NHS STW Integrated Care Board - Appendices

MEETING

26 March 2025 14:00 GMT

PUBLISHED
20 March 2025

Agenda

Location	Date	Time
Meeting Room 1, Wellington Civic Offices, Larkin Way, Tan Bank, Wellington, TF1 1LX	26 Mar 2025	14:00 GMT

Contents

Agenda Item

ICB 26-03.134

System Board Assurance Framework (SBAF & SORR)

Appendix A - NHSSTW System BAF 2024.25 - Mar 25

Appendix B - SYSTEM SORR 202425 Mar 25

Appendix C - ICB SORR 202425 Mar 25

Appendix D - Risk Management Matrix SORR 202425

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

NHS STW – SYSTEM BOARD ASSURANCE FRAMEWORK

2024/25

Version 5 March 2025

NHS Shropshire, Telford and Wrekin Strategic Objectives:

1) **Reducing Health Inequalities:**
   - **Wider determinants**
   - **Tackling health inequalities**

2) **Improving population health**
   - **Best start in life**
   - **Healthy weight**
   - **Alcohol drugs domestic abuse**
   - **Mental health and wellbeing**

3) **Improving Health and Care**
   - **Strengthen prevention, early detection and improve treatment outcomes – mental health, heart disease, diabetes, cancers and musculoskeletal disease.**
   - **Urgent and Emergency Care**
   - **Integrated person-centred care within communities – strong focus on primary and secondary care.**

Risk Matrix

Consequence	**5 Catastrophic**	**5 Low**	**10 Moderate**	**15 High**	**20 Extreme**	**25 Extreme**
	4 Major	**4 Low**	**8 Moderate**	**12 High**	**16 High**	**20 Extreme**
	3 Moderate	**3 Very Low**	**6 Low**	**9 Moderate**	**12 High**	**15 High**
	2 Minor	**2 Very Low**	**4 Low**	**6 Low**	**8 Moderate**	**10 Moderate**
	1 Negligible	**1 Very Low**	**2 Very Low**	**3 Very Low**	**4 Low**	**5 Low**
		1 Rare	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost Certain**
		Likelihood				

	1 – 3	Very Low risk
	4 – 6	Low risk
	8 – 10	Moderate risk
	12 – 16	High risk
	20 – 25	Extreme risk

Objective: ALL **Strategic Risk no.1: Unable to sustain a culture of strategic collaboration and partnership working and secure delivery of integrated care priorities**		Risk Score 20 Extreme 4 likely x 5 catastrophic
If we are unable to develop and sustain a culture of collaborative working and build effective partnerships	*Then* we will not be able to achieve our aims and focus on our priorities and deliver our objectives	*Resulting in* poor outcomes for our population, adverse impacts on our partner organisations and increased scrutiny of our effectiveness

	Consequence	Likelihood	Score	Risk Trend
Current	5 catastrophic	4 likely	20 Extreme	⟷
Target	4 major	3 possible	12 High	

Risk Lead	ICB Chief Executive Officer	Assurance committee	Board

System Controls	Assurances reported to ICB Board and committees
Strategies and Plans • ICB Constitution • ICP Terms of Reference • Governance Handbook / Functions and Decisions Map • System Development Plan • Better Care Fund Plans • Primary Care Strategy • Clinical and Professional Leadership Programme • Integrated Care Strategy • Joint 5 year forward plan • People Priorities Partnerships and Services • Integrated Care Partnership • ICS Chief Executive Group • ShIPP • TWIPP • Health and Wellbeing Boards • ICS People Strategic Workstreams 2024- 2027 Governance & Engagement Structures • Integrated Care Partnership; Board of the Integrated Care Board and Integrated Delivery Committee • STW Mental Health Collaborative • GGI Review of ICB/ICS governance structures • ICB Strategic Partner on development of ICB version 3.0 • People Culture and Inclusion Committee	First Line of Assurance • Monitoring and oversight at ICB Executive Group and ICS Chief Executive Group • Provider Collaborative Committees in Common Second Line of Assurance • Population Health Board Third Line of Assurance • Integrated Care Partnership oversight • National Health Service England Integrated Care Board Establishment Assessment and Establishment Order
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
1. Independent assessment (NHSE, CQC) 2. Development of provider collaborative and supporting governance structure	1. Self-assessment against NHSE/CQC regulatory framework completed. NHSE Improvement Director attendance at CiC meetings 2a Interim ICS Director of Strategy leading development of STW Provider Collaborative 2b. Creation of dedicated Director level role to support development of Provider Collaborative.

	2c. Finalising Provider Collaborative Committees in Common (CiC) ToR and Joint Working Agreement. 2d. CB CEO co-chair of HWBB's 2e. Director of Partnerships and Place supporting delivery of JFP priorities and integrated place Working. 2f. Creation of PC CEOs group reporting to CiC 3. System Transformation Group working on collaborative workstreams to drive improvement in areas such as MSK, UEC and workforce.

Current Performance – Highlights
Development of provider collaborative and partnerships is now progressing with some dedicated ICB capacity. CiC now in place and key priority areas of work agreed. Provider Collaborative CEOs Group in place. Work programme reporting is embedding Additional workstream areas are being considered. Focus on establishing appropriate resourcing, infrastructure and reporting for the Collaborative is underway. System Transformation Group in place with CEOs to aid drive in several system wide improvement programmes.

Associated Risks on the System Strategic Operational Risk Register	
Risk no.	Description
	Non identified

Relevant risks on system partners risk registers
Description
SaTH - BAF 12 - There is a risk of non-delivery of integrated pathways, led by the ICS and ICP MPFT – BAF B8 - There is a risk to service stability and equity, due to the fragmentary influence of Place Based Partnerships on service commissioning Shropshire Council – Corporate Risk Register - Extreme pressures upon partners (social care, health, and criminal justice) within the system impacting on Shropshire Council through increased expectation, demand, need and complexity.

Strategic Objective: ALL			Risk score 20 Major 4 x Almost Certain 5
Strategic Risk No.2a: Risk of not achieving underlying financial balance (ICB and System)			
If we are unable to adopt best practice and integrated modelling as rapidly as we need to	*Then* we will be unable to use our budgets and wider resources more effectively and efficiently and share risks and benefits	*Resulting in* long term financial instability and challenges in service delivery for our population, poor health outcomes, and increased scrutiny of our effectiveness	

	Consequence	Likelihood	Score	
Current	Major 4	Almost Certain 5	20 Extreme	Risk Trend ⟺ (aligned with system provider scores)
Target	Major 4	Possible 3	12 High	
Target Date for risk closure	TBC after the MTFP trajectory is agreed			

Risk Lead	ICB Chief Finance Officer	Assurance committee	ICB and ICS Finance Committee

System Controls	Assurances reported to ICB Board and committees

Strategies and Plans
• System Financial Strategy, incorporating:
  ○ Healthcare Financial Management Association (HFMA) Financial sustainability checklist
  ○ Strategic Decision-Making Framework
  ○ Capital Prioritisation Framework
• Financial Revenue Plan
• Financial Capital Plan
• Joint 5 year forward plan
• Financial Recovery Plan inclusive of the Financial Improvement Programme and Efficiency, Productivity and Strategic Transformation Plans
• ICS Infrastructure Estates Strategy
• General Practice Estate Strategy
• System Digital Strategy
• System Workforce Strategy
 	
Partnerships and Services
• ShIPP
• TWIPP
• ICS Digital Delivery Group
• Strategic Estates Group
• People Board
• Strategic Transformation Group supported by delivery boards for all major programmes e.g. Planned Care Board, UEC Delivery Board
 	
Governance & Engagement Structures
• Finance Committee
• Commissioning Working Group
	First Line
	• Monitoring delivery of System Financial Strategy and Financial Plan by System Finance Group and System Finance, Planning and Performance Group
	
	Second Line
	• Finance Report to Finance Committee
	• Integrated Performance Report to the Board
	
	Third Line
	• Monthly Integrated Finance Return (IFR) and Provider Finance Return (PFR) reporting to NHSE
	• Quarterly NHSE Financial Stocktake
	• NHSE Annual planning process (and triangulation of Finance, Activity and workforce planning)

• Strategic Commissioning Committee • Audit Committee • Provider Collaborative Committees in Common	
Gaps in Controls and Assurances	Actions and mitigations to address control / assurance gaps
1. Long term financial plan and strategy now out of date 2. System transformational projects in place but at varying stages of maturity. 3. Existing transformation plans do not fully address the target savings position.	Action 1) Agree the Financial Recovery Plan and refresh and agree with System partners the System financial strategy by Mar 25 aligned to the SIIP delivery action timescale - ASz. Action 2) System partners will agree the detail of the three to five-year strategic transformation plans (quality and inequality impact assessments will be carried out on the impact of equality of population health outcomes and health inequalities as a result of any transformation plans) - to be reported through Financial Improvement Programme Board, known as 'the Recovery Plan' by Mar 25 aligned to the SIIP delivery action timescale - IB. Action 3) Refresh the medium and long-term financial plan for latest financial projections and HTP by Mar 25. (Including developing the 25/26 operational plan inclusive of efficiency plans (quality and inequality impact assessments will be carried out to confirm the impact to equality of population health outcomes and on health inequalities as a result of any efficiency plans). [Links to SBAF entry 2b] ASz.

