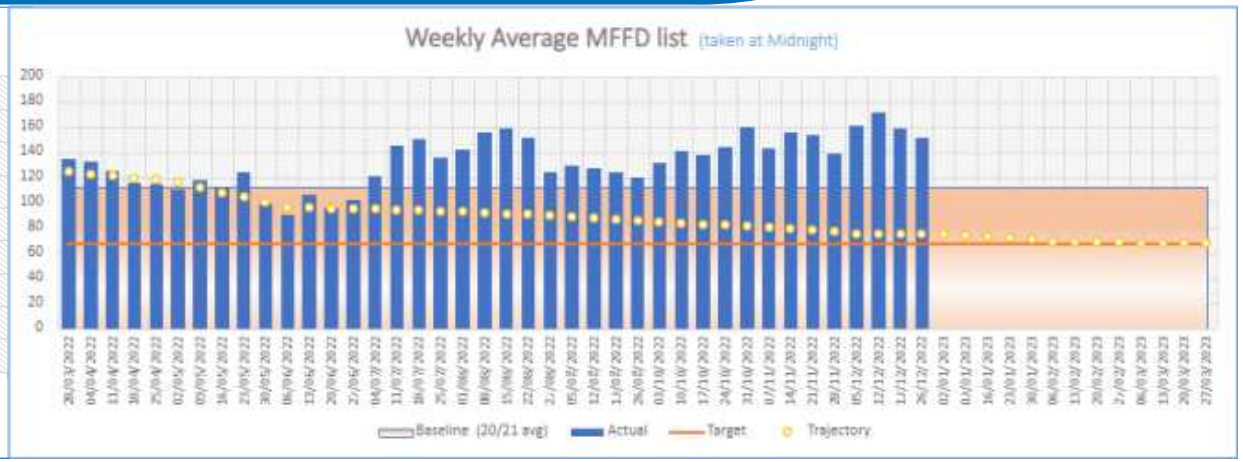
Cases remaining consistent

The chart above reports the improving use of the Discharge lounge.
Improvement continues to achieve trajectory.
Awaiting latest figures from SaTH, due to BI pressures with current focus on planning.

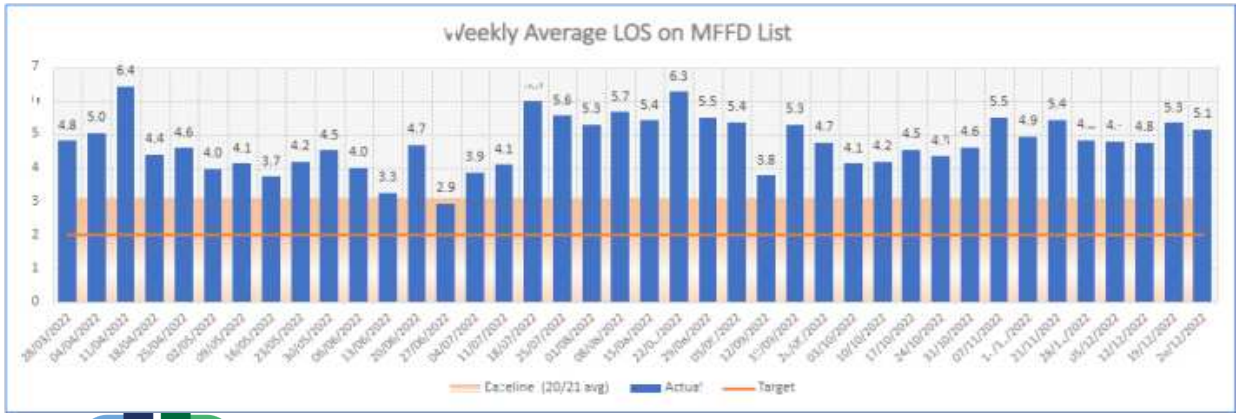
UEC Dashboard – MFFD



The average daily number of persons reported.
SaTH yet to achieve trajectory since set back in July.
Average monthly number on the MFFD Increased in December to 159 patients, which is 111% above trajectory.



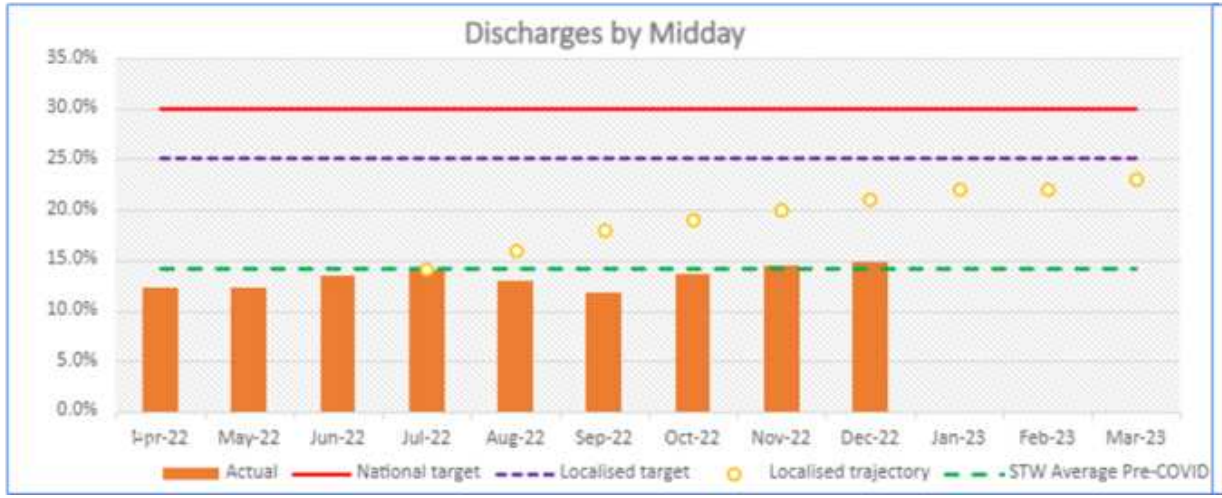
The latest weekly average discharge, 26/12/22, is reporting an average of 152 patients per day on the MFFD list.
In light of additional ASC funding a revised trajectory is being created to reflect the new discharge plans.

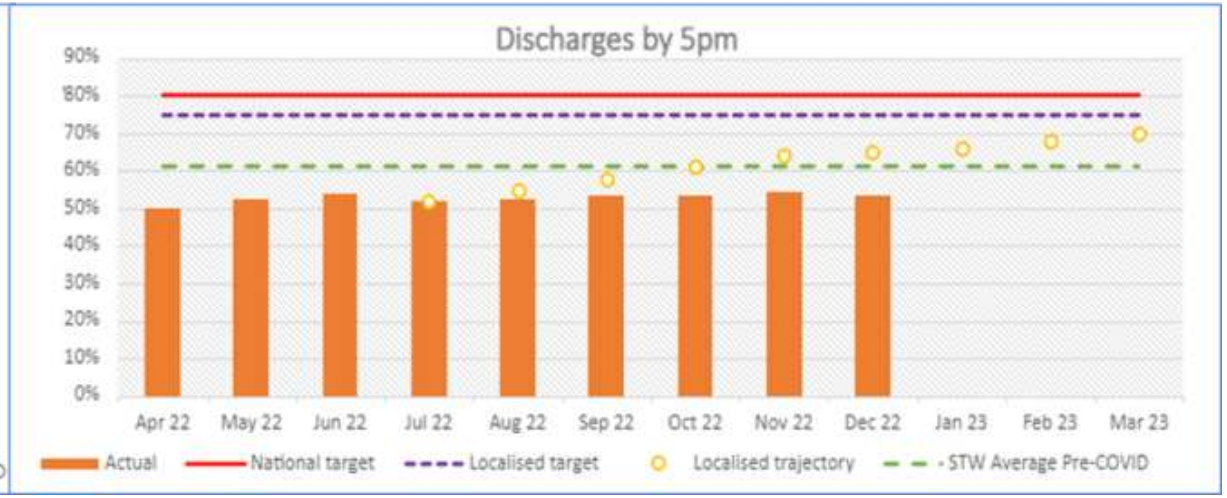


The latest average Length of Stay MFFD reports 5.1 days. The baseline average during 21/22 reported 3.1 days.
LOS from MFFD to Discharge has maintained at a LOS of 5 through November and December. Shropshire social work staff are working on the wards and completing all assessments in hospital rather than undertaking a D2A model. Limited capacity in domiciliary care in Shropshire is limiting the ability to discharge all PW1 patients without delays. PW2 bed capacity has also been challenged due to the number of No Criteria To Reside patients in community beds.

NB, STW is moving from MFFD to the national No Criteria to Reside definition from February data flows, March reporting

UEC Dashboard – Discharges





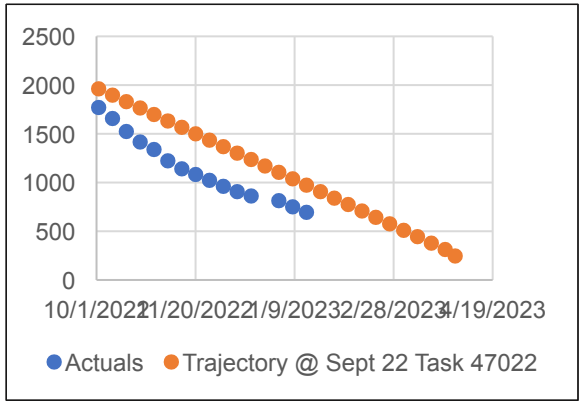
Review of discharge data has been captured for Midday and 5pm achievement.
Midday: Performance for December improved to 14.8%. Trajectory was set for 19%.
5pm discharges are reporting an improved position for December of 54%. The regional average reporting 46%.
STW pre-covid achievement was 61%

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

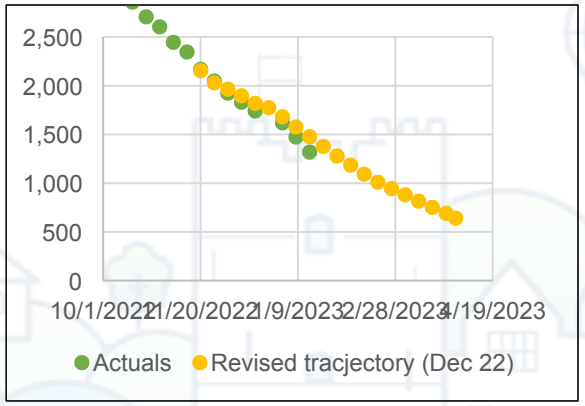
Elective Recovery

Key Data

RJAH 78 week recovery trajectory



SaTH 78 week recovery trajectory



Summary

- There is a target to achieve zero 104-week waits by the end of March 2023. RJAH is reporting a plan of zero 104-week waits but SaTH is now showing 34 for the end of March. This is a potential problem as patients can only be booked when theatre and clinic capacity become available . SaTH are flagging this as a potential issue but are monitoring these closely and are confident at this point that these will not translate into 104-week breaches.
- There is a National target of zero 78-week waits by the end of March 2023, although the system is currently planning for 889, with a stretch target of 749. The system is predicting that it will achieve the stretch target for 78-week waits.
- There is ongoing work with NHSE and mutual aid in place for RJAH (with ROH & The Walton Hospital for Spinal Disorders) as well as increasing theatre capacity. Daily meetings are taking place internally at both organisations and weekly with NHSE to ensure rigorous oversight of delivery and support with escalation. There remains concern due to the capacity constraints in spinal surgery and patients' willingness to travel for treatment. The application of Choice guidance is being clarified by NHSE as it has been applied differently across the country and this is expected to allow some patients to be taken out of the local totals.
- It should be noted that the 2023-24 Planning Guidance has a target of zero 65-week waits by the end of the forthcoming year.

What have we done/ next steps

- Close operational management, in conjunction with NHSE of all elective care targets in place
- System operational plan to achieve 104% submitted with plans in place to deliver 102.8%, and ongoing work to mitigate the gap through the use of:
  - Independent Sector capacity
  - Mutual aid with NHS trusts
  - Maximising use of regional hub approach
- Regional hub approach set up to manage long waiters.
- TIF2 Elective Hub Scheme Phase 1 at PRH has been approved. Planning in place to commence delivery of phase 1, to deliver eight beds and one theatre ringfenced capacity at PRH from June 2023.
- OP Transformation Steering Group conducting focussed initiatives with an aim to further reduce the long waiters in the non-admitted backlog.

Elective Recovery

Key Data

104 week waits

104 ww STW SYSTEM	April 2022	May 2022	June 2022	Jul-22	Aug-22	September 2022	October 2022	November 2022	December 2022	January 2023	February 2023	March 2023
System 104ww Waitlist (PLAN) (EXCLUDES CHOICE) (Based on the Overall system activity to deliver 102.8%)	176	154	99	61	53	45	39	33	27	20	9	0
ACTUAL (Patient Choice)	174	153	11	13	3	10	11	21	5			
ACTUAL (Complex)			88	64	64	48	28	13	14			
TOTAL ACTUAL (Inc Choice + Complex)	**174**	**153**	**99**	**77**	**67**	**58**	**39**	**33**	**19**			
Variance to plan (TOTAL ACTUAL (inc Choice) - PLAN)	-2	-1	0	16	14	13	0	0	-8			
Forecast(Patient Choice)										0		
Forecast (Complex)										21		
TOTAL Forecast(Inc Choice + Complex)										21		

78 week waits

	April	May	June	July 2022	August	September	October	November	December	January	February	March
System 78ww Waitlist (PLAN) (EXCLUDES CHOICE) (Based on the Overall system activity to deliver 102.8%)	850	857	776	714	741	713	589	563	825	761	695	759
System 78ww Waitlist (PLAN) DEC 22 PLAN (SATH)												
Variance to plan	145	180	119	136	57	65	134	180	10			
ACTUAL	**995**	**1037**	**895**	**850**	**798**	**778**	**723**	**743**	**835**			

Summary

Key Issues impacting 104 ww & 78 ww

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

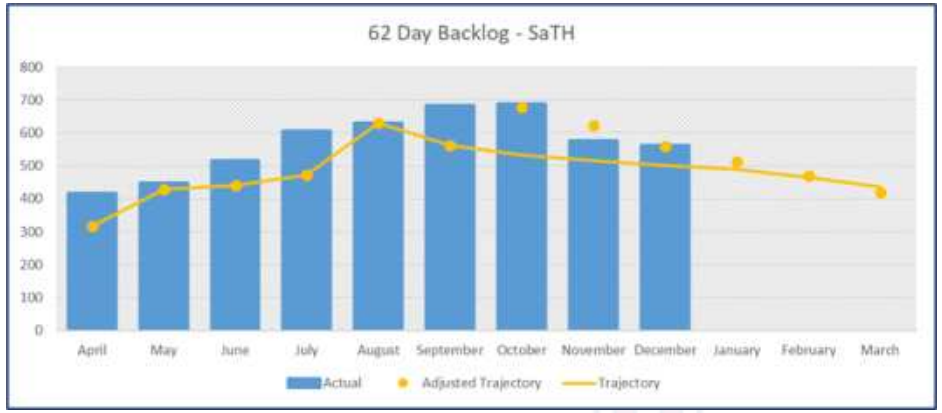
Key Actions for recovery 104 ww & 78 ww

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

Cancer Recovery

Key Data

SATH current position (as at 04/01/23):
613 patients waiting 63-104 days
206 patients waiting over 104 days.



Summary

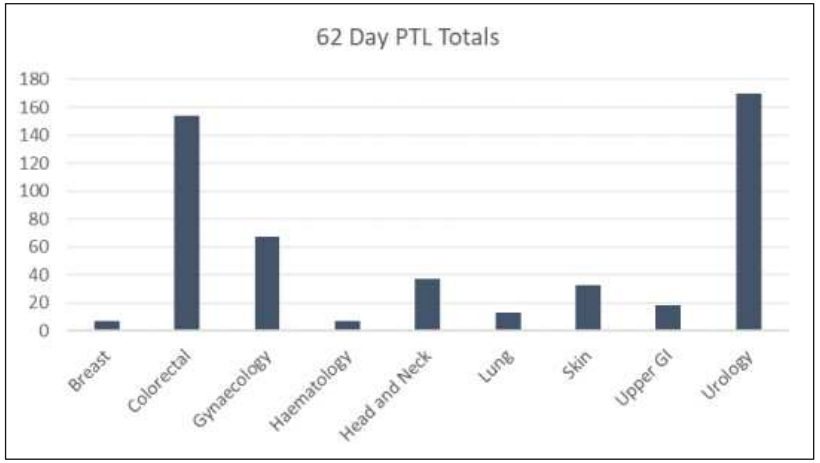
- Currently SaTH is aiming to reach the planned target of 420 patients in the 62-day backlog by the end of March 2023
- The plan to achieve the 65% target for 28-day FDS by the end of March 2023 is in place, standing at 60.8% year to date position at end of November 2022
- Radiology reporting remains extremely constrained due to increased volume of referrals. SaTH are utilising WLI and additional outsourcing activity, including two additional reporting providers being introduced. These have now begun and are providing 100 CT & MRI cases and plain film reports each per week which is starting to have a significant effect on supporting patients through their pathways and the clearing of backlogs.

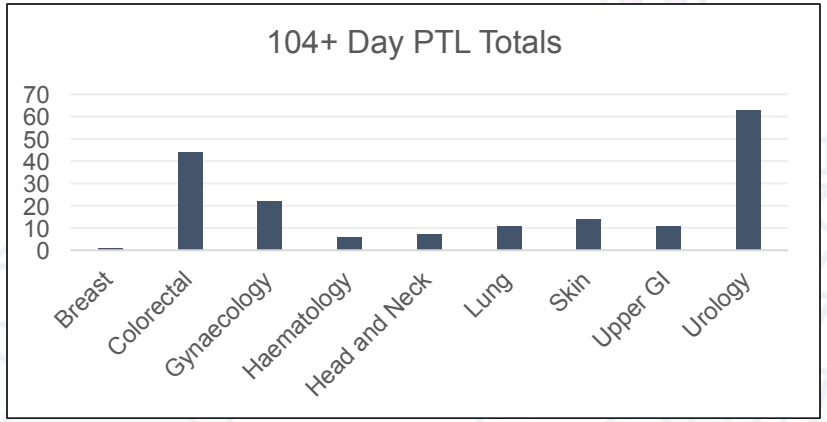
What have we done / next steps

- Continue to utilise radiology insourcing services, with further capacity expected when the current intake of overseas staff are fully trained and the Community Diagnostic Hub comes online – these will help reduce the 62 day backlog & increase the 28 day FDS performance
- All challenged cancer pathways (urology, lower GI, gynaecology and skin) have recovery plans in place and are monitored on a weekly basis
- New service for carrying out the FIT (Faecal Immunochemical Test) process for colorectal referrals expected to be in place for April 2023 start
- Teledermatology pilot beginning this month in one locality to help reduce pressure on the skin cancer pathway, full roll-out expected to follow
- Additional urology biopsy procedures funded by the West Midlands Cancer Alliance (WMCA)

Cancer – challenged pathways

Key Data





Summary

62 day improvement performance plans in place for all challenged tumour pathways in SaTH. Delivery monitored at weekly assurance meetings.

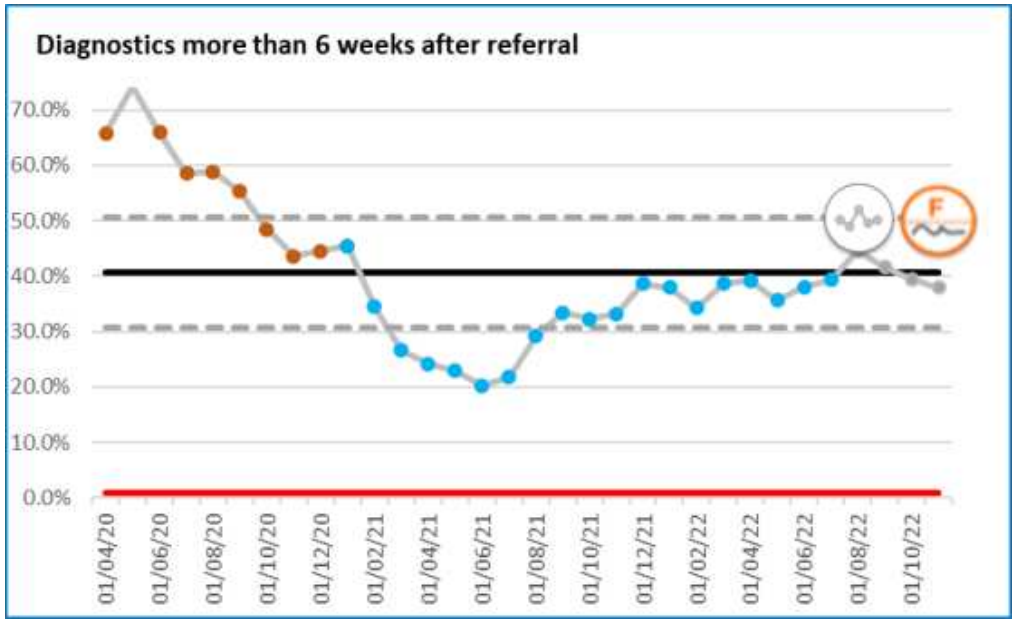
The urology pathway is now the most challenged, with 83 patients waiting over 104 days, of these 43 have no confirmed cancer. We are working with NHSE to identify and utilise mutual aid opportunities.

For colorectal, a revised FIT pathway is now moving forward and is expected to be underway imminently. The tender process for a new service from April 2023 onwards has now finished and a new contract will be awarded shortly. Also, there is new CNS capacity to allow suitable patients to go straight to test for their 1st appointment.

What have we done and next steps

- Capacity for skin pathway has increased by 44 minor ops slots from early December and the Teledermatology pilot will now begin in late January. Assuming this is successful, this will be expanded to cover the whole of STW and deal with all referrals for moles and lesions.
- For the gynaecology pathway, a straight to scan pathway is now in place and 2 week wait appointments for USS and PMB now booking within target. Reduced theatre capacity planned to return to pre-covid levels in April 23.
- Radiology reporting remains extremely constrained due to increased volume of referrals. SaTH are utilising WLI and additional outsourcing activity, including two additional reporting providers being introduced. These have now begun and are providing 100 CT & MRI cases and plain film reports each per week which is starting to have a significant effect on supporting patients through their pathways and the clearing of backlogs.
- For urology, actions include:
- non consultant roles being trained and utilised to deliver Cancer activity (extra 48 slots a month).
- clinics to be run by middle grades under Consultant supervision (up to 80 slots a month); insourcing for OPD, Flexi Sigmoidoscopies and LATP (40 LATP to funded by WMCA and carried out shortly).
- follow GIRFT guidance to invest in innovations such as Urology Investigations Unit to deliver diagnostic activities (plans currently being formulated).

Diagnostics Recovery



	Aug-22		Sep-22		Oct-22	
Diagnostic	22/23 Actual % of 19/20 Baseline - Working Day Adjusted	22/23 Actual % of 22/23 Operational Plan	22/23 Actual % of 19/20 Baseline - Working Day Adjusted	22/23 Actual % of 22/23 Operational Plan	22/23 Actual % of 19/20 Baseline - Working Day Adjusted	22/23 Actual % of 22/23 Operational Plan
Cardiology - Echocardiography	101%	95%	122%	102%	131%	93%
Colonoscopy	112%	96%	112%	96%	130%	87%
Computed Tomography	128%	120%	100%	99%	127%	105%
Flexi Sigmoidoscopy	48%	116%	35%	91%	38%	85%
Gastroscopy	112%	107%	93%	120%	118%	128%
Magnetic Resonance Imaging	112%	115%	114%	118%	129%	113%
Non-Obstetric Ultrasound	97%	113%	90%	109%	90%	97%

Summary

The overall 6 weeks standard for diagnostics was not achieved for both SaTH and RJAH, however there continues to be improvement month on month. In the latest month there was improvement for radiology at SaTH with significant improvement in MRI. A second outsourced Imaging provider for reporting at SaTH commenced on the 1st of December 2022. There was improvement for radiology at RJAH with increase in both CT and MRI performance for November. STW activity is above 100% of the 2019/20 baseline and 100% or more of the 2022/23 Operational Plan except for Flexi-sigmoidoscopy (32% of the baseline and 79% of the plan) where pathway changes due to Faecal Immunochemical Testing (FIT) has reduced demand.

What have we done and next steps

- Insourcing of radiology support, increasing capacity by using mobile scanners, enhanced payments and WLIs
- RJAH – Ongoing radiologists being onboarded and new capacity coming online for MRI
- SATH – Further capacity with 3 new rooms and funding for staffing in Endoscopy and further activity throughput via IS providers.

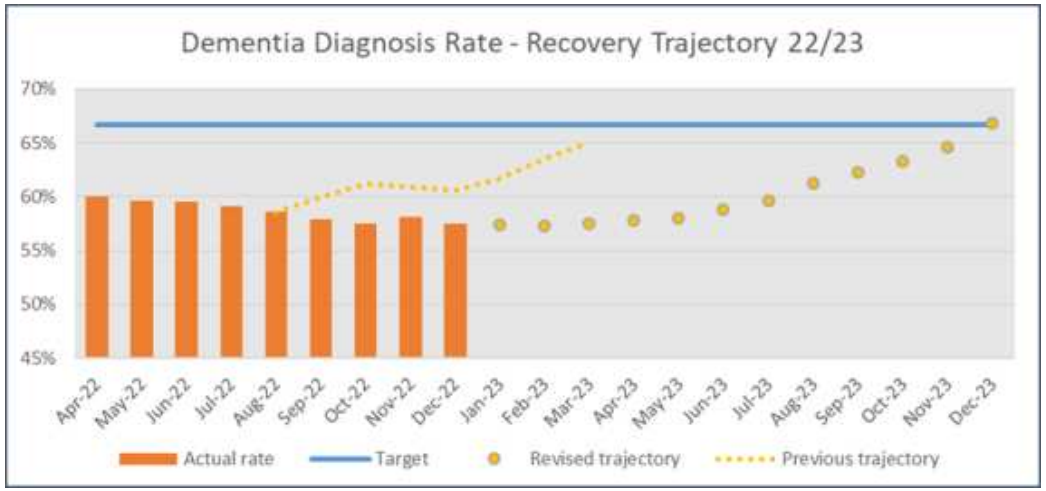
Mental Health Indicators

KPI	Latest month	Measure	Target	Assurance	Varriation	Mean	Lower process limit	Upper process limit
Dementia Diagnosis rate (STW)	Dec 22	58%	67%			63%	62%	64%
Dementia Diagnosis rate (England)	Sep 22	62%	67%			64%	63%	65%
IAPT Recovery Rate (MPFT)	Nov 22	52%	50%			52%	42%	62%
Finished IAPT first seen < 6 weeks (MPFT)	Nov 22	96%	75%			96%	93%	100%
Finished IAPT first seen < 18 weeks (MPFT)	Nov 22	99%	95%			100%	99%	101%
SMI patients with Health Checks (in-month figure)	Dec 22	70	186			55	8	103

Summary

- National published figures show that dementia diagnosis rates have been declining since the start of the pandemic, dipping below 60% for STW since May 2022 and below the National average of 62%.
- Unvalidated IAPT figures from MPFT show that recovery rates and waiting times for follow-up appointments are below target but have been prone to fluctuation.
- Health checks for SMI patients show slight improvement but remain considerably short of target. This is the subject of a deep dive at the Q&P Committee in February.

Mental Health: Dementia Diagnosis Rate, CYP ED Waits



Dementia Diagnosis Rate

The first chart shows the expected improvement from December 2022 for older adults who are referred and currently waiting for a diagnosis of dementia, given the actions being taken in the recovery plan.

Progress has been hampered by a combination of high levels of sickness, delayed recruitment to vacancies within the assessment and diagnosis team in MPFT, and other pressures in the system. There are circa 480 patients now on the waiting list for this service; in addition to the level of referrals from primary care increasing which are being reviewed for appropriateness. It is now not expected to reach target of 66.67% until later in 2023.

CYP ED waits

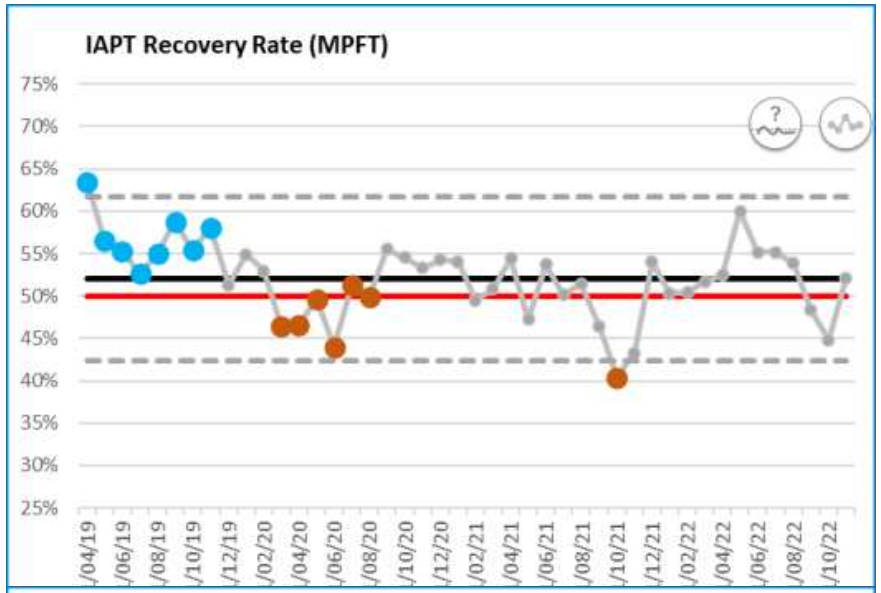
Rolling 12-month performance to September		Target
Urgent: seen within 1 week	**56%**	**95%**
Routine: seen within 4 weeks	**48%**	**95%**

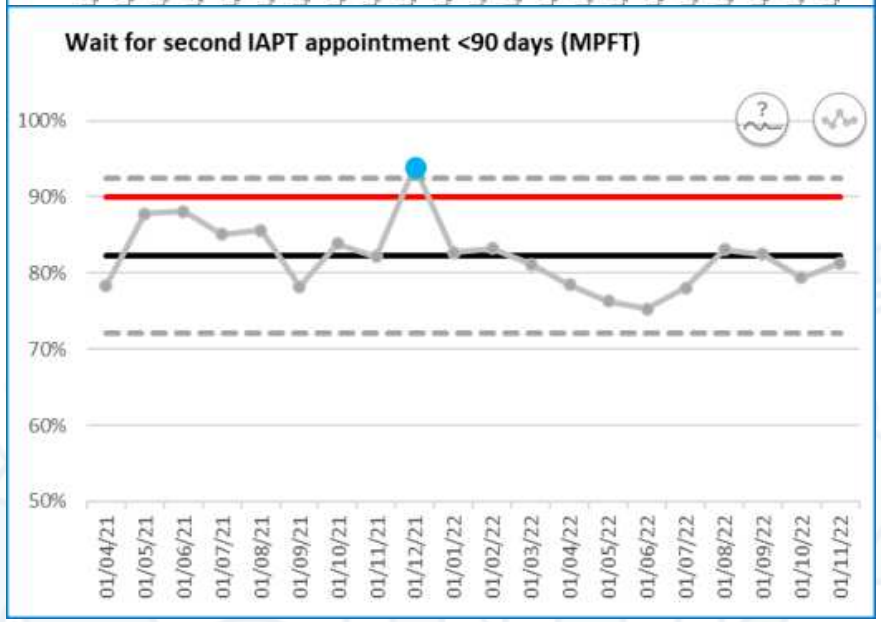
CYP ED Waits

For Children and Young People (CYP) with Eating Disorders (ED), performance has been slowly deteriorating since January 2021 where previously the 95% target had been met. Difficulties with recruiting and retaining skilled staff, combined with an increase in demand have contributed to the deterioration in performance.

A remedial action plan is in place and additional staff have been recruited to resulting in performance improvements. Performance for October and November is showing 80% of patients were seen within 4 weeks.