Current Performance – Highlights
Updates as of 19th February 2025 Action 1) Draft System financial strategy updated for the Recovery Plan through Strategic Transformation Programmes to be presented to System Finance Planning and Productivity Group and System Finance Committee in March 2025. Action 2) High level strategic transformation programmes are actively under discussion through the Financial Improvement Programme and progress is reported to the System Transformation Group and System Finance Committee. Action 3) The System MTFP and LTFP is on track to be updated with the Financial Recovery Plan by the end of March 2025.

Associated Risks on the System Strategic Operational Risk Register	
Risk no.	Description
System Risk 7 System Risk 20 System Risk 21	Financial Sustainability Financial Plan 24/25 – Revenue and Capital Risk to System ERF Income delivery.

Relevant risks on system partners risk registers
Description

SaTH BAF 5 - The Trust does not operate within its available resources (as per Board papers – Jan 25 (latest) - 4 Consequence and 4 Likelihood)
RJAH BAF 3 - Delivering the financial plan (as per Board Papers – November 25 (latest) - 5 Consequence and 4 Likelihood)
Shropcom BAF 8.1 – Costs exceed plan (as per Board papers Feb 25 (latest) - 4 x 3 = 12)
MPFT BAF IB01 – Financial sustainability (as per board papers November 2024 (latest) (– 4 x 5 = 20)

Telford & Wrekin Council – Corporate Risk Register R2 - Inability to:

a) Match available resources (both financial, people and assets) with statutory obligations, agreed priorities and service standards
b) deliver financial strategy including capital receipts, savings and commercial income
c) fund organisational and cultural development in the Council within the constraints of the public sector economy

Shropshire Council – Corporate Risk Register:

a) Extreme pressures upon partners (social care, health, and criminal justice) within the system impacting on Shropshire Council through increased expectation, demand, need and complexity.
b) Sustainable budget

Strategic Aim: ALL	System Risk Score 20 Major 4 x Almost Certain 5
Strategic Risk No.2b: Failure to deliver the System and ICB Revenue and Capital Resource Limit Plans for 2024/25.	

If we are unable to adopt best practice and integrated modelling as rapidly as we need to	*Then* we will be unable to use our budgets and wider resources more effectively and efficiently and share risks and benefits	*Resulting in* challenges in service delivery for our population, poor health outcomes, and increased scrutiny of our effectiveness

SYSTEM	Consequence	Likelihood	Score	
Current	Major 4	Almost Certain 5	20	Risk Trend ⇔ (aligned with system provider scores)
Target	Major 4	Possible 3	12 High	
Risk closure date	29/04/2025			
ICB	Consequence	Likelihood	Score	Risk Trend ↓
Current	Major 4	Possible 3	12 High	
Target	Major 4	Unlikely 2	8 Moderate	
Risk closed	19/02/2025			

Risk Lead	ICB Chief Finance Officer	Assurance committee	ICB/ICS Finance Committee

System Controls	Assurances reported to ICB/S Board and committees
Revenue and Capital • System financial principles and risk management framework in place across the system as part of development of system financial recovery plan approach as set out within the financial strategy. • System governance arrangements in place through finance committee and system strategic committee and commissioning working group to ensure that new investments are not made unless recurrent resource is available. **Revenue** • Financial Improvement Programme and System Transformation Group in place. • Provider Vacancy Panels, ICB Establishment Control Panel and System vacancy assurance panel in place. Workforce monitoring of vacancies in place. • System workforce programme and agency reduction group implemented, weekly agency reporting and action plan to reduce agency expenditure in line with system cap. • Discretionary spend controls in place in all partners • Organisation self-assessments of plan conditions/financial controls in place - Triple Lock, vacancy controls, HFMA sustainability and NHSE Grip and Control.	First Line • Monitoring of financial performance by System Finance Group and System Finance, Planning and Performance Group • Standing Orders, Standing Financial Instructions and Delegated Financial Limits • Financial Accounting Performance Metrics • HFMA Financial Sustainability Checklist • NHSE Grip and Control Checklist • Better Payment Practice Code • System productivity and FIP group in place for efficiency. • FIP reports into System Transformation Group which provides Assurance to the Board. • System agency reduction group implemented, weekly agency reporting and action plan to reduce agency expenditure in line with system cap. • System Vacancy Assurance Panel in place. • Triple Lock for non-pay expenditure in place. Second Line • Regular Finance Report and Efficiency Report to Finance Committee • Integrated Performance Report to the Board Third Line • Monthly Integrated (Care System) Finance Return and Provider Finance Returns reporting to NHSE

Capital • Capital Prioritisation Oversight Group	• External review of HFMA financial sustainability and NHSE Grip and Control self-assessments.
Gaps in Controls and Assurances	Actions and mitigations to address control / assurance gaps
£90m revenue deficit plan in year with a forecast that does not have risks fully mitigated. This means that there is limited assurance that the financial forecast can be met. Current risks are as follows: 1. Efficiency delivery – risk of not delivering to plan; 2. Escalation costs not reducing as planned due to UEC pressure and links to discharge; 3. Costs and inflation pressures beyond what was anticipated during budget setting; 4. New NICE appraisals with significant implementation costs; 5. Income Risk if income assumptions in the forecast are not supported by NHSE.	**Revenue Financial Plan/Limit** **Efficiency:** Action 1) Review of most likely expected FOT on a regular basis through financial governance, specifically for high risk and medium risk schemes to identify potential slippage, mitigation actions/schemes. [In place] - ASz Action 2) Ensure sufficient PMO capacity is allocated to support recovery of medium/high risk efficiency schemes and the development of the pipeline mitigation schemes to support de-risking the overall efficiency programme. [In place] - IB Action 3) Support the implementation of the actions recommended in the System PMO report including changes to financial governance, efficiency documentation and processes and the utilisation of PMO resources across the System. [In progress to be completed by 31/03/25] - IB **Cost:** Action 1) As part of the Monthly Financial Review processes interpret current financial performance: 1a) analyse special variation changes in the run-rate trend of spend for Pay and Non-Pay. 1b) analyse key drivers of overspends and underspends. This will inform accurate forecasting and identification of risks and risk mitigations. [In place] - ASz Action 2) Review all requests for pay through the existing Vacancy Control Panels ensuring the completion of the benefits/benefit realisation supports financial delivery and recovery. [In place] ASz Action 3) Review all discretionary non-pay over £10k though the existing financial governance processes including the Triple Lock and reduce discretionary spend. [In place] - CS Action 4) Review all contingencies, provisions and prior year accruals. [In place] - ASz **Income:** Action 1) ICB/SaTH formally requested a National Payment Variation from NHSE in October 2024. Agreed in principle; awaiting formal written confirmation. – Asz Received – Action Completed. Action 2) ICB to support providers to recover all income paid under previous income agreements/arrangements or where funding may be accessed. [In place] - ASz Action 3) System providers to maximise all commercial income and non nhs income opportunities. [In progress] – HT/SL/CM **Capital Financial Plan/Limit** Action 1) All organisations review their priorities in line with current agreed strategies for estates, digital, clinical, workforce etc. Ongoing monthly review is

	undertaken through the Capital Prioritisation Oversight Group (CPOG) and reported to the System Finance Committee as appropriate. – HT/SL/CM/CS Completed Action 2) Use the System prioritisation framework to prioritise requirements based on key system criteria including equality of population health outcomes, value for money, broader socio-economic factors and health inequalities including Equality Diversity and Inclusion (e.g. DDA compliance and digital inclusion IT software and hardware). Initially completed July 2024 and updated as at Month 8 FOT by all organisations. Review of prioritisation at CPOG continues as required. – Asz Completed Action 3) Complete business case requests for NHSE approval as required ensuring full system governance and sign off is applied. – Asz Completed Action 4) All organisations to review IFRS16 operating lease commitments with a view to reducing the overcommitment in year – reviewed monthly at CPOG. – Asz – NHSE provided additional funding – action closed. Action 5) If required - Agree mitigations for potential overspends with budget holders - ie, deferral of uncommitted capital scheme expenditure. Organisational senior finance team and CPOG to review monthly. – HT/SL/CM/CS Ongoing Action 6) If required - Agree mitigations for potential underspends with budget holders -i.e. bring forward pipeline schemes - reviewed monthly by organisational senior finance team with budget holder and via CPOG. – HT/SL/CM/CS Ongoing Action 7) Submit business case proposals for replacement capital schemes to NHSE asap as required - organisational senior finance team review/CPOG review monthly. – Asz Completed – Closed

Current Performance – Highlights
Updates as of 19th February 2025 Revenue: All organisations have signed off expected FOT for 24/25 as part of M10 reporting as per NHSE guidance. SCHT and ICB are expecting favourable variances to plan. RJAH is expecting adverse variance to plan but is in surplus. SaTH are expecting a £28.8m adverse variance to plan mitigated by system favourable variances of £3.7m netting the system position down to £25.1m. Capital: All organisations reviewed most likely capital forecasts in line with planned spend as at Month 8 forecast outturn, all providers and the ICB are expected to deliver in line with the agreed capital plan. IFRS16 operating leases overall across the system exceeded the level of system IFRS16 uplift allocation by £2.1m, this issue has been resolved as NHSE have funded this. NHSE have approved SaTH's request to reprofile the HTP capital budget.

Associated Risks on the System Strategic Operational Risk Register	
Risk no.	Description
System Risk 7 System Risk 20 System Risk 21	Financial Sustainability Financial Plan 24/25 – Revenue and Capital Risk to System ERF Income delivery.

Relevant risks on system partners risk registers
Description

SaTH BAF 5 - The Trust does not operate within its available resources (as per Board papers – Jan 25 (latest) - 4 Consequence and 4 Likelihood)
RJAH BAF 3 - Delivering the financial plan (as per Board Papers – November 25 (latest) - 5 Consequence and 4 Likelihood)
Shropcom BAF 8.1 – Costs exceed plan (as per Board papers Feb 25 (latest) - 4 x 3 = 12)
MPFT BAF IB01 – Financial sustainability (as per board papers November 2024 (latest) (– 4 x 5 = 20)

Telford & Wrekin Council – Corporate Risk Register R2 - Inability to:

a) Match available resources (both financial, people and assets) with statutory obligations, agreed priorities and service standards
b) deliver financial strategy including capital receipts, savings and commercial income
c) fund organisational and cultural development in the Council within the constraints of the public sector economy

Shropshire Council – Corporate Risk Register:

c) Extreme pressures upon partners (social care, health, and criminal justice) within the system impacting on Shropshire Council through increased expectation, demand, need and complexity.
d) Sustainable budget

Strategic Aim: Objective 1 Reducing Health Inequalities			Risk score 20 Extreme Likely 4 x Catastrophic 5
Strategic Risk No.3 Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them. There is a risk that with competing priorities in a challenged system, insufficient focus is given to targeted interventions for populations identified as experiencing the greatest levels of inequality i.e. CORE20+ populations			
If we do not ensure sufficient priority and allocation of resources across all system partners to develop capacity and capabilities to identify and target interventions to reduce inequalities	*Then* we we collectively will not be addressing known and emerging avoidable differences in access, experience and outcomes as per section 14Z35 of the NHS Act 2006.	*Resulting* poorer outcomes which will disproportionately impact our Core20+populations. Additionally, it will result in poorer outcomes for all our population due to avoidable additional financial costs and increased demand pressures across the system	

	Consequence	Likelihood	Score	Risk Trend
Current	Catastrophic 5	Likely 4	Extreme 20	⇔
Target	Major 4	Possible 3	High 12	

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

System Controls	Assurances reported to ICB Board and committees
Strategies and Plans • 5 Year Forward Plan • System Development Plan • Integrated Care Strategy • System Healthcare Inequalities Operational Plan • HWBB Strategies • Place based Committee Strategies • Clinical Condition Strategies • System Digital Strategy • Individual Partner Health Inequality and EDI Strategies • ICB Inclusion and Health Inequality Strategy • Strategic Decision-Making framework Partnerships and Services • CEO Group • Urgent and Emergency Care Delivery Group • Planned Care Delivery Group • Finance Advisory Board • ShIPP • TWIPP • Mental Health Delivery Board • Emergency Preparedness Resilience and Response Framework • System People Board • Local Maternity and Neonatal System • Primary Care Networks • System Quality Group	First Line of Assurance • ICB Health Inequalities Team review of commissioning projects and business case proposals impact on Core20+5 via Commissioning Working Group • ICB Health Inequalities Team oversight of system performance of related objectives in system plans Second Line of Assurance • Monthly reporting of the ICB Prevention and Health Inequalities Group to the Strategic Commissioning Committee. • Cancer and Planned Care Report to ICB Quality and Performance Committee • Urgent and Emergency Care Report to ICB Quality and Performance Committee • Integrated Performance Report to ICB Quality and Performance Committee • Learning Disability and Autism Assurance Report to ICB Quality and Performance Committee • Performance Report to ICB Quality and Performance Committee • Annual Operating Plans to Finance Committee • Local Maternity and Neonatal System Report to ICB Quality and Performance Committee • Primary Care Quality reporting to Quality and Performance Committee • Integrated Provider Report to ICB Quality and Performance Committee

• ICS Digital Delivery Group Governance & Engagement Structures • Integrated Care System CEO Group • ICB Board • ICB Strategy Committee • ICB Quality and Performance Committee • ICB Strategy Committee • ICB Prevention and Health Inequalities Group • ICB Service Review Group • Equality and Inclusion Committee	• Quarterly reporting to Board via Strategic Commissioning Committee Third Line of Assurance • National System Oversight Framework • NHSE Quarterly System Review ~~Meetings~~ Returns • Core 20 +5 reporting to regional NHSE • In person/ onsite Regional NHSE review meetings
Gaps in Controls and Assurances	Actions and mitigations to address control / assurance gaps
1. Independent assessment (NHSE, CQC) 2. Development of advice, guidance and training resources for ICB and subcommittees to ensure ongoing priorisation alongside financial and performance risks. 3. Quantitative Health Inequalities Metric Reporting to demonstrate reduction across healthcare inequalities contributing to gap in Life and Health Life Expectancy	1. Complete self-assessment against NHSE/CQC regulatory framework - CQC - timeframe yet to be published nationally. 2. Complete self-assessment using Confederation Board Assessment Framework built on the Care Quality Commission's (CQC) well led domain eight key lines of enquiry measures (KLOEs)and the five national priorities for tackling health inequalities Develop and implement action plan to increase board and subcommittee maturity to increase assurance of actions to address health inequalities. 3. Complete User Testing of PHM /health inequalities dashboard Incorporate metric reporting into performance dashboard to Quality and Performance Committee.

Current Performance – Highlights
• Health inequalities – Health Inequalities & Prevention group has established well, with executive and senior representation from across system partners. The work programme is focused on the 24/25 agreed objectives and priorities (as briefed at ICB in summer 24). Group reports to Strategic Commissioning Group. • ICB Management of change has established substantive staff for health inequalities. • Population Health Management – clear link with system Population Health Management group. Population Health Board also reports into Strategic Commissioning Committee to clarify assurance reporting lines.

- Work continues to describe the growing gap between healthy life expectancy/ overall life expectancy between different segments of our communities and consider risk in context of multiple completing pressures whilst maintaining/enhancing focus on health inequalities.
- Implementation of strategic decision-making framework including prioritisation of impact of decisions on reducing health inequalities
- Agreement of reporting requirements for Schedule 2N in contracts
- Health Inequalities dashboard developed by ICB BI and PHM analysts entered User Assessment Testing Phase

Associated Risks on the System Strategic Operational Risk Register	
Risk no.	Description
Risk 1	CYP Mental Health
Risk 3	Palliative care/end of life
Risk 4	Maternity services
Risk 5	Urgent and Emergency Care
Risk 7	Diabetes Management
Risk 15	Acute Paediatric pathway
Risk 16	C Diff

Relevant risks on system partners risk registers
Description
RJAH – BAF 3 - Failure to effectively promote equality, diversity and inclusion MPFT – BAF B4 - The Trust in committed to embedding equality and inclusion in everything we do Shropshire Council – Corporate Risk Register: a) Extreme pressures upon partners (social care, health, and criminal justice) within the system impacting on Shropshire Council through increased expectation, demand, need and complexity. b) Sustainable Budget (i.e. budget will not keep track with current population projections overlaid with level of need to the demography of the population and long term investment in preventive/demand management approaches needed)

Strategic Objective: Objective 3 Improving health and care		Risk score 16 High Major 4 x Likely 4
Strategic Risk No.4: Inability to recruit, retain and keep our ICS Workforce well.		
If were unable to provide the workforce to deliver clinical and non-clinical services due to inability to recruit, retain and keep our workforce well	*Then* we will not develop our inclusive culture and effectively deploy a workforce with the necessary skills and expertise that meet service requirements	*Resulting* in a failure to deliver services to the population of STW.