Mental Health: IAPT





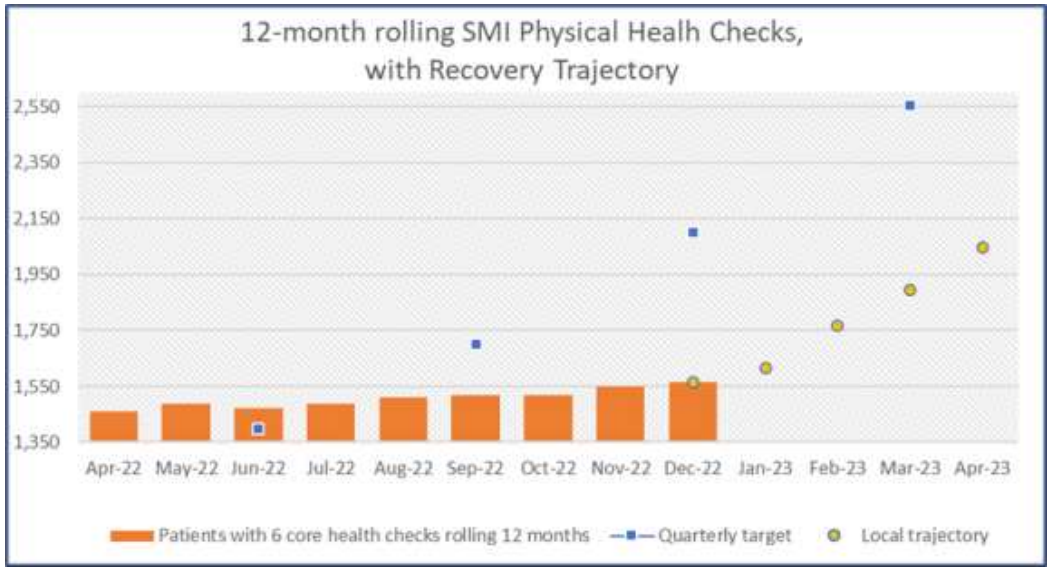
Summary

Unvalidated IAPT figures from MPFT show that recovery rates and waiting times for follow-up appointments have been prone to fluctuation.

Access continues to be below target for both first contact and for in-treatment waits, the former being a consequence of insufficient funding.

Performance of waits from 1st to 2nd appointment had been deteriorating since December 2021. A waiting list initiative has been agreed to reduce 50-70% of these waits over the next twelve months. The contract is now in place to start delivering from December. There is an expectation to reach target of 90% waiting less than 90 days by April 2023.

Mental Health: SMI Health Checks, OoA Placements



Serious Mental Illness Physical Health Checks

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

A recovery action plan is in progress, but not showing demonstrable improvement; issues with the IT solution are under investigation and current working practices between MPFT and GP colleagues will be considered in a service review commencing in January. DNA rates and clinic utilisation will also be included in the review.

Out of Area Placements

During November there were 8 service users in inappropriate Out of Area placements over and above the Acute and PICU bed capacity. The position at the end of November saw these numbers reduce to 4. Current demand for acute and PICU beds remains high and does fluctuate, mirroring the national picture. Issues remain in regard to care packages and limited care home availability, causing delays.

Mitigating actions include a system group review of length of stay and delayed discharges to reduce occupied bed days. Multi Agency Discharge Events (MADE) continue to support and challenge discharge planning.

Finance- M9 position

Key Data

- £49.8m YTD deficit at M9
- £28.8m adverse to plan YTD at M9
- £4.1m adverse to plan FOT at M9 in line with previous months reporting, discussing amendment to the FOT with NHSE as part of the FOT change protocol. Significant risk in the current forecast position under discussion with NHSE.
- £5.3m COVID expenditure above plan at M9
- £13.5m above agency expenditure cap at M9
- The overspend is mainly driven by increased staffing costs due to open escalation areas at SATH and overspends in the ICB on Independent sector ophthalmology activity and community discharge beds which are partially offset with prior year accrual reversal benefits.

	M9 YTD			FULL YEAR		
Organisation	Plan Surplus/ (Deficit) £000	Actual Surplus/ (Deficit) £000	Variance to Plan £000	Plan Surplus/ (Deficit) £000	Forecast Surplus/ (Deficit) £000	Variance to Plan £000
Commissioners						
NHS Shropshire, Telford and Wrekin	(9,521)	(16,179)	(6,658)	(11,740)	(12,743)	(1,003)
System Affordability Gap	6,968	0	(6,968)	13,934	13,934	0
Total Commissioners	**(2,553)**	**(16,179)**	**(13,626)**	**2,194**	**1,191**	**(1,003)**
Providers						
The Shrewsbury and Telford Hospital NHS Trust (SaTH)	(16,125)	(33,610)	(17,485)	(19,135)	(24,074)	(4,939)
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT (RJAH)	(1,744)	(1,091)	653	(772)	0	772
Shropshire Community Healthcare NHS Trust (SCHT)	(617)	1,087	1,704	(1,330)	(311)	1,019
Total Providers	**(18,486)**	**(33,614)**	**(15,128)**	**(21,237)**	**(24,385)**	**(3,148)**
TOTAL SYSTEM Performance Financial Position Surplus/(Deficit)	**(21,039)**	**(49,793)**	**(28,754)**	**(19,043)**	**(23,194)**	**(4,151)**

Finance- M9 position

Summary

- A number of operational pressures are impacting on our system and the financial impact of these is manifesting in our expenditure run rate. We continue to work through a thorough review of anticipated spend and actions to mitigate costs for the rest of the year.
- The pressures which place further stress on the STW deficit plan are well recognised both within the system and by the Regional NHSE team. The forecast scale of the impact of these is a matter of serious concern for which STW ICS remain committed to continuing to give close scrutiny and challenge.
- The current reported forecast outturn (FOT) position shows a £4.1m overall system adverse variance to plan in line with the forecast reported at M8. The majority of the overall variance relates to the unrecoverable year to date COVID overspend and escalation areas remaining open and includes assumptions about mitigations to current overspends which are being discussed and tested as part of the exercise to review the FOT with NHSE in line with the FOT change protocol. These mitigations are currently flagged as extremely high risk.
- Whilst SaTH activity remains below 19/20 levels there has been a significant increase in expenditure due to the number of Medically Fit For Discharge (MFFD) patients. This increase from less than 100 per day on average pre-covid to between 150-190 on a regular basis has resulted in additional escalation areas being opened to support both flow from ED and ambulance handovers. This coupled with recruitment difficulties has resulted in an increase in agency and bank expenditure in order to keep patients safe.
- There remains significant risk around delivery of the financial plan with key risks centred around:
    - Increases to agency/bank expenditure driven by open escalation areas, staff sickness, extremely high levels of NRTR (No Right to Reside patients) and lack of discharge capacity
    - Increases to independent sector ophthalmology activity driven through patient choice and long waiting times at our main provider.
    - Increases in capital charges due to the need for capital improvements to support service improvement. Relative to other systems, this is a large sum for STW ICS.
    - Expenditure with Local Authorities on additional discharge support earlier in the year which wasn't matched with national funding. Non Recurrent Social care funding now in place for the remainder of the year.
    - Increased package prices in Individual Commissioning due to inflationary pressures and increased acuity of need.
    - Prescribing - there is a national issue around NCSO and Cat M pricing and we understand that some national funding may be available to regional teams but that it is unlikely to flow to us as a system
- Whilst excess inflation was funded in the planning round, inflationary pressures are exceeding those originally forecast particularly in energy and care market costs.
- The current reported forecast assumes delivery of the system stretch target (£13.9m). This is all currently flagged as a risk.
- £5.3m of expenditure requirement noted as a priority for the system (£13.2m FYE) is currently sat outside of the financial plan. Whilst not a financial risk whilst expenditure is not incurred, this does pose a quality risk for our system if left unaddressed in the long term.

What have we done and next steps

STW recognises its material underlying deficit and local challenges, including those associated with geography, configuration of estate and availability of substantive workforce. We are committed to delivering our plans at a time when we are also battling heavy demand in urgent care and COVID-19 pressures.

- Review of forecast position continues with NHSE. All organisations continue to collectively work on an action plan to mitigate current overspends.
- Medium to long term financial plan development underway for refresh in Q4, includes detailed mapping of underlying position as part of above exercise
- Updates to 'triple lock' process actioned
- Winter summit took place in December to understand drivers of increased MFFD and LOS and to explore potential actions and impact on escalation costs
- Efficiency plan development (see efficiency slide)
- Financial sustainability self assessments have now been through an internal audit process and there have been very few amendments made.
- Detailed analysis of run rate and regular monthly enhanced reporting actioned around COVID, Agency, ERF and efficiency trajectories.

Financial Performance by Organisation

NHS Shropshire, Telford and Wrekin

At month 7 the ICB has an adverse position against plan of £4.9m YTD. The overspend continues to be due to independent sector NCA ophthalmology activity, a small COVID overspend and continued community discharge expenditure offset with primary care prior year benefits. FOT remains in line with M6 and assumes significant mitigations to overspending areas. These mitigations are currently flagged as high risk.

Shrewsbury and Telford Hospitals NHS Trust

At Month 7 SaTH has an adverse position against plan of £10.4m YTD. This variance is mainly due to escalation areas remaining open due to COVID and staffing cost increases due to higher tier agency staff, offset by reduced elective activity due to COVID levels. Significant risk remains with regards to bringing the COVID spend back in line with plan. The forecast position is based on the unrecoverable YTD COVID position and escalation areas remaining open.

Robert Jones and Agnes Hunt

Month 7 position £358k favourable to plan. YTD £1,200k deficit. Income adverse driven by variable clinical income and private patient activity shortfalls against plan offset by marginal cost reductions and independent sector usage below plan. In month recognition of NHSE income underperformance YTD assuming no clawback driving net favourable position to plan. FOT remains in line with M6.

Shropshire Community Health Trust

At Month 7 SCHT has a favourable position against plan of £0.9m YTD. Covid vaccination activity is below plan YTD resulting in lower income and cost. Favourable variance to plan YTD is due mainly to high levels of vacancies with net leavers over 3% of staff in post at 31 March 2022, plan is to grow workforce. FOT remains in line with M6.

Risk

Unmitigated Risk Summary	SATH	RJAH	SCHT	ICB	System	TOTAL unmitigated system risk
	£'000	£'000	£'000	£'000	£'000	£'000
Growth risk on non system contracts	(1,200)					(1,200)
Continued COVID expenditure	(4,423)	0	(25)			(4,448)
Escalation areas remain open	(12,000)					(12,000)
						0
Agency Expenditure above Ceiling		0				0
Inflation pressure	(2,400)	(100)				(2,500)
Casemix Complexity		(150)				(150)
Efficiency Programme			0			0
Estates contract			(100)			(100)
Community bed/discharge scheme				0		0
Prescribing volatility				(1,000)		(1,000)
Independent Sector				0		0
Overspends				(9,744)		(9,744)
System efficiency stretch risk					(13,936)	(13,936)
TOTAL unmitigated risk	**(20,023)**	**(250)**	**(125)**	**(10,744)**	**(13,936)**	**(45,078)**

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

Key issues remain around:

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

CEOs have nominated leads to work through a rapid financial improvement planning process aimed at significantly improving the scale of the savings plan. The Integrated Delivery Committee is supporting and overseeing financial recovery planning.

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

Finance – Capital

Key Data

- Capital programme underspending by £10.8m YTD at M9
- The forecast has been updated to an underspend of £2.8m. This is because there has been an opportunity to bid for theatre improvement work through TIF2 national funding rather than funding through the BAU capital allocation.

Summary

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

What have we done and next steps

- There is a detailed 2022/23 forecast outturn for the capital programme across all providers which is monitored monthly at the Capital Prioritisation and Oversight Group.
- A high level 2023/24 capital plan has been drafted which shows the capital plan to be within the 105% tolerance set in planning guidance.
- Over the coming months, a detailed 24 month, 5 year and 10 year capital plan will be developed across the system.
- Capital Prioritisation and Oversight Group to oversee longer term capital plan to run alongside revenue plan

CAPITAL PROGRAMME	M9 YTD			FULL YEAR		
Organisation	Plan £000	Actual £000	Variance £000	Plan £000	Forecast £000	Variance to £000
NHS Shropshire, Telford and Wrekin	0	0	0	(869)	(869)	0
The Shrewsbury and Telford Hospital NHS Trust (SaTH)	(14,546)	(5,380)	9,166	(19,822)	(19,822)	0
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT (RJAH)	(5,902)	(3,912)	1,990	(11,659)	(14,403)	(2,744)
Shropshire Community Healthcare NHS Trust (SCHT)	(963)	(1,276)	(313)	(2,500)	(2,500)	0
TOTAL SYSTEM	**(21,411)**	**(10,568)**	**10,843**	**(34,850)**	**(37,594)**	**(2,744)**

ICS Workforce Dashboard – M08

22,198

WTE

6.4%

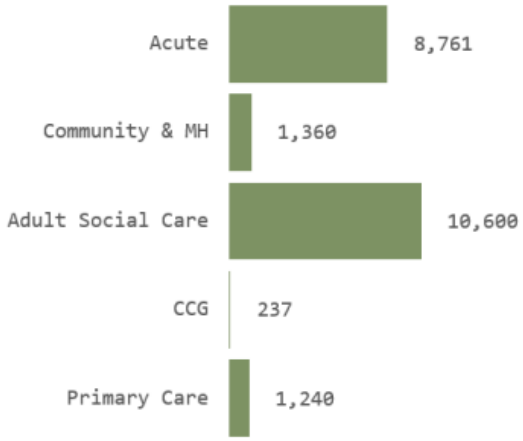
Vacancy

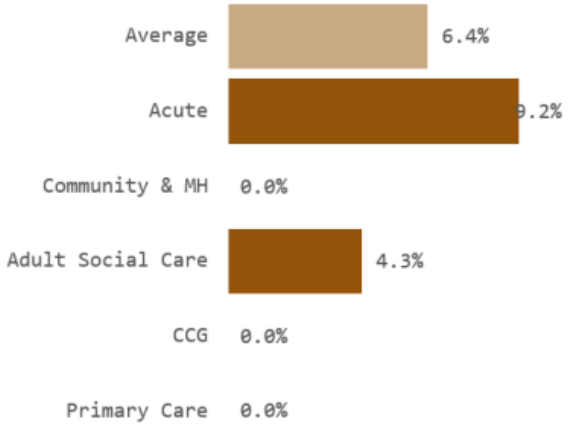
21.9%

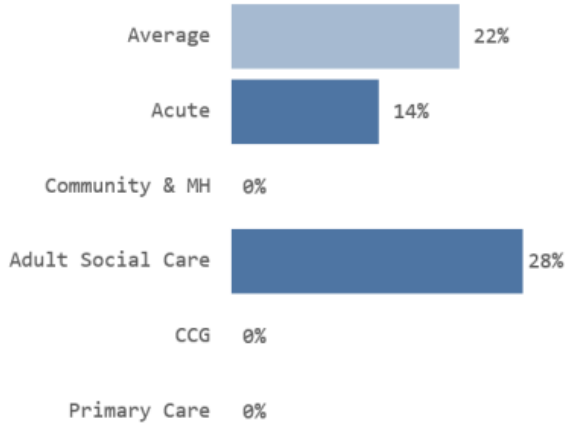
Turnover

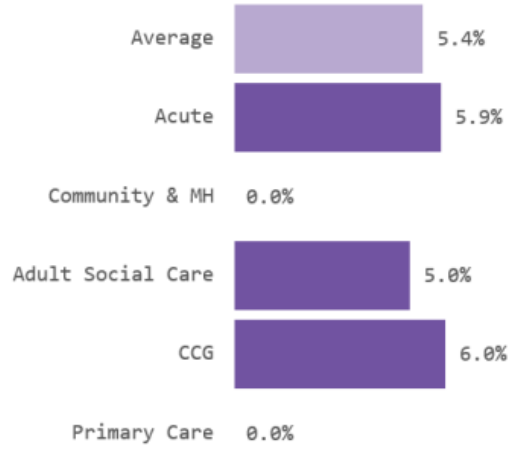
5.4%

Sickness









82%

AfC Appraisals

85%

Medical Appr.

90%

Mand. Training

Month/Year	WTE	Vacancy	Turnover	Sickness
Nov 22	22,198	6.4%	21.9%	5.4%
Oct 22	22,076	6.4%	22.2%	5.5%
Sep 22	21,851	6.1%	21.8%	5.3%
Aug 22	21,857	6.5%	21.9%	5.4%
Jul 22	21,865	5.8%	21.9%	5.8%
Jun 22	21,879	5.8%	21.8%	5.3%
May 22	21,738	5.7%	21.6%	5.0%
Apr 22	21,683	5.9%	21.7%	5.2%
Mar 22	21,835	5.5%	21.6%	4.9%
Feb 22	21,732	5.5%	21.4%	4.8%
Jan 22	21,645	5.6%	21.3%	5.1%
Dec 21	21,484	5.6%	21.3%	5.1%

Data Sources:
NHS Trust Monthly Provider Workforce Returns
Skills for Care Sept 2019 and March 2020
Primary Care NHS Digital November 2022

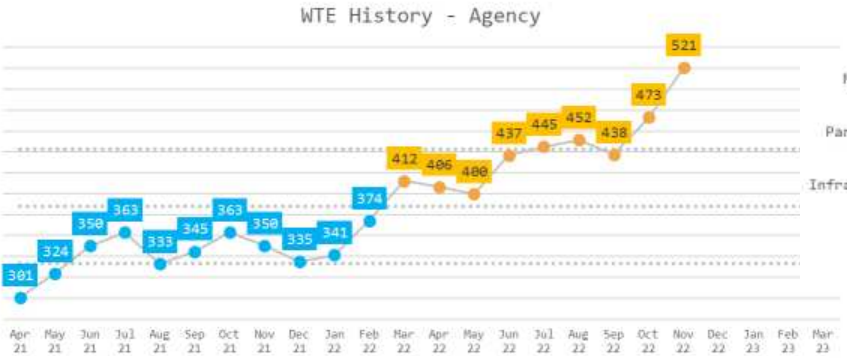
ICS Workforce Dashboard - Metrics M08 November 2022 (NHS Only) - 1

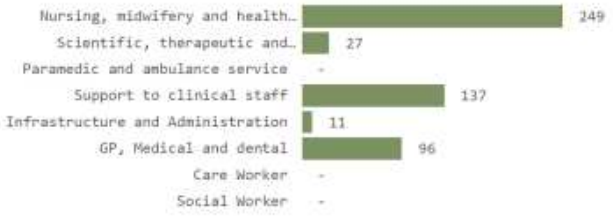
Measure	Dimension	Data Source	Data Period	System	SaTH	RJAH	SCHT
Sickness Absence	Monthly Sickness Absence Rate	PWR	Nov 22	5.9%	5.9%	5.7%	6.3%
Substantive (WTE)	Total	PWR	Nov 22	8,973	6,321	1,386	1,266
	Registered Nursing & Midwifery	PWR	Nov 22	2,568	1,823	282	462
	HCSW	PWR	Nov 22	1,191	884	175	132
	Infrastructure	PWR	Nov 22	1,796	983	508	306
	Allied Health Professionals	PWR	Nov 22	655	358	155	142
	Pharmacy	PWR	Nov 22	134	96	17	21
	Other STT	PWR	Nov 22	269	223	27	20
	GP, Medical and Dental	PWR	Nov 22	889	725	143	21
Vacancies (WTE)	Total	PWR	Nov 22	990	630	154	207
	Registered Nursing & Midwifery	PWR	Nov 22	211	99	47	65
	HCSW	PWR	Nov 22	218	169	30	19
	Infrastructure	PWR	Nov 22	145	57	44	45
	Allied Health Professionals	PWR	Nov 22	94	60	13	22
	GP, Medical and Dental	PWR	Nov 22	126	109	12	4

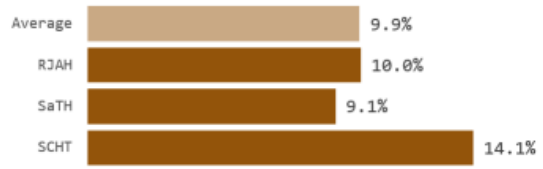
ICS Workforce Dashboard - Metrics M08 November 2022 (NHS Only) - 2

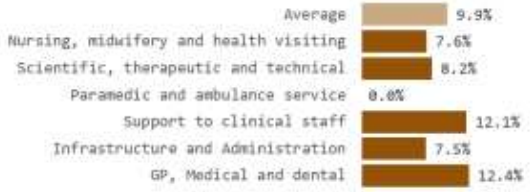
Measure	Dimension	Data Source	Data Period	System	SaTH	RJAH	SCHT
Vacancy Rate %	Total	PWR	Nov 22	9.9%	9.1%	10.0%	14.1%
	Registered Nursing & Midwifery	PWR	Nov 22	7.6%	5.2%	14.2%	12.3%
	HCSW	PWR	Nov 22	15.5%	16.0%	14.6%	12.8%
	Infrastructure	PWR	Nov 22	7.5%	5.4%	7.9%	12.9%
	Allied Health Professionals	PWR	Nov 22	12.6%	14.3%	7.5%	13.3%
	GP, Medical and Dental	PWR	Nov 22	12.4%	13.1%	8.0%	17.3%
Temporary Staffing	Bank WTE	PWR	Nov 22	628	514	60	55
	Agency WTE	PWR	Nov 22	521	441	40	40
	Bank WTE %	PWR	Nov 22	6.2%	7.1%	4.0%	4.0%
	Agency WTE %	PWR	Nov 22	5.1%	6.1%	2.7%	2.9%
Turnover	In-month leavers rate	PWR	Nov 22	14.5%	14.7%	12.5%	15.6%
	Leavers - All	PWR	Nov 22	1,297	927	173	198

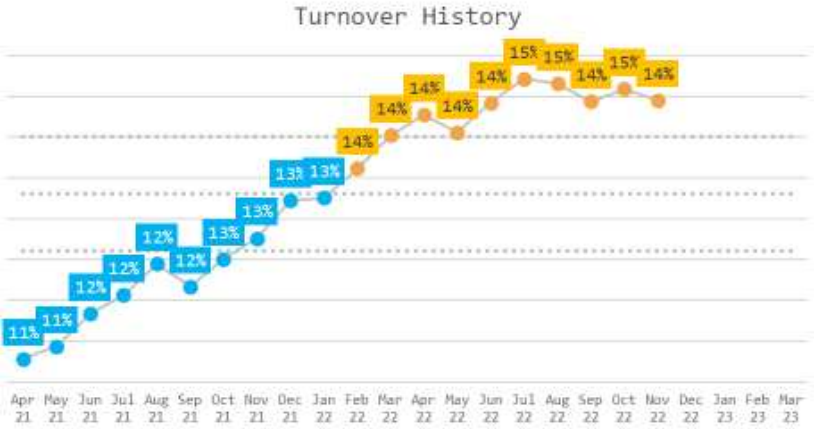
ICS Workforce (NHS) Dashboard – M08 November 2022

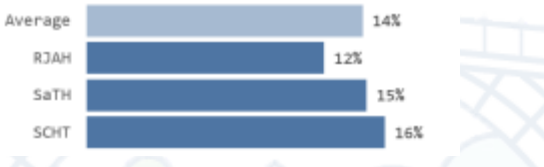


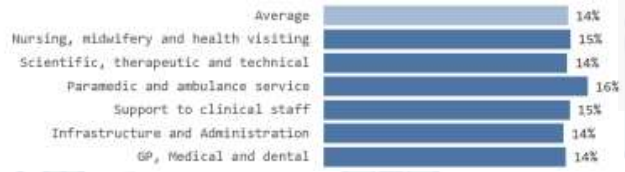












Agency

- Steadily increasing from the start of the financial year
- 48% of agency is for nursing & midwifery
- 26% of agency is for support to clinical
- 18% of agency is for GP, medical & dental

Vacancies

- SCHT have the highest vacancy rate of 14.1% compared to SATH 9.1% and RJAH 10.0%
- Medical & dental 12.4% (decreasing)
- Support to clinical staff 12.1% (increasing)
- Nursing & midwifery 7.6% (increasing)

Turnover

- Turnover peaked over summer but has now stabilized around 14% to 15%
- SCHT has the highest turnover of 16% compared with 15% in SATH and 12% in RJAH
- Nursing turnover is at 15%
- Remaining staff groups are all generally around 14% to 15%

Agenda Item

ICB 25-01-058

Transfer of POD Commissioning Services from NHSE to ICB

Dated 2023

(1) **{●} INTEGRATED CARE BOARD**

- and -

(2) **{●} INTEGRATED CARE BOARD**

- and -

(3) **{●} INTEGRATED CARE BOARD**

- and -

(4) **{●} INTEGRATED CARE BOARD**

- and –

(5) **{●} INTEGRATED CARE BOARD**

Primary Care Pharmacy, Optometry and Dental Joint Commissioning Group Agreement

DRAFT - NOT AVAILABLE FOR ACCEPTANCE

NOTE ****
This Agreement is ICB to ICB for the establishment of the ICB East & West Joint Commissioning Groups (as a sub-committee of the main 'Tier 1' Joint Committees).
There will be a separate Tier 1 - nationally supplied / locally amended - Joint Working Agreement (JWA) into which the arrangements within this POD-specific JWA will need to fit.

THIS AGREEMENT is made on the_____ day of _____2023 to enable the Joint Commissioning of Primary Care Pharmacy, Optometry and Dentristry (POD) Services

BETWEEN[1]**:**

(1) **{●} Integrated Care Board** of [insert address] ("**{●} ICB**");

(2) **{●} Integrated Care Board** of [insert address] ("**{●} ICB**");

(3) **{●} Integrated Care Board** of [insert address] ("**{●} ICB**");

(4) **{●} Integrated Care Board** of [insert address] ("**{●} ICB**"); and

(5) **{●} Integrated Care Board** of [insert address] ("**{●} ICB**").

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

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

BACKGROUND

(A) NHS England (NHSE) has delegated functions in relation to the commissioning of Primary Dental and prescribed Dental services, Primary Ophthalmic services, Pharmaceutical services and local Pharmaceutical services to the ICBs in accordance with its statutory powers under section 65Z5 of the NHS Act.

(B) Pursuant to the Delegation agreements in respect of these services between the respective ICBs and NHSE and the section 65Z5 of the NHS Act, the ICBs are able to establish and maintain joint arrangements in respect of the discharge of these functions. These arrangements must be made with the written agreement of NHSE.

(C) The ICBs agree to jointly exercise the functions described in this agreement that have been delegated to them by NHSE through the decisions of the Joint Committee and POD Joint Commissioning Group under section 65Z5 of the NHS Act and as set out in this agreement and the Terms of Reference (the 'Joint Functions'). All functions delegated by NHSE to the ICBs not exercised jointly are Reserved functions.

(D) The ICBs acknowledge and agree that making arrangements to exercise these functions jointly is likely to lead to an improvement in the way the Commissioning Functions of all Partners, including those delegated to the ICBs by NHSE are exercised.

(E) This Agreement sets out the arrangements that will apply between the ICBs in relation to the joint commissioning of Primary Care POD services for the ICBs' populations.

(F) The ICBs have entered into this Agreement to define their arrangements for joint working. To avoid doubt, none of the Partners are delegating any functions other than those set out in this agreement.

[1] Complete Partners' names as appropriate.

NOW IT IS HEREBY AGREED as follows:

1. COMMENCEMENT AND DURATION

1.1 This Agreement has effect from the date of this Agreement and will remain in force unless terminated in accordance with clause [X] (Termination) below.

2. PRINCIPLES AND AIMS

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

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

2.1.2 consider how in performing their obligations they can address health inequalities;

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

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

2.2 The Partners agree:

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

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

2.2.3 to act in a timely manner;

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

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

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

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

3. SCOPE OF JOINT COMMISSIONING ARRANGEMENTS

3.1 This Agreement sets out the arrangements through which the Partners will together plan and oversee the exercise of those services that are subject to this Agreement, including:

3.1.1 the establishment of a Primary Care POD Joint Commissioning Group, acting as a sub-committee of the East and West Joint Committees (comprised of ICBs & NHSE);

3.1.2 the participation by all Partners in the work of the Primary Care POD Joint Commissioning Group in exercising the Functions;

3.1.3 the population-based planning and commissioning of those services that are subject to this Agreement;

3.1.4 the development of proposals for alignment between the exercise of the Partners' respective Commissioning Functions and the Joint Functions;

3.1.5 Identifying and setting strategic priorities for those services that are subject to this Agreement.

3.1.6 Carrying out needs assessments, and regular reviews of such assessments, to determine the needs of the population;

3.1.7 Taking decisions in respect of the population-services outlined in [Schedule X] (other than those which relate to reserved functions) and undertaking financial planning;

3.1.8 Ensuring access to appropriate clinical advice and leadership, including through clinical reference groups and local clinical networks;

3.1.9 Integration of Services and facilitating links between Primary Care POD Joint Commissioning Group, and other service pathways commissioned by ICBs;

3.1.10 Oversight and monitoring of the quality of Joint Services, including establishing links with quality, finance, governance and assurance processes, including to ICB's own local variant forums / groups;

3.1.11 Ensuring effective engagement with stakeholders, including patients and the public and involving them in decision making;

3.1.12 Risk and issue management (predominantly financial and clinical risk management);

3.1.13 Collaboratively commissioning those services that are subject to this Agreement and;

3.1.14 Collectively referred to as the "Joint Commissioning Arrangements".

4. JOINT COMMISSIONING GROUP

4.1 The Partners shall each nominate an Authorised Officer, who shall be the main point of contact and shall be responsible for representing the Partner and liaising with the other Partner's Authorised Officer in connection with the Agreement (and who may also be a member of the Joint Committee and/or Joint Commissioning Group).

4.2 The ICBs will establish the Joint Commissioning Group which will operate in accordance with the Terms of Reference set out in Schedule [ ] The Joint

Commented [PW(SI1]: A list of current functions will be prepared for ICBs to locally map in their Governance documents (Schemes of Reservation & Delegation etc) about where decisions are taken. It is currently expected we may need to include in the responsibilities Commissioning / Planning duties and Population Health Committees & Primary Care Operational Group(s) – if so ICBs will need to update their Committee / Group TORs as appropriate and include within the updates of their SORDs as required.

Commented [PW(SI2]: 4.6 notes that the Authorised Officer is also the principal member on the Joint Commissioning Group suggested as Exec / Director level Primary Care most-senior lead from each ICB.

Commissioning Group (and each member of it) will act at all times in accordance with the Terms of Reference.

4.3 ICBs shall exercise the Joint Functions collaboratively with the ICBs in accordance with this Agreement and must reach decisions in relation to the Joint Functions (and any ICB Functions) through discussion and agreement. Where (in exceptional cases) consensus cannot be reached between the members of the Joint Commissioning Group in respect of matters under consideration, the arrangements set out in the Terms of Reference will apply.

4.4 The decisions of the Joint Commissioning Group will be binding on the ICB(s) as provided for in the Terms of Reference.

4.5 The Partners may establish sub-groups of the Joint Commissioning Group with such terms of reference as may be agreed between them from time to time. Where this occurs, the sub-structure and delegation recording (a standard set of SoRD inclusions the same for all) will be included in a Schedule so the Agreement has the full governance structure.

4.6 The ICBs shall ensure that their Authorised Officers and respective representatives on the Joint Commissioning Group have appropriate authority, in accordance with each ICB's internal governance arrangements, to represent the interests of each ICB in the Joint Commissioning Group and any other sub-groups established by it.

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

4.8 Each Partner shall make available such resources and provide such assistance and support to the Partners to allow for the timely and effective operation of the Joint Commissioning Arrangements.

5. JOINT FUNCTIONS

Commissioning and Contract Management

5.1 The Joint Commissioning Committee and Group will make decisions relevant to the exercise of the Joint Functions in line with the agreed Scheme of Reservation & Delegation established by the ICBs, set out at Schedule X.

5.2 In discharging its responsibilities, the Joint Commissioning Group must comply at all times with the law and any relevant guidance (including any applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services).

5.3 When the Joint Commissioning Group makes decisions in connection with the awarding of contracts it should ensure that it is able to demonstrate compliance with requirements for the award of such contracts, including that the decision was:

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

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

5.3.3 made transparently, and

5.3.4 compliant with the rules of the regime as set out in the relevant Guidance and Legislation.

5.4 Where the Joint Commissioning Group wishes to develop and offer a locally designed contract, it must ensure that it has consulted with the relevant Local Professional Committee for the individual POD; and that it can demonstrate that the scheme will:

5.4.1 improve outcomes for patients;

5.4.2 reduce inequalities in the population; and

5.4.3 provide value for money.

5.5 **Contract Management**

5.5.1 NHSE may by Contractual Notice allocate, add or remove contracts to the Joint Commissioning Group such that they are included as part of the Joint Functions. For the avoidance of doubt, NHSE may add or remove contracts where this is associated with an extension or reduction of the scope of the Joint Functions. The Joint Functions must be exercised both in respect of the relevant contract and any related matters concerning any Service Provider that is a party to contract or arrangement where within the scope of the delegated functions.

5.5.2 Any new contract entered into in respect of POD Services for the population shall be managed by the Joint Commissioning Group in accordance with the provisions of this Agreement.

5.6 NHSE may, at its discretion, issue Contractual Notices from time to time relating to the manner in which the Joint Functions must be exercised. Contractual Notices will have effect as variations to this Agreement.

5.7 In relation to the contract management of the Joint Functions, the Joint Commissioning Group agrees to perform the following general obligations:

5.7.1 to manage the contracts and perform all of NHSE's obligations under each of the contracts or arrangements in accordance with the relevant terms as if it were named in the contract in place of NHSE;

5.7.2 actively manage the performance and contracts of the Service Providers in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services including, as appropriate, by taking timely action to enforce contractual breaches, serve notices or working with Service Providers to address any issues;

5.7.3 ensure that it obtains value for money on behalf of NHSE, and avoids making any double payments under any contract or arrangement;

5.7.4 notify all partner ICBs and NHSE immediately or in any event within two (2) Operational Days of any failure to perform any of NHSE's obligations under the contracts;

5.7.5 undertake any investigations relating (among other things) to whistleblowing claims, infection control and patient complaints;

5.7.6 keep a record of all of the contracts that the Joint Commissioning Group manages setting out the following details in relation to each contract:

(a) name of the Service Provider;

(b) the name by which the Service Provider is known (if different to the name recorded under paragraph 2.4.6.1);

(c) location of provision of services; and

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

5.8 The Joint Commissioning Group must actively manage each of the relevant contracts including by:

5.8.1 reviewing the performance of the relevant contract, including in respect of quality standards, incentives, observance of service specifications, and monitoring of activity and finance;

5.8.2 assessing quality and outcomes (including clinical effectiveness, patient experience, patient safety and addressing inequalities);

5.8.3 managing variations to the relevant contract or services in accordance with national policy, service user needs and clinical developments;

5.8.4 agreeing information and reporting requirements and managing information breaches (including use of the NHS Digital Data Security & Protection Toolkit as relevant to an ICB's organisational obligations under the DSPT assessment);

5.8.5 agreeing local prices, managing agreements or proposals for local variations and local modifications;

5.8.6 conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes; and

5.8.7 complying with and implementing any relevant Mandated Guidance issued from time to time.

6. RESERVED FUNCTIONS

6.1 Any functions delegated by NHSE to the ICBs that are not set out within the scope of the Joint functions are retained by the ICBs and will be reserved functions that will continue to be exercised by the ICBs.

6.2 The Scheme of Delegation and Reservation set out at Schedule X provides further detail on functions and decisions that will be exercised by the ICBs as reserved functions.

6.3 If there is any conflict or inconsistency between functions that are named as Joint Functions and functions that are named as Reserved Functions, then such functions shall be interpreted as Reserved Functions.

7. FINANCE

7.1 Without prejudice to any other provision in this Agreement, the Joint Commissioning Group must comply with the NHS statutory financial duties for the reporting and accounting of funds used for the purposes of the Joint Functions.

7.2 The Joint Commissioning Group's expenditure on the Joint Functions must be no less than that necessary to:

7.2.1 meet all liabilities arising under or in connection with all contracts allocated to the Joint Commissioning Group in so far as they relate to the Joint Functions; and

7.2.2 meet national commitments from time to time on expenditure on specific Joint Functions.

7.3 The ICBs will advise the Joint Commissioning Group of the level of funding available in respect of the Joint Functions. As allocated to each ICB individually and not subject to any POD Pooled Budget arrangements (due to the ICB ledger / processing requirements belonging to each ICB and "Hosted Team" ICB-support arrangements from financial personnel within this Team and each ICB's own existing structures). Further details of a proposed Financial Risk Share arrangement to support individual ICB Financial Schemes of Delegation is set out as a Schedule X).

7.4 The ICBs may not increase or reduce any Joint Funds if / where so agreed, during the financial year without the full agreement of the Joint Commissioning Group

7.4.1 in order to take into account any monthly adjustments or corrections to the Joint Funds that the ICBs considers appropriate, including without limitation adjustments following any changes to the Joint Functions, changes in allocations, changes in contracts or otherwise;

7.4.2 in order to comply with a change in the amount allocated to NHSE by the Secretary of State pursuant to section 223B of the NHS Act;

7.4.3 to take into account any adjustments that ICBs consider appropriate (including without limitation in order to make corrections or otherwise to reflect notional budgets) to reflect any funds transferred (if agreed to have been transferred) to the Joint Commissioning Group in respect of the Joint Functions and in respect of which the Joint Commissioning Group has management or administrative responsibility for if / where set out under clauses or schedules [INSERT] of this Agreement; or

7.4.4 in order to ensure compliance by ICBs with its obligations under the NHS Act (including without limitation, Part 11 of the NHS Act) or any action taken or direction made by the Secretary of State in respect of NHSE under the NHS Act.

7.5 Further financial provisions in respect of the exercise of the Joint Functions is set out in Schedule [ ] (Financial Provisions)

8. POOLED FUNDS

8.1 The Partners may, for the purposes of exercising the Joint Functions under this Agreement, establish and maintain a pooled fund in accordance with section 65Z6 of the NHS Act.

8.2 Any pooled fund arrangements agreed by the Partners and documented in a separate Section 65Z6 Agreement will be overseen by the Joint Commissioning Group, unless otherwise agreed between the Partners, in accordance with the terms of the relevant Section 65Z6 Agreement.

9. STAFFING

9.1 The staffing arrangements shall be as set out in Schedule [ ].

9.2 Schedule [ ] makes further provision about deployment of NHSE Staff to an ICB for the purposes of carrying out the relevant Delegated Functions.

9.3 Each ICB must comply with any Mandated Guidance issued by NHSE from time to time in relation to the NHSE Staff.

10. VARIATIONS

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

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

11. DATA PROTECTION, FREEDOM OF INFORMATION AND TRANSPARENCY

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

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

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

11.2.2 becomes aware of any security breach,

11.2.3 in respect of the Relevant Information it shall promptly notify the Joint Commissioning Group and NHSE. The Partners shall fully co-operate with one another to remedy the issue as soon as reasonably practicable.

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

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

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

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

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

11.8 Schedule [INSERT] makes further provision about information sharing and information governance.

12. IT INTER-OPERABILITY

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

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

13. FURTHER ARRANGEMENTS

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

14. FREEDOM OF INFORMATION

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

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

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

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

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

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

15. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY

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

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

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

16. CONFIDENTIALITY

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

16.2 Subject to clauses [X], the receiving Partner agrees:

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

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

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

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

16.3.1 in connection with any Dispute Resolution;

16.3.2 to comply with the Law;

16.3.3 to any appropriate Regulatory or Supervisory Body;

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

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

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

16.4 The obligations in clauses [X] will not apply to any Confidential Information which:

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

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

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

16.5 This clause [ ] does not prevent the Joint Commissioning Group making use of or disclosing any Confidential Information disclosed by an ICB where necessary for the purposes of exercising its functions in relation to that ICB.

16.6 This clause [ ] will survive the termination of this Agreement for any reason for a period of 5 years.

17. LIABILITIES

17.1 Nothing in this Agreement shall affect:

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

17.2 The ICBs shall be responsible for and shall retain the conduct of any Claim in relation to the Joint Functions or Reserved Functions.

17.3 Each ICB must:

17.3.1 comply with any policy issued by NHSE from time to time in relation to the conduct of or avoidance of Claims and/or the proactive management of Claims;

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

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

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

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

18. DISPUTE RESOLUTION

18.1 Where any dispute arises within the Joint Commissioning Group in connection with this Agreement, the ICB(s) must use their best endeavours to resolve that dispute on an informal basis within the Joint Commissioning Group.

18.2 Where any dispute is not resolved under clause [X] on an informal basis, any ICB Representative may convene a special meeting of the Joint Commissioning Group to attempt to resolve the dispute.

18.3 Where there is any dispute that relates to the exercise of the Joint Functions and it is not resolved under Clause [X], it will be referred to [*NHSE Regional Director]* whose decision will be final and binding on the Partners.

18.4 If any dispute is not resolved under clause [X], it will be referred by the [Chair / Secretary] of the Joint Commissioning Group to the Chief Executives of NHSE and the ICB(s), who will co-operate in good faith to resolve the dispute within ten (10) days of the referral.

19. BREACH

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

19.1.1 exercise its rights under this Agreement; and/or

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

19.2 Without prejudice to clause [ ], if any Partner does not comply with the terms of this Agreement (including if the Joint Commissioning Group or any Partner exceeds its authority under this Agreement):

19.2.1 waive its rights in relation to such non-compliance in accordance with clause [ ];

19.2.2 ratify any decision in accordance with clause [ ]

19.2.3 terminate this Agreement in accordance with clause [ ] (Leaving the Joint Commissioning Group*)* below;

19.2.4 exercise the dispute resolution procedure in accordance with clause [ ] *(Dispute Resolution Procedure)*; and/or

19.2.5 exercise its rights under common law.

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

19.4 If:

19.4.1 a Partner does not comply with this Agreement; or

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

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

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

19.4.4 a plan for how the Partner proposes to remedy the non-compliance.

20. LEAVING THE JOINT COMMISSIONING GROUP

20.1 If an ICB wishes to exit the Joint Commissioning Group and end its participation in this Agreement, the following provisions will apply:

20.1.1 the ICB must notify partner ICBs and NHSE of its wish to exit the Joint Commissioning Group and end its participation in this Agreement and the notice must clearly set out the ICB's reasons for wishing to leave the Joint Commissioning Group; and

20.1.2 within thirty (30) days of receipt by partner ICBs and NHSE of the notice referred to at clause [ ] above, NHSE, partner ICBs and the ICB will meet to discuss the ICB's proposals for exiting the Joint Commissioning Group.

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

20.3 The ICB(s) acknowledge that the exercise of Joint Functions delegated by NHSE remains the responsibility of NHSE.

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

21. CONSEQUENCES OF TERMINATION

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

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

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

21.2 The provisions of Clauses [ ] (Data Protection), [ ] (Freedom of Information), [ ] (Confidentiality), [ ] (Liabilities) and [ ] (Consequences of Termination) shall survive termination or expiry of this Agreement.

22. PUBLICITY

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

23. EXCLUSION OF PARTNERSHIP OR AGENCY

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

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

24. THIRD PARTY RIGHTS

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

25. NOTICES

26. Any notices given under this Agreement must be sent by e-mail to the address set out in the Particulars [and must request a delivery receipt and read receipt].

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

28. ASSIGNMENT AND SUBCONTRACTING

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

29. SEVERABILITY

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

30. WAIVER

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

31. STATUS

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

32. ENTIRE AGREEMENT

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

33. GOVERNING LAW AND JURISDICTION

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

34. FAIR DEALINGS

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

35. COMPLAINTS

Any complaints received by the Partners shall be dealt with in accordance with the statutory complaints procedure of the Partner to whose Commissioning Function(s) the complaint relates.

36. COUNTERPARTS

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

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

SIGNATURE PAGE

SIGNED by ....

for and on behalf of {●} Integrated Care Board (Signature)

.....

(Date)

SIGNED by ....

for and on behalf of {●} Integrated Care Board (Signature)

.....

(Date)

SIGNED by ....

for and on behalf of {●} Integrated Care Board (Signature)

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(Date)

SIGNED by ....

for and on behalf of {●} Integrated Care Board (Signature)

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(Date)

SIGNED by ....

for and on behalf of {●} Integrated Care Board (Signature)

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(Date)

SIGNED by ....

for and on behalf of {●} Integrated Care Board (Signature)

.....

(Date)

SCHEDULE 1 - Definitions and Interpretations

1. DEFINITIONS AND INTERPRETATION

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

"Agreement"	this agreement between the Partners comprising these terms and conditions together with all schedules attached to it;
"Area"	[xxx]
"Authorised Officer"	either NHSE's Authorised Officer or the relevant ICB Authorised Officer (as appropriate), the Commencement Date as set out in Schedule [ ] (Authorised Officers) and as updated by notice from time to time;
"Change in Law"	a change in Law that is relevant to the arrangements made under this Agreement, which comes into force after the Commencement Date;
"Claim"	means, for or in relation to the Joint Functions and Reserved Functions (a) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal or the Secretary of State, any governmental, regulatory or similar body, or any department, board or agency or (b) any dispute with, or any investigation, inquiry or enforcement proceedings by, any governmental, regulatory or similar body or agency;
"Commencement Date"	{●};
"Commissioning Functions"	the respective functions of the Partners in arranging for the provision of services as part of the health service;
"Confidential Information"	means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement or arrangements made pursuant to it and: (a) which comprises Personal Data or which relates to any patient or his treatment or medical history;

	(b) the release of which is likely to prejudice the commercial interests of a Partner; or (c) which is a trade secret;
"Contracts"	Means any contract entered into by NHSE in exercised of its Commissioning Functions;
"Data Controller" / "Data Processor"	shall have the same meaning as set out in the Data Protection Legislation;
Data Guidance	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement regarding information governance, confidentiality, privacy or compliance with legislation to the extent published and publicly available or their existence or contents have been notified to the ICB by NHSE and/or any relevant Regulatory or Supervisory Body. This includes but is not limited to guidance issued by NHS Digital, the National Data Guardian for Health & Care, the Department of Health & Social Care, NHSE, the Health Research Authority, the UK Health Security Agency and the Information Commissioner;
"Data Protection Legislation"	means the UK General Data Protection Regulation, the Data Protection Act 2018, the Regulation of Investigatory Powers Act 2000, the Telecommunications (Lawful Business Practice) (Interception of Communications) Regulations 2000 (SI 2000/2699), the Privacy and Electronic Communications (EC Directive) Regulations 2003 (SI 2426/2003), the common law duty of confidentiality and all applicable laws and regulations relating to the processing of personal data and privacy, including where applicable the guidance and codes of practice issued by the Information Commissioner;
"Dispute Resolution Procedure"	the procedure set out in Clause 18 (Dispute Resolution);
"FOIA"	the Freedom of Information Act 2000 and any subordinate legislation made under it from time to time, together with any guidance or codes of practice

	issued by the Information Commissioner or relevant government department concerning this legislation;
"ICB Authorised Officer"	the authorised officer of a ICB as set out in Schedule 5 (Authorised Officers);
"ICB Functions"	The Commissioning Functions of the ICB to be jointly exercised by the Joint Commissioning Group as set out in [INSERT]
"IG Guidance for Serious Incidents"	IG Guidance for Serious Incidents NHS Digital's Checklist Guidance for Information Governance Serious Incidents Requiring Investigation June 2013, available at: https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-informationgovernance/data-security-and-protection-toolkit
"Information"	has the meaning given under section 84 of FOIA;
"Information Sharing Agreement"[2]	the information sharing agreement set out in Schedule 6 (Information Sharing Agreement);
"Indemnity Arrangement"	means either: (i) a policy of insurance; (ii) an arrangement made for the purposes of indemnifying a person or organisation; or (iii) a combination of (i) and (ii)
"Joint Commissioning [Committee] - [Group]"	means the Joint Commissioning Group of the ICBs established on the terms set out in the Terms of Reference;
"Joint Commissioning Arrangements"	Means the arrangements for joint working as set out in Clause [X]
"Joint Functions"	those aspects of the NHSE Commissioning Functions jointly exercised by the ICBs through the decisions of the Joint Commissioning Group in accordance with the Terms of Reference and as set out in detail in Schedule [INSERT REF]

[2] Information sharing arrangements will need to be considered if the collaboration arrangements will involve sharing of patient personal data and where existing arrangements to allow for such sharing are not in place. This will need to be considered on a case-by-case basis.

“Joint Funds”	Means the funds that NHSE or ICBs have allocated to the Joint Functions
"Law"	means: (a) any statute or proclamation or any delegated or subordinate legislation; (b) any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and (c) any judgment of a relevant court of law which is a binding precedent in England;
“Mandated Guidance”	means any protocol, policy, guidance, guidelines, framework or manual relating to the exercise of the Joint Functions and issued by NHS England from time to time,
“NHS Act”	The National Health Service Act 2006
"NHSE's Authorised Officer"	NHSE’s authorised officer, as set out in Schedule 5 (Authorised Officers);
“NHSE’s Functions”	NHSE’s functions exercisable under or by virtue of the NHS Act;
“Aim”	the aim of the Joint Commissioning Arrangements described at Clause 3.2;
“Partners”	The parties to this Agreement
"Personal Data"	has the meaning set out in the Data Protection Legislation;
“Population”	Means the population for which an ICB or all of the ICBs have the responsibility for commissioning health services;
“Regulatory or Supervisory Body”	means any statutory or other body having authority to issue guidance, standards or recommendations with which the relevant Party and/or Staff

must comply or to which it or they must have regard, including:

(i) CQC;

(ii) NHS England;

(iii) the Department of Health & Social Care;

(iv) NICE;

(v) Healthwatch England and Local Healthwatch;

(vi) the General Medical Council;

(vii) the General Dental Council;

(viii) the General Optical Council;

(ix) the General Pharmaceutical Council;

(x) the Healthcare Safety Investigation Branch; and

(xi) the Information Commissioner;

"Relevant Information"	means the Personal Data and Non-Personal Data processed under this Agreement, and includes, where appropriate, "confidential patient information" (as defined under section 251 of the NHS Act), and "patient confidential information" as defined in the 2013 Report, The Information Governance Review – "*To Share or Not to Share?*");
"Request for Information"	has the meaning set out in the FOIA;
"Reserved Functions"	those aspects of the Specialised Commissioning Functions which are not Joint Functions including but not limited to those set out in Schedule [ ];
"Sensitive Personal Data	has the meaning set out in the Data Protection Legislation;
"Specified Purpose"	means the purpose for which the Relevant Information is shared and processed, being to facilitate the exercise of the Joint Functions, ICB Functions and Reserved Functions as specified in Schedule [ ]; *(Further*

	Information Governance and Sharing Provisions) to this Agreement;
"Need to Know"	Has the meaning set out in Schedule [ ];
"Term"	the Initial Term, as may be varied by: (a) any extensions to this Agreement that are agreed under Clause (Commencement and Duration); or (b) the earlier termination of this Agreement in accordance with its terms;
"Terms of Reference"	For the Joint Commissioning Group agreed between the ICBs [a draft of which is included at Schedule [ ].
"Triple Aim"	The duty on each of the Partners in making decisions about the exercise of their functions, to have regard to all likely effects of the decision in relation to – (a) the health and well-being of the people of England; (b) the quality of services provided to individuals by the NHS; (c) efficiency and sustainability in relation to the use of resources by the NHS;
"Working Day"	any day other than Saturday, Sunday, a public or bank holiday in England.

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

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

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

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

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

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

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

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

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

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

SCHEDULE 2

[***INSERT***] AGREED POD JOINT COMMISSIONING GROUP Terms of Reference

SCHEDULE 3

[*INSERT*] FINAL Proposed Financial Transitional Risk Framework – Pharmacy, Optometry, and Dentistry (PODs)

Working Draft =

(1) Changes to Delegation

This document has been written in response to the upcoming delegation of Pharmacy, Optometry, and Dentistry (PODs) commissioning to ICBs, with these services to commence from April 2023.

(2) What is a financial risk framework?

The financial risk framework is a set of rules and behaviours (as set out in section 5) which govern the way we manage the risk that may arise from variation in POD budgets between delegated ICBs of the Midlands Region. This will be to mitigate the potential risks to systems from allocation methodology change, as well as in year budget variation in year by ICB due to unknown factors. This will not include risk sharing as a result of individual commissioning decisions made by ICBs. The focus of this risk share being a pooling of resources enabling risks to be understood, as well as the impact of overspend risk.

It should be noted that the risk framework is intended to support the transition, and therefore will require review to determine its continuation or cessation.

The document aims to describe:

- How over, and underspends are managed within the regional hosted service
- How the changes to services are managed between organisations and services
- The risk mechanism that is in place
- The process for changes to the risk mechanism

(3) Who / What does this document concern?

This document is intended for all ICBs within the Midlands Region that will be in receipt of delegated budgets as at 1st April 2023.Initial entry into the risk share is for all ICBs in the region but to protect the risk share ICBs can only leave at the point of review (section 8).

This agreement relates to the Pharmacy, Optometry and Dental budgets delegated at April 2023. The document has been written with a 'commissioner lens'. As a result this excludes the financial impact of under/overperformance within providers accounts as part of the risk share. This risk share excludes previously delegated primary care budgets, on only those that transfer under the current delegation process.

This document may touch on expected financial reporting routes as part of the risk management, but reporting is subject to the development of a reporting framework. The two documents must be written and read in consideration of each other.

(4) Why do we need a financial risk framework?

- ICBs are new organisations, and not all ICBs have experience managing these specific commissioning budgets. Until that knowledge is built up, this may mean additional caution in applying budgets in year, or additional exposure to risk. A risk share allows a mitigation to this while there is a common route to delivery.
- POD budgets are currently managed across the Midlands which provides a large budget in which to manage variability in activity across contracts and movements in patient charge revenue. After delegation budgets / areas covered will be smaller meaning risk management agreements will be needed to manage variability between ICBs.
- Allocations have been established using 2019/20 activity and spend levels. However, two years of alternative financial processes may impact on the accuracy of allocations at an ICS level. In addition, there are changes to the Dental contract expected in the second half of 2022/23 all of which creates additional uncertainty on ICB allocations.
- As part of the move to delegated budgets, allocations may change as they are transferred to ICB level. There is an expectation of a move to a more capitated share of budgets after 2024. This raises the risk of variation to in year budgets which may not be fully known when budgets are first delegated, therefore future risk sharing needs to mitigate this risk.
- A number of 'wicked' problems as examples have been listed below to prompt the draft framework proposed in this slide/document:
  - How does the system minimise variation to plan?
  - An ICB may wish to make a change to service that is within the risk share, this could include additional investment, change in policy, or pathway. How will this be managed within the risk share?
  - An ICB may wish to withdraw a service from the risk share: how will this be managed?
  - An ICB may work unilaterally on service changes or savings which then impacts on the overall risk share. How is this managed?
  - Should risk sharing be the answer to an overspend?
  - If ICBs disagree on how a risk should be handled, how is this resolved?
  - If there are differential impacts against system allocations due to new allocation methodologies, how are these risks managed?

(5) Behaviours and Standards

This document has been written with an expectation of openness, transparency, and trust in mind between ICBs. These risk principles should be considered in the application of the document. This also means that while we use this document there will be elements of clarity and refinement required. It's expected that in these cases partners use judgement for the spirit of document in its application; however, this should not be used to challenge each aspect of the framework.

Any ambiguity that cannot be resolved between partners, through use of the Finance & Contracting Sub-Group should then follow the escalation process (section 11); however, this should be avoided wherever possible.

(6) In Year Financial Management

- Risk sharing should not be the primary source of net cost avoidance and should only be applied once the Finance & Contracting Sub-Group (FCAG) has assured itself that appropriate mitigations have been put in place.
- Virement should not be enacted between services or ICBs without express agreement by FCAG on POD budgets, to allow maximum knowledge gained in this first year by ICBs. Unlike specialised commissioning budgets, POD budgets should be risk shared on the total financial position for POD within ICBs.

- Should appropriate mitigation and virement proposals not bring the budget back to plan then risk sharing should be considered. Enacting the risk sharing should be a recommendation of the FCAG to the East and West Joint Committees.

(7) Financial risk sharing

- The principles of any financial risk (and reward) sharing agreement are based on agreeing fair and equitable funding to control expenditure whilst optimising outcomes.
- Financial risk sharing agreements should be the final option after all efforts have been made to manage the risk in-year.
- It is expected these risk shares will allow the movement of budget in year between systems within the hosting organisation in a balanced economy to resolve allocation methodology issues to system allocations mismatching to historical spend.
- The first route recognises individual ICB shortfalls in total POD budgets. Therefore allowing an adjustment to vire budgets between ICBs below the bottom line position to bring in line with plan. This excludes individual commissioning decisions made by ICBs, e.g. a variance to budget spend caused by investment. As a result variances to budget should be explained before virement or risk share is made to ensure it is due to unexpected causes.
- If the above is not possible due to an overall shortfall, the position will be shared based on proportionately based on plan budget values by ICB delegated budgets agreed at plan. This is with the exception of decisions made by individual ICBs e.g. ICB investment / disinvestment above initial financial plan levels decisions are excluded from the risk share unless with the explicit agreement of all ICBs.
- System allocation mismatch assumes an overall balanced economy. As the reporting develops, reporting will also be produced at a system level (by Q2 of 2023), and a balancing adjustment between systems will be proposed by the hosted team to bring systems in line with budgets. Any overall shortfall from budget will be dealt with as highlighted in the previous paragraph. The balancing adjustment should be shown within the reporting to support transparency and understanding.
- Quarterly position statements of agreed risk sharing should be produced including a forecast at each quarter. These will form the basis of recommended adjustments, and at Q3 a forecast and recommendation will be made for the year end to support delivery of year end positions. This may be supplemented by a Month 11 update and recommendation.
- Reporting will be in place monthly to support budget monitoring. Application of risk arrangements will commence by Q2 of 2023 to allow sufficient actual activity to be available. Reporting will be at a level that allows the drilling down into PODs to understand the cause of variances. (This will be developed by a separate sub-group).
- Enacting the risk share will be a recommendation of the FCAG to the East and West Joint Committees.
- The risk share will be region-wide i.e. East and West Midlands. This should be part of a review after year 1 and a better understanding of budget variations.
- All services that are part of the delegation will be included in the risk share. Currently there are not specific risk shares for each speciality.

(8) The future of risk sharing for Pharmacy, Optometry, and Dentistry (PODs)

- This risk share is intended to be in place to allow a greater degree of understanding by ICBs of the risks inherited from delegating budgets either from changes in allocation methodology, or in year changes in spend.

- Whilst the risk share continues to be in place it will be subject to annual review and amendment by consensus agreement.
- The risk share is seen as transitional; however the risk share will continue by default in the absence of any agreed changes that would be recommended by the FCAG and approved by the East/West Joint Committee.
- The review should consider the geographical coverage, as well as service coverage.
- Removal and addition of services from the risk share should be by agreement of all members of the risk share group, including resource flow. This means an ICB cannot unilaterally leave the risk share. This should form a review at the end of the first year. Changes should not remove the viability of a risk share.

(9) Use of contingency / unallocated funds

- Best practice looks to avoid holding back significant sums from the planning process, in terms of a central contingency. This is in part because of the requirement on the public sector to use the funds allocated for the purposes intended and in part to discourage organisations relying on such funds to 'bail them out' or ending with last minute year-end expenditure resulting in a sub-optimal use of resources. However, there are often unforeseen costs and a small level of contingency set aside to support may be required.
- To meet unforeseen costs a planned contingency of 1% should be aspired to from within the delegated budgets, and form a part of the mitigation process, however this should be reviewed each time plans are agreed to ensure affordability of contingency creation is possible, and if not possible, a recommended level put forward to the Finance & Contracting sub-group.

(10) Assurance

Following delegation there will be Joint Committees for East Midlands and West Midlands with a specific finance sub-committee. Through delegation from the ICBs this sub-committee will have responsibility for oversight and delivery of the risk management framework. Regular financial performance reporting will facilitate monitoring and management of financial risk and application of the terms of the framework will be the responsibility of the finance sub-committee.

(11) Appeals and escalation

- While there may be a financial risk sharing agreement, there will need to be a process for dispute resolution where consensus cannot be agreed.
- Primarily risk sharing disagreements will be managed by the chair of the FCAG, unless conflicted. In the case of conflict, an agreed independent party will provide arbitration.
- Escalation to the East and West Joint Committees is required upon recommendation of the FCAG chair should a disagreement not be settled.
- Should this not be resolved, NHSE will be requested to provide arbitration, however this should be avoided where possible and alternative routes identified.

[*EAST*] / [*WEST*] Midlands Integrated Care Boards[1]
POD JOINT COMMISSIONING GROUP
Terms of Reference

Effective from 1st April 2023

(1) Introduction and Statutory Framework

1.1 In accordance with its statutory powers under section 13YB of the National Health Service Act 2022, NHS England (NHSE) has delegated the exercise of the functions specified in these Terms of Reference (TOR) to NHS Integrated Care Boards ("the ICBs"). The delegation and list of participant ICBs is set out in Schedule One.

1.2 In accordance with the delegation and section 65Z5 of the NHS Act 2022, the ICBs have together established the Pharmacy-Ophthalmic-Dentistry ("POD") Joint Commissioning Group ("the Group"). It will function as a joint entity, to act as the collaborative ICB decision-making body for the joint management and exercise of the powers delegated to each ICB by NHSE.

1.3 Arrangements made under section 13YB do not affect the liability of NHSE for the exercise of any of its functions. However, the ICB(s) together acknowledge that in exercising its / their functions, it / they must comply with the statutory duties set out in the 2022 Act and including:

(a) Management of conflicts of interest (section 14Z30);
(b) Duty to promote the NHS Constitution (section 14Z32);
(c) Duty to exercise its functions effectively, efficiently and economically (section 14Z333);
(d) Duty as to improvement in quality of services (section 14Z34);
(e) Duty as to reducing inequalities (section 14Z35);
(f) Duty to promote the involvement of each patient (section 14Z36);
(g) Duty as to patient choice (section 14Z37);
(h) Duty as to promoting integration (section 14Z42);
(i) Public involvement and consultation (section 14Z45);
(j) Duty to have regard to impact on services in certain areas (section 14Z43).

1.4 The ICB members together acknowledge that the Group is subject to any directions made by NHSE or by the Secretary of State.

(2) Constitution

2.1 The Group is established in accordance with Section 65Z5 of the NHS Act 2006 (as amended) and within each ICB's Constitution; as a group of the ICB. These TOR set out the membership, remit, responsibilities and reporting arrangements and shall have effect as if incorporated into the ICBs' Constitutions.

(3) Role of the Group

3.1 The Group has been established in accordance with the above statutory provisions to enable the members to make collective, joint decisions on the review, planning and procurement of Primary Care POD services in the *[East] and [West]* Midlands.

[1] One Joint Group shall be formed for each of the East and West Midlands sub-regional footprints.

3.2 In performing its role, the Group will jointly exercise the management of individually-delegated functions in accordance with the agreements entered into between NHSE / each ICB individually. Which will sit alongside the delegation and these TOR.

3.3 Its functions are to be undertaken jointly in the context of a desire to promote increased collaborative commissioning and at-scale decision-making on quality, efficiency, productivity and value for money and to remove administrative barriers.

3.4 The Group shall carry out the broad functions relating to the commissioning of Primary Care POD services under section 83 of the NHS Act. This includes, but is not exclusive to, the areas outlined below and more fully in Schedule Two (the full functions / decisions of the Group and its subsidiaries):

- Carrying out of those Delegated Functions relating to Primary Care POD and Secondary Care Dental Services outlined in each NHSE-to-ICB Delegation Agreement[2] including;
- Receive and approve newly-designed pan-ICBs Enhanced Services funded entirely from the delegated Primary Care POD budget[3];
- Note the introduction of new "Directed Enhanced Services" and the financial impact on the Primary Care POD budget;
- Decision-making on whether to establish new POD Contractors in the combined area or as unique to their own ICB area;
- Approving POD Contractor mergers; and
- Making decisions on 'discretionary' payment schemes.
- Decision-making on POD services closure proposals;
- Planning Primary Care POD services, including carrying out needs assessments with Local Authorities aligned to ICS Integrated Care Strategies;
- To undertake reviews of Primary Care POD services;
- To co-ordinate a common approach to commissioning Primary Care POD services;
- To manage the budget for commissioning of Primary Care POD services across the [*East*] *and* [*West*] Midlands footprint;
- Procurement of Agreed Services – the ICBs will make collaborative procurement decisions relevant to the exercise of Delegated Functions in accordance with the detailed arrangements regarding procurement set out in the protocols issued and updated by NHSE from time to time.