	Consequence	Likelihood	Score	Risk Trend
Current	4 major	4 likely	16 high	
Target	3 moderate	3 possible	9 moderate	

Risk Lead	ICS Chief People Officer	Assurance committee	System People Committee

System Controls	Assurances reported to ICB Board and committees
Strategies and Plans • One People Plan Recommendations and Insights Report • workforce information dashboards to consider workforce information (sickness, turnover, vacancies, staff in post, Agency and bank usage etc) • 5 year Joint forward Plan Partnerships and Services • People related workstreams being led by the ICS People Team Governance & Engagement Structures • System People Committee provides oversight of the development of our system people strategy and annual programmes and strategic direction of travel • System People Committee oversight of Annual operational workforce planning process to set direction of travel for next 12 months	First Line of Assurance • Workforce information dashboards outputs Second Line of Assurance • People Plan Programme Progress Report to the People Committee of the Integrated Care Board
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
Gaps in controls: 1 The System People Strategy and priorities are not agreed by system CEOs. 2 The System People Collaborative approach, including HRD SROs and refreshed operational delivery and oversight processes/meetings, is not agreed by system CEOs. 3 An appropriate and resourced structure – within the system People Team and through provider partner employers – is not agreed by system CEOs. 4 The system People Committee is not meeting regularly, and its authority and remit requires a refresh – this gap is now completed and closed.	2 Finalise our ICS People Strategy and priorities by September 2023 – completed 2 A refreshed People strategy is required as part of NHS Oversight Exit criteria for 24/25. There is leadership and a delivery plan to meet this KPI 2 GGI Making Meetings matter review includes System People Committee – due to report in September 2023 –completed CEO decisions on system people collaborative approach, structures and resources – following discussion papers taken to CEOs meetings and HRD meetings for

5 There is no consistent system oversight of workforce metrics, workforce supply or the delivery of our People Strategy, or progress on the delivery of the 10 people outcomes – this gap is now completed and closed. Gaps in assurances: 2) Regular minutes from the System People Committee – this gap is now closed	consideration. An external review of HR/people function across NHS partners (except MPUFT) is concluded Dec 24 with recommendations presented to CEO's for consideration. Current available people infrastructure continues to deliver the current people strategy within the constraints of resources available. 4. Refresh of the System People Committee as the oversight function – in progress from September 24. This continues to be in progress with recent changes in chair and is expected to be completed February 25. 5. Refresh of the People Delivery Committee as the operational delivery programme board – completed. There is now a consistent suite of workforce metrics providing oversight across NHS partners across the system. There has been an amalgamation of three workforce related groups into one for strategic leadership, oversight and accountability 2. see (4) above

Current Performance – Highlights
A system workforce dashboard is now in place providing robust insights into NHSE workforce data intelligence and oversight to inform against the annual NHS workforce plan. There is a system workforce assurance and planning steering group chaired by the SRO for Reform from which workforce intelligence reports into several system committees and groups including System Transformation Committee, Quality Committee, Finance improvement committee, Agency workforce group, ICS People Culture and inclusion committee and ICS People collaborative. The workforce assurance group has now merged with the agency workforce reduction group which has Director chair. This aims to brings together workforce planning, monitoring, finance and productivity leads from across the system. Workforce data dashboard has enabled greater visibility of fragile workforce groups against 24/25 plan and there are greater opportunities to undertake targeted actions to attract and train fragile workforce groups. There is an agreed overarching STW ICS people strategy 2023- 2027 signed off at STW Strategy Committee 18th May 2023. With this are an agreed suite of annual people delivery priorities and delivery against these can be seen on the 23/24 annual People Programmes report presented to ICB Board in June 24. CEO's have agreed to the SRO leadership arrangements across the four strategic people programmes. This is further strengthened by the CEO SRO for people chairing STW ICS People collaborative from August 24. CEOs had not agreed to invest in the ICB people team infrastructure, further compounded by NHSE financial oversight scrutiny during 24/25. An external review of HR/people services and the ICB people team has been completed and the teams are now working through an action plan to address the areas highlighted. System Committee was meeting quarterly and from October 24/25 is now meeting monthly and has renewed chairmanship Whilst there has been no robust secretariat support to this Committee or to the People delivery collaborative and as of September 2024 which has now been addressed, there is evidence of minutes and actions from Committee, and it has been subject to a good governance review with positive feedback.

Associated Risks on the System Strategic Operational Risk Register	
Risk no.	Description
Risk 10 Risk 12 Risk 13 Risk 14	ICB Financial staff capacity Chief People Officer for the system Deputy Chief People Officer capacity Capacity to deliver 10 people pledge outcomes

Relevant risks on system partners risk registers
Description
SaTH – BAF 3 - If the trust does not ensure staff are appropriately skilled, supported and valued this will impact on our ability to recruit/retain staff and deliver the required quality of care SaTH BAF 4 - A shortage of workforce capacity and capability leads to deterioration of staff experience, morale, and well-being. RJAH – BAF 1 – Lack of effective engagement with workforce RJAH – BAF 2 - The workforce does not have the required capacity and capability Shropcom – BAF 3.1 – Recruitment challenges MPFT- BAF F1 - There is a risk to the health and wellbeing of staff due to existing workforce shortages, high acuity and demand, and the long-term effects of the pandemic; leading to staff burnout, absence and increased turnover. MPFT – BAF F2 - There is a risk to the delivery of Trust services due to national workforce supply issues and skills shortages; leading to an inability to recruit and retain sufficient numbers of clinical, technical and managerial staff. Telford & Wrekin Council – Corporate Risk Register – R3 - Losing skills, knowledge and experience (retention & recruitment) in relation to staffing. Shropshire Council - Corporate Risk Register - Critical skills shortage impacting on Retention, Recruitment & Succession Planning

Strategic Objective: ALL			Risk score 16 High Major 4 x Likely 4
Strategic Risk No.5: Lack of capacity and strategy to develop and use digital and data systems to enable efficient and effective care across the ICS			
If we are unable to develop and use our digital and data systems	*Then* we will not be able to make informed decisions, develop integrated services that are digitally enabled and monitor their effectiveness against our aims	*Resulting in* challenges in service provision, staff dissatisfaction, and poorer health and care outcomes for our local population	

	Consequence	Likelihood	Score	Risk Trend
Current	Major 4	Likely 4	High 16	
Target	Moderate 3	Possible 3	Moderate 9	

Risk Lead	ICB Chief Medical Officer	Assurance committee	ICB Strategic Commissioning Committee

System Controls	Assurances reported to ICB Board and committees
Strategies and Plans • Integrated Care Strategy • Clinical Strategy • Infrastructure and Estates Strategy • Joint Forward Plan • 10 Year Capital Plan • ICS Green Plan • Population Health Roadmap • Joint Strategic Needs Assessments • Local Operational Plan • Big Conversation analysis • ICS Digital Strategy and ICS Digital Portfolio Plan • Health Inequalities Plan – KLOE for Digital Inclusion • NHSE What Good Looks Like/Digital Maturity Assessment • NHSE Digital Capability Framework for Electronic Patient Records • NHSE GP IT Operating Model • NHSE Cyber Assessment Framework Partnerships and Services • Population Health Management Board • Telford & Wrekin Integrated Place Partnership (TWIPP) • Shropshire Integrated Place Partnership (ShIPP) • People's Network • Shropshire Digital Inclusion Network • MLCSU Contracted Technology Support Services – GPIT, Corporate IT, Cybersecurity, IG, Procurement, BI/Analytics • ICB Senior Leadership Team • ICB Digital Strategy Group • Commissioning Working Group • ICS Strategic Programme Boards • ICS Climate Change Group	First Line of Assurance • ICB Digital Operations Group reports to ICB Digital Strategy Group and ICB Digital Strategy Group report to ICS Digital Delivery Group • ICB Digital involvement in ICB Senior Leadership Team • Regular ICS partner portfolio updates including programmes, projects and group reports to the ICS Digital Delivery Group • Regular involvement in the Commissioning Working Group • Regular engagement and involvement in community and place-based partnership groups • Regular engagement and involvement with clinical and care professional networks • Routine progress reports from key workstreams • Regular Population Health Management Workstream Update to the Population Health Board • Regular Inequalities Workstream Update to the Population Board Second Line of Assurance • ICB Digital updates to SBAF and SSORR to Audit Committee • IG updates on DSPT and Cybersecurity to Audit Committee • ICS Digital Delivery Group report to Strategic Commissioning Committee • Population Health Report to Integrated Delivery Committee • Regular engagement via regional and sub-regional digital transformation and related national programme groups/networks