3.5 The majority of operational, day-to-day decisions will be taken by the three "Pillar Groups" (operational groups at tier three, set out in Schedule Two) that sit underneath this Group. With each providing upwards assurance to the Group on their own pillar, including related quality and finance decisions. This will also act as the formal route of escalation from Pillar Groups. As set out within Joint Working Agreement escalation / mediation / dispute resolution procedures.

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[2] Being in summary: decisions in relation to the planning. commissioning & management of Primary Dental Services in the Area, including carrying out needs assessments; undertaking reviews of Primary Dental / Ophthalmic Services in the Area; management of the Delegated Funds in the Area; co-ordinating a common approach to the commissioning & delivery of Primary Dental / Ophthalmic Services with other commissioners where appropriate; and in such other ancillary activities that are necessary in order to exercise the Delegated Functions. *[A complete list will be presented as a full Schedule in the Joint Working Agreement each ICB will be requested to sign].*

[3] Where LES arrangements are locally developed (e.g. from multiple funding sources or are bespoke, single-ICB facing in nature), to inform partners of the relevant local funding and design / co-ordination contributions towards those from single-ICB budgets or resources.

3.6 In discharging its / their responsibilities in the performance and joint exercise of the Delegated Functions (set out by the Delegation Agreement), each ICB must comply at all times with procurement law and other statutory guidance.

3.7 Where an ICB wishes to develop and offer a locally-designed contract, it should engage their Local Pharmacy - Ophthalmic - Dental Committee in relation to the proposal and demonstrate whether / how the scheme will improve outcomes, reduce inequalities and provide value for money.

(4) Membership and Attendees

4.1 The ICBs will work collaboratively to ensure that the membership of the committee includes sufficient expertise to enable it to discharge its functions effectively.

4.2 The Group will operate a 'Distributed Leadership' model to enable safe decision-making is embedded into its processes; and shall consist of the following members:

- The 'Authorised Officer' of each ICB in respect of the Joint Working Agreement (usually the Executive Director responsible for Primary Care), who shall have voting rights;
- One other Executive Director from each of the following ICB functions, providing specific advice and expertise from those functions to the whole Group, on a multi-ICB, representational basis. Who shall not have voting rights or count towards quoracy Their purpose is to provide the Group with relevant advice / expertise to ensure robust, transparent decision-making under the Distributed Leadership model[4]:
  - Finance
  - Quality & Patient Safety / Clinical
  - People
  - Digital
  - Governance

4.4 A suitably empowered individual acting as deputy may be agreed, in advance, with the Chair, where a member or attendee is unable to attend a meeting. Where members are unable to attend, they should ensure that any named and fully-briefed deputy in attendance is able to participate (and vote, if so empowered) on their behalf.

4.5 The following will be invited to routinely attend meetings of the Group. For the avoidance of doubt, these will hold the same "Participant Member" (in-attendance, representational) status as may be set out within ICB Constitutions for certain posts. As such, they will not be entitled to vote on matters:

- Hosted POD Team Functional Leads
- Hosted POD Team reps from each Tier 3 'Pillar Group' (DAIG – PSRC – GOSC)

4.6 One of the Authorised Officers shall be appointed / nominated from those who express an interest by the members as Chair of the Group. Another one of whom shall similarly be appointed as Vice-Chair[5].

[4] ICB CEOs gave approval at their 4th January 2023 Time Out to the 5/6 ICBs within each Group agreeing one Finance Director-level lead, one Quality Director-level lead etc from amongst all, to represent their professional discipline collectively. Rather than require one from each ICB, due to capacity concerns.

[5] Ideally both should not be selected from the same ICB within the sub-regional footprint.

4.7 The Group may call additional experts to attend meetings on an ad hoc basis to inform their joint discussions.

(5) Meetings, Quoracy and Voting Rights

5.1 The Group can by agreement meet 'in common' with the corresponding meeting in the other sub-regional footprint, if both East & West Midlands agendas have joint, common areas that would benefit from a broader, whole-Midlands regional discussion.

5.2 Members will operate in accordance with each individual representative ICB's own Standing Orders. The Secretariat will be appointed from within the same ICBs who comprise the from-ICBs elected Chair and Vice-Chair roles.

5.3 The Secretariat will be responsible for giving notice of meetings. When the Chair deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as they specify. Where all efforts will be made in advance of such exceptional-needs circumstances to mirror any variable arrangements as may be established differently by each ICB's own Standing Orders.

5.4 The standard decision-making basis will be to achieve a consensus, wherever possible. However, where this is not possible, each ICB shall have one vote each. The Group shall reach decisions by a simple majority. Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result (of an exceptional vote) will be recorded in the minutes: to note those for, or against a motion, or if any member abstained).

5.5 To be quorate, the Chair or Vice-Chair and **a minimum of one member from each of the participant ICBs** must be present to enable joint working to take place. An ICB's Authorised Officer (or nominated deputy) shall ordinarily be this member.

5.6 This is required to reflect the consensus, joint working nature of Group decision-making. And in order to avoid all bar the most exceptional decisions being challenged under ICB Joint Working Agreement escalation and/or dispute resolution procedures.

5.7 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic media. Any decision will be reported in the minutes of the subsequent meeting.

(6) Frequency and Operation of Meetings

6.1 Meetings will be held monthly as a minimum; and shall be held in private. Consideration may be given to bi-monthly, dependent on the frequency of Joint Committee and ICB Board meetings.

6.2 Members have collective responsibility for the joint operation and focus of all meetings. They will participate in joint discussions, jointly review evidence and jointly provide objective expert input to the best of their knowledge, ability and endeavours to reach a collective, pan-ICB consensus view.

6.3 The Group may devolve decision-making tasks to such individuals, to sub-groups or to individual members as it sees fit, provided that these are recorded in ICB Schemes of Reservation & Delegation (SoRDs), are governed by these Terms of Reference or

Collaborative Working Agreements as appropriate and reflect each ICB's arrangements for the management of conflicts of interest.

6.4 All members shall respect confidentiality requirements set out in ICB Constitutions.

6.5 The Committee shall be supported with a Secretariat function who will ensure that the agenda and papers are prepared / distributed a minimum of five (5) calendar days before the meeting. The Secretariat support will be provided by the relevant Executive Chair's ICB administrative pool (unless otherwise agreed by members).

(7) Accountability of the Group

7.1 The Group is established as a Joint Commissioning Group. It will be accountable to the Unitary Board of each member ICB and also the Tier One Joint Committee.

7.2 Responsibility of this Group is outlined within each ICB's 'Governance Handbooks' and within each ICB's SoRD. Where each ICB's Delegated Financial Limits (a.k.a 'Scheme of Financial Delegation': SoFD) will also outline any local budgetary delegation / approval arrangements applicable to their members in attendance[6].

7.4 Minutes of the meetings (including any sub-groups will be made available to each ICB's Unitary Board.

7.5 The Group is responsible for both overseeing the management of Primary Care POD delegated and pooled or aligned budgets; and for ensuring that joint decisions made do not exceed these. In addition to the management of those budgets delegated by NHSE, an ICB's Unitary Board may delegate the management of additional budgets as deemed appropriate by it.

7.6 The Group will ensure that patient and public engagement / consultation is considered, and undertaken as appropriate or required, as part of its remit. Members must also demonstrably consider the Equality and Diversity implications of decisions they make.

(8) Conflicts of interest

8.1 Members should comply with their ICB's Standards of Business Conduct and/or Declarations of Interest policy and complete declarations as required. If a member feels compromised by any agenda item they should declare a conflict of interest as soon as they are aware of it, ideally before the meeting.

8.2 The conflict will be considered by the Chair, either prior to the meeting or at it; who will then determine the appropriate course(s) of action available from the generally-accepted standard policy options pertinent to ICBs.

8.3 A detailed record of declarations made in relation to agenda items and their agreed actions will be recorded in the minutes of the meeting.

8.4 Failure to disclose an interest, whether intentional or otherwise, will be treated in line with the ICB's policy for managing Conflicts of Interest, and may result in suspension from the Group.

[6] If an ICB is delegating to the Group via their SoRD, rather than to individual members via their SoFD, the delegation here will be to the joint body and not individual ICB staff. Each ICB will therefore need to determine accordingly whether it is delegating financial decisions to a joint body or a person, or both, in their own local delegation governance arrangements, set out as best suits local circumstances.

(9) Decisions

9.1 The Group will only make decisions within the bounds of its remit; and ultimately responsible for the delivery of Primary Care POD services.

9.2 The Group will produce an executive summary report on decisions made, which will be presented to the next-available ICB Unitary Board meeting.

9.3 Each ICB may establish a local arrangement that incorporates POD oversight of ICB-specific, sovereign decisions (or indeed to prepare for decisions to be reached at this joint meeting); which may run alongside or separate to local arrangements similarly made for Primary Medical Services.

9.4 The members note that many decisions on contract management and/or service delivery are made following national processes and contract procedures through mandated committees.

9.5 ICBs will each receive regular performance, activity, finance and quality reports. Where local decisions are made by an ICB's own individual decision-making arrangements, it will be responsible under its own SoRD to arrange for how those best fit with the decisions made by this Group. For example, how ICB-specific concerns and/or reports will come to the appropriate ICB body for local decision in response to the wider delegated from ICB to ICBs decisions reached at this Group.

Effective From: 1st April 2023

Review Date: Annual, unless specific circumstances require more-frequent review (especially in the first year of operations while new arrangements bed in). A review log for the TOR may also be kept within each ICB's 'Governance Handbook', if so required locally.

Schedule One: Primary Care POD Delegation

TO EMBED the relevant Schedule of the Joint Working Agreement, setting out Delegated Functions in line with NHSE-to-ICB Delegation Agreement Paperwork, once fully confirmed.

TO LIST the participant ICBs (East & West), in the final draft prepared for approval at meeting #1 in April-22.

Schedule Two: ICB Delegated Decisions and role / duties of the Group

THE INITIALLY-PROPOSED LIST AS EMERGING FROM GOVERNANCE / PRIMARY CARE WORKSTREAMS (i.e. WILL ALSO need to include Quality / Finance / Other considerations as these become identified too)

(a) CORE COMMISSIONING FUNCTIONS: joint POD decision-making by ICBs as a Tier Two Joint Commissioning Group

- The delivery of POD commissioning as a whole - oversight, assurance, risk management (inc. audit, counter fraud) and high-level decision-making of the POD function and Secondary Care Dental services, including reviewing the performance of the relevant contract in respect of quality standards, incentives, observance of service specifications, monitoring of activity and finance, assessing quality and outcomes (including clinical effectiveness, patient experience, patient safety and addressing inequalities);
- The delivery of POD commissioning pertinent to Sections 3.4 / 3.5 of these TOR inc. POD LES commissioning (barring individual ICB-bespoke arrangements for its own patch only);

(b) CORE COMMISSIONING FUNCTIONS: joint POD decision-making by ICBs at Tier Three "Pillar Groups"

- Pharmaceutical Services Regulations Committee (PSRC):
  - The majority of decisions must be made following nationally-governed rules through this mandated committee;
  - For all other operational decisions / service development / strategic input, the meeting will need to split into a Part A: PSRC; Part B: Pharmacy Governance Group, which will require ICB SORD resolution inc. for procurement decisions;
  - This will report into the ICB POD Joint Group: it is not envisaged that each ICB will need to send representatives, though it may choose to;
- Dental Assurance & Improvement Group (DAIG):
  - This will be responsible for the majority of decisions, development of strategy and operational delivery, which will require ICB SORD resolution inc. for procurement decisions;
  - E.g. Dental Activity Redistribution Activity: work undertaken by the hosted POD team and presented to DAIG for sign off unless the figure hit the threshold for escalation to the ICB POD Joint Group
  - Exceptions to this principle and therefore necessary to escalate to ICB POD Joint Group are non-recurrent additional funding for winter pressures and funding for urgent access on a short term basis to meet a gap in service provision
  - This will report into the ICB POD Joint Group: as there are more decisions here that can be influenced by ICBs, it is suggested there are ICB reps at this group;
- General Ophthalmic Services Committee (GOSC):
  - This committee will be responsible for the majority of decisions, development of strategy and operational delivery, which will require ICB SORD resolution inc. for procurement decisions;
  - This group will report into the ICB POD Joint Group: it is not envisaged that each ICB will need to send representatives, though it may choose to;

The following may also be further delegated from the ICB POD Joint Group to Tier Three: i.e. the 'Appropriate Working Groups for other joint commissioning functions', whose own Terms of Reference as to be established would need to be approved by this Group:

(c) CORE COMMISSIONING FUNCTIONS: joint decision-making on ICB-led POD **Quality**[7]

The core tasks are:

- Incident management
- Complaints management
- Routine quality monitoring, surveillance, identification of quality risks
- Managing serious quality risks (e.g. IPC concerns, Safeguarding concerns, Serious patient safety concerns, Serious Incidents)
- Quality Improvement
- Other key tasks including the management of Performer Concerns, and the Controlled Drugs Accountable Officer role are the responsibility of the Medical Directorate;

[7] A workshop for ICB CNOs / CMOs on 6th December confirmed a consensus, broad alignment to the agreed Governance Model and what is done, where: e.g. ICBs will still need to agree locally where the responsibility lies for day-to-day delivery / management of quality & decision making, via an agreed Quality Governance Framework for these functions and what will be undertaken at East & West sub-regional Quality Committees (Tier Two) level – under separate TORs, to be developed with CNOs & CMOs / Governance Leads – and what will be undertaken at an individual ICB level.

(d) CORE COMMISSIONING FUNCTIONS: joint decision-making on ICB-led POD **Finance**[8]

The core tasks are:

- Financial Planning: shared discussions on ICB baseline allocations in a Risk Share environment
- Financial Planning: POD contractual development / service-level financial decision-making
- Development of a financial risk management framework for PODs
- Engagement in and agreement of underlying principles for workforce models

[8] A Finance Workstream suite of papers and planned workshop for ICBs in January will work on aligned / agreed Financial Governance Models to support what is done by a proposed Tier Two Joint ICB-to-ICB Finance & Contracting Group and where ICBs will need to agree locally where responsibility lies for day-to-day delivery / management of finance decisions and supporting technical / operational processes, via an agreed Finance Risk Framework.

[*EAST*] / [*WEST*] Midlands Integrated Care Boards[1]
POD JOINT COMMISSIONING GROUP
Terms of Reference

Effective from 1st April 2023

(1) Introduction and Statutory Framework

1.1 In accordance with its statutory powers under section 13YB of the National Health Service Act 2022, NHS England (NHSE) has delegated the exercise of the functions specified in these Terms of Reference (TOR) to NHS Integrated Care Boards ("the ICBs"). The delegation and list of participant ICBs is set out in Schedule One.

1.2 In accordance with the delegation and section 65Z5 of the NHS Act 2022, the ICBs have together established the Pharmacy-Ophthalmic-Dentistry ("POD") Joint Commissioning Group ("the Group"). It will function as a joint entity, to act as the collaborative ICB decision-making body for the joint management and exercise of the powers delegated to each ICB by NHSE.

1.3 Arrangements made under section 13YB do not affect the liability of NHSE for the exercise of any of its functions. However, the ICB(s) together acknowledge that in exercising its / their functions, it / they must comply with the statutory duties set out in the 2022 Act and including:

(a) Management of conflicts of interest (section 14Z30);
(b) Duty to promote the NHS Constitution (section 14Z32);
(c) Duty to exercise its functions effectively, efficiently and economically (section 14Z333);
(d) Duty as to improvement in quality of services (section 14Z34);
(e) Duty as to reducing inequalities (section 14Z35);
(f) Duty to promote the involvement of each patient (section 14Z36);
(g) Duty as to patient choice (section 14Z37);
(h) Duty as to promoting integration (section 14Z42);
(i) Public involvement and consultation (section 14Z45);
(j) Duty to have regard to impact on services in certain areas (section 14Z43).

1.4 The ICB members together acknowledge that the Group is subject to any directions made by NHSE or by the Secretary of State.

(2) Constitution

2.1 The Group is established in accordance with Section 65Z5 of the NHS Act 2006 (as amended) and within each ICB's Constitution; as a group of the ICB. These TOR set out the membership, remit, responsibilities and reporting arrangements and shall have effect as if incorporated into the ICBs' Constitutions.

(3) Role of the Group

3.1 The Group has been established in accordance with the above statutory provisions to enable the members to make collective, joint decisions on the review, planning and procurement of Primary Care POD services in the *[East] and [West]* Midlands.

[1] One Joint Group shall be formed for each of the East and West Midlands sub-regional footprints.

3.2 In performing its role, the Group will jointly exercise the management of individually-delegated functions in accordance with the agreements entered into between NHSE / each ICB individually. Which will sit alongside the delegation and these TOR.

3.3 Its functions are to be undertaken jointly in the context of a desire to promote increased collaborative commissioning and at-scale decision-making on quality, efficiency, productivity and value for money and to remove administrative barriers.

3.4 The Group shall carry out the broad functions relating to the commissioning of Primary Care POD services under section 83 of the NHS Act. This includes, but is not exclusive to, the areas outlined below and more fully in Schedule Two (the full functions / decisions of the Group and its subsidiaries):

- Carrying out of those Delegated Functions relating to Primary Care POD and Secondary Care Dental Services outlined in each NHSE-to-ICB Delegation Agreement[2] including;
- Receive and approve newly-designed pan-ICBs Enhanced Services funded entirely from the delegated Primary Care POD budget[3];
- Note the introduction of new "Directed Enhanced Services" and the financial impact on the Primary Care POD budget;
- Decision-making on whether to establish new POD Contractors in the combined area or as unique to their own ICB area;
- Approving POD Contractor mergers; and
- Making decisions on 'discretionary' payment schemes.
- Decision-making on POD services closure proposals;
- Planning Primary Care POD services, including carrying out needs assessments with Local Authorities aligned to ICS Integrated Care Strategies;
- To undertake reviews of Primary Care POD services;
- To co-ordinate a common approach to commissioning Primary Care POD services;
- To manage the budget for commissioning of Primary Care POD services across the [*East*] *and* [*West*] Midlands footprint;
- Procurement of Agreed Services – the ICBs will make collaborative procurement decisions relevant to the exercise of Delegated Functions in accordance with the detailed arrangements regarding procurement set out in the protocols issued and updated by NHSE from time to time.

3.5 The majority of operational, day-to-day decisions will be taken by the three "Pillar Groups" (operational groups at tier three, set out in Schedule Two) that sit underneath this Group. With each providing upwards assurance to the Group on their own pillar, including related quality and finance decisions. This will also act as the formal route of escalation from Pillar Groups. As set out within Joint Working Agreement escalation / mediation / dispute resolution procedures.

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[2] Being in summary: decisions in relation to the planning. commissioning & management of Primary Dental Services in the Area, including carrying out needs assessments; undertaking reviews of Primary Dental / Ophthalmic Services in the Area; management of the Delegated Funds in the Area; co-ordinating a common approach to the commissioning & delivery of Primary Dental / Ophthalmic Services with other commissioners where appropriate; and in such other ancillary activities that are necessary in order to exercise the Delegated Functions. *[A complete list will be presented as a full Schedule in the Joint Working Agreement each ICB will be requested to sign].*

[3] Where LES arrangements are locally developed (e.g. from multiple funding sources or are bespoke, single-ICB facing in nature), to inform partners of the relevant local funding and design / co-ordination contributions towards those from single-ICB budgets or resources.

3.6 In discharging its / their responsibilities in the performance and joint exercise of the Delegated Functions (set out by the Delegation Agreement), each ICB must comply at all times with procurement law and other statutory guidance.

3.7 Where an ICB wishes to develop and offer a locally-designed contract, it should engage their Local Pharmacy - Ophthalmic - Dental Committee in relation to the proposal and demonstrate whether / how the scheme will improve outcomes, reduce inequalities and provide value for money.

(4) Membership and Attendees

4.1 The ICBs will work collaboratively to ensure that the membership of the committee includes sufficient expertise to enable it to discharge its functions effectively.

4.2 The Group will operate a 'Distributed Leadership' model to enable safe decision-making is embedded into its processes; and shall consist of the following members:

- The 'Authorised Officer' of each ICB in respect of the Joint Working Agreement (usually the Executive Director responsible for Primary Care), who shall have voting rights;
- One other Executive Director from each of the following ICB functions, providing specific advice and expertise from those functions to the whole Group, on a multi-ICB, representational basis. Who shall not have voting rights or count towards quoracy Their purpose is to provide the Group with relevant advice / expertise to ensure robust, transparent decision-making under the Distributed Leadership model[4]:
  - Finance
  - Quality & Patient Safety / Clinical
  - People
  - Digital
  - Governance

4.4 A suitably empowered individual acting as deputy may be agreed, in advance, with the Chair, where a member or attendee is unable to attend a meeting. Where members are unable to attend, they should ensure that any named and fully-briefed deputy in attendance is able to participate (and vote, if so empowered) on their behalf.

4.5 The following will be invited to routinely attend meetings of the Group. For the avoidance of doubt, these will hold the same "Participant Member" (in-attendance, representational) status as may be set out within ICB Constitutions for certain posts. As such, they will not be entitled to vote on matters:

- Hosted POD Team Functional Leads
- Hosted POD Team reps from each Tier 3 'Pillar Group' (DAIG – PSRC – GOSC)

4.6 One of the Authorised Officers shall be appointed / nominated from those who express an interest by the members as Chair of the Group. Another one of whom shall similarly be appointed as Vice-Chair[5].

[4] ICB CEOs gave approval at their 4th January 2023 Time Out to the 5/6 ICBs within each Group agreeing one Finance Director-level lead, one Quality Director-level lead etc from amongst all, to represent their professional discipline collectively. Rather than require one from each ICB, due to capacity concerns.

[5] Ideally both should not be selected from the same ICB within the sub-regional footprint.

4.7 The Group may call additional experts to attend meetings on an ad hoc basis to inform their joint discussions.

(5) Meetings, Quoracy and Voting Rights

5.1 The Group can by agreement meet 'in common' with the corresponding meeting in the other sub-regional footprint, if both East & West Midlands agendas have joint, common areas that would benefit from a broader, whole-Midlands regional discussion.

5.2 Members will operate in accordance with each individual representative ICB's own Standing Orders. The Secretariat will be appointed from within the same ICBs who comprise the from-ICBs elected Chair and Vice-Chair roles.

5.3 The Secretariat will be responsible for giving notice of meetings. When the Chair deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as they specify. Where all efforts will be made in advance of such exceptional-needs circumstances to mirror any variable arrangements as may be established differently by each ICB's own Standing Orders.

5.4 The standard decision-making basis will be to achieve a consensus, wherever possible. However, where this is not possible, each ICB shall have one vote each. The Group shall reach decisions by a simple majority. Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result (of an exceptional vote) will be recorded in the minutes: to note those for, or against a motion, or if any member abstained).

5.5 To be quorate, the Chair or Vice-Chair and **a minimum of one member from each of the participant ICBs** must be present to enable joint working to take place. An ICB's Authorised Officer (or nominated deputy) shall ordinarily be this member.

5.6 This is required to reflect the consensus, joint working nature of Group decision-making. And in order to avoid all bar the most exceptional decisions being challenged under ICB Joint Working Agreement escalation and/or dispute resolution procedures.

5.7 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic media. Any decision will be reported in the minutes of the subsequent meeting.

(6) Frequency and Operation of Meetings

6.1 Meetings will be held monthly as a minimum; and shall be held in private. Consideration may be given to bi-monthly, dependent on the frequency of Joint Committee and ICB Board meetings.

6.2 Members have collective responsibility for the joint operation and focus of all meetings. They will participate in joint discussions, jointly review evidence and jointly provide objective expert input to the best of their knowledge, ability and endeavours to reach a collective, pan-ICB consensus view.

6.3 The Group may devolve decision-making tasks to such individuals, to sub-groups or to individual members as it sees fit, provided that these are recorded in ICB Schemes of Reservation & Delegation (SoRDs), are governed by these Terms of Reference or

Collaborative Working Agreements as appropriate and reflect each ICB's arrangements for the management of conflicts of interest.

6.4 All members shall respect confidentiality requirements set out in ICB Constitutions.

6.5 The Committee shall be supported with a Secretariat function who will ensure that the agenda and papers are prepared / distributed a minimum of five (5) calendar days before the meeting. The Secretariat support will be provided by the relevant Executive Chair's ICB administrative pool (unless otherwise agreed by members).

(7) Accountability of the Group

7.1 The Group is established as a Joint Commissioning Group. It will be accountable to the Unitary Board of each member ICB and also the Tier One Joint Committee.

7.2 Responsibility of this Group is outlined within each ICB's 'Governance Handbooks' and within each ICB's SoRD. Where each ICB's Delegated Financial Limits (a.k.a 'Scheme of Financial Delegation': SoFD) will also outline any local budgetary delegation / approval arrangements applicable to their members in attendance[6].

7.4 Minutes of the meetings (including any sub-groups will be made available to each ICB's Unitary Board.

7.5 The Group is responsible for both overseeing the management of Primary Care POD delegated and pooled or aligned budgets; and for ensuring that joint decisions made do not exceed these. In addition to the management of those budgets delegated by NHSE, an ICB's Unitary Board may delegate the management of additional budgets as deemed appropriate by it.

7.6 The Group will ensure that patient and public engagement / consultation is considered, and undertaken as appropriate or required, as part of its remit. Members must also demonstrably consider the Equality and Diversity implications of decisions they make.

(8) Conflicts of interest

8.1 Members should comply with their ICB's Standards of Business Conduct and/or Declarations of Interest policy and complete declarations as required. If a member feels compromised by any agenda item they should declare a conflict of interest as soon as they are aware of it, ideally before the meeting.

8.2 The conflict will be considered by the Chair, either prior to the meeting or at it; who will then determine the appropriate course(s) of action available from the generally-accepted standard policy options pertinent to ICBs.

8.3 A detailed record of declarations made in relation to agenda items and their agreed actions will be recorded in the minutes of the meeting.

8.4 Failure to disclose an interest, whether intentional or otherwise, will be treated in line with the ICB's policy for managing Conflicts of Interest, and may result in suspension from the Group.

[6] If an ICB is delegating to the Group via their SoRD, rather than to individual members via their SoFD, the delegation here will be to the joint body and not individual ICB staff. Each ICB will therefore need to determine accordingly whether it is delegating financial decisions to a joint body or a person, or both, in their own local delegation governance arrangements, set out as best suits local circumstances.

(9) Decisions

9.1 The Group will only make decisions within the bounds of its remit; and ultimately responsible for the delivery of Primary Care POD services.

9.2 The Group will produce an executive summary report on decisions made, which will be presented to the next-available ICB Unitary Board meeting.

9.3 Each ICB may establish a local arrangement that incorporates POD oversight of ICB-specific, sovereign decisions (or indeed to prepare for decisions to be reached at this joint meeting); which may run alongside or separate to local arrangements similarly made for Primary Medical Services.

9.4 The members note that many decisions on contract management and/or service delivery are made following national processes and contract procedures through mandated committees.

9.5 ICBs will each receive regular performance, activity, finance and quality reports. Where local decisions are made by an ICB's own individual decision-making arrangements, it will be responsible under its own SoRD to arrange for how those best fit with the decisions made by this Group. For example, how ICB-specific concerns and/or reports will come to the appropriate ICB body for local decision in response to the wider delegated from ICB to ICBs decisions reached at this Group.

Effective From: 1st April 2023

Review Date: Annual, unless specific circumstances require more-frequent review (especially in the first year of operations while new arrangements bed in). A review log for the TOR may also be kept within each ICB's 'Governance Handbook', if so required locally.

Schedule One: Primary Care POD Delegation

TO EMBED the relevant Schedule of the Joint Working Agreement, setting out Delegated Functions in line with NHSE-to-ICB Delegation Agreement Paperwork, once fully confirmed.

TO LIST the participant ICBs (East & West), in the final draft prepared for approval at meeting #1 in April-22.

Schedule Two: ICB Delegated Decisions and role / duties of the Group

THE INITIALLY-PROPOSED LIST AS EMERGING FROM GOVERNANCE / PRIMARY CARE WORKSTREAMS (i.e. WILL ALSO need to include Quality / Finance / Other considerations as these become identified too)

(a) CORE COMMISSIONING FUNCTIONS: joint POD decision-making by ICBs as a Tier Two Joint Commissioning Group

- The delivery of POD commissioning as a whole - oversight, assurance, risk management (inc. audit, counter fraud) and high-level decision-making of the POD function and Secondary Care Dental services, including reviewing the performance of the relevant contract in respect of quality standards, incentives, observance of service specifications, monitoring of activity and finance, assessing quality and outcomes (including clinical effectiveness, patient experience, patient safety and addressing inequalities);
- The delivery of POD commissioning pertinent to Sections 3.4 / 3.5 of these TOR inc. POD LES commissioning (barring individual ICB-bespoke arrangements for its own patch only);

(b) CORE COMMISSIONING FUNCTIONS: joint POD decision-making by ICBs at Tier Three "Pillar Groups"

- Pharmaceutical Services Regulations Committee (PSRC):
  - The majority of decisions must be made following nationally-governed rules through this mandated committee;
  - For all other operational decisions / service development / strategic input, the meeting will need to split into a Part A: PSRC; Part B: Pharmacy Governance Group, which will require ICB SORD resolution inc. for procurement decisions;
  - This will report into the ICB POD Joint Group: it is not envisaged that each ICB will need to send representatives, though it may choose to;
- Dental Assurance & Improvement Group (DAIG):
  - This will be responsible for the majority of decisions, development of strategy and operational delivery, which will require ICB SORD resolution inc. for procurement decisions;
  - E.g. Dental Activity Redistribution Activity: work undertaken by the hosted POD team and presented to DAIG for sign off unless the figure hit the threshold for escalation to the ICB POD Joint Group
  - Exceptions to this principle and therefore necessary to escalate to ICB POD Joint Group are non-recurrent additional funding for winter pressures and funding for urgent access on a short term basis to meet a gap in service provision
  - This will report into the ICB POD Joint Group: as there are more decisions here that can be influenced by ICBs, it is suggested there are ICB reps at this group;
- General Ophthalmic Services Committee (GOSC):
  - This committee will be responsible for the majority of decisions, development of strategy and operational delivery, which will require ICB SORD resolution inc. for procurement decisions;
  - This group will report into the ICB POD Joint Group: it is not envisaged that each ICB will need to send representatives, though it may choose to;

The following may also be further delegated from the ICB POD Joint Group to Tier Three: i.e. the 'Appropriate Working Groups for other joint commissioning functions', whose own Terms of Reference as to be established would need to be approved by this Group:

(c) CORE COMMISSIONING FUNCTIONS: joint decision-making on ICB-led POD **Quality**[7]

The core tasks are:

- Incident management
- Complaints management
- Routine quality monitoring, surveillance, identification of quality risks
- Managing serious quality risks (e.g. IPC concerns, Safeguarding concerns, Serious patient safety concerns, Serious Incidents)
- Quality Improvement
- Other key tasks including the management of Performer Concerns, and the Controlled Drugs Accountable Officer role are the responsibility of the Medical Directorate;

[7] A workshop for ICB CNOs / CMOs on 6th December confirmed a consensus, broad alignment to the agreed Governance Model and what is done, where: e.g. ICBs will still need to agree locally where the responsibility lies for day-to-day delivery / management of quality & decision making, via an agreed Quality Governance Framework for these functions and what will be undertaken at East & West sub-regional Quality Committees (Tier Two) level – under separate TORs, to be developed with CNOs & CMOs / Governance Leads – and what will be undertaken at an individual ICB level.