• ICS Digital Delivery Group • ICB Operating Model • System Digital Governance Model (Recommended, not in place) Governance & Engagement Structures • Audit Committee (Cybersecurity, ICB IT) • Strategic Commissioning Committee • Integrated Care Board • NHS Midlands Digital Transformation • NHSE Programme Networks	Third Line of Assurance • Audit Committee on Cybersecurity and ICB IT to the Board • Strategic Commissioning Committee report on ICS Digital to the Board
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
Gaps in controls: 1. ICB and ICS Executive roles - remit, authority/span of Data, Digital and Technology (DDAT) decision-making 2. Involvement and alignment of digital and technology requirements in prioritisation, funding allocation, organisational development e.g. workforce literacy, strategic programmes and functional operations and working groups for 2nd and 3rd line assurance 3. Single view of digital/technology spend within the ICB and across the system - BAF Risk 2 4. Insufficient ICS partner reporting into Digital Portfolio 5. Insufficient resources to support delivery of the Digital Portfolio 6. Unclear commitment to implement a Digital Inclusion framework 7. Aligned ICS Digital Procurement Framework and Plan 8. Unclear timeline for an information, data, analytics and intelligence strategy across ICP 9. Independent assessment (NHSE, CQC) 10. Lack of system policy on use of AI technologies and embedded solutions Gaps in Assurances: 11. System data, digital and technology governance with aligned system digital operating model, evolving from ICB management of change programme	1. Confirm approach and timeline to develop an information and data strategy across ICP 2. Clarify and agree the ICB and ICS Executive digital roles 3. Commit to a board development programme for data and digital 4. Update the Integrated Impact Assessment to include digital inclusion and digital sustainability 5. Incorporate Digital voice in prioritisation and decision-making - strategic commissioning, financial planning and budget allocation, service design, quality improvement, leadership development and public involvement for digital inclusion 6. Commit to specific funding principles for digital operations financial sustainability and digital inclusion services 7. Commit to a system funding allocation model to ensure adequate digital resources to support delivery of the agreed Digital Portfolio and management of operationalised services 8. Involve ICB Digital in Infrastructure and Estates programme design 9. Involve Digital in the design of the Provider Collaborative 10. Commit resources to a system digital operating model for controls that address assurance gaps

Current Performance – Highlights
• ICS Digital Strategy approved by the Board March 2024 as a culture lever to enable change • Delivered a restructured ICS Digital Portfolio to surface known priorities and show relationships amongst initiatives and programmes to inform gap analysis • Met deadlines for system submission for NHSE What Good Looks like Digital Maturity Assessment for the ICS including Primary Care • Identified key work on core digital and data capabilities and high priority STW ICS digital programmes - One Health & Care (our integrated care record), Digital Inclusion, Cybersecurity, while working within unclear, reduced financial envelope, increased delivery pressure and reduced workforce capacity. • Maintained ICB Digital during management of change programme and completed recruitment of substantive ICB Head of Digital role to support ICB and ICS digital priorities.

- Raised awareness of key opportunities and challenges for ICB and ICS Digital through ICB prioritisation and strategic commissioning workshops.
- Raised awareness of need for ownership of undocumented risks related to operating model design, capacity and experience challenges and prioritised mitigation of issue impacts related to finance/budgeted spend, unmanaged, contracted services and legacy projects/programmes with unclear ownership and reporting.
- Raised awareness and shared opportunities for digital innovation and research.
- Developed relationships across care setting and functional role specialisms to open doors for collaboration, innovation, and joint delivery with a focus on problem assessment, promoting the use of standards and good practice for inclusive engagement, options assessment before solution design and working within known financial and workforce constraints.
- Established first iteration ICB Digital function and role protocols with a focus on service, continuous improvement, and risk management rigour, while ICB undertook management of change.
- Actively practiced and advocated respectful check and challenge within existing governance structure to existing norms, transparent reporting, and continuous sharing of opportunities for learning and improvement.
- ICB Head of Digital commenced in post which completes full recruitment to the digital structure
- Has undertaken stocktake of digital workstreams and achievements and identified challenges and opportunities, based on ICS Digital Strategy (approved March 2024)
- Annual work plan for 25/26 under construction based on the 7 strategic areas of focus in the Strategy

Associated Risks on the System Strategic Operational Risk Register		
Risk no.	Description	Current score
Risk 8	Emergency Planning, Resilience and Response	16
Risk 14	System Digital Operating Model	16
Risk 15	Difficulty of finding patient information across different systems	20
Risk 16	System digital inclusion framework	16
Risk 17	System capacity and funding to support digital clinical risk management	20
Risk 23	System-wide Cybersecurity Operating Model and Strategy	16

Relevant risks on system partners risk registers
Description
SaTH BAF 7A - Failure to maintain effective cyber defences impacts on the delivery of patient care, security of data and Trust reputation. SaTH BAF 7B - The inability to replace implement modern digital systems impacts upon the delivery of patient care. RJAH BAF 6 - IT unable to support new ways of working. RJAH BAF 7 – Loss of data/unable to restore services following a cyber-attack. MPFT BAF risk that the appropriate cyber security controls are not in place services following a cyber-attack. Shropshire Council - Corporate Risk Register - Critical skills shortage impacting on Retention, Recruitment & Succession Planning

Strategic Objective: ALL		Risk score 16 High major 4 x likely 4
Strategic Risk No.6: Inability to respond strategically to ICS objectives due to the impact of external factors beyond the influence of the ICS (e.g. Emergencies, Incidents and Disruptive Events such as: climate change, adverse weather, cyber-attack, utilities failure, transport accidents, malicious attacks, industrial action, infectious disease, economic and political changes).		
If we are unable to respond collectively to the external challenges facing our local area	*Then* we will not be able to, meet our ICS objectives to improve the health and wellbeing of our population.	*Resulting in* poorer outcomes for our population and with further pressure on health and care services.

	Consequence	Likelihood	Score	Risk Trend
Current	4 - Major	4 - Likely	16 High	⟺
Target	3 - Major	3 - Possible	9 Moderate	

Risk Lead	ICB Accountable Emergency Officer (AEO)	Assurance committee	ICB Board Audit Committee (EPRR Programme Group)

System Controls	Assurances reported to ICB Board and committees
Strategies and Plans • Integrated Care Strategy • Joint Forward Plan • Health and Wellbeing Strategies • Local Authority Strategies • Civil Contingencies Act 2004 (CCA), NHS Act 2006, Health and Care Act 2022, NHS Standard Contract. • NHS EPRR Framework • NHS England Incident Response Plan • Local Authorities EPRR Response Plans and Business Continuity Management Plans. • ICB EPRR Policy, Incident Response Plan, Business Continuity Management Plans (Corporate & Directorate), EPRR Communications Plan • ICB On-Call Policy • STW Health Protection Strategy • ICS Green Plan • Individual NHS organisations EPRR Policies, Incident Response Plans, and Business Continuity Management Plans. • Individual NHS organisations Green Plans • ICB Risk Management Policy • NHS Shropshire, Telford and Wrekin ICS West Mercia Local Resilience Forum Representation Agreement • ICB EPRR Training and Exercise Programme (includes systemwide exercising) • West Mercia Local Resilience Forum (LRF) response and recovery plans. • Winter Plan 24/25 Partnerships and Services • Integrated Care Partnership • West Mercia Local Resilience Forum (LRF)	First Line of Assurance • Audit Committee • UEC Board/STG Second Line of Assurance • ICB EPRR Programme Group. • NHSE Annual Assurance Process of NHS Core Standards for EPRR. • NHSE Quarterly Green meetings. • Board – Winter pressures • NHSE – Winter pressures