(d) CORE COMMISSIONING FUNCTIONS: joint decision-making on ICB-led POD **Finance**[8]

The core tasks are:

- Financial Planning: shared discussions on ICB baseline allocations in a Risk Share environment
- Financial Planning: POD contractual development / service-level financial decision-making
- Development of a financial risk management framework for PODs
- Engagement in and agreement of underlying principles for workforce models

[8] A Finance Workstream suite of papers and planned workshop for ICBs in January will work on aligned / agreed Financial Governance Models to support what is done by a proposed Tier Two Joint ICB-to-ICB Finance & Contracting Group and where ICBs will need to agree locally where responsibility lies for day-to-day delivery / management of finance decisions and supporting technical / operational processes, via an agreed Finance Risk Framework.

Agenda Item

ICB 25-01-060

Board Committee Minutes

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

NHS Shropshire, Telford and Wrekin
ICS Quality & Performance Committee Meeting

Wednesday 26th October 2022 at 9.00am to 11.00am

Via Microsoft Teams

Present:

Meredith Vivian - Chair & Non-Executive Director, NHS Shropshire, Telford, and Wrekin
Alison Bussey – Chief Nursing Officer - NHS Shropshire, Telford and Wrekin
David Lee – Non-Executive Director, SaTH
Jacqueline Small - Non-Executive Director MPFT
Lynn Cawley, Chief Officer, Healthwatch Shropshire
Julie Garside – Director of Planning and Performance, NHS Shropshire Telford and Wrekin
Vanessa Whatley, Deputy Director of Nursing and Quality, NHS Shropshire, Telford and Wrekin
Liz Noakes - Director of Public Heath, Telford & Wrekin Council
Nick White – Chief Medical Officer, NHS Shropshire Telford and Wrekin
Tina Long – Non-Executive Director, Shropshire Community Health NHS Trust
Sara Ellis-Anderson - Chief Nurse RJAH

Attendees:
Tracey Slater, Assistant Director of Quality, NHS Shropshire Telford and Wrekin
Sam Cooke, Interim Deputy Director of Performance, NHS Shropshire, Telford and Wrekin
Sharon Fletcher, Senior Perinatal Quality Lead and Patient Safety Specialist NHS Shropshire Telford and Wrekin
Emma Biggs, Quality Midwife, NHS Shropshire Telford and Wrekin
Rachel Cox, Engagement Officer - Healthwatch Shropshire
Cynthia Fearon – Corporate PA, Note Taker, NHS Shropshire Telford, and Wrekin

1.0 Minute No. ICS/QPC- QPC-22-10.33 – Welcome/Apologies by: Meredith Vivian

1.1 The Chairperson of the Committee - Meredith Vivian welcomed members and attendees to the meeting.

Apologies:

Clair Hobbs – Director of Nursing, Shropshire Community Healthcare NHS Trust
Liz Lockett –Chief Nurse and Director of Quality & Professional Leadership, MPFT
Claire Horsfield - Deputy Director for Quality & Chief AHP, Shropshire Community Healthcare NHS Trust
Cllr Jonathan Rowe – Executive Director of Adults Social Care and Health and Wellbeing, Telford & Wrekin Council
Laura Tyler – Assistant Director Joint Commissioning Shropshire Council and NHS Shropshire, Telford and Wrekin

Ruth Longfellow – Medical Director, RJAH

Apologies were noted as above

2.0 ICS/QPC- QPC-22-10.34 Members' Declarations of Interests

There were no declarations or conflicts of interest noted.

3.0 Minute No. ICS/QPC-22-10.35 - Minutes of Meeting held on 28th September 2022

The minutes of the meeting held on 28th September 2022 were reviewed and accepted as an accurate record with following amendment:

Claire Horsfield's organisation wasn't listed. Linda Vaughan - System Implementation Manager works for MPFT.

Lynn Crawley requested that the wording for Health Watch Shropshire update 13.0 could be outlined as followed:

Lynn stated that Healthwatch Shropshire are now drafting a report from the feedback they received from the public about their experiences of calling for an ambulance in an emergency. She has shared initial findings with Shropshire Integrated Place Partnership (SHIPP). The report received feedback from over 130 people in Shropshire and 8 in Telford and Wrekin. Members of SHIPP are now looking at the Falls Pathway in Shropshire. Also, currently finishing off the work in Shropshire regarding the NHS Accessible Information Standard, which also covers social care. The aim was to raise awareness amongst groups such as, individuals with learning disabilities, autism, sight and hearing loss and to make them aware of what their rights under that standard, as well as reminding services what their duties are under the standard. Healthwatch Shropshire will be producing an engagement report from what they have heard from focus groups. Lynn Cawley stated, part of the new Healthwatch England project, is looking at people getting an appointment with their GP. Not only their experience of interacting with the GP. But also, the length of time potentially waiting for the appointment to happen and any challenges and barriers along the way. Healthwatch Shropshire will be launching this project formally next week with a press release. Lynn Cawley is requesting for partners to promote that.

4.0 QPC-22-10.36 Matters Arising and Action Log

Points raised as matter arising with actions have been outlined on the action log.

5.0 Minute No. QPC-22-10.37 - System Quality Risk Register – Vanessa Whatley

Vanessa Whatley presented the report and highlighted the two new risks in September 2022 which were discussed at SQG where it was agreed that these (SQG7 and SQG8) were added to the risk register. The previously suggested risk relating to insufficient anaesthetic support to the specialist dental service has not been added yet as the risk is still being investigated.

QPC to note recommendations:

- The Diabetes risk is recommended for further escalation.
- Consider other risks for ongoing progress/action

Nick White raised a point about the risk relating to radiology waits. A letter had been received from the regional team on this issue asking all ICS to be aware of this issue. Nick White emphasised, from an assurance stance, that the QPC were ahead of the game regarding this, as radiology waits were now highlighted as a risk across the system.

Liz Noakes referred to the Children's mental health risk update and welcome the suggestion that a more in-depth report can be given at a future meeting. Liz Noakes also referred to the performance exception report and noted that the system will not be able to meet the increasing demand. Liz Noakes added that she welcomes diabetes being put on the risk register and requested if there could be an intelligence piece to underpin that piece of work which would include looking at the outcomes. Julie Garside stated that they do have that list of information and is happy to share it. Which also include primary and secondary care. Meredith Vivian added that he thinks the QPC needs to be aware of the whole programme of work, to have a clearer understanding of how it all works. Julie Garside stated that there is now a whole project initiation document that is going to the Planned Care Board next week. Julie Garside suggested that the document could be shared to the QPC for next month's meeting.

Action: Julie Garside to share Project Initiation Document to QPC for the next scheduled meeting.

Tina Long referred to the Children's Mental Health risk and noted, that they had been four serious incidents reported for CAMHS which looked as though it had been linked to four appropriate beds not being available. Tina Long queried what was the outcome of those four young people. Alison Bussey normally stated the provider such as MPFT would have the detail behind the serious Incidents and would give that update.

Sara Ellis-Anderson stated, she recognises a lot of work has been undertaken regarding long waits within the system. But wondered whether that risk needs to be added to the QPC risk register. Vanessa Whatley suggested, that each organisation within the system could add that risk to their own risk register to monitor and mitigate accordingly.

Meredith Vivian requested if Vanessa Whatley could review the gaps and control columns within the risk register to ensure information is captured accordingly and what needs to be put in place.

Action: Vanessa Whatley to review the gaps and control columns within the risk register to ensure information is captured accordingly and what needs to be put in place for the appropriate control.

6.0 Minute No. ICS/QPC-22-10.38 – Performance Exception Report by: Julie Garside

Report received as read.

Julie Garside acknowledged the support of Sam Cook who is now in place as Interim Deputy Director of Performance.

Julie Garside requested for future meetings if the Performance Exception Report is circulated as a single attachment, as it is difficult to read data/graph information when papers are combined and PDF.

Julie Garside stated that the TWIPP report should have not been appended to the report for this month as they are still waiting for the SHIPP and TWIPP dashboard, which need to go to the Place Partnership Board for approval. That report will be brought back to QPC for November 2022 meeting.

Regarding Urgent and Emergency Care, Julie Garside has arranged with Sam Tilley to bring a focus paper on the Improvement Plan to the QPC Meeting.

Action: Julie Garside has arranged with Sam Tilley to bring a focus paper on the Improvement Plan to the QPC Meeting.

Tina Long referred to the 104 weeks wait, saying the target is to clear all patients off the list by the end of October 2022. Tina Long queried what current progress was being made against that target. Julie Garside stated spinal remains a significant challenge as they have been let down by some independent sector capacity for spinal patients. There is a lot of capacity in London but some limitations on what they will do. Julie Garside added that they are now working closely with NHS England regarding mutual aid.

Tina Long queried around cancer performance overall. Julie Garside replied that they have a number of tumour sites where things are ok. However, they have three tumour sites where there are significant challenges. Julie Garside added that they have also got significant challenges in Urology, colorectal and diagnostic. Julie Garside said that they are now anticipating some additional workforce third party capacity in October 2022.

Liz Noakes stated that Helen Onions is doing a piece of work around early diagnosis. However, capacity is very limited. Liz Noakes added that they have now got a partnership with Lyngen Davis and Cube in Shropshire to do some community-based work in terms of Cancer awareness.

Liz Noakes also referred to the maternity information on the dashboard which is good to see. Liz Noakes added once we are assured around the overall dashboard, we need to think about some of the equity issues that we should also be shining a light upon and closing those gaps.
Jackie Small referred to the physical checks, with people with severe mental health illness. Jackie Small stated when you look at the JSON data, the life expectancy in terms of that group is low. Jackie Small added that there needs to be more understanding of the challenges and why the checks are not being done in the first place. Julie Garside stated that she would liaise with Claire Parker to see whether an update could be given from Primary Care to a future QPC meeting.

Action: Julie Garside to liaise with Claire Parker for an update to be given from Primary Care around the challenges with people with mental and severe mental illness.

Lynn Cawley stated, at the last meeting she mentioned about the report Healthwatch Shropshire are doing regarding patient experience of calling for an ambulance in an emergency. Lynn Crawley asked whether it would be appropriate to bring that report to the QPC or where the QPC felt the report would be best placed to be shared. Meredith Vivian suggested that Julie Garside could use Lynn Cawley's information in her update. Julie Garside added that was as a good idea, but it would need to be seen by Gareth Robinson and Sam Tilley.

Lynn Cawley asked, who within the ICB would she ask for a comment on the report, as that is a real opportunity for the system to tell the public what they are doing and what is being done to address some of the challenges.

Meredith Vivian requested that Julie Garside outlines on future Performance Exception Reports, the name of the Executive Director, which would be Nicola Dymond.

Meredith Vivian mentioned that he is aware that there is a possibility of a strike coming up for the ambulance service. Alison Bussey stated that it is the GMB Union balloting for the strike to happen. Alison Bussey added, it is too early to say what the impact will be as it is too early to give any indication. Alison Bussey gave assurances that any responses that come because of the outcome of that will be managed through the EPR Process.

Meredith Vivian stated that he just wanted to inform the QPC that Sir Neil McKay stated at the last Integrated Care Board, that they are looking at the performance data, and asked – what can the QPC do more of or and better for performance? Tina Long mentioned that deep dive sessions allows you to really understand the issues and get behind some of the data challenges. Tina Long also stated it would be good to have a systematic plan over the year to have deep dives review periodically.

Vanessa Whatley stated having a risk register that really works was a good result for QPC. There is a need for clear process of de-escalation as well as escalation.

David Lee agreed that as an assurance committee, QPC could ensure the that the work plan is comprehensive and clear. The areas that we are not assured on to do a further deep dive.

Julie Garside stated that they will bring the results back from the deep dive to the QPC, which will help to identify the risks within respective delivery Boards. Julie Garside emphasised that it is the responsibility of this committee to hold to account the delivery Boards regarding their plans. For example, the Emergency Care Board and the Planned Care Board. Julie Garside added how the risks are identified and how the risks are worded is important, in order to get the right risk owners.

7.0 Minute No. ICS/QPC-22-10.39 – System Quality Metrics – Vanessa Whatley

Following discussion at System Quality Group the following points were raised to the Committee.

Vanessa Whatley reported the key points of discussion at SQG:

The report was received as read.

QPC to note recommendations:

- Consider the metrics with performance metrics and system risks.

Meredith Vivian referred to the complaints data and queried when data is received whether the data is separated out into Shropshire and Telford and Wrekin. Vanessa Whatley clarified that data is split and separated out into Shropshire and Telford and Wrekin.

Liz Noakes made reference to the data and the excess mortality in the under seventy fives. Liz Noakes stated that she thought the data was not quite correct. The report highlights excess mortality in the under 75 those with serious mental illness is high across the Shropshire, Telford and Wrekin. Liz Noakes added it isn't suicide that necessarily is the cause of death. The population average for suicide in both areas are similar to the national average. Whilst suicide is one component, it is more about how well we are integration of how well we are looking after the physical health of those with physical mental health. For example, screening for illnesses such as cancer. Julie Garside added that she has a monthly catch-up with Jane Williams and Meryl Flaherty before the Contract Review Meeting where they all go through all the data in the packs that are received before the meeting and would pick these points up.

Action: Julie Garside to clarify the performance of undertaking health checks for those with serious mental health illness

Tina Long stated, one of the areas that could be strengthened is around the patient experience. For example, we know how many complaints they have been, we don't have a summary of the trends, across the system of what are patients are telling us about their experience. Meredith Vivian stated that Hayley Cavanagh puts an insight paper together quarterly to tell us of what patients and user of services are telling us about their care, but this is limited. Meredith Vivian added that they is going to be a System Experience of Care Group set up to look at this.

Lynn Cawley also stated that Healthwatch Shropshire run the Independent Health Complaints Advocacy Service for Shropshire. Because of Healthwatch's role within complaints and general feedback Lynn Cawley has been asking for a long time, that more system level understanding of issues is raised about complaints. This is one of the problems with the report from the ICB although it is a good report, it is about what is shared with the ICB. Lynn Cawley added that she thinks there is a lot of people who don't understand what the ICB does and the role it plays. Lynn Cawley emphasised that she would like to encourage and remind people of the role Healthwatch play across Shropshire, Telford, and Wrekin as that independent organisation to gather this. The more intelligence we have, the more we can contribute to the work Julie Garside is doing.

8.0 Minute No. ICS/QPC-22-10.40 – Escalation Report – System Quality Group Chairs Report: Meredith Vivian

The report was presented and received as read.

Vanessa Whatley highlighted a key update from the report, that there had been a BBC Panorama programme on care of patients in a mental health hospital in Manchester prior to the SQG. This was

discussed in relation to assurances in quality systems. All partners thought lessons could be learned. MPFT agreed to bring the results of their review back to the System Quality Group in December 2022.

Lynn Cawley stated that Healthwatch Shropshire and Healthwatch Telford and Wrekin are returning to do entering view visits in hospitals, care homes and other services such as clinics. Lynn Cawley added this is where we pick up regarding people's dignity and respect. Healthwatch will be able to feedback those reports into the system.

9.0 Minute No. ICS/QPC-22-10.41 – SOAG Update by: Vanessa Whatley

The report was presented and received as read.

10.0 Minute No. ICS/QPC-22-10.42 – The Health Protection Assurance Board by: Liz Noakes

The paper was presented and received as read.

Liz Noakes highlighted that the STW Health Protection Assurance Board met on the 16th Sept 2022. The Board received reports from NHSEI Screening and Immunisation Team, STW Covid Immunisation team, Local Authority Health Protection teams and verbal updates from the UKHSA and STW IPC Lead.

Liz Noakes highlighted from her report that the STW Health Protection Assurance Board understood that the screening back log in the Breast Screening Service should be cleared by the end of September 2022 and that all other screening services were restored. The Board was also informed that capacity issues in radiology was impacting on NIPE screening resulting in increased waiting times for neonatal hip scans but that babies were being triaged with most urgent scans being prioritised. With respect to Abdominal Aortic Aneurysm (AAA) screening, waiting times for CT scans (currently 12-13 weeks) is impacting the service. However, mitigations are that cases are reviewed at MDTs for their clinical urgency and there are pathways that cases follow based on clinical urgency.

The Board held a discussion about Monkey pox and lessons learnt and agreed a Terms of Reference for a STW Health Infectious Disease Rapid Response Group that would be stood up as a response to any new emergent infection.

A standing Health Infection Rapid Response Group will be in place to look at and respond to any emergent situation of infectious outbreaks such as monkey pox and Covid 19. Liz Noakes gave thanks to Vanessa Whatley with her support regarding that group.

QPC to note recommendations:

- NHS Shropshire, Telford, and Wrekin Quality & Performance Committee is asked to note the contents of this report.

11.0 Minute No. ICS/QPC-22-10.43 – Palliative and End of life care strategy update by: Alison Massey

The report was received as read with the following key points to note for escalation:

Alison Massey highlighted that the Palliative and End of life care strategy was ratified in May 2022. There is an implementation plan in place and a working group structure underneath the System Steering Group. Of the 11 strategy aims:

- 4 are on target
- 3 have a delay in progress against the milestones for 2022 – 23 with Steering Group oversight
- 4 not started

There was some delay in progress to achieve milestones for 2022-23:

- Progress delayed as the Integrated Care Record is being rolled out
  An options appraisal needs to be completed to understand the opportunity of using the Electronic Palliative Care Coordinating System (EPaCCS) System Dashboard in development.
- Engagement Workshops in planning for November/December original workshops needed to be cancelled due to the period of national mourning in September 2022

QPC were asked to note recommendations:

It is recommended that Quality and Performance Committee accept the paper as assurance of progress against the aims of the Shropshire Telford and Wrekin Palliative and End of Life Care (PEoLC) Strategy (adults) 2022 – 2025.

Lynn Cawley raised the example of a child with a life limiting condition and wondered if there is any planned connection between someone who is formally identified as being at end of life and those individuals who have been given a diagnosis. Is there any plan to bring that work together? Alison Massey stated the conversations that have been had with the Steering Group for Children and Young People. The children's hospice, the children's nursing team and other specialists recommend that there should be a children's and young person's strategy because there are some very specific differences and do not want it to be lost in an all-age strategy (being reviewed). Alison Massey added the group was looking at collaboration with services that can offer long term support to children long term life illnesses and end of life. The adult strategy focus on the last year of life.

Alison Massey agree to link with Tina Long regarding some of her stories outside this meeting, regarding palliative and end of life care.

David Lee suggested that we need to build on the integration of records and then move to an integrated plan approach.

12 .0 Minute No. ICS/QPC-22- 10.44 – LMNS Update by: Alison Bussey

Alison Bussey stated that there was not a written report due to capacity within the team for various reasons. For moving forward Alison Bussey is proposing that there are quarterly reports which will commence from January 2023.

13.0 Minute No. ICS/QPC-22-10.45 – Healthwatch Shropshire Update (Verbal Update) by: Lynn Cawley

Lynn Cawley stated that Healthwatch are currently doing a piece of work to understand people's experience of asking for a GP referral to secondary care. So, it is not just about the challenge of getting the referral, but it is about what happens next.

Lynn Cawley would also like to let this committee know that SaTH approached Lynn Cawley to ask for some help, in understanding peoples experiences of receiving appointment letters. An issue that was raised at the Outpatient Transformation Board. People were saying they were being contacted by SaTH, that they had cancelled their own appointment, therefore, they would be taken off the waiting list. People were saying that they hadn't receive the appointment letter in the first place. At the moment, Healthwatch has not got any evidence of that from the person who raised it has a concern. So initially Healthwatch are going out on social media to see if anyone can share that experience with Healthwatch

and provide a copy of the letter to Healthwatch to help SaTH identify particular department where that might be the case.

Healthwatch England are nationally looking at revisiting the maternity mental health cases. Healthwatch has previously done a report on this, and Lynn Cawley wondered if it was worth sharing with Alison Bussey and Sharon Fletcher and can then reconsider whether that it is something that can be revisited.

Lynn Cawley stated that Healthwatch are about to go into a process of re-tendering for contracts from 2023.

14.0 Minute No. ICS/QPC-22-10.46 – Healthwatch Telford & Wrekin Update (Verbal Update): Barry Parnaby

No verbal update was given to this meeting, as Barry Parnaby was not in attendance at this meeting.

15.0 Minute No. ICS/QPC-22-10.47 - Evaluation of the meeting – All

Meredith Vivian stated that he received positive feedback from the last meeting. Meredith Vivian added, if anyone wants to feedback on how today's meeting went to contact him via email.

16.0 Minute No. ICS/QPC-22-10.48 - Items for escalation/referral to other Board Committees by: Chair

No items were raised for escalation

17.0 Minute No. ICS/QPC- QPC-22-10.49 – Any Other Business

There were no further matters to report.

Date and Time of Next Meeting

Wednesday 23rd November 2022, 9.00am, via Microsoft Teams.

11.09am – Meeting Closed

SIGNED …….. DATE ……

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

NHS Shropshire, Telford and Wrekin
ICB Finance Committee (Section 1) Meeting
Wednesday 2nd November 2022 at 09.45 am
Via Microsoft Teams

Present:

Name	**Title**
Trevor J McMillan (Chair)	Non Executive Director NHS STW
Claire Skidmore	Chief Finance Officer NHS STW
Nicola Dymond	Director of Strategy and Transformation NHS STW

Attendees:

Gareth Robinson	Director of Delivery and Transformation NHS STW
Angus Hughes	Associate Director of Finance NHS STW
Jill Price	Associate Director of Finance NHS STW

Apologies:

Laura Clare	Deputy Director of Finance NHS STW

Minute Taker:

Sally-Anne Smith	PA to Claire Skidmore

Minute No. FC-02.11.001 – Introduction and Apologies

1.1 The Chair, **TMcM**, welcomed everyone to the meeting and **CS** confirmed apologies had been received from **LC.**

Minute No. FC-02.11.002 – Declarations of Interests

2.1 No declarations of interest were noted.

Minute No. FC-02.11.003 – Minutes from the Previous Meeting held 28th September 2022 & Minutes from the CCG Meeting held on 22nd June 2022

3.1 **CS** explained that it had taken a long time to access the minutes form the final CCG Finance Committee meeting. She explained that she was the only person present who had attended that meeting; she had reviewed the minutes and would be happy to recommend that they be signed off. **CS** explained that there were only two actions on the action list that she had picked up through conversations into the ICB or have been superseded, **CS** recommended that they are both closed formally. **CS** said that this is for governance to ensure an accurate record had been captured and actions closed down. **TMcM** agreed.`

3.2 **TMcM** asked if in future papers could be formatted onto one pdf document, **CS** explained that **SAS** had experienced access issues to pdf but this is due to be resolved and papers will, in the future, be distributed as a single document.

3.3 **TMcM** confirmed one amendment to the minutes from the last meeting to accurately capture his role as Non Executive Director of NHS STW (rather than his Vice Chancellor role).

There being no other amendments, both sets of minutes were taken as a true and accurate record and the final CCG actions were agreed to be closed.

Minute No. FC-02.11.004 – Matters Arising and Action List from Previous Meetings

4.1 **TMcM referred to the action list from the** last meeting:

ACTION: **Secretary** to provide final CCG Finance Committee action list to the next meeting for sign off. **CS** confirmed that this was now complete.

ACTION: **CS** to liaise with Alison Smith regarding the appointment of a seconded Lay Advisor to Finance Committee as soon as practicable.

CS had not completed the conversation with Alison about the seconded Lay Advisor and asked for the action to remain open. **TMcM** said that there are ongoing discussions about how broad the role should be and asked that the need for technical finance expertise is not diluted in any role description. **ND** said she had been in discussion with Alison and Neil McKay to reiterate that, and confirmed that Alison is working on a job description.

CS noted that some of the actions listed were for the end of November and all others are closed.

Minute No. FC-02.11.005 – Month 6 Position Update – Revenue and Capital

5.1 **CS** said that additional information is being brought into the report which brings a richer picture regarding what is taking place however this work is not yet complete as there had been a lot of time and energy focussed this month on the re-forecast position and the work done to support conversations with NHS England. **CS** described the comprehensive pack submitted to NHSE on Monday afternoon and agreed that this would be circulated to all Part 1 and Part 2 committee members to ensure that everyone is sighted on it.

CS noted that **GR** and **ND** have seen the pack, it has already been shared with ICB Directors and DoF and Chief Executives across partner organisations. She felt that is really important all of the committee see what was sent, and it will also show the level of information that we are picking up around actions that we are taking and some of the other supplementary information that will provide supporting activity information in future committee reporting.

CS said in terms of Month 6 we had a deficit plan of 6 million pounds, and we are reporting a year to date of 8.4 million, we are off track and that continues the pattern we have been seeing month on month. The drivers of that distance from plan have not changed so predominantly it is still the additional independent sector activity for ophthalmology which is still coming through at half a million over budget a month; the discharge expenditure and the funding that we are pushing towards the local authorities to support better flow in the hospitals and it is also increased costs in our CHC packages for which the market pressures are significantly beyond the uplifts that we planned for. We are using balance sheet flexibilities to offset what we can but in spite of that we do have a significant overspend.

At the moment we are reporting a forecast outturn that meets plan except for those Covid expenditure items that were beyond plan. We now have to follow national process to agree a change to our forecast. Hence we currently present a position that has assumptions about how we might bring that expenditure back to plan by the end of year but we show delivery of them as significant risk in the position. At Month 6 we presented a net risk of £15m.

GR said that he felt that we have done all the things that we can in terms of providing the diagnostic and benchmarking to support focus on delivery of transformation and savings and we've got a process in place. We regularly brief the Chief Executives, and we have the Integrated Delivery Committee focussed on this, but ultimately, for some reason we cannot gain traction

with our work. He raised concern that the messages shared with senior colleagues do not always filter into organisations sufficiently. **GR** noted that even if we go through process and ultimately deliver very little to start with, at least that provides assurance that we are lifting all the stones and working hard to deliver driving cost out. **GR** told the committee however that he cannot currently assure them or NHSE that we are in that place.

TMcM said that he had had a brief conversation with Neil McKay and Simon Whitehouse about this last week, recognising that CEOs are held to account on a day-to-day basis by people other than the ICB and that even if they are personally committed to action they could be hampered by a differing view from their Board. **GR** said that that is the dynamic all systems have. Harry Turner, chair of the Integrated Delivery Committee, will recognise that as a NED himself. Boards are not necessarily giving contrary guidance or direction, but they may have a subtly different perspective. The Boards have however all signed up to the financial plan.

TMcM asked using this as a prelude to the System meeting if there is anything that we can do as a group, or himself personally could do to move action on. **CS** felt that it was important that the committee develop the relationship between this committee and the Integrated Delivery Committee with Finance Committee seeking assurance of delivery of the programme of work in support of the finance position.

TMcM refocussed the conversation to the ICB for this 'Part 1' of the meeting and asked if there was anything specific that needed to be addressed or escalated. **CS** asked that when we meet again to review month 7, she would like to focus discussion on the actions agreed to improve the forecast and the impact that they are having. **GR** agreed with this and said that we must keep focussed on the things we can control, for example the sustainability working group delivering the ICB 1.6% savings target (and some to contribute to the stretch target); the impact of the work that was done by our primary care colleagues to release funds to the bottom line over the coming months. **GR** emphasised that demonstrating that we have done everything in our power to do will help to gain credibility for our plans.

After discussion about the in-year position, **CS** raised the Oversight Framework that the ICB has produced to map actions to satisfy the exit criteria from our national 'level 4' status. This includes work on the finance strategy and recovery plan and noted work that is not ready for committee yet but will come in future months.

ND explained that any System that is in SOF Level 4 has a range of exit criteria it needs to address to demonstrate that it is fit for purpose. **ND** said that we are in the process of taking those quite generic exit criteria and making them relevant to our system, so what is it specifically that were going to do as a range of metrics or measures and actions against those criteria. We are also looking to set out how we hold ourselves to account to deliver that. She said that a key aspect of that is going to be our self-assessment process. The process has started with the development of a set of 'plans on a page' and **ND** noted that **CS** has those in place for the finance related exit criteria.

CS said that what is into the action plan is not there just to 'tick a box' to satisfy the requirements of the exit criteria. It's important to note that this is all work that we know we need to do to deliver sustainable services.

TMcM agreed with **ND's** suggestion that it would be helpful for this committee to be sighted on the plan and suggested that consideration be given to raising the profile of the criteria with the Board, and also the governance of oversight, for example it may be appropriate to consider a sub-committee of the Board to oversee progress of actions. **CS** agreed that it is important the NEDS are sighted on progress and understand the drivers for the assessments that we are making and offered to raise this with Simon Whitehouse and Neil McKay.

ND offered to share the MOU with NHSE that describes the process.

Resolved:

The committee noted the month 6 finance position; continued distance from plan and associated risks.

Actions:

SAS to circulate the Reforecast information provided to NHSE to committee members after the meeting.

CS to bring the finance elements of the NOF4 exit criteria to the next meeting.

CS to speak to Simon Whitehouse and Neil McKay to plan how to best raise the profile of the NOF4 exit process and agree the associated governance and oversight for the NEDs and Board.

ND to share NHSE/ICB MOU with **TMcM.**

Minute No. FC-02.11.006 – For Information Only Financial Sustainability Audit (at request of Audit Committee)

6.1 Roger Dunshea, chair of the Audit Committee had asked that the finance committee are sighted on work that is happening to self assess the ICB against a national governance framework. Internal audit of the self-assessment is underway and there is nothing material of concern flagged at this stage.

Resolved:

The committee noted the contents of the Terms of Reference and agreed to receive further updates at future meetings.

Minute No. FC-02.11.007- ANY OTHER BUSINESS

7.1 **CS** to sit down with **SAS** and plan future meetings to the end of the financial year.

10.30 am – Meeting Closed.

Date and Time of Next Meeting

29th November 2022 at 14.00 pm to 15.00 pm.

NHS Shropshire, Telford and Wrekin
ICS System Finance Committee (Section 2) Meeting
Wednesday 2nd November 2022 at 11.00 am
Via Microsoft Teams

Present:

Name:	**Title:**
Trevor J McMillan OBE (Chair)	Non Executive Director NHS STW
Claire Skidmore	Chief Finance Officer NHS STW
Helen Troalen	Director of Finance Shrewsbury and Telford Hospitals NHS Trust
Sarah Lloyd	Director of Finance Shropshire Community Health NHS Trust
Mark Salisbury	Operational Director of Finance RJAH (Deputising for C Macbeth)
Michelle Broadway	Shropshire Council (Deputising for J Walton)
Peter Featherstone	Shropshire Community Heath Finance Committee Chair (NED)
Nicola Dymond (part)	Director of Strategy and Integration NHS STW

Attendees:

Gareth Robinson	Director of Delivery and Transformation NHS STW

Apologies:

Ken Clarke	S151 Officer Telford and Wrekin Council
Chris Sands	Chief Finance Officer MPFT
Craig MacBeth	Chief Finance Officer RJAH

Minute Taker:

Sally-Anne Smith	PA to Claire Skidmore

Minute No. SFC-02.11.001 Introductions and Apologies

1.1 The Chair, **TMcM,** welcomed everyone to the meeting and apologies were received as noted.

Minute No. SFC-02.11.002 Members' Declarations of Interests

2.1 No Declarations of Interest in addition to those already declared were noted.

2.2 **HT** noted that she had submitted her conflicts of interest through the register of interests. at SATH and asked whether we should each do something specific for this meeting. **CS** agreed to check this with Alison Smith.

Action: CS to check with ICB's Governance Lead, Alison Smith, what conflict of interest information is required by this committee.

Minute No. SFC-02.11.003 Minutes of the Previous Meeting held on 28th September 2002 & Minutes of the CCG Meeting held on 22nd June 2022

3.1 A point of accuracy was made on the SFC Minutes, it was noted that:

- **TMcM** should be listed as a NED rather than his University title.

3.2 **CS** said that the CCG Minutes were not required for this meeting. They had been discussed in the Part 1 Meeting and had been agreed to be accurate.

Minute No. SFC-02.11.004 Matters Arising and Action List from Previous Meeting

4.1 The action list from the previous meeting was reviewed.

CS commented that work on the content of the month 6 report had been addressed in part and that further supplementary information would be included in future reporting. **CS** asked that the first action be kept open and reviewed in next month's meeting to ensure that the content is relevant and useful.

CS noted that the second two actions were not due until the end of November.