• West Mercia Local Health Resilience Partnership (LHRP) • West Mercia Health Emergency Preparedness Operational Group (HEPOG) • STW Health Protection Quality Assurance Board • ICS IPC & AMR Group • Population Health Board • Shropshire Integrated Place Partnership (ShIPP) • Telford and Wrekin Integrated Place Partnership (TWIPP) • Primary Care Networks • ICS Climate Change Group Governance & Engagement Structures • Integrated Care Partnership • Health and Wellbeing Boards • ICB EPRR Programme Group • Individual NHS organisations EPRR committees/groups • West Mercia Local Resilience Forum (LRF) • West Mercia Local Health Resilience Partnership (LHRP) • UEC Board	
Gaps in Controls and Assurances	Actions and mitigations to address control / assurance gaps
1. Limited ICB and individual NHS organisations EPRR resource. 2. No existing system level EPRR frameworks, policies, plans for organisations to align own policies and plans to enhance a coordinated response. 3. Lack of documented Standard Operating Procedures for the System Coordination Centre (SCC) 4. Low level of compliance with NHS Core Standards for EPRR. 5. Recent combining of STW LHRP & HEPOG and Herefordshire & Worcestershire LHRP & HEPOG to form the West Mercia LHRP and HEPOG.	1. ICB EPRR work programme has actions to produce system level EPRR policies, frameworks and plans for organisations to align own policies and plans. 2. Individual NHS organisations EPRR work programmes. 3. LHRP work programme 4. ICB EPRR lead meets with provider EPRR leads monthly. 5. STW ICB EPRR lead to work closely with H&W ICB EPRR lead to drive the LHRP and HEPOG work programme ensuring links to system/locality risks, issues, and challenges. 6. Accountable Emergency Officers (AEO) for each NHS organisation to review EPRR resourcing to ensure it is adequate for the size, type, and services of their organisation and duties placed on them under the CCA, NHS Act 2006, Health and Care Act 2022, and the NHS Standard Contract. 7. Systemwide exercise schedule 8. Completion of NHS Core Standards for EPRR. 9. Complete self-assessment against NHSE/CQC regulatory framework

Current Performance – Highlights
• The ICB and individual NHS organisations have an annual EPRR work programmes in place to ensure there is a continuous cycle of improvement. These work plans cover review and updates of policies and plans, training, exercising, business continuity management systems and incident response arrangements. • The ICB and individual NHS organisations submitted their annual self-assessment against the NHS Core Standards for EPRR at end of August 2024. These self-assessments will be reviewed by the ICB and NHSE during September with final outcomes of the assessment and assurance levels confirmed in early October 2024. Following the issuing of the final assurance levels, the ICB will work with all organisations to develop individual and systemwide improvement plans. These improvement plans will be overseen by the ICB EPRR

Senior EPRR Lead reporting to the ICB Accountable Emergency Officer (AEO) via the West Mercia LHRP, ICB EPRR Programme Group through to Audit Committee and Board

- Detailed review of Greener NHS progress in STW against the NHSE national objectives and priorities carried out in Aug 24, and discussed with NHSE regional leads. Plan to enhance link to ICS Infrastructure group (chair – ICB Director of Finance). Follow up review with NHSE in late autumn 24, with objective of improving ICS rating.
- Reporting on Winter Pressures to Board in its meeting in January 2025

Associated Risks on the System Strategic Operational Risk Register	
Risk no.	Description
Risk 8 System SORR	EPRR
Risk 3 System SORR	Delays in UEC

Relevant risks on system partners risk registers
Description
NHS STW ICB – SORR 24 – EPRR. **ShropCom** – BAF 4.1 External pressures impact on capacity (wider system escalation or rising pandemic levels) **Telford & Wrekin Council** – Corporate Risk Register – R4 - Significant business interruption affecting ability to provide priority services, e.g. critical damage to Council buildings, pandemic, etc. **Telford & Wrekin Council** – Corporate Risk Register R7 - Inability to respond adequately to a significant emergency affecting the community and/or ability to provide priority services. **Telford & Wrekin Council** – Corporate Risk Register R8 - Inability to respond to impact of climate emergency on severe weather events including heat, cold and flood. **Shropshire Council** – Corporate Risk Register: a) Responding and Adapting to Climate Change b) Delivery of the Economic Growth Strategy c) Sustainable Budget **The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust** – BAF 7 – ***if*** *the Trust does not have adequate plans in place to respond to a significant disruptive event beyond the control of the Trust, such as a pandemic, or cyber-attack,* ***then*** *it will be unable to provide an adequate response to the immediate need and/or maintain other key services due to unavailability of the required resources/staff,* ***resulting in*** *potential patient harm, increased waiting times etc.*

Strategic Aim: ALL			Risk score 16 High Major 4 x Likely 4
Strategic Risk No.7: Inability to contribute effectively as a system to support broader social and economic development			
If we are unable to respond collectively to the social and economic challenges facing our local area,	*Then* we will not be able to make a difference to wider economic growth across our system	*Resulting in* poorer longer-term outcomes for our local population in relation to health and wellbeing	

	Consequence	Likelihood	Score	Risk Trend
Current	Major 4	Likely 4	16 High	
Target	Major 4	Possible 3	12 High	

Risk Lead	ICB Chief Executive Officer	Assurance committee	Board

System Controls	Assurances reported to ICB Board and committees
Strategies and Plans • Integrated Care Strategy • 5 year Joint Forward Plan • Health and Wellbeing Strategies Partnerships and Services • TWIPP • ShIPP • Provider Collaboratives • ICS Chief Executives Group • Networks Governance & Engagement Structures • Integrated Care Partnership and Integrated Care Board and associated committees • ICB – agreed values and behaviours • Health and Wellbeing Boards	First Line of Assurance • Joint Strategic Needs Assessments • Workforce mapping Second Line of Assurance • Population Health Board report to ICB Integrated Delivery Committee Third line of Assurance • Health and Wellbeing Boards
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
Gaps in Controls: 1. Strategic partnership focus on broader social and economic development of the area has been limited to date. Gaps in Assurances: 2. No clear committee that has this oversight in its remit.	1. Population health management approach needs to be adopted. 2. GGI review of meetings and governance structure – phase 1 October 2023

Current Performance – Highlights
• GGI review phase 1 due to report proposed revised governance structure for ICB/ICS in October 2023. • Population Health - Population Health analysts capacity secured in Planning and Performance directorate. Population Health Board now reports into Strategic Commissioning Committee to clarify assurance reporting lines. • Initial meeting held in July 24 with Office of West Mids/Centre for Economic development to consider areas of development.

- ICB working to support major Local Authority-led initiative – Marches Forward Partnership (Shropshire, Powys, Monmouthshire and Hereford & Worcester). Range of workstreams including health, housing, skills and energy, with focus on economic development.

Associated Risks on the System Strategic Operational Risk Register	
Risk no.	Description
	None identified

Relevant risks on system partners risk registers
Description
Shropshire Council – Corporate Risk Register: a) Delivery of the Economic Growth Strategy b) Extreme pressures upon partners (social care, health, and criminal justice) within the system impacting on Shropshire Council through increased expectation, demand, need and complexity.

Strategic Objective: ALL			Risk score 12 High Major 4 x Possible 3
Strategic Risk No.8: Patient and Public Involvement			
If the ICB fails to meet its statutory duty to involve patients, the public, marginalised groups and to consider the 9 protected characteristics in planning and commissioning arrangements, and in the development of proposals to change or cease existing services	*Then* services will not be tailored to local people's health and care needs	*Resulting* in potential judicial review, discrimination, not meeting the population's health needs, increasing health inequalities and leading to poorer health outcomes	

	Consequence	Likelihood	Score	Risk Trend
Current	Major 4	Possible 3	High 12	⟺
Target	Moderate 3	Unlikely 2	Moderate 8	

Risk Lead	ICB Chief Business Officer	Assurance committee	Strategic Commissioning Committee Equality and Involvement Sub Committee

System Controls	Assurances reported to ICB Board and committees
Strategies and Plans • Integrated Care Strategy • 5 Year Forward Plan • Big Health and Wellbeing conversation communications and engagement plan socialised and approved by Board • Communications and Engagement Strategy for STW ICB approved by the Board – outlines how we will involve, engage and consult including focussing on health inequality groups and the Equality Act 2010 - 9 protected characteristic groups as part of any activity. • The Gunning Principles Partnerships and Services • Presence of Healthwatch for both areas at Board meetings and Quality and Performance Committee • System Involvement and Engagement Network established which assesses engagement and adherence to the Equality Act 2010 requirements. • Communications and Engagement teams working jointly across ICB, ICS and Providers providing more capacity and expertise in planning and delivery • Board meetings are held in public and board papers published to the ICB website to increase transparency.	First Line of Assurance • Reporting on Engagement as part of wider reporting and decision making at SCC and Q&P Committee on commissioning decisions Second Line of Assurance • Reporting to Equality and Involvement Sub-Committee. EIC receives comms and engagement plans from commissioners and Integrated Impact Assessments (IIA), Chair provides reports to SCC • EIC also have a role in scoring Equality Delivery System 2 self-assessment for domain 1 - commissioned services. Third Line Assurance • Health and Overview Scrutiny Committees (HOSC) • NHSE review of ICB Annual Report which must include content on patient and public engagement over the period of reporting. • NHSE Annual ICB assessment includes component on statutory responsibility to engage with the local population and partners.

• In house ICB Comms and Engagement team supplements capacity of partner organisations • System-wide Integrated Impact Assessment (IIA) tool developed to streamline the way we identify the impact of change on equality groups (9 protected characteristics) which are then presented to the ICB's Equality and Involvement Sub-committee for scrutiny. Governance & Engagement Structures • Integrated Care Partnership and Integrated Care Board and associated committees • Reports to Governing bodies/Committees require section completing on Patient involvement • Equality and Involvement Sub-Committee as part of ICB Governance • Non Executive Director for Inequalities in place on Board to act as specific check and balance with regard to patient involvement	
Gaps in Controls and Assurances	Actions and mitigations to address control / assurance gaps
Gaps in Controls: 1) Limited engagement capacity within the ICB comms and engagement team 2) Development of advice, guidance and training resources for commissioners, partner organisations 3) Involvement strategy refresh required. Gaps in Assurances: None	1a) CSU comms and engagement capacity is used when required. 1b) People's network needs focus to add in more diversity to enable ongoing engagement on a regular basis with a wide range of citizens. 1c) Need for ICB C&E team to focus on ICB prioritised areas of work - programme has been provided by Commissioning team to allow prioritisation of support. March/April 2025 2) ICB C&E team to develop guidance on statutory consultation and non-statutory engagement and on managing media enquiries. 3)Refresh of Involvement Strategy during 2025. Timeline currently being developed. March 2025

Current Performance – Highlights
• Plan in place for use of CSU resources for remainder of 24/25 - Quarter 4 • Additional recruitment to the People's Forum has started, particularly focussing on groups that are under-represented – currently we have low numbers of young people and men. - quarter 4 • Work on support resources to new commissioning teams and partners delayed due to need for ICB to prioritise commissioning objectives via Senior Leadership team – quarter 4/quarter 1 • ICB Communications and Engagement Team have started to collate existing guidance resources and information and identifying gaps to then develop new resources to communicate out to Senior Leadership team and ICB generally via staff huddle. Quarter 4

Associated Risks on the System Strategic Operational Risk Register	
Risk no.	Description
23	Patient and Public Involvement - risk of not meeting statutory duty.

Relevant risks on system partners risk registers
Description
MPFT – BAF P2 - There is a risk that the Trust will not be able to adequately measure and respond to the experiences of our service users due to the limitations of the current feedback systems and approaches. This may impact on the Trust reputation due to reduced confidence in the ability to learn, respond and improve services in response to customers voice / views

NHS STW - Strategic Operational Risk Register for the System (System SORR) 2024/25
ICS Strategic Objectives:

Appendix A

1) Reducing Health Inequalities:
   - Wider determinants
   - Tackling health inequalities
2) Improving population health:
   - Best start in life
   - Healthy weight
   - Alcohol drugs domestic abuse
   - Mental health and wellbeing

3) Improving Health and Care:
   - Strengthen prevention, early detection and improve treatment outcomes – mental health, heart disease, diabetes, cancers and musculoskeletal disease
   - Urgent and Emergency Care
   - Integrated person centred care within communities – strong focus on primary and secondary care