Minute No. SFC-02.11.005 Month 6 Position Update – Revenue and Capital

5.1 **CS** shared that a letter and supporting information pack had been submitted to Nicola Hollins, Regional Director of Finance. This was in response to a letter that she had written to the System regarding the forecast outturn position and the actions being taken to bring it back in line with plan. **CS** said that this would be circulated to the committee after the meeting.

Action: CS to circulate letter and supporting documents to committee members**.**

CS shared headlines from the month 6 report noting that at the halfway point of the year, the System was showing a £9.2m adverse position against plan. This predominantly being driven by the positions in SATH and for the ICB.

Key drivers of variance from plan for SATH were described as COVID expenditure, which has continued beyond the planning period that guidance required to be modelled and the cost of escalation capacity given the urgent and emergency care pressures throughout the System. For the ICB, drivers are independent sector activity around ophthalmology, particularly cataracts, at a cost of half a million pound overspend against plan per month; significant costs to support discharge and a large overspend against the CHC plan driven by market pressures and inflationary costs being far in excess of the 6% increase modelled for the plan.

CS mentioned that organisations and Systems are required to seek sign off from NHS England to formally report a deviation from the forecast. This has been noted in the conversations with Nicola Hollins. **CS** said that currently there is a £4m adverse variance to the £19m System deficit plan which exposes the COVID costs that have fallen outside of plan. There is also a reported net risk in the position of around £39 million. This highlights the extent to which there is a risk that the system will outturn at a level much greater than plan.

CS highlighted that there had been a shift in forecast out turns between the providers this month after a tactical conversation between the DoFs (with support from organisations). **CS** highlighted that SATH's monthly spend continues to be significantly in excess of plan and therefore in agreement between the providers, SATH's forecast deficit had been slightly increased with a corresponding improvement across the RJAH and SCHT forecasts. This is allowable within NHS reporting rules as there is a zero impact to the system bottom line.

TMcC invited questions, noting the unacceptable nature of the variance from plan.

HT suggested that one of the key things that we do need to do as a system is to map out our five-year financial plan. She said without having that five-year backdrop and an understanding of the assumptions around how our services may change across that period, we end up risking being in a position where we will be asked to sign up, to a really ambitious plan for 23/24 that we cannot deliver. **HT** said that if she looked at the SATH position, they are in line with their underlying plan, the issues that they have are non-recurrent, although she was unable to say for how many years.

CS agreed with **HT** and noted work already underway on this. **TMcC** asked if there was any discussion required in the system to gain support for a five-year plan. **CS** highlighted that there is already full support for a 5 and a 10-year finance model. A version was produced some time ago and the refresh of this is built into the work plan. **HT** added that in mapping five years, then years one and two drop out.

CS also pointed to information in the pack produced for NHSE that describes headlines on the overall planning process and highlighted the need to make sure that we triangulate activity, work force and finance information as we go. **TMcM** said he would like the committee to have the plan and timetable all in place.

CS noted that the planning timetable is on the agenda for the system finance meeting in the morning and suggested that the team bring a paper to the next Committee meeting to illustrate the process and key dates.

Action: CS to bring paper to next Committee meeting that outlines the plan for production of the finance plan.

CS concluded her comments by reminding the committee that she planned to bring more detailed information to the next committee on actions to either maintain or improve the position. This will allow the members to challenge progress where appropriate and potentially seek further assurance from individuals or other committees. Further, she noted that **TMcM** as chair of the Finance Committee and Harry Turner (chair of the Integrated Delivery Committee) are crucial leads in terms of steering their committees to both drive actions as well as escalating key messages to the Board.

TMcM highlighted his concerns regarding the pace of delivery not being fast enough, and particularly referenced that oversight through this committee is only monthly. TMcM felt it important that we see the progression of the work plan, but we are reliant on other forums to deliver the work on a day-to-day basis. This committee needs to see more information on what we are actively doing to manage the finance rather than it feeling as it currently does like we're still talking about what we could do.

RESOLVED:

The Committee:

Noted the year-to-date deficit for the system of £28m (being £9.2m adverse to the plan) and the current forecast deficit for the system of £23.2m (being £4.1m adverse to the plan).

Further, they noted a gross risk of £74.3m for the year on top of the current deficit and that so far, only £35.2m of potential mitigations have been identified to address that risk if it were to materialise.

Noted the exercise underway with NHSE to scrutinise and challenge the forecast position in order to produce a revised forecast position.

Minute No. SFC-02.11.006 Intelligent Fixed Payment Group Update (inc TOR sign off)

6.1 **CS** explained that we have three subcommittees of the System Finance Committee, the first for training and development with the finance community within the system, which has not been established yet and the others are the subject of the next two papers on the agenda.

She presented a paper that gave an update on the work of the Intelligent Fixed Payment Group, and also sought sign off for the terms of reference for the sub-committee. She explained how the group had come about after a decision last year to step away from the traditional NHS 'payment by results' methodology and described the benefits gained in doing so with focus of contractual relationships shifting from long funding negotiations to distribution of system monies up front so that focus could be on service improvement and redesign.

CS gave an overview of the work programme for the group, which is currently predominantly preparation of the mechanism for funds flow, risk assessment etc for next financial year. This is using the experience we have gained over the last twelve months, taking the time to reflect on that and making sure that we are improving those things that maybe haven't quite worked as well and building on some of the actions that we didn't have chance to take initially.

TMcM asked the committee if they had any questions regarding the IFP or the TOR before committee agreed to sign them off.

HT highlighted the 5th bullet point in the responsibilities section of the TOR, "ensure controls are in place for delivery of financial plans across the ICS." She noted that now we have the governance and the infrastructure of the ICS set up, this is not a core remit for this group and actually, linked to **CS's** comments, the role is more about ensuring the contract itself isn't standing in the way of the development and the transformation work that we want to do.

The Committee agreed with this suggestion and signed off the TOR subject to that change.

Action: CS to update the IFPMG TOR to reflect the amended responsibility for the group.

Resolved:

The Committee noted the work of the Intelligent Fixed Payment Management Group and approved the Terms of Reference for the group

Minute No. SFC-02.11.007 Capital Prioritisation and Oversight Group (inc TOR sign off)

7.1 **CS** explained that this was the third of the subcommittees to the Finance Committee and asked for the Terms of Reference to be signed off. There were no comments or suggested amendments and therefore the TOR were agreed.

Resolved:

The Finance Committee signed off the TOR for the Capital Prioritisation and Oversight Group.

Minute No. SFC-02.11.008 ANY OTHER BUSINESS

8.1 No other business raised by the committee.

Date and Time of Next Meeting

Tuesday 29th November 2022, at 15.15 pm. – TO BE CONFIRMED ONCE QUORATE.

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

NHS Shropshire, Telford and Wrekin
Strategy Committee

Thursday 15th December 2022 at 12.30 p.m.
Via Microsoft Teams

Present	
Mrs Cathy Purt	Chair and Non Executive Director, Shropshire Community Health Trust
Mrs Nicola Dymond	ICB Director of Strategy and Integration (Vice Chair)
Mr David Brown	Non-Executive Director, Shrewsbury and Telford Hospital NHS Trust
Mrs Liz Noakes	Director of Public Health, Telford and Wrekin Council
Mrs Rachel Robinson	Director of Public Health, Shropshire Council
Mrs Cherry West	NHSE National Improvement Team

In Attendance	
Miss Alison Smith	ICB Director of Corporate Affairs
Mrs Tricia Finch	Associate Director Transformation, Planning and Performance, Shropshire Community Health Trust
Mrs Julie Garside	ICB Director for Planning and Performance
Mr Nigel Lee	Director of Strategy and Partnerships, Shrewsbury and Telford Hospital NHS Trust
Mrs Cathy Riley	Managing Director, Shropshire and Telford and Wrekin Care Group, Midlands Partnership NHS Foundation Trust
Mrs Shelley Ramtuhul	Director of Governance, Shropshire Community Health NHS Trust

Apologies:	
Mr Peter Featherstone	Non-Executive Director, Shropshire Community Health NHS Trust
Professor Paul Kingston	Non-Executive Director, The Robert Jones Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Minute No. SC-22-09.001 – Introductions & Apologies

1.1 Mrs Purt welcomed ICB Strategy Committee members to the meeting, and a round of introductions took place.

1.2 Apologies received were noted as above. In Mr Featherstone's absence, the Chair confirmed that Mr Featherstone held the Chair of the Performance and Resources Committee of Shropshire Community Health NHS Trust.

Minute No. SC-22-09.002 – Members' Declarations of Interests

2.1 Declarations of Interest:

Members were asked to confirm any conflicts of interest with any agenda items as the meeting progressed and to also complete the declaration of interest form which will be circulated after the meeting, declaring any interest that they have for the ICB's register of interests.

Minute No. SC-22-09.003 – Overview of the Role of Strategy Committee

3.1 Mrs Dymond introduced the first item and explained that this committee's key role was to ensure the strategic vision for the ICS is clear and addressed in the development of strategic planning across the system as well as assure the transition of plans into delivery. The committee will also review work on our oversight framework and performance programme. She went on to explain however, that it would be important to not duplicate the work of other committees particularly the Integrated Delivery Committee (IDC), and that she and Mrs Purt would be meeting shortly with the Chair and Vice Chair of the IDC to agree how this relationship can be managed.

3.2 Mrs Dymond drew the members and attendee's attention to the terms of reference of the committee in the ICB Governance Handbook, which were approved by the Board on 1st July, with the further request to review and amend as necessary at the committees inaugural meeting. It was clear that the membership and responsibilities of the Committee required some revision and some proposals had been included in the covering report. Mrs Dymond confirmed that she would like to see the membership of this committee expanded to ensure we have a good presence of key partners and organisations within the committee.

3.3 Mrs Finch raised the need to include primary care representatives on the committee as key providers within the ICS. Mrs Dymond acknowledged that primary care was a key partner in the ICS and that the LMC were supporting the ICB in how to involve PCN's in the governance infrastructure of the ICS and that this should be added into the membership.

3.4 Mrs Noakes highlighted that the terms of reference mention the five-year sustainability plan and the Integrated Care Strategy interchangeably and that it would be useful to use the same terminology throughout. Mrs Dymond agreed that the language and abbreviations are not helpful in describing the two which are separate documents. The Integrated Care Strategy document is developed by the ICP and represents 'what' priorities we should address for the population. The 5 year plan is now referred to as the 5 year Joint Forward Plan (JFP) and is the responsibility of the ICB to develop as the 'how' we will address these priorities. Mrs Noakes went onto suggest that the terms of reference also needed to clarify the relationship between this committee and Finance Committee, Integrated Delivery Committee and Primary Care Commissioning Committee. Finally, the Committee asked for clarity on whether the reference to the Population Health Management Board was the Population Health Board? And, whether

the operational Board for Estates HR and Digital also reported into the Strategy Committee?

3.5 Mrs Purt had received a message from Mr Featherstone prior to the meeting asking if the Terms of Reference on section 3 sufficiently covered the "left shift"? Mrs Purt asked that this be considered.

3.6 Mr Lee suggested that an additional heading be added under section 3 of "System Wide Service Transition Programmes that would incorporate anything we wanted in the future, for example; Hospital Transformation Programme, Local Care Programme and other Social Care programmes.

3.7 Mrs Riley also suggested that an organisational chart showing the interaction with other committees may be useful that could also include interactions with Local Authority Committees where appropriate and also queried whether those operational boards undertaking strategy development should also report into this committee as well as IDC?

3.8 Mrs Robinson asked that the reference in the terms of reference to population health is expanded to include strategic health inequalities and health prevention and that the committee also recognises the links with the strategy work that TWIP and SHIP undertake.

3.9 Mrs Garside also raised the query as to how the committee will link into the provider collaborative development?

3.10 Mrs Dymond thanked the members and attendees for their helpful feedback and acknowledged that work will need to be undertaken on where oversight and assurance was being discharged to prevent duplication or gaps.

3.11 Mrs Purt added that she felt that the membership of the Committee needed to include not only a Non Executive Director from each provider but also a senior executive strategy lead.

Action: Terms of Reference to be amended and presented at the next meeting.

Minute No. SC-22-09.004 – System Utilisation Review

4.1 Mrs Garside introduced the item and explained the meaning of MCAP (Making Care Appropriate for Patients), initially the service review audit is about the ICS getting an initial recognised methodology to establish our baseline, our model of care baseline, where we are now and what our opportunities are. This is a real time system wide review of capacity with audits taking place at SaTH, RJAH and Shropcom. The audits will furnish us with a single data set, objective/evidence-based assessments which will inform the 5 year plan and strategic commissioning intentions.

4.2 Mrs Dymond explained that MCAP can help to address clinical reluctance/confidence to engage sometimes in new ways of working as well as helping us when we are thinking about our left shift, we are not just tapping into what could be unmet need. But we really are challenging ourselves to think about the shift in some of our acuity

aspects of work as well of where we might be able to do things differently, but hopefully what will transpire from this piece of work.

4.3 Mrs West challenged whether the audits also needed to include nursing home data? Mrs Garside confirmed that this data would be included in phase 2 of the audit.

4.4 Mr Lee acknowledged that the updated capacity modelling for HTP which would be linked into the Local Care Programme will also need to link into the MCAP work.

4.5 Mrs Riley highlighted whether primary care data is part of this audit? Mrs Garside confirmed that some data is available but not all. The audit is using nationally accessible data and we are also working with two PCNs, but there are some challenges in that they are commercial organisations and under their contract we only have access to some data. Mental health data will be included in phase two.

4.6 Mrs Dymond emphasised that the audit will also deliver post-coded information and in real time so it will highlight some patient behaviour data which in itself will provide insights about our own processes and at the next meeting of the Committee, we should be able to present what the data map is starting to look like. Mrs Dymond explained we will see two key sets of projections in the study presentation slides, one that will show us the way projections will be looking if we carry on as we are and do nothing, the other will show us what some of the opportunity projection shift is.

The Committee noted the presentation.

Action: MCAP outputs to be reported to the January meeting.

Mr Lee left the meeting at 13:17pm

Minute No. SC-22-09.005 – Integrated Care Strategy Development Update

5.1 Mrs Dymond explained the aim of this interim strategy led by the ICP was to capture what we have already done as an ICS, what we already know about the needs of our populations in Shropshire and Telford and Wrekin, what we have worked with our communities and stakeholders on already, the work of our two health and wellbeing boards across Shropshire and Telford and Wrekin, and we are looking to consolidate all of this knowledge and data into an interim Integrated Care Strategy for the whole population of Shopshire, Telford and Wrekin.

5.2 There are four key strategic objectives in the development of the integrated care strategy. There are four things we need to do and focus on:

- Improving outcomes in health population
- Tackle inequalities in outcomes, experience, and access
- Support broader social economic development
- Enhance productivity and value for money

5.3 Mrs Dymond, Mrs Noakes and Mrs Robinson then presented the slide pack which outlined the strategy content to the Committee which highlighted the key priorities that could

be drawn from the consolidated information. This was then followed by questions and comments from the Committee.

5.4 Mrs West suggested that presentation of the strategy needed to be amended so that it is clear that the first few slides are part of an executive summary.

5.5 Mrs Riley asked if the life expectancy gap shown in slide 25 in deprived areas was reflected in place based work? Mrs Noakes confirmed that the Health and Wellbeing Boards and Place programmes focus on deprivation and health inequalities, and that the approach is to coproduce solutions and interventions with our communities that are population health based.

5.6 Mr Brown suggested splitting the graphs for birth/deaths to make it easier for the reader to make direct comparisons between the two population areas. He went on to ask if there is data on leakage of patients over our borders into other health systems? Mrs Garside confirmed that this data is known but cautioned that it was normally due to patient choice.

5.7 Mrs Purt queried how the Committee will receive assurance on the delivery of the Integrated Care Strategy and how could we communicate this to a member of the public? Mrs Ramtuhul went onto highlight that the committee will need to receive assurance from other delivery committees and suggested developing a work plan to help map this.

5.8 Mrs Dymond confirmed that the next steps will be to present the final version of the Strategy to the Integrated Care Partnership next week following some further fine tuning. The ICP is the statutory committee to own and sign off the document. This will then be followed by an extensive engagement program both with our local communities and professional stakeholders. The ICS document will be included in the engagement process to influence the ICB development of a 5 year plan. We are expecting the five-year planning guidance in the next few weeks, however it would appear that some timelines previously communicated for the production of a 5 year Forward Plan may be slipping from March to June which will be challenging given the need for both the operational planning process and financial planning process to be completed for the end of March.

The Committee noted the Draft Integrated Care Strategy

ACTION : Circulate slides for further comments.

ACTION : Develop a work plan to help identify and map sources of assurance.

ACTION : Provide assurance on capacity and ownership of delivery of the Integrated Care Strategy and the governance of how delivery will be tracked and reported.

ACTION : Report at the next meeting providing more detail on the engagement plan for the Integrated Care Strategy and development of the 5 year Plan.

ACTION : Report at the next meeting on the SOF4 Exit Criteria progress.

Minute No SC-22-09.006 – Agreement on Committee Meeting Schedule

6.1 Committee noted and agreed.

Minute No SC-22-09.007 – Any Other Business

7.1 None arising

14.30p.m. Meeting Closed

Date and Time of Next Meeting

The next meeting of ICB Strategy Committee will take place on Thursday 19th January 2023 at 12.30 p.m. via Microsoft Teams.

SIGNED **DATE**

Appendix 1 – V43
NHS Shropshire, Telford and Wrekin

Strategy Committee

Terms of Reference

1. Constitution

1.1 The Strategy Committee ('the Committee') is established by the Board of NHS Shropshire, Telford and Wrekin (the Board or NHS STW) as a Committee of the Board in accordance with its Constitution

1.2 These Terms of Reference (ToR), which must be published on NHS STW website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

1.3 The Committee is an executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of NHS STW.

2. Authority

2.1 The Committee is authorised by the Board to:

2.1.1 Promote the engagement of the boards of all organisations across the ICS to support the delivery of the Joint Forward~~5 Year Health~~ Plan and Integrated Care~~ICS~~ Strategy

2.1.2 Monitor the ICS's progress against the System Oversight Framework Segment 4 (SOF4) Exit Criteria, holding the relevant committees and partners accountable

2.1.3 Accelerate the delivery of the ICS's strategic aims, objectives and plans with the ambition of driving improvement in quality and safety, strengthen workforce resilience, reduce duplication and drive productivity improvements and cost reduction

2.1.4 Promote a system-wide approach and cross functional alignment to the ICS's strategic activities

2.1.5 Ensure alignment of strategic activities with the ICS's Ten Pledges

2.1.6 Work to ensure that the roles and individuals required to support the delivery of agreed strategically-focused tasks, projects, work-streams or actions are identified and resourced and that the requirement to provide sufficient resources is understood at System and organisational level.

2.1.7 The Strategy Committee is authorised by the Board to:

- Investigate any activity within its terms of reference
- Seek any information it requires within its remit, from any employee or member of NHS STW (who are directed to co-operate with any request made by the Committee) as outlined in these terms of reference
- Commission any reports it deems necessary to help fulfil its obligations,
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by NHS STW for obtaining legal or professional advice
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with NHS STW's constitution, Standing Orders and Scheme of Reservation and Delegation (SoRD) but may not delegate any decisions to such groups.
- For the avoidance of doubt, the Committee will comply with NHS STW Standing Orders, Standing Financial Instructions and the SoRD

3. Purpose

3.1 The duties of the Committee will be driven by NHS STW's objectives and the associated risks. An annual programme of business will be agreed before the start of the financial year; however this will be flexible to new and emerging priorities and risks.

3.2 The purpose of the Committee is to develop the Joint Forward Plan~~5 Year Health Plan~~ (owned by NHS STW) which will be informed by; the ICP's Integrated Care Strategy, the key needs of the STW population and the NHS mandated priorities.

3.3 The Committee will provide strategic oversight, alignment and scrutiny to the development of the following system-wide programmes of work:

3.3.1 Data and Digital

Ensure the development and delivery of our STW ICS Digital Strategy 2022- 25, underpinned by our Data and Digital Transformation Plan

3.3.2 Estates

Review the strategic alignment of the One Public Estates' plans with other strategic estates programmes, such as the Hospitals Transformation ~~ealthier Together~~ Programme (HTP).

3.3.3 People and Culture

Ensure alignment of our One People Plan (previously our People Plan and Workforce Transformation Programme) with other strategic priority areas.

3.3.4 System Oversight

Monitor the system's progress against the key areas of the System Oversight Framework Segment 4 (SOF4) Exit Criteria, as described by NHSE~~I~~

3.3.5 Commissioning

Monitor the strategic implementation of our Commissioning practice in alignment with national policy and our Operating Model for delegated commissioning once signed off (anticipated July 2022).

3.3.6 Primary Care

Ensure the alignment of system plans relating to Primary Care with other strategic programmes of work in NHS STW

3.3.7 System-wide service transformation programmes

Ensure the alignment of system-wide programmes of work to the Joint Forward Plan to include but not limited to: Hospital Transformation Programme (HTP) and Local Care Programme (LCP)

3.3.8 Health Inequalities

Ensure that health inequalities are addressed in the ICB's strategic objectives and that the 5 year Forward Plan seeks to improve the outcomes in population health.

4. Membership and attendance

4.1 The committee members will be appointed by the Board in accordance with NHS STW Constitution.

4.2 The Board will appoint no fewer than 4 members of the Committee. Other members of the Committee need not be members of the Board.

4.3 When determining the membership of the Committee, active consideration will be made to diversity and equality.

4.4 The Committee members shall be appointed by the Board in accordance with the constitution.

4.5 The Membership of the Committee is:

- The Chair
- ICB Director of Strategy and Integration (Vice Chair)
- ICB Chief Finance Officer or deputy
- ICB Chief Medical Officer or deputy
- A nominated Senior Executive strategy lead from:
    - Shropshire Community Healthcare NHS Trust
    - Shrewsbury and Telford NHS Trust
    - The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
    - Midlands Partnership Foundation Trust

- A nominated non-executive director from:
    - Shropshire Community Healthcare NHS Trust
    - Shrewsbury and Telford NHS Trust
    - The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
    - Midlands Partnership Foundation Trust
- A representative from Shropshire Council
- A representative from Telford and Wrekin Council
- A representative of General Practice Primary Care Providers
- A representative of the NHSE~~I~~ National Improvement Team
- A representative from VCS

If a member is unable to attend then they may nominate a deputy:

- The deputy for non-executive members must be a non-executive director from the member's own organisation;
- The deputy for the General Practice Primary Care Providers must be another individual from a General Practice Primary Care Provider

- The deputy for other members must have delegated authority on behalf of the organisation they represent
- The deputy shall be treated as a full member, and count toward quoracy.

4.6 The chairs of the Operational Bboards and Place based boards will be responsible for escalating issues or risks to the Committee.

4.7 Attendees

4.7.1 Only members of the Committee have the right to attend Committee meetings, however all of the meetings of the Committee may be attended by individuals who are not members of the committee.

4.7.2 Additional attendees shall be invited as required at the discretion of the Chair and specifically the following:

- ICS Digital Lead
- ICB Director of Planning and Performance
- ICB Director of Communications and Engagement
- ICB Director of Place and Partnerships
- ICB Director of Corporate Affairs
- Healthwatch Shropshire
- Healthwatch Telford and Wrekin

4.8 Chair and Vice Char

4.8.1 In accordance with the Constitution, the Committee will be chaired by the Chair of an NHS Provider Trust, appointed on account of their specific knowledge, skills and experience making them suitable to chair the Committee.

4.8.2 The Vice Chair of the Committee shall be NHS STW Executive Director for Strategy and Integration.

4.8.3 In the event that the Chair is unavailable, the Vice Chair who will chair the meeting. Where the Chair and Vice Chair are not in attendance, committee members may appoint a temporary Chair who is qualified and appropriate to lead the meeting in their absence.

4.8.4 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference.

4.9 Attendance

4.9.1 Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable alternative attendee may be agreed with the Chair.

5. Meetings, quoracy and decisions

5.1 Meetings

5.1.1 The Committee will meet remotely, members attending using electronic means will be counted towards the quorum.

5.1.2 Meetings will take place in private.

5.1.3 The Committee shall meet a minimum of four times per year.

5.2 Quorum

5.2.1 For a meeting to be quorate a minimum of 50% members is required, including the Chair or Vice Chair (or their deputy).

5.2.2 If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

5.2.3 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

5.2.4 Decisions deemed by the Chair to be 'urgent' can be taken outside of the meeting via email communication, and with the agreement of a quorate number of members.

5.3 Decision-making and voting

5.3.1 Decisions will be taken in accordance with the standing orders.

5.3.2 The expectation is that the Committee shall ordinarily reach conclusion by consensus when making decisions

5.3.3 If consensus cannot be achieved each member may cast a vote

5.3.4 Only members of the committee may vote. Each member is allowed one vote and a majority will be conclusive on any matters.

5.3.5 If a majority cannot be reached by voting, the Chair shall have a second, deciding vote.

6. Responsibilities of the Committee

6.1 Development of the Joint Forward Plan~~5 Year Sustainability Strategy~~

6.1.1 The Committee will recommend the overall strategic direction of the ICS to the Board, and oversee the development of the ICS Joint Forward Plan~~five year sustainability strategy~~, working in collaboration with the Statutory Boards, including:

- Formulation of a clear approach to developing and delivering the Joint Forward Plan ~~strategy~~ agreed with all organisational boards
- Development of a decision-making approach in conjunction with organisation boards to agreed any additions to costs across the STW system and to pursue opportunities for cost reduction. This will be in conjunction with both the Integrated Delivery Committee~~Board~~ and Finance Committee.
- Benchmarking against regional and national population health outcomes data to develop future opportunities
- Approve the involvement ~~consultation~~ arrangements for the Joint Forward ~~commissioning P~~plan.
- Recommend the ~~commissioning plan~~ Joint Forward Plan to the Board and approve any revisions to it.
- Recommend the commissioning strategic intent for the ICB to the Board.
- Leading system wide action on data and digital: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services to put the citizen at the centre of their care.
- Using joined up data and digital capabilities to understand local priorities, track delivery of plans, monitor and address unwarranted variation, health inequalities and drive continuous improvement in performance and outcomes
- Driving joint work on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support wider goals of development and sustainability.

6.2 System Improvement ~~Sustainability~~ Plan

6.2.1 The Committee will oversee the development and monitor the delivery of the System Improvement~~Sustainability~~ Plan to deliver financial balance including:

- Establishment of robust decision-making processes for agreement of investments within the affordable funding envelope, in conjunction with the Finance Committee
- Development of an integrated approach to system planning processes
- Development of a financial model for the system, in conjunction with the Finance Committee
- Development of performance processes to provide oversight of SOF Exit criteria to include metrics and improvement plans.

6.3 Delegated Assurance Activity

6.3.1 The Committee will provide oversight and assurance of any other activity delegated to it by the ICS Board or, at the discretion of the Chair, at the request of any system member organisation.

6.4 Public and Patient Involvement

6.4.1 The Committee will oversee and assure at least annually that the ICB is discharging its statutory responsibilities for involvement of its population in service planning and decision making and that this is meeting the Public Sector Equality Duty under the Equalities Act 2010.

7. Behaviours and conduct

7.1 ICB Values

7.1.1 Members will be expected to conduct business in line with NHS STW values and objectives.

7.1.2 Members of, and those attending, the Committee shall behave in accordance with NHS STW's Constitution, Standing Orders, and Standards of Business Conduct Policy.

7.2 Equality and Diversity

7.2.1 Members must demonstrably consider the equality and diversity implications of decisions they make.

8 Accountability and reporting

8.1 The Committee shall report to the Integrated Care Board on how it discharges its responsibilities.

8.2 The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board in accordance with the Standing Orders.

8.3 The Chair will provide assurance reports to the Board at each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

8.4 The Committee will provide an annual report to the Board to describe how it has fulfilled its terms of reference, details on progress and a summary of key achievements in delivering its responsibilities.

8.5 The following sub committees and groups will report into this Committee:

- Strategy Leads Group
- Equality and Involvement Assuring Sub Committee (annually)
- Population Health Board
- Digital Board
- Strategic Estates Working Group
- Procurement Working Group
- Workforce Transformation Board

9 Secretariat and administration

9.1 Agenda and Papers

- The Agenda for each meeting shall be approved by the Chair.
- Final agendas and relevant papers will be circulated electronically to members in advance of each meeting.

9.2 Secretariat

- The production of papers, agendas and minutes shall be supported by a secretariat provided by the STW ICS.
- The secretariat function will ensure that:
  - The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;
  - Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;

- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;
- Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept;
- The Chair is supported to prepare and deliver reports to the Board;
- The Committee is updated on pertinent issues/ areas of interest/ policy developments;
- Action points are taken forward between meetings and progress against those actions is monitored.

10 Review

10.1 The Committee will review its effectiveness at least annually.

10..2 These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to NHS STW for approval.

Date of approval:

Date of review: 30th June 2023

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

NHS Shropshire, Telford and Wrekin
Audit Committee Meeting

Wednesday 21 September 2022 at 9.30 a.m.
Via Microsoft Teams

Present:

Mr Roger Dunshea (Chair)	Non-Executive Director, NHS STW ICB
Mr Meredith Vivian	Non-Executive Director, NHS STW ICB

In Attendance

Mrs Claire Skidmore	Chief Finance Officer, NHS STW ICB
Mrs Laura Clare	Deputy Director of Finance, NHS STW ICB
Mrs Sam Tilley	Director of Urgent & Emergency Care & Emergency Planning, NHS STW ICB
Mr Angus Hughes	Associate Director of Finance, NHS STW ICB
Ms Sarah Swan	Assistant Director, CW Audit Services
Ms Lisa O'Brien	Audit Manager, CW Audit Services
Mr Paul Westwood	Head of Counter Fraud Services, CW Audit Services
Mr Neil Preece	Partner, Grant Thornton
Mrs Lisa Kelly	HR Business Partner, MLCSU
Mrs Chris Billingham	Corporate PA (Minute Taker)

Apologies:

Mrs Niti Pall	Non-Executive Director, NHS STW ICB
Mr Trevor McMillan	Non-Executive Director, NHS STW ICB
Miss Alison Smith	Director of Corporate Affairs, NHS STW ICB
Mr Paul Capener	Interim Consortium Director, CW Audit Services
Mr Andrew Smith	Director, Grant Thornton – External Audit

Minute No. AC-22.09.01 – Introductions & Apologies

1.1 Mr Dunshea welcomed Audit Committee members to the meeting, and a round of introductions took place.

1.2 Apologies received were noted as above.

Minute No. AC-22.09.02 – Members' Declarations of Interests

2.1 Members had previously declared their interests, which were listed on the ICB's Register of Interests and was available to view on the website at:

Register of Interests - NHS Shropshire, Telford and Wrekin (shropshiretelfordandwrekin.nhs.uk)

2.2 Members were asked to confirm any new interests that needed declaring or any existing conflicts of interest that they had relating specifically to the agenda items. There were no further conflicts of interest declared.

Minute No. AC-22.09.03– Minutes of Previous Meetings

3.1 The minutes of the previous meetings held on 18 May 2022 and 15 June 2022 were approved as a true and accurate record.

Minute No. AC-22.09.04– Matters Arising & Action List from Previous Meetings

4.1 The action list was reviewed and updated as appropriate.

Minute No. AC-22.09.05– Review of Audit Committee Terms of Reference

5.1 The paper prepared by Alison Smith, Director of Corporate Affairs, was taken as read.

5.2 The Board had approved all Committee Terms of Reference at its meeting on 1st July 2022. The Board also agreed that each Committee would review its respective Terms of Reference at the first ICB Committee meeting to ensure that they accurately described the purpose, responsibilities, and membership of the Committee.

5.3 All proposed amendments will be collated into a report to the Board by the Director of Corporate Affairs at its next meeting on 28th September for consideration and approval.

5.4 The Committee reviewed the Terms of Reference and proposed the undernoted amendments.

Section 5.4.1 – Quoracy. Mr Vivian queried the sentence "a minimum of 50% of the members need to be present with at least 1 ICB Non-Executive Director in attendance". Committee members agreed that if a minimum of 50% of the members is required, a minimum of two members would need to be present as there are four Non-Executive Directors.

Section 6.11.1 – Communication. "To co-ordinate and manage communications on governance, risk management and internal control with stakeholders internally and externally". Mr Vivian queried use of the word "manage" in relation to communication and questioned whether that term was appropriate. Committee members agreed that the word "manage" should be replaced with "oversee".

Section 6.5 - Counter Fraud. This section referred to the old NHS standards for commissioners. These have now changed to the Government functional standards for commissioners.

ACTION:	**Mr Westwood to share the appropriate wording regarding the Government functional standards for Commissioners with Mrs Skidmore after this meeting for insertion into Section 6.5 of the Terms of Reference.**

5.5 Sarah Swan was pleased to see that the Terms of Reference referenced system risk. The Audit Committee Handbook was currently being updated to include some of the challenges mentioned and she suggested that it may be worthwhile revisiting this later in the year.

ACTION: Committee members to reflect on the requirement for this Committee to co-ordinate system risk.

The Committee was asked to review the Audit Committee Terms of Reference and agree any proposed amendments for approval by the Board.

RESOLVE: Audit Committee Members NOTED the content of the report and APPROVED the amendments as discussed above.

Minute No. AC-22.09.06– Approval of EPRR Policies

6.1 Mrs Tilley was in attendance to present her paper.

6.2 Integrated Care Boards (ICBs) are required to operate as Category 1 responders for Emergency Planning, Resilience and Response (EPRR) purposes and as such this places new duties on them that Clinical Commissioning Groups did not have as Category 2 responders. As part of the transition from the CCG to the ICB and in preparation for this year's annual NHS England EPRR assurance process, several polices have been created or updated. Her report set out those policies that have been established or updated to ensure the ICB is compliant with the necessary requirements.

6.3 The large amount of documentation was largely due to transferring responsibility from the CCG to the ICB formally and reflects the change of category of response for the ICB from a Category 2 as a CCG to a Category 1 responder as an ICB. Therefore, there is a wholesale refresh of policies.

6.4 A key point to highlight is the change to the category of response and the paper sets out the responsibilities of Category 1 responders.

6.5 A process has been followed to refresh some of these policies, part of which was collaboration with other ICBs in the development of the documents. Other policies have been introduced to reflect the increased level of responsibility.

6.6 Mrs Tilley referred to the annual core standards assessment for emergency planning undertaken by NHS England. That process was currently taking place and the documents submitted to Committee were part of the evidence base for that process. Feedback will be received in due course and Mrs Tilley will bring a report to a future Committee when that assessment has concluded.

6.7 Included in the report was a recommendation regarding the reporting cycle for this Committee.

6.8 Mrs Tilley invited questions or comments.

6.9 Mr Dunshea asked whether Mrs Tilley felt that any weaknesses existed in terms of how this policy could be enacted.

6.10 Mrs Tilley advised that the main policy that would be used in terms of the blueprint for managing an incident was the Incident Response Plan and this had been tested as an exercise with the On Call team. Feedback from that exercise had been incorporated in the version of the plan submitted to Committee today. Mrs Tilley believed that the policy was fit for purpose but there will undoubtedly be further adjustments and learning as the organisation deals with future incidents and a process is set out for incorporating that learning going forward.

6.11 Mr Dunshea referred to the Executive team's ownership of this requirement together with the other Trusts and the ambulance service and asked whether Mrs Tilley had any concerns regarding their ownership of this.

Mrs Tilley replied that she had no concerns and was as confident as she could be that this would work on a system footprint. However, all Category 1 responders will be looking quite clearly to NHS England in terms of their role in determining when an incident occurs, who will take certain roles etc. and we expect that as an ICB we will take on a full and central co-ordination role.

6.12 Mr Dunshea thanked Mrs Tilley for her attendance at Audit Committee and looked forward to receiving further assurances going forward as reviews and tests take place.

Audit Committee was asked to approve the following EPRR policies:

- ***ICB Incident response Plan***
- ***ICB EPRR Policy***
- ***ICB Business Continuity Plan***
- ***ICB EPRR Communications Plan***
- ***ICB On Call Policy***

Audit Committee was also asked to support a cycle of reporting to the Committee of a further report by the end of the calendar year to receive the outcome of the annual assessment and a further update report in March 2023 followed by a minimum of bi-annual reporting in subsequent years.

RESOLVE: ***Audit Committee members NOTED the content of the report and APPROVED the EPRR policies as outlined above. Audit Committee members also gave their support to a cycle of reporting to the Committee as outlined above.***

Minute No. AC-22.09.07 – Financial Sustainability

7.1 Mr Hughes' paper had been distributed to Audit Committee members in August 2022 and was included on today's Agenda for information and completeness.

7.2 NHS England (NHSE) issued guidance in July 2022 that required all organisations to commission from their internal auditors a review of a completed self-assessment on Financial Sustainability. The checklist had been issued by HFMA and is being adopted nationally across all NHS organisations.

This exercise provides an opportunity to review and challenge the robustness of internal processes and procedures. Throughout this review actions will be identified that can be implemented to improve control and assurance over financial sustainability.

Areas under review were as outlined in Mr Hughes' paper.

7.3 Committee members were asked to note that this piece of work is ongoing. The Internal Audit team have been commissioned and will be completing the Internal Audit review during October/November in advance of the required deadline of end of November. The final Internal Audit report will be published in January 2023.

7.4 The internal work is almost complete, and approval will be requested from the Executive team prior to the auditors' initial assessment being submitted to NHS England.

7.5 Mr Hughes invited questions.

7.6 Mr Vivian asked whether the process had revealed any issues.

7.7 Mr Hughes replied that initial discussions had highlighted several areas that were already under discussion by the Finance team. He felt comfortable and reassured that by the time Internal Audit carry out their work, many of the requests will already be under development or being implemented by the Finance team.

7.8 Mrs Skidmore confirmed that Mr Hughes' report would be submitted to Finance Committee for information.

The Committee was asked to note the contents of the Financial Sustainability Terms of Reference. Further updates on the findings of the report and any associated actions will be shared at future meetings.

RESOLVE: ***Audit Committee members NOTED the content of the Terms of Reference and agreed to receive further updates at future meetings.***

Minute No. AC-22.09.08 – IG Update

8.1 Ms Spencer was asked to highlight key points of her report.

8.2 Ms Spencer responded that as part of the transfer from the CCG to the ICB all IG policies have been rebranded.

The only policy to have material changes made was the privacy notice which, as well as being rebranded, had also been reviewed in all areas and included an update of the legal basis for Continuing Health Care information. The revised privacy notice was attached to Ms Spencer's report as Appendix A for approval by the Committee.

The other reports were to be noted by the Committee.

8.3 The Chair invited questions, but none were raised.

8.4 Mrs Skidmore thanked Ms Spencer for her excellent work on the crossover of reporting between the CCG and the ICB.

The Committee was asked to:

- ***Approve** the changes in the Privacy Notice – Appendix A.*

The Committee was also asked to note:

- *The latest bi-monthly IG report – Appendix B*
- *The changes in the DSPT briefing note for ICBs – Appendix C*

***RESOLVE:** Audit Committee members APPROVED the changes in the Privacy Notice (Appendix A) and NOTED the latest bi-monthly IG report (Appendix B) and the changes in the DSPT briefing note for ICBs (Appendix C).*

Minute No. AC-22.09.09 – Losses, Special Payments & Waivers

9.1 Mr Hughes' advised that a paper was submitted to Audit Committee on a regular basis to provide an update in relation to waivers that had been raised in the previous period.

9.2 The paper circulated for today's meeting provided an update in relation to waivers that were reported as a CCG, i.e. up to end of June. During that period there were 7 waivers totalling slightly more than £400k in total.

In the period since the CCG became an ICB there had been 2 waivers totalling slightly more than £90k.

9.3 There were no losses or special payments in the period being reported.

9.4 Full details of the waivers were provided as an appendix to Mr Hughes' report. However, in response to a request from Mr Vivian, he agreed to provide the details in the body of the report going forward.

ACTION: Mr Hughes to incorporate information relating to waivers into the body of his report and not provide it separately as an Appendix.

The Committee was asked to note:

- ***There were no losses or special payments in the period May 2022 to June 2022 (CCG) July to August 2022 (ICB)***
- ***There have been 7 waivers up to 30th June 2022 - Appendix 1 (CCG)***
- ***There have been 2 waivers since 1st July 2022 - Appendix 2 (ICB)***

***RESOLVE:** Audit Committee members NOTED that:-*

- ***There were no losses or special payments in the period May 2022 to June 2022 (CCG) July to August 2022 (ICB)***
- ***There have been 7 waivers up to 30th June 2022 - Appendix 1 (CCG)***
- ***There have been 2 waivers since 1st July 2022 - Appendix 2 (ICB)***

Minute No. AC-22.09.10 – HR Policies for Approval

10.1 Mr Dunshea queried whether Audit Committee was the correct forum for Mrs Richards' report, or whether it should be submitted to Remuneration Committee.

10.2 Mrs Skidmore advised that the Remuneration Committee Terms of Reference were very specific regarding sign-off of remuneration-related policy, but not about broader policy. Audit Committee Terms of Reference state that Audit Committee is responsible for anything else that is relevant to the Committee, hence the reason the HR Policies have been submitted to this Committee today rather than Remuneration Committee. This Committee must decide whether that is appropriate or whether we wish to make a recommendation to Board suggesting that Remuneration Committee responsibilities are extended.

10.3 Mr Vivian replied that Remuneration Committee only took place when required. He believed that it may be beneficial for policies to be submitted to Audit Committee which is a standing Committee.

10.4 Mr Dunshea observed that the ICB did not have a People Committee which was the logical place for policies to go and queried whether this should be addressed, bearing in mind the organisational development changes that could happen in due course within the ICB and the wider system. He also queried whether this could be delegated to the Executive Management Committee who then report directly to the Board.

10.5 Mrs Richards clarified that certain policies – Annual Leave Policy, Family Leave Policy and Performance Management Policy - were not new policies and had not changed following previous approval. They were largely to contain points of clarity following HR matters that had been dealt with recently.

10.6 Mrs Skidmore suggested that, based upon the information provided by Mrs Richards, if the policies were a continuance of the previous policy, it felt appropriate for the Committee to support them today on the basis that she took an action away to review the three policies referred to at paragraph 10.5 above with the Executive team as certain elements of the policies may need to be updated as applicable to the new organisation.

ACTION: Mrs Skidmore to review the updated Annual Leave Policy, Family Leave Policy and Performance Management Policy with the Executive team.

Mrs Skidmore then referred to the Training & Development Policy and queried whether that policy had been formally adopted by the CCG to be carried forward or whether it was work in progress.

10.7 As far as Mrs Richards was aware, it was agreed that it would be taken forward. However, when the policies were re-branded in May 2021 following the merger of the two CCGs, the Training & Development policy was overlooked. She would be guided by the Committee should they feel that they wished to review the Training & Development Policy for the purposes of the ICB.

10.8 Mrs Skidmore expressed a preference not to agree the Training & Development Policy but for it to be reviewed separately as a priority as she wished to ensure that it was consistent and equitable to staff.

10.9 Mr Westwood advised that when policies are revised, there are occasions when a counter fraud statement is included, particularly where fraud allegations and investigations could be relevant.

ACTION: Mr Westwood to send to Mrs Richards a counter fraud statement for inclusion in the Annual Leave Policy and Family Leave Policy.

Audit Committee was asked to:

- ***Note the contents of the report;***
- ***Note the adoption of the policies from the CCG to the ICB, as outlined in the report***
- ***Approve the policies as outlined in the report***

RESOLVE: Audit Committee members NOTED the content of the report and AGREED that Mrs Skidmore should review the updated Annual Leave Policy, Family Leave Policy and Performance Management Policy with the Executive team.

Audit Committee members DID NOT AGREE the Training & Development Policy and believed that it should be reviewed separately to ensure that it was consistent and equitable to staff.

Minute No. AC-22.09.11 – Internal Audit Update

11.1 Lisa O'Brien advised that the following Internal Audit reports had been finalised and presented to the September 2022 Audit Committee:

- ICB Handover Support - memo
- Interim 3 month Head of Internal Audit Opinion - CCG
- Internal Audit Progress report
- Internal Audit Recommendations Update report
- Customer Satisfaction Survey - 2021/22
- Performance Outcomes and KPIs Report - 2021/22

11.2 As expected, progress with the Audit Plan had been tailored to allow for focus to be placed on transition and handover arrangements within the organisation.

11.3 The handover support piece of work has been completed and will be presented later on the Agenda.

11.4 Work has commenced with the Better Care Fund audit. The Financial Sustainability audit referred to by Mr Hughes will commence in October which aligns with national guidance.

11.5 The Safeguarding audit was paused earlier in the year due to pressures within the Safeguarding and Quality teams. However, the Internal Audit team had recently been advised that those audits can be resumed, and they are liaising with Vanessa Whateley to agree a start date.

11.6 It had also been requested that the audit of the Quality Governance Framework should be moved into next year's plan to allow changes to the national guidance to be embedded further. The days earmarked for this audit will then be utilised for the Financial Sustainability audit. In line with national guidance the proposed number of days for this is 15 days and the time freed up by moving the Quality Governance Framework audit will be used to cover a shortfall in days for the Financial Sustainability audit.

Mrs Skidmore requested that changes to the Audit Plan could be agreed by Chair's action outside of this meeting to avoid delays to the work involved.

Mr Dunshea confirmed his agreement to this proposal.

ACTION: Mrs Skidmore and Mr Dunshea to agree changes to the Audit Plan via Chair's action.

11.7 As of 7 September 2022, the cut-off date for progress reporting around recommendations, 10 recommendations were due for completion. However, they had been subject to date revisions and re detailed in a separate report. Updates had been provided for all 10 recommendations from the owners.

11.8 Ms O'Brien invited questions.

11.9 Mr Vivian referred to quality and safeguarding which were across the system and not only the ICB. He asked what Internal Auditors would be looking at in their reviews of those areas, bearing in mind that the areas under enquiry were being done elsewhere.

11.10 Ms O'Brien advised that reviews of Safeguarding Audits would be carried out by referring to original reports and action plans and following up on any actions to monitor progress. In relation to Quality Audits, the overall framework would be referred to. A wider view could also be taken as to assurances on quality.

11.11 Mr Dunshea observed that many of the recommendations had gone into slippage and requested information as to who was responsible for monitoring these recommendations and slippages.

11.12 Mrs Skidmore advised that in the past the CCG had very few slippages. She believed that the slippages may have been caused because of the transition from CCG to ICB with resources being focused on other work.

ACTION: Mrs Skidmore to raise slippages with the Exec team and action to be taken if slippages are not being resolved within a reasonable timescale.

Audit Committee members were asked to NOTE and RECEIVE ASSURANCE from the Internal Audit reports presented.

RESOLVE: Audit Committee members NOTED and RECEIVED ASSURANCE from the Internal Audit reports presented.

Audit Committee members also NOTED that changes to the Audit Plan would be agreed via Chair's action.

Minute No. AC-22.09.12 – External Audit Update

12.1 Mr Preece highlighted key points of his paper and referred to the Sector Update which provided information in relation to the six targets identified by NHS England for ICSs this winter: -

- Increasing capacity and operational resilience in Urgent and Emergency Care ahead of winter
- Winter planning and response
- Workforce recruitment, training and retention in health and social care
- Backlogs and waiting times in England
- HFMA publications
- Financial sustainability

12.2 Mr Preece referred to the CCG's part-year accounts for which there was no specified timetable for completion. Agreement had therefore been reached between Mr Preece and Mrs Skidmore that the CCG audit would commence in the new year. A three-month audit of the CCG would take place together with a nine- month audit of the ICB.

12.3 For the financial year ending March 2022, Grant Thornton had reported significant weaknesses around the CCG's financial position and would look to update that in relation to the period from April to June 2022.

ACTION: Mr Preece to provide the Committee with a proposed timetable for the process relating to the forthcoming part-year and nine-month audit of the CCG and ICB accounts.

RESOLVE: The Committee NOTED the report.

Minute No. AC-22.09.13 – Counter Fraud Update

13.1 Mr Westwood had no further updates to the information contained within his report, key points of which were:-

- At the time of writing, no new incidents had been reported since the previous Audit Committee.

- Concerns had been reported in relation to possible fraud within the Personal Health Budget (PHB). A review was carried out which resulted in no concerns being identified. The PHB budget appeared to be a well-managed account. However, a line-by-line review will take place and Mr Westwood will receive a report on the findings later this month.

13.2 Mr Westwood invited questions.

13.3 The Chair referred to the counter fraud analysis across the ICS in relation to activity within the Trusts and asked whether there were any potential areas that Local Government should be considering in terms of ICB activity, bearing in mind the overlap between the two organisations in certain areas.

13.4 Mr Westwood replied that an annual fraud risk assessment was undertaken for the ICB and elements of that assessment could be shared with Local Government colleagues to identify whether there were any potential risks for them to assess. Much improved links now existed into the Local Authorities, particularly through Finance.

13.5 Mrs Skidmore confirmed that, as part of the risk assessment process, any overlap or issues identified with other agencies would be acted upon, and in particular regarding joint commissioning.

13.6 Mr Preece was not aware of any joined-up counter fraud work between the NHS and Local Government in the manner described by the Chair. He worked across almost all the Councils in the West Midlands and his experience was that counter fraud in Local Government tended to be completed by internal auditors who were employed by the organisation concerned and do not have a view across other organisations in the way that external auditors would.

13.7 Mr Dunshea referred to his involvement with other Audit Committee Chairs, Community Chairs and Chairs within Local Councils and may raise it with them to seek their opinion.

ACTION: Mr Dunshea to seek the opinion of other Audit Committee Chairs, Community Chairs and Chairs within Local Councils regarding joined-up counter fraud work between the NHS and Local Government in view of the overlap between the ICS and Local Authorities.

RESOLVE: Audit Committee NOTED the contents of the report and ACKNOWLEDGED that CW Audit Services will work with ICB colleagues to ensure any new requirements are addressed in the ICB's counter fraud provision.

Minute No. AC-22.09.13 – Any Other Business

14.1 Mr Dunshea initiated discussion regarding how the Committee would work going forward and believed that further discussion was required around risk.

14.2 He had spoken to Alison Smith and Nicola Dymond about how the ICB was going to manage risk in terms of its Risk Registers, assurance frameworks, etc. and believed that system-wide workshops had been arranged to consider this. He anticipated that in due course, Audit Committee would have an oversight of the risk management process and governance of risk when it was available. As part of that, the Committee would not only look at risk management but also the audit of systems and the role of Internal Audit in that process.

14.3 Mr Dunshea invited comment from other members of the Committee.

14.4 Mr Vivian supported the idea, stating that there would need to be a common approach to how the system scored risk which would be a useful discussion within the workshops to gain agreed recognition of the importance of managing and scoring risk. Once the risk-based approach was linked back to the strategy of the ICS it would be possible to carry out deep dives on particular topics to assess how well the assurance processes were working.

Minute No. AC-22.09.14 – Any Other Business

15.1 Ms Swan referred to the Action Plan outlined in Appendix No. 8A to her report – Handover Support – and asked the Chair whether he wanted an update to be provided to this Committee or by exception to the next Committee.

15.2 Mr Dunshea replied that a report by exception to the next Committee would be preferable.

15.3 Mr Dunshea asked the Committee and attendees to review the effectiveness of the meeting and invited comment.

No comments or concerns were expressed by members of the Committee.

10.45 a.m. Meeting Closed

Date and Time of Next Meeting

The next meeting of Audit Committee will take place on Wednesday 8 January 2023 at 9.30 a.m. via Microsoft Teams.

SIGNED ..... **DATE** .....

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

NHS Shropshire, Telford and Wrekin
Primary Care Commissioning Committee Part 1 Meeting

Friday 7 October 2022 at 8.30 a.m.
Via Microsoft Teams

Present:

Mrs Niti Pall	**Lay Member – Primary Care (Chair)**
Mr Nick White	**Chief Medical Officer (Deputy Chair)**
Mrs Claire Skidmore	**Chief Finance Officer**
Mr Gareth Robinson	**Executive Director of Delivery & Transformation**
Mr Roger Dunshea	**Lay Member**

Attendees:

Dr Deborah Shepherd	**Deputy Chief Medical Officer**
Ms Claire Parker	**Director of Partnerships & Place**
Ms Emma Pyrah	**Associate Director of Primary Care**
Dr Julian Povey	**Primary Care Partner Member**
Dr Ian Chan	**Primary Care Partner Member**
Ms Angharad Jones	**Finance Business Partner**
Mr Tom Brettell	**Partnership Manager**
Mrs Janet Gittins	**Partnership Manager**
Ms Jane Sullivan	**Senior Quality Lead**
Mrs Bernadette Williams	**Primary Care Lead for Contracting & Delegated Commissioning**
Mr Phil Morgan	**Primary Care Lead for Workforce**
Mrs Vanessa Barrett	**Chair, Healthwatch Shropshire**
Mrs Chris Billingham	**Corporate PA; Minute Taker**

Apologies:

Ms Alison Bussey	**Chief Nursing Officer**
Ms Nicola Dymond	**Director of Strategy & Integration**
Mrs Julie Garside	**Director of Planning & Performance**

1.1 Mrs Pall welcomed Primary Care Commissioning Committee members to the meeting and thanked Mr White for chairing the July meeting on her behalf.

Minute No. PCCC-22.10.14 – Apologies

2.1 Apologies received were as noted above.

Minute No. PCCC-22.10.15 – Members' Declarations of Interests

3.1 Members had previously declared their interests, which were listed on the ICB's Register of Interests and was available to view on the website at:

Register of Interests - NHS Shropshire, Telford and Wrekin (shropshiretelfordandwrekin.nhs.uk)

3.2 Members were asked to confirm any new interests that needed declaring or any existing conflicts of interest that they had relating specifically to the agenda items.

3.3 Mrs Pall declared that as an independent health systems consultant she has been working with the national Cavell Centre programme. When that item is discussed, she will step down as Chair and ask Mr Dunshea to Chair the meeting on her behalf for that item of discussion.

Minute No. PCCC-22.10.16 – Minutes of Meeting held on 6 July 2022

4.1 The Committee received and approved the minutes of the meeting held on 6 July 2022 as a true and accurate record of the meeting.

Minute No. PCCC-22.10.17 – Actions Raised from Previous Meetings and Matters Arising

5.1 The Action Tracker was reviewed and updated as appropriate.

Minute No. PCCC-22.10.18 – Terms of Reference

6.1 Mr White confirmed that the last time the Committee met the draft Terms of Reference had been reviewed.

6.2 When the ICB came into being on 1 July 2022 the ICB Board approved all Terms of Reference but requested that they should be reviewed by each separate Committee going forward. It is likely that as the ICB develops the Terms of Reference will be reviewed regularly.

6.3 The Committee reviewed the TOR and suggested the following amendments: -

Item 10.3: "The Committee will make allowance for consultation with members of the public and other ICBs".

Mrs Barrett believed this to be rather ambiguous and questioned whether the allowance referred to was a time allowance or a financial allowance or both. Mr White agreed and suggested that the paragraph could be amended to read "The Committee will make allowance to ensure we engage and have appropriate resource to enable us to engage".

Dr Shepherd referred to the previous meeting where discussion took place as to whether she could be included as an Attendee to the meeting rather than merely deputising for Mr White when required. The Committee agreed with Dr Shepherd's request.

***Item 5.2 Membership*:**
The paragraph stated that voting members should include "a second Non-Executive Director for Remuneration". Mr White confirmed that this should read "a second Non-Executive Director".

Item 3 Role of the Committee
Mr Dunshea referred to integration with Primary Care and other sectors within the ICS and believed that this role should be reflected in the Terms of Reference. Community Health services has an overlap with Primary Care and he questioned whether reference to Community service partners should also be included.

Dr Povey referred to Community Care and the Committee's delegated power from NHS England around commissioning Primary Care that will broaden to include pharmacy, optometry and dentistry next year and questioned whether those services were part of the delegated responsibility of the ICB or part of the day-to-day running of the ICB that should sit elsewhere.

Discussion followed regarding the governance structure, integration, and whether reference should be made to development issues in the Terms of Reference for this Committee. The Committee agreed that the following wording should be inserted into the TOR: -

"There will be a developmental space around which the Primary Care Commissioning Committee will receive papers".

Minute No. PCCC-22.10.19 Extension to Practice Boundaries

7.1 Mrs Williams reviewed her paper relating to the extension of Practice boundaries and provided the following background.

7.2 During 2021/22 the Primary Care team undertook an exercise to ensure that all geographical areas of Shropshire Telford and Wrekin were covered by a GP Practice boundary.

7.3 A number of Practices were approached, and the following agreed to extend their boundary: -
- Alveley
- Cambrian
- The Meadows

7.4 Following approval of the boundary change, the relevant documentation was sent to the Practices for completion.

7.5 Cambrian Medical Practice advised that after discussions with partners they no longer wished to proceed.

7.6 Consideration then had to be given as to how the ICB could assign patients if they needed to register in areas that were not covered.

7.7 As the Primary Care Team have been unable to secure any agreement from other Practices to extend their boundaries, the only viable solution is to assign patients on a case-by-case basis. There are no contractual obligations to boundary changes on Practices so these cannot be imposed. However, if negotiations to register a patient fail, the ICB can assign the patient to a Practice.

7.8 The number of enquiries from patients has diminished so the need to allocate/negotiate with Practices is less. Despite the identified areas not having full Practice coverage, patients do have access to primary medical care.

7.9 The Chair invited comment.

7.10 Dr Povey referred to the statement in Mrs Williams' paper that patients would be allocated as an out of area patient to a Practice. His understanding was that the ICB has no Practices that have opted to visit and see out of area patients at home. His concern was the issue in relation to the ICB allocating out of area patients to Practices where a visiting service has not been commissioned for those patients between 9.00 a.m. and 5.00 p.m. He also referred to the potential risk of allowing that to happen without a provider to provide those visits.

7.11 Mr Dunshea questioned what had happened previously when Practices had not matched the population need. He also asked how communication takes place with patients who are not on the list and how they would get primary care access going forward. Mrs Williams provided assurance that all patients are registered and do have access to primary care.

7.12 Dr Povey confirmed that all patients resident in Shropshire are covered by the ICS and the ICB. Many of these areas will be covered by Practices outside our boundaries, i.e. non-Shropshire Practices. For example, Claverley is a Shropshire Practice geographically but is in a different ICB/ICS area.

ACTION: Ms Parker to pick up the issues around out of area patients with the Primary Care team and provide an update to the December Committee.

RESOLVE: ***The Committee noted the contents of the report and supported the approach to assignment of patients when required.***

Minute No. PCCC-22.10.20 Shrewsbury Health & Wellbeing Hub – Progress Update

8.1 Mrs Pall stepped down as Chair for this item due to a potential conflict of interests and declared that in the event of the Committee being required to vote on any action, she would not vote.

8.2 Mrs Pall handed over Chairmanship of the meeting to Mr Dunshea.

8.3 Ms Pyrah's paper provided the background to, and status of, the Shrewsbury Health & Wellbeing Hub project which represents a significant investment from national funds of between £40m and £60m if the business case is approved.

8.4 The Outline Business Case is currently on hold while the site options appraisal is re-run in response to significant concerns raised by both members of the public and Councillors when the ICB announced the Otley Road site.

8.5 The dialogue and messaging need to be improved although it had already been made very clear publicly of the consequences for the six Practices of not proceeding with the project.

8.6 A public meeting took place on Tuesday 4 October 2022 attended by the Project Team, STW GP representatives and Shropshire Council.

8.7 On Thursday 6 October a second Stakeholder Reference Group meeting took place which included the Patient Participation Group, patients, Councillors, Healthwatch and other stakeholders. The meeting discussed all appraised options and ICB representatives reiterated to those present that the Hub was the only viable option. No other form of funding was available on the scale required to support those Practices to be sustainable going forward.

8.8 Delays to the timeline mean that an indicative date for the formal consultation start is April 2023.

8.9 There is currently significant risk attached to this programme which the Committee need to be aware of. The Council's position on the project has changed in the sense that they have confirmed they will not pay for any required public transport links to the chosen site. The Committee needed to be aware of the tone of public support. The Primary Care team were re-opening the site options appraisal and casting the geographical net for potential sites slightly wider to bring in more locations which will help with management of our population. It was confirmed that there is only one viable solution to providing these 6 practices with sustainable fit for purpose premises and that is the Shrewsbury Hub.

8.10 Mr Dunshea believed that the project is hugely important, and communication is critical.

8.11 Ms Parker referred to input by the clinicians to the Council meeting and the difficulties they encountered because of the restrictions imposed at the time by the national Cavell Programme.

8.12 If the project does not go ahead, the Practices involved all have significant estates issues that will threaten their viability and sustainability in the medium term.

8.13 Mr Robinson had attended the Council meeting on 4 October 2022 and wished to specifically thank Dr Jutsum, Dr Ingram and Dr Hart who had all given very personal views on the importance of this project.

8.14 Mr Dunshea endorsed the points made by Mr Robinson and thanked the GPs who stood up and spoke at the Council meeting on 4 October 2022.

8.15 Dr Chan made the point that this initiative was a centrally driven pilot with a specific objective to co-locate services to drive a new way of working. He acknowledged the limitations on communication but believed that the narrative for the Cavell Centre should be pushed centrally with the public rather than by GPs. He also believed that projects such as this need to be communicated well in advance of meetings with the Council and the public.

8.16 Mr Dunshea agreed with Dr Chan, stating that normally this kind of project would have a communication strategy prepared well in advance. A key message was evolving, particularly about protecting the GPs who are involved, and taking the initiative with communication. He queried the communication strategy going forward and suggested that a more proactive approach should be adopted.

8.17 Mr Robinson agreed with Mr Dunshea's suggestion that this Committee should have detailed assurance on the communication strategy going forward. However, he disagreed with Dr Chan's comment and believed that GP support for the project was a vital component of its success.

ACTION: Edna Boampong to provide Committee members with detailed assurance of a communication strategy and timeline for future communication regarding the Cavell Centre project as a matter of urgency.

RESOLVE: Primary Care Commissioning Committee Members NOTED the content of the report.

8.18 Mr Dunshea returned Chairmanship of the Committee to Mrs Pall.

Minute No. PCCC-22.10.21 Implementation Plans – Enhanced Access from 1 October 2022

9.1 The purpose of Mrs Williams' report was to provide the Committee with information on the Primary Care Network (PCN) Enhanced Access service and to advise on the process used for the approval of the PCN enhanced access plans.

9.2 The service commenced on 1 October 2022. All PCN plans were approved. However, several PCNs had flexibilities around digital, and these were being worked through with NHSE colleagues at Region. Otherwise, the service is up and running.

9.3 These are two services that have been combined - capacity is not increased.

9.4 The Committee discussed one of the challenges faced by all PCNs which is the requirement to provide both routine and same day appointments and the requirement that several same day appointments are ring fenced. At weekends, urgent same day appointments are provided by Shropdoc who are commissioned to provide that service.

9.5 Mrs Pall referred to digital and asked how it will integrate with virtual wards.

9.6 Mrs Williams advised of feedback received from one PCN that they were experiencing difficulties with demographic import of patient information when a patient is consulting at a Practice where they are not registered. The clinical supplier can offer a solution although varying costs are being quoted.

9.7 Mrs Pall believed this to be an important issue and asked for it to be brought back to a future meeting. She requested information regarding a solution to the digital issues as it would become an integration issue going forward.

9.8 Mr Robinson confirmed that information would be brought back to the Committee regarding digital and virtual ward. A huge amount of work was being undertaken under the local care programme.

9.9 Dr Povey stated that virtual ward is an important piece of work, but he was not entirely sure how it aligned with the PCN DES. Mrs Pall confirmed that she would discuss this with Dr Povey offline.

9.10 Mr Dunshea referred to paragraph 2.8 of the report regarding Charlton Medical Practice which was still not part of a PCN and asked whether this was a concern. Mrs Williams replied that those patients do have access to Primary Care and it is not a concern.

ACTION: Mrs Williams to investigate solutions to the issues around digital including costs and information.

ACTION: Mrs Pall to discuss with Dr Povey how virtual ward aligns with the PCN DES.