1 Risk ID	2 Strategic Objective	3 Opened / added by	4 Risk and description	5 Opportunity	6 Existing key controls	7 Existing sources of assurance	8 Gaps in controls or assurances	9 Risk score (consequences x likelihood)	10 Risk score trend	11 Action plan / cost / action lead /(target date) /sufficient mitigation	12 Target risk score for end of financial year	*New 13 Target Risk Closure Date	14 Director or Risk Owner	15 Risk Owner	16 Committee/ ICB oversight	17 Last Review: name and date	18 Amendments: name and date	19 Rationale for amendments/increasing or decreasing risk levels
3 (SQG4)	2 & 3	Vanessa Whatley Chief Nursing Officer, NHS STW	If there are delays to urgent and emergency care caused by lack of flow through unscheduled care creating congestion in the ED and related areas, lengthy ambulance off load delays and extended lengths of time in the emergency departments then patients are more likely to deteriorate and/or come to harm in ambulances, in the Emergency Department or in the community whilst waiting for an ambulance.	Urgent and emergency care is delivered in a timely and effective manner that supports urgent care pathways and high quality care.	1) There is an UEC Board that directs UEC performance and resources (Mar 24). 2) Providers have an established risk register with relevant escalation to the Board. This includes WMAS (Mar 24). 3) Serious incidents from WMAS are shared with STW via Black Country ICB (Mar 24) 4) SaTH have completed the first round of harm reviews (Mar 24) 5) SaTH patients who are subject to an ambulance off load delay will undergo a harm review and this will continue for as long as there are ambulance offload delays (Mar 24). 6) Plan devised through the Discharge Alliance Group (Mar 24) 7) Winter schemes for 23/34 were monitored for effectiveness (Mar 24) 8) A revised harm review process has been agreed with SaTH and system partners as relevant in line with PSIRF (Mar 24) 9) The ICS has moved into Tier 1 and has associated oversight and metrics from GIRFT/NHSE (Mar 24) 10) There is a harm review process in place (Mar 24)	1) Contract Review Meetings hold performance data with Quality support and oversight (Mar 24). 2) Each organisation is represented at SQG and is able to escalate any quality concerns (Nov 23). 4) Healthwatch are engaged and monitoring patient experience including UEC (Nov 23). 5) Each organisation has a quality governance process to escalate risks and concerns to the Board for consideration and direction (Nov 23). 6) Findings from Exemplar and Quality Assurance visits (Nov 23). 7) Virtual ward uptake, constantly at >80% capacity (Mar 23)	Gaps in Controls: 1) GIRFT has identified there are gaps in 1a) Acute Medicine: Ward process, ensuring consistency and starting at 8am. 1b) Frailty: Delirium/Frailty recognition and response at the front door. 1c) Emergency Medicine: Specialty engagement and Ambulance handover threshold. System: 1d) Care coordination improvements Gaps in Assurances: None	Likely 4 x Catastrophic 5 = Extreme 20	↔ ↔	Deliver UEC improvement plan (ICB, SaTH and ICS) (Control no.12 in column 6) Delivery of System Winter Plan and outcomes Establish workstreams with clear aims and objectives which can be monitored, to address GIRFT recommendations (April 24) Workstream progress monitored via UEC Board Develop system-wide UEC Improvement Programme for 2025/26 aligned to the System Integrated Improvement Plan	3 possible x 3 moderate = 9 Moderate		Ian Bett Interim Executive Director - Director of Delivery and Transformation	Gareth Wright - Head of Clinical Ops	Quality and Performance Committee	7 Jan 25 Gareth Wright - Head of Clinical Ops	Vanessa Whatley Jan 24 Vanessa Whately Mar 24 Vanessa Whately July 24 Gareth Wright Jan 25	Jan 25 amendment to include development of system-wide UEC Improvement Programme for 2025/26.
4 (SQG8)	2 & 3	Vanessa Whatley Chief Nursing Officer, NHS STW	If there is not a cohesive approach to diabetes management across the STW ICS then people living with diabetes will come to significant harm through acute presentations or the long term effects of poorly controlled or delayed diagnosis of diabetes. 2) Inability to roll out NICE TA for Hybrid Closed Loop System for people with Type 1 Diabetes due to workforce and capacity issues with Specialist Services.	To have a cohesive integrated diabetes pathway. Opportunity to develop a pathway through clinical advisory group. (CAG) To be able to work in different ways to support primary care in developing an integrated neighbourhood approach to proactive and personalised care. To be able to release specialist diabetes teams to manage the more complex people living with diabetes. Develop the delivery of the 8 care processes including foot screening and other modifiable factors. Reducing long term complications and admissions to hospital. To reduce inequalities and variations in health outcomes.	1) Data and actions are monitored by the Diabetes Programme Board- sent monthly and reviewed. Monthly CAG meetings. Submissions to the national diabetes audit.	1) There is a primary care QOF for managing diabetes. 2) 63% of suitable patients are on is CGM -type 1 diabetics, (Nov)(up from 51%) 3) 18% of suitable patients are on rtCGM - type 1 diabetics (Aug 23) 4) All Telford Place GP's are signed up to undertaking low risk foot screening (Aug 23) 5) Diabetes classified as a clinical priority (Aug23) 6) Patient engagement events x 2 have been completed (Dec 22) 7) There is a training available programme across the ICS via the PLT (Complete). 8) There is training for primary care practitioners though the training hub (Aug 23) 9) The is a summer PLT planned focussing on Diabetes (Completed) 10) There is a quarterly published diabetes dashboard (Aug 23). 11) There is now funding to sustain low risk foot screening in Shropshire place in 23/24 as well as T&W . 12) There is now assurance that NICE NG 17, NG18, NG28 guidance is implemented.(Aug 23 13) Funding for Continuous Glucose monitoring NG28&17 has been approved for 23/24 (Complete). 14) The Diabetes clinical advisory group is up and running and first 5 pathways are agreed (Aug 23) 15) SaTH has recruited into a Diabetes Tech Lead Role to support implementation of developments in Diabetes technologies 16) Diabetes Management in Pregnancy is part of the Saving Babies Lives Care Bundle version 3 (SBLCBv3) and is monitored as part of the SBLCBv3 and CNST submission. 11) Increase capacity in SaTH foot clinic through partnership working. (jan 24) 12) Waiting times for MDFT have now reduced from 21 days to 14 Jan 2024 13. Interviews for new Diabetes Clinical Director taking places w/c 17.06.24.upate 07.01.25- no CL was appointed- interviews in Jan 25 pending SLT, remcom approval. 14. New Chief Medical Officer appointed for NHS STW. Sept 24. 15. New diabetes project launched with oversight from CMO and DS&D from Autumn 2024	Gaps in Controls: 1) Amputation rate: We are a significant outlier Minor Amputation rate 39.8 STW compared with England 20.8 (per 10.000 registered Diabetic people). Major Amputation rate 10 Stw compared with England 7.5 (per 10,000 registered Diabetic people) 2) STW ICS are outliers for completing the 9 care processes as defined by NHSE and reported through national diabetes audit. In Shropshire on 29% of all 8 care processes achieved in last 12 months, 11/38 practices have had less than 50% of patients have had a foot exam. In Telford, 40% of patients have had all 8 care processes achieved, and 1/13 practices has had less than 50% of patients have had a foot exam. 3) The National Diabetes Audit result for STW is 98.1% practice participation against an England average of 99.2% 4) The National Diabetes foot audit result for STW shows that we have an older population with a greater level of peripheral arterial disease. We have a greater number of Diabetic Patients with CKD. Out patients are waiting longer to be seen and have more severe ulcerations. 5) Outdated or absent service specifications for diabetes pathways and related outcome measures. Current pathways follow an outdated fragmented framework. There has been a 16% increase our Diabetes Population over the last 5 years without any significant review or long-term investment. 7) SaTH Diabetic foot clinic is unable manage the demand. Current wait to be seen in MDFT is 2 weeks, National standard is 24-48hrs. Current non urgent wait for general diabetes outpatient appointment is 12 months. 8)There is no consistent ICS training plan for diabetes. 9) There are 7 (improved from10) GP practices who are not signed up to undertaking low risk foot screening in Shropshire place (May 23). 12) There is no data on the uptake of type 2 insulin dependant diabetic patients in STW uptake of CGM (May 23). 13) SaTH cannot deliver a 7 day specialist nurse service for Diabetes (May23). 14) Management of diabetes in pregnancy is monitored and oversight gained via LMNS as the SBLCBv3 Element 6 and is reported within the ICS and also at Regional level. Gaps in Assurances:	5 catastrophic x likely 4 = 20 Extreme	↔	1) Develop CYP pathway including transition of care as part of the transformation work (ICB, Dec 23). 2) Publish updated policy on the use of CGM (Mar 23) - delayed until June 2023 (Still awaiting final approval, was put on HOLD due to Primary Care Concerns, due to go back to CWG Dec 23. Now approved through CWG and IDC (March 24) (Completed June 24) 3) Develop a Business case to support the diabetic foot pathway (March 24). 4) Meeting with NHSE and Clinical Leads to support issues within Primary Care (Completed Feb 2024). 5) Agree a system strategy to communicate a vision and guide actions over the next 3 years (ICB, Dec 2023). Work ongoing around long term condition strategy. 6) Review low risk foot screening in primary care to ensure equity of access (June 23). 20.11.2023 Still low uptake of Low Risk Foot screening in Primary Care, 7 practices still not undertaking it, and many more have low numbers below national target. Shropcom podiatry are going out to these practices to offer support. 7) Identify clinical leadership input into the Diabetes Transformation Program from SaTH (now agreed in principle). Still no Clinical Director for Diabetes at SaTH (March 2024) 8) Proposal planned to go to GP Board 20th Dec to discuss LCS for Type 2 Pathway to ensure quality outcomes. will then go to CWG in New Year. (Decision made more work needs to be done on LCS's and Long Term Strategy Dec 2023) 9) Diabetes approach agreed by SLT November 24, PID awaiting sign off, and in conjunction work on LCS review commenced.	4 major x 4 likely = 16 High		Diabetes Programme Board - updated programme governance November 25- project board reports into Health and Care Models Transformation Group for progress updates 25/26	Claire Parker Director of Strategy and Development	Quality and Performance Committee	Claire Parker reviewed on 07/01/2025	Nov 23 Fiona Smith July 24 Reviewed at QPC Claire Parker made amendments including additons and deletions on 07/01/2025.	07/01/2025 - No amendments to risk levels.
6	1, 2 ,3	Angela Szabo, Director of Finance	**Financial Sustainability** Failure to deliver long term system financial sustainability and exit NOF4 arrangements	Opportunity to create a financially sustainable system	Strategies and Plans - System Financial Strategy, incorporating: Healthcare Financial Management Association (HFMA) Financial sustainability checklist , Strategic Decision Making Framework, Capital Prioritisation Framework, Financial Revenue Plan, Financial Capital Plan , Joint 5 year forward plan, Financial Recovery Plan inclusive of the Financial Improvement Programme and Efficiency, Productivity and Strategic Transformation Plans, ICS Infrastructure Estates Strategy, General Practice Estate Strategy /Programme. Partnerships and Services – ShIPP, TWIPP, ICS Digital Delivery Group, Strategic Estates Group, People Board, Strategic Transformation Group supported by delivery boards for all major programmes e.g. Planned Care Board, UEC Delivery Board. Governance & Engagement Structures - Finance Committee, Commissioning Working Group, Strategic Commissioning Committee, Audit Committee, Provider Collaborative Committees in Common	First Line - Monitoring delivery of System Financial Strategy and Financial Plan by System Finance Group and System Finance, Planning and Performance Group Second Line - Finance Report to Finance Committee, Integrated Performance Report to the Board. Third Line - Monthly Integrated Finance Return (IFR) and Provider Finance Returns (PFR) reporting to NHSE, Quarterly NHSE Financial Stocktake, NHSE Annual planning process (and triangulation of Finance, Activity and workforce planning)	**Gaps in assurances:** Long term financial plan and system financial strategy now out of date System transformational projects in place but at varying stages of maturity. Existing transformation plans do not fully address the target savings position. **Gaps in assurances:** None	**Almost Certain 5 x Major 4 = Extreme 20**	↔	Action 1) Agree detail of the Financial Recovery Plan and refresh and agree with System partners the System financial strategy by Mar 25 aligned to the SIIP delivery action timescale - ASz. Action 2) System partners will agree the detail of the three to five-year strategic transformation plans (quality and inequality impact assessments will be carried out on the impact of equality of population health outcomes and health inequalities as a result of any transformation plans) - to be reported through Financial Improvement Programme Board, known as 'the Recovery Plan' by Mar 25 aligned to the SIIP delivery action timescale - IB. Update provided in MTFP paper Feb 25. Action 3) Refresh the medium and long-term financial plan for latest financial projections and HTP by Mar 25. (Including developing the 25/26 operational plan inclusive of efficiency plans (quality and inequality impact assessments will be carried out to confirm the impact to equality of population health outcomes and on health inequalities as a result of any efficiency plans). [Links to SBAF entry 2b] - ASz. Target completion date Mar 25 on track	**Possible 3 x Major 4 = High 12**	TBC one the trajectory has been agreed for the MTFP	Claire Skidmore	Angela Szabo	Finance Committee	05/03/25 Angela Szabo	27/10/23 Laura Clare 17/01/2024 Laura Clare 22/04/2024 Angela Szabo 23/07/2024 Angela Szabo 21/10/2024 Angela Szabo 20/11/2024 Angela Szabo - No Change 27/12/2024 Angela Szabo 05/03/2025 Angela Szabo	