RESOLVE: ***Primary Care Commissioning Committee Members NOTED the contents of the report.***

Minute No. PCCC-22.10.22 PCN Development Workshop – 31 October 2022

10.1 Mr Morgan provided a verbal update regarding the background to the forthcoming PCN Development Workshop.

10.2 In 2021-22 funding was received from NHS England badged as PCN Development funding. A decision was made by the PCNs that most of that funding should be distributed to the 8 PCNs for their own development work. However, an amount was retained to carry out an element of joint work and that funding was used to commission the King's Fund to work with each individual PCN to look at issues and processes.

10.3 That work was undertaken by six of the eight PCNs over the summer. One of the other two PCNs had already done something similar and the eighth one chose not to be involved.

10.4 Following further discussion, it was agreed to hold a Development Day. Consultants from the King's Fund will lead on that together with senior leaders from the ICB, bringing forward all the themes and issues from their work with the individual PCNs to consider solutions and next steps.

10.5 The PCNs have also requested that time is spent during the workshop examining the relationship between PCNs, the wider ICS and the part PCNs will play in the wider system.

10.6 The Agenda for the day was currently being finalised and will be issued prior to 31 October 2022. Unless agreed otherwise at the event, this will be the end of the current contract with the King's Fund.

ACTION: Mr Morgan to provide the next Committee with an update as to benefits and key learning points of the PCN Development Day to assist with evaluation of the benefits, and information as to how this will be communicated through the PCNs.

RESOLVE: ***Primary Care Commissioning Committee Members NOTED the contents of Mr Morgan's update which was provided for information only.***

Minute No. PCCC-22.10.23 Supporting PCNs Through Winter

11.1 The purpose of Ms Pyrah's report was to provide the Committee with information on national and local requirements on Primary Care for winter planning and any associated funding streams. There are both national and local sources of funding available to support winter. The details are set out in this report.

11.2 Plans are in development and the Committee will be provided with updates on progress at future meetings.

11.3 Ms Pyrah had shared the outcome of the evaluation panel with senior clinical Primary Care leaders and the accompanying caveat that it must be targeted towards specific Practices for maximum impact. Significant concern had been raised as to how that would be done and the impact it would have in terms of creating tension between Practices who do receive it and Practices who do not. Practices who do not need it now may need it during the winter pressures.

11.4 As a result, Ms Pyrah had written to the planning team to explain the rationale and to request removal of the caveat, thereby allowing the funding to be distributed as it was previously on a fair shares basis across all Practices as winter impacts equally on all Practices.

11.5 The Chair invited comments and questions.

11.6 Dr Povey supported Ms Pyrah's proposed solution of distributing the funding on a fair shares basis.

11.7 Mr Robinson undertook to work with Ms Pyrah and the planning team to make sure that this issue is resolved.

ACTION: Ms Pyrah and Mrs Tilley to work through winter planning to take account of best use of the funding. Mr Robinson to pick this up with Ms Pyrah and Mrs Tilley.

11.8 Discussion took place as to how impact from this investment would be measured. Mr Robinson advised that as part of the bidding process the funding request had to be accompanied by a set of KPIs against which it would be measured. The 28,000 additional appointments that this is likely to deliver will be tracked through winter. The leading KPI is the number of appointments. The intention is to relieve the pressure within Primary Care and to attempt to reduce the pressure on ED and all parts of the urgent and emergency care pathway.

11.9 Mrs Pall asked to receive more information relating to outcome-based impact at future Committees. Mr Robinson advised that those impacts are monitored through the Integrated Delivery Committee

ACTION: Mr Robinson to share the paper relating to winter planning submitted to Integrated Delivery Committee with Primary Care Commissioning Committee members.

11.10 The meeting discussed funding and the estimated figure required to ease pressure on A&E and ED. Mr Robinson did not believe that the answer to winter sits within funding. The constraint is not resource in financial terms; the constraint is workforce. He believed that the route in terms of moving services into the right place is the local care programme and suggested that it would be helpful for representatives of that programme to attend a future Committee to promote a better level of understanding of the programme.

ACTION: Local Care Programme representatives to attend a future Committee to provide an update as to what the programme offers in terms of alleviating the pressures on ED and A&E and moving services into primary community.

11.11 Ms Pyrah referred to the national support offer which comprised two funding streams. One stream supports this winter and is a monthly payment to PCNs to help them increase the number of clinical services and workforce to support them during the winter. The other stream is a separate funding stream which is the system development fund which links to PCN development work.

11.12 The Primary Care team were pulling together a survey to be issued to PCNs to gather their views on where they need help and support.

***RESOLVE:* Primary Care Commissioning Committee Members NOTED the content of the report which was submitted to the Committee as a discussion item.**

Minute No. PCCC-22.10.24 GP Survey Results

12.1 Ms Pyrah presented her paper relating to the results of the GP Survey. The report summarised the overall results of the survey for Shropshire, Telford & Wrekin Integrated Care System (ICS), compared against:-

- 2021 results
- 2022 national results
- 2022 ICB results for the system.
- Results at both PCN and GP Practice level against the 2022 GPPS.

- Overall, GP Practices across Shropshire, Telford and Wrekin scored equal to or above national averages. However, local results compared to the 2021 survey showed a reduction on patient satisfaction against all criteria. The largest reduction in results relates to the front door of General Practice and patients' ease of accessing the service. This compares to only a small reduction in satisfaction with the quality of patient experience during a consultation.

- Although overall average scores across the system were in line with or exceeded the national average, individual Practice scores ranged widely in some areas.

- The Primary Care and Quality teams will work with the GP Practices that scored below the national average on multiple domains of the GPPS or where scores are particularly low in one or more domain. Practice level data will also be incorporated into the planning of future Practice visits carried out by the Primary Care team and will be an area of focus where required.

- Access to online services remains a key area for improvement. The Primary Care Team is working with NHSEI on an improvement programme in conjunction with relevant teams within the ICB.

12.2 Mrs Pall asked Mr White whether he would like to see any other aspects of Primary Care included in the report.

12.3 Mr White replied that the survey was a national one and the ICB did not ask the questions. The key is what we do with the information.

12.4 Mrs Pall queried whether the report should be submitted to Quality Committee or whether PCCC needed to discuss future actions.

12.5 Mr White replied that any actions coming from the report would need to go through PCCC because the ultimate decision will be how the ICB spends the money.

12.6 Mrs Pall requested that information from the GP Survey should be triangulated against patient outcomes, patient safety and clinical effectiveness and triangulated with patient experience, the results to be submitted to a future PCCC.

ACTION: GP Survey data to be triangulated against patient outcomes, patient safety and clinical effectiveness and submitted to a future PCCC.

12.7 Mr Dunshea presumed that the GP survey was discussed within each GP Practice. Dr Chan confirmed that GP Practices are paying active attention to feedback from the survey because the survey forms a large part of CQC monitoring, especially in terms of access. However, questions had been raised about its validity in terms of the number of surveys being sent out which do not relate to the size of the Practice. Several hundred surveys had been sent to Practices with thousands of patients.

Primary Care Commissioning Committee was asked to:

- Note the 2022 GPPS results, and in particular the very high scores achieved by many Practices against the challenges of the preceding 12 months.
- Agree to receive an update from the Primary Care team at a later date on progress with those Practices that scored lowest in this year's GPPS.
- Agree to receive updates from the Primary Care team on work to support performance across specific domains e.g. online consultation, telephone access.

RESOLVE: ***Primary Care Commissioning Committee Members NOTED the content of the report and the requests as outlined above.***

Minute No. PCCC-22.10.25 Risk Register

13.1 The Risk Register had been reviewed and updated by Ms Pyrah.

13.2 A Covid funding related item had been removed as there is no more Covid funding available from the national team. This had been added to the list of closed risks.

13.3 An update was added regarding the risk relating to Highley Medical Practice which will be outlined in more detail in the Part 2 Confidential section of the meeting.

13.4 Mrs Pall asked if a Risk Register was held at Quality Committee or Audit Committee and asked how risks from other Committees were escalated into this Committee.

13.5 Mrs Skidmore advised that this Committee is responsible for overseeing the Risk Register for the area that it covers therefore PCCC was the appropriate place for the Risk Register to be reviewed. If the Committee believes that there is an escalation point, then escalation would be to the Board Assurance Framework. If there is a risk that would be detrimental to our system priorities it would be escalated to Board for discussion.

Audit Committee has a slightly different remit which is to make sure that the process is robust and there is read across between different Committees.

13.6 Ms Parker questioned whether the ICB had a risk management and escalation policy to ensure that an escalated Directorate risk would reach the Board Assurance Framework from all levels of the organisation. She suggested that this could be monitored by Audit Committee. It was usual practice that closure of risks from statutory Committees was approved by Audit Committee, an action she would like to see embedded in the ICB.

13.7 Mr Dunshea advised that work was being carried out by Nicola Dymond and Alison Smith on the Governance Framework and the Board Assurance Framework. The Risk Register will change and will become more focused on our strategic objectives to ensure and assure our delivery processes. In terms of this Committee, it would very much relate to the risks around digital, integration, virtual wards, etc. and become much more transformational than at present.

13.8 Dr Povey asked whether the Moderate rating was an accurate reflection of the potential risks around workforce including the underspend on ARRS funding and the lack of GPs. He also asked whether the Cavell development should appear on the Risk Register, as failure of the Cavell process would result in potentially problematic impacts on Shrewsbury in terms of GP provision.

13.9 Mr Morgan referred to the potential underspend on ARRS and agreed that it was a risk, but such a risk had always existed, predominantly because of the lack of staff available to be recruited rather than unwillingness to use the funding.

Mr Morgan then referred to the ongoing drop in the number of GP partners and the work being done to encourage newly qualified GPs to become partners. There are broadly the same number of GPs across our Practices but more of them are working fewer hours.

13.10 Mr White advised that the ICB Risk Register at Board level reflected the risks posed by workforce in general across the entire system.

13.11 Ms Parker replied that risks relating to operational delivery sat with Committees and groups at a lower level within the organisation and changes to those risks should be escalated and be reflected in the detail of the Board Assurance Framework. She suggested that the workforce element of the GP Strategy should be reflected in the BAF.

ACTION: Risks around ARRS and GP numbers to be reflected in the Risk Register – higher risk for GP numbers; lower risk for ARRS.

***RESOLVE:* Primary Care Commissioning Committee Members NOTED the content of the Risk Register and the suggested amendments.**

Minute No. PCCC-22.10.26 Finance Update

14.1 Ms Jones' paper was submitted to the Committee for information and summarised the Month 5 financial position for Primary Care. Key points of her paper were: -

- Co-Commissioning budgets (those delegated to the ICB from NHSE) were currently underspent by £381k with a reported full year forecast underspend of £1,051k. This mainly relates to some prior year benefits where expenditure had been slightly less than 21/22 year end estimates, an in-year underspend on ARRS (Additional Roles Reimbursement Scheme) and expected income in relation to the rates rebates efficiency scheme.

- Other Primary Care budgets had a year-to-date underspend of £2,768k and a full year underspend forecast of £914K. The main driver of this underspend is prior year benefit in relation to Prescribing and Enhanced Services which is non-recurrent in nature.

- Both the delegated and non-delegated Primary Care areas are currently anticipated to deliver expenditure less than plan this year. The Finance team are working to review the underlying position in this area, as whilst there is a benefit in 22/23, there is a risk that there will be an underlying pressure in the recurrent budget which would be carried into future years and will need to be addressed.

14.2 Ms Jones invited questions.

14.3 Dr Shepherd commented on the significant underspend on the Primary Care budget which the ICB must ensure is kept within Primary Care and used to improve and support Primary Care services.

14.4 Mrs Skidmore responded to Dr Shepherd that a large element of the figure in the report was the result of prudence in accounting assumptions.

14.5 Mr Dunshea asked whether it was possible for performance data to be included in the report in terms of numbers of attendances, visits, etc.

14.6 Dr Chan believed that the current underspend in the ARRS scheme should be recognised as a risk around the deliverability of the PCN DES which poses a risk to the outcomes of patients.

ACTION: Mrs Skidmore and Ms Jones to discuss with the Performance team inclusion of performance data in the Finance report.

ACTION: Mrs Pall and Ms Jones to discuss Primary Care financial reporting outside of this Committee and the format and content of financial updates going forward.

Minute No. PCCC-22.10.27 Primary Care Team Update Report

15.1 Ms Pyrah's report had been submitted to Committee for information only.

ACTION: Comments on the Primary Care team update report to be fed back via email to Ms Pyrah.

Minute No. PCCC-22.10.28 Any Other Business

16.1 There was no other business.

Minute No. PCCC-22.10.29 Date and Time of Next Meeting

17.1 The next meeting of the Committee will take place on Friday 2 December 2022 at 9.30 a.m. via Microsoft Teams.

17.2 The Part 1 meeting closed at 10.35 a.m.

NHS Shropshire, Telford and Wrekin Primary Care Commissioning Committee RESOLVED that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (section 1(2) Public Bodies (Admission to Meetings) Act 1960.)

***SIGN*ED ..... DATE .....**

Agenda Item

ICB 25-01-061

Other Minutes

INTEGRATED CARE PARTNERSHIP

Minutes of a meeting of the Integrated Care Partnership held on Wednesday 5 October 2022 at 12.30 pm in The Telford Room, 3rd Floor, Addenbrooke House, Ironmasters Way, TF3 4NT

Present:
Councillor L Picton (Co-Chair)
A Begley (Chief Executive) (Shropshire Council)
J Britton (Executive Director: Children's Services) (TWC)
L Cawley (Healthwatch Shropshire)
S Dillon (Director: Adult Social Care) (TWC)
N Dymond (Executive Director ICB)
Simon Jones (Portfolio Holder Adult Social Care and Public Health) (Shropshire)
Sir N McKay (Chair - ICB)
L Noakes (Director: Health & Wellbeing (TWC))
A Olver (Voluntary Sector Representative) (Telford)
B Parnaby (Healthwatch Telford & Wrekin)
R Robinson (Executive Director: Health, Wellbeing & Prevention) (Shropshire Council)
D Sidaway (Chief Executive) (TWC)
S Whitehouse (Chief Executive) (ICB)

In Attendance:
J Clarke (Senior Democracy Officer (Democracy)) (TWC)
A Lowe (Director: Policy & Governance) (TWC)
R Phillips (Service Delivery Manager: Legal & Democracy) (TWC)
J Rowe (Executive Director of Adults Social Care and Health and Wellbeing) (TWC)

Apologies: Councillor S Davies (Co-Chair), J Jeffery Voluntary Sector Representative (Shropshire), Councillor A D McClements and T Miles Executive Director of People (Shropshire Council)

1 Declarations of Interest

None.

2 Welcome and Introductions

The Chair asked the members of the Integrated Care Partnership (ICP) to introduce themselves and welcomed everyone to the inaugural meeting of the ICP. The aim of the ICP was to look for ways to achieve better care and wellbeing and strengthen integrated working which was vital within the new partnership arrangements. Residents would be at the centre of any work undertaken and it would be necessary to recognise the differences and

similarities, the work of the voluntary and community sector and work in a strong, impactful and collaborative way.

Sir N McKay informed the ICP that the Integrated Care Board (ICB) had been in legal existence since 1 July 2022. It had responsibility for delivering better health care and tackling the issues and root causes of ill health and inequality and to contribute towards the economic regeneration of the locality. The ICP was a vital part of this with responsibility to deliver both health and care and to deliver an integrated care strategy.

3 Public Speaking

No requests to speak had been received.

4 Terms of Reference and Ways of Working

The Service Delivery Manager: Legal & Democracy (TWC) presented the report on the Terms of Reference and Ways of Working.

He highlighted section 5.2 of the report that Telford & Wrekin had a Director for both Adults Services and Children's Services and suggested that this be reflected for Shropshire Council. At 8.2 of the report, the Chair for Telford & Wrekin was referred to as Leader or Cabinet Lead and it was also suggested that this be amended for Shropshire Council.

The Terms of Reference set out had been a collaboration between the Councils, NHS, ICP and ICB and set out the membership, how it would operate, code of conduct and dispute resolution provisions.

The dispute resolutions had not yet been before the ICB and these would have to go to the Board for official confirmation.

Following a discussion it was:

RESOLVED – that

a) **Subject to the changes to the Terms of Reference be agreed; and**

b) **The Terms of Reference be approved by Shropshire Council, Telford & Wrekin Council and the ICB.**

5 Guidance on Development of Integrated Care Strategy

The Chief Executive: ICB and The Executive Director: ICB gave a presentation on the Integrated Care Strategy and ICS Priorities.

The ICP was a key part within the governance framework of setting a strategic direction and would look at how to build on the work undertaken by the two Health and Wellbeing Boards and its links. It needed to be relevant to local people and incorporate the local differences across the communities of

Shropshire and Telford & Wrekin. This would enable the ICP to develop the direction of travel and highlight key health and wellbeing priorities for STW. It looked to building an operating model, workstreams and assurance on delivery.

The creation of an ICP was a mandatory requirement in order to establish and the Integrated Care System (ICS) and to develop the strategy. The process of integration would be ongoing but the timescales for completion and sign off of the strategy was tight (end of December 2022).

The work would give the opportunity for joint and collaborative working across a wide range of partners in order to improve the health and wellbeing of the local population. It would be necessary to understand the bigger picture and take into account local needs, community agendas and neighbourhood discussions. Consultation would take place with people, organisations and stakeholders in order to understand the different needs and perspectives of our communities.

The next steps would be to think about engagements with stakeholders. An ICS development day would take place in early November to look at opportunities for broader engagement and consultation with the Integrated Care Strategy (ICS) being reviewed and signed off for publication in December. A timeline from the ICB was available, but it was important to manage expectations on what could be achieved as the ICS was an interim document and a crucial starting point to develop the five year plan. This document would set the scene, vision and key priorities with the five year plan being drawn up by March 2023.

During the discussion it was felt that a sensible and pragmatic approach would need to be taken and working together in order that duplication of work did not occur. Work was already being undertaken across the Local Authorities, Health & Wellbeing Boards, Health Scrutiny Committees and Joint Health and Overview Scrutiny Committees. It was important that expectations were managed and that people were involved. Healthwatch could give support on the ground and give people a voice. Council Leaders and Councillors could get the message out to the community. A working group had been set up and would look at engagement, communications and development of the ICS and it was felt assured that there was reasonable resources to move this forward.

The ICP noted the presentation.

6 Headlines of the JSNA - Shropshire and Telford & Wrekin

The Director: Health & Wellbeing (TWC) and the Executive Director: Health, Wellbeing & Prevention (Shropshire Council) presented a joint report on the headlines in relation the JSNA. The Health and Wellbeing Board (TWC) received an update on 29 September 2022 in relation to the Joint Strategic Needs Assessment (JSNA) giving key information. Telford & Wrekin had the fastest population growth since 2011 in the West Midlands, which equated to 11.4% and had the second fastest growth nationally in the 65+ population

being 35.7%. More than 1 in 4 people in the borough live in the 20% most deprived areas nationally. Both these factors had significant impacts on health and social care needs. The information would be used to shape how services were tailed to reach into local communities. The wider determinants of health, public health outcomes and child poverty rates were likely to worsen with the current cost of living crisis – with ongoing impact on the health of our residents.

Some improvements had been reported in the numbers of 16/17 year olds being in employment, education or training and this was attributed to a tailored approach. There had been an improvement in terms of teenage pregnancy over a number of years and this was now in line with the national average.

Shropshire Council's Health and Wellbeing Board had also received an update using an interactive tool which was continually fed with live information. The population had been predicted to increase by 28% by 2043. In relation to population, 23% of Shropshire's population was age 65+. There are inequalities within the rural population but this was often masked. This created a number of challenges and demands on the health and care services. The Covid 19 pandemic had highlighted how services could be adapted and services could be adapted by the use of technology and physical and digital access.

The cost of living, poverty and an older age population profile was a particular challenge for winter and longer term; this was a similar picture to that of Telford & Wrekin.

The presentation highlighted health statistics for Shropshire and Telford & Wrekin compared to the national average. The information was RAG rated to show which area had statistically significantly different health outcomes compared to the national average.

During the discussion, it was noted that the actual numerical differences between the two areas were not as great as suggested by the RAG rating
The Partnership heard that child poverty and homelessness rates were higher than the national average in Telford & Wrekin and the % of NEETs were higher than the national average in both Telford & Wrekin and Shropshire. The Director: Health & Wellbeing (TWC) highlighted, however, that the numbers in Telford & Wrekin had fallen more recently due to a more tailored approach.

Life expectancy was worse than the national average in Telford & Wrekin but with both areas having a significant gap in life expectancy between more deprived and affluent areas. Heart disease and cancer was the significant contributor to this gap in both areas. Life expectancy rates had been falling particularly amongst men. In both areas excess deaths in those with serious mental illness was higher than the national average.

Both areas had high rates of unhealthy weight and hospital admission rates due to smoking and Telford & Wrekin had high rates of alcohol related admissions.

In Telford & Wrekin a range of health outcome indicators for Children and young people were worse than the national average but both areas had high rates of smoking in pregnancy.

The current cost of living crisis was of concern for both Shropshire and Telford & Wrekin with them both being in the bottom quartile of vulnerability due to the impact of fuel poverty and transport costs, isolation, mental health, hospital admissions and the longer term impact on children and young people.

A discussion took place in relation to the work on the JSNA. The presentation had been informative and gave an indication on the areas for preventative work. It was also helpful in the resource allocation process which could be influenced by age and deprivation. It was suggested that data was used to influence early intervention and prevention and these be key agenda items.

The ICP noted the presentation.

7 Our Health & Wellbeing Strategies - Shropshire and Telford & Wrekin

The Director: Health & Wellbeing (TWC) and the Executive Director: Health, Wellbeing & Prevention (Shropshire Council) presented a joint report on the Health and Wellbeing Strategies for Shropshire and Telford & Wrekin.

The purpose of the ICP and the ICS Plan was to highlight key priorities to the ICB using the JSNA and existing strategies of the Health and Wellbeing Boards. It was reported that both Telford & Wrekin and Shropshire were in a strong position. Shropshire had updated their Strategy earlier in the year focusing on a refresh in relation to the right place and the right impact and it was felt that they had a good provision in this regard.

Telford & Wrekin were undertaking a light refresh of the Health and Wellbeing Strategy with the focus on population health, inequalities and integrated care and support. The proposed priorities were Start Well, Live Well, Age Well which included priorities for population health, health inequalities, health and care support. Proposed priorities include unhealthy weight, mental health, preventable mortality, health inequalities and integrated care in neighbourhoods. The Health & Wellbeing Board had wanted a stronger focus on Best Start in life and inequalities in this refresh.

Shropshire Council priorities included workforce, mental health, children and young people, looked after children, healthy weight, cardio vascular disease and diabetes. A review on children and young people and healthy weight would be launching shortly. There would be further work in relation to workforce, integration and integrated primary care and access to care and the cost of living crisis.

The JSNA and the Health and Wellbeing Strategies had some similarities and common themes. It was highlighted that integrated working was also needed

across the system to support Health Protection. The pandemic had increased the joint working and there was a joint health protection board in order to give reassurance.

A draft outcomes framework was highlighted which was welcomed and members agreed that it was key that measuring impact at individual and population level would be part of evaluating the difference the ICS would make.

During the discussion, it was suggested that a timeline be drawn up for a wider engagement event in November and production of a draft strategy by the end of December. The need to set a date for the next ICP in December soon was highlighted.

The ICP noted the presentation.

8 ICS Priorities

This item had been discussed under Minute Number ICP5.

The ICP noted the priorities.

9 Next Steps

The Chair suggested that a meeting took place at the end of the year to look at priorities utilising the work already undertaken.

Members of the Partnership suggested that they considered the underlying issues in relation to finance, capacity and performance and whether this should be raised politically or in a different way. Other areas of consideration were the cost of living and homelessness. The funding allocation process for the NHS was complex and refined year on year. Additional funding was difficult to achieve. It was suggested that the totality of the funding be considered and how it was allocated equitably against needs and priorities. The risks and consequences of the re-direction of funds should be considered.

A suggestion came forward that although the Terms of Reference had been agreed, could a broader range of partners be brought to the workshop with a wider range of experiences.

The meeting ended at 2.02 pm

Chairman: ----------

Date: Date Not Specified

INTEGRATED CARE PARTNERSHIP

UNCONFIRMED Minutes of the meeting of the Integrated Care Partnership held on 21 December 2022 2.00 pm – 3.10 pm in The Council Chamber, Shirehall, Shrewsbury, SY2 6ND

Present:
Councillor Lezley Picton, Leader - Shropshire Council (Co-Chair)
Andy Begley, Chief Executive - Shropshire Council
Councillor Andy Burford, Portfolio Holder Adult Social Care and Health, Integration and Transformation -Telford & Wrekin Council
Lynn Cawley, Chief Executive - Healthwatch Shropshire
Terry Gee, Chief Executive - Stay
Angela McClements, Chair of Health and Wellbeing Board - T&W Council
Councillor Cecilia Motley, Chair of Health and Wellbeing Board and Portfolio Holder for Adult Social Care, Public Health and Communities - Shropshire Council
Sir N McKay, Chair - ICB
Tanya Miles, Executive Director People - Shropshire Council
Liz Noakes, Director: Health & Wellbeing **-** T&W Council
Heather Osborne, Chief Executive - Age Concern Shropshire
Rachel Robinson, Executive Director: Health, Wellbeing & Prevention - Shropshire Council

In Attendance:
Edna Boampong, Director of Communications and Engagement - NHS Shropshire T&W
Tim Collard, Assistant Director Legal and Governance - Shropshire Council
Nicola Dymond, Executive Director of Strategy and Integration - NHS T&W
Amanda Holyoak, Committee Officer - Shropshire Council (minutes)
Jackie Robinson, Associate Director Communications and Engagement - NHS Shropshire T&W

1 Apologies for Absence

Apologies were received from: Councillor Shaun Davies (Co-Chair), Jackie Jeffery, Alan Olver, Jo Britton, Sarah Dillon, David Sidaway, Chief Executive, Telford and Wrekin Council

Councillor Andy Burford substituted for Councillor Davies.

2 Declarations of Interest

None

3 Public Questions

There were no public questions

4 Minutes of last Meeting

The minutes of the meeting held on 5 October 2022 were confirmed as a correct record.

5 Update on Integrated Care Strategy Workshop Engagement Work held on 16 November 2022

The Director of Strategy and Integration introduced the report and explained the purpose and outcomes of the workshop which had involved 40 participants. Those who had been present reported that an open and honest discussion had taken place. The proposed vision of a 'healthier, happier, wealthier population' had been debated, particularly use of the word 'wealthier', and work on vision and mission was still underway. It was confirmed that a representative of the primary care sector had been present and that going forward engagement activity would seek input from both primary care and acute sectors. ICP members felt that the vision should be kept simple and agreed quickly and based upon both Health and Wellbeing Board Visions.

The report on feedback from the workshop was noted.

6 Draft Interim Integrated Care Strategy

A presentation summarising the contents of the draft strategy was presented by the Director of Strategy & Integration, NHS T&W, and the Directors of Public Health from Shropshire Council and Telford and Wrekin Council.

They explained the intent was for the Strategy to draw on and consolidate the work, engagement and knowledge of the two Shropshire Telford & Wrekin Health and Wellbeing Boards. They also referred to the 10 ICS Pledges; development of the ICP vision and mission; Integrated Care Strategy Vision and four strategic objectives; the governance, planning and delivery cycle supporting the partnership working across the system; the priorities for population health, health inequalities and health and care; the plans for performance monitoring and scrutiny; the intended outcome focus; and the outline strategy and plan development timeline.

National guidance on moving forward was expected imminently and this would outline the requirements for next steps with regard to the Forward Plan which would involve a significant engagement piece.

The ICP heard that there had been a positive discussion around the Strategy at the Joint Health Overview and Scrutiny meeting on 19 December 2022 and that the Committee had suggested that more clarity be given to the term 'mental health' - for example whether dementia should be specified separately and also highlighted as a focus. The Joint HOSC had also suggested additional emphasis be given to suicide prevention, and felt that as housing was of such significance to population health, that it should be given more prominence throughout the strategy.

Other comments and issues raised during discussion included:

- The impact of jobs and education should be brought out more clearly, as well as housing;
- The importance of avoiding overwhelm through too many priorities - those set out in the draft should be synthesised to ensure connectivity;
- The need for demonstrable outcomes – how would people know there had been a change?;
- Whether there was capacity in the system to deliver the strategy and the importance of building on knowledge and structures already in place;
- Use of words within the strategy such as 'empowerment, innovation and person centred' were very much welcomed by the voluntary and community sectors who were ready to seize opportunities and deliver value for money
- The 'slide deck' approach to presenting the draft strategy rather than a dense report was welcomed;
- Next steps should include 'what' and 'how' and the work of SHIPP and TWIPP would be vital in progressing this quickly
- It was acknowledged that generally the population would not be concerned with structures but only on outcomes and how it would affect them and their families.

The Chair envisaged that the strategies of Shropshire Council and Telford and Wrekin Councils would link with the Integrated Care Strategy and create focus on how to leverage capability of one true system to join up and deliver on priorities and activity. It was suggested that a simple one page 'map' or 'plan on a page' would help to illustrate this, with a clear reference to the raison d'etre of the Strategy.

It was confirmed that omission of Healthwatch Shropshire and Healthwatch Telford and Wrekin as system partners from the first draft of the Strategy and been an error and they were now included.

RESOLVED:

A To agree the Draft Interim Integrated Care Strategy

B To approve publication of the Draft Interim Integrated Care Strategy

7 Next Steps - Integrated Care Strategy and Five Year Plan Development – Engagement Approach

Edna Boampong, Director of Communications and Engagement, NHS STW gave a presentation on the engagement activity to come to inform the Strategy and Joint Five Year Plan and set out the ten principles for involving people and communities and the overarching strategic objectives of the engagement activity.

Potential names for this piece of work were still under discussion but was likely to be either 'The Big Health and Care Conversation' or 'The Big Health and Wellbeing Conversation'.

Deadline for submission of the Five Year Forward Plan signed off by the ICB was currently end of March 2023 but it was envisaged that this might be deferred to June which would allow a more authentic engagement process ahead of the consultation. All acknowledged that this would still remain a tight timescale.

Part 1 of engagement activity would be with key decision makers and system leaders and partners. ICP members agreed that whilst discussion should be aspirational, realism would be needed. Part 2 of engagement would progress drafting of the plan informed by engagement outputs and involve sharing this with stakeholders for comment and input. The risks around engagement fatigue were recognised.

The ICP welcomed what it felt was a well-planned, ambitious and comprehensive engagement activity but also reiterated the need to manage expectations carefully. During consideration of the proposed activity to come, ICP members also commented and suggested that:

- A briefing be provided to both Shropshire and Telford and Wrekin Councillors at the same time;
- Clinicians would need to be very well briefed;
- The engagement process should include another local media briefing;
- Great care needed to be taken in reaching out to marginalised groups, there would only be one chance to get this right;
- Different approaches for different audiences should be tailored as appropriate – both Councils had expertise and links that could be utilised;
- An on-line short briefing approach would suit some contexts – for example a presentation to members of the Social Task Force which had an extensive network and very good social media exposure
- Healthwatch and other Voluntary and Community Groups be asked to share their networks and help deliver this work;
- Shropshire Association of Local Councils be involved and used to share information with parish and town councils;
- Rural populations could be reached via 'warm spaces' at village halls and other locations; these could also be utilied to test proposed terminology at a very local level;
- Shropshire Parent and Carer Council and PODS be included in engagement work;
- The approach taken could be used as a blue print for the ICB in moving forward

Welcoming these suggestions, the Director of Communications and Engagement confirmed that mapping of existing contacts and networks was underway and that further ideas and information was always welcome. She

also confirmed a positive relationship had been established and was being developed with the media. The pulling together of resource across the whole system and involvement of Healthwatch and other voluntary and community organisations would be essential to this work.

RESOLVED

A To note the content of the paper;
B To agree the outline approach and timeline;
C That the ideas and suggestions of the ICP for additional engagement and briefing of key partners as set out above be taken into account moving forward;

8 Date of Next Meeting

The next meeting had been planned for 17 February 2023, it was noted that this was likely to be changed to a date in March, depending on guidance received from NHSE regarding next steps.

Chairman: ----------

Date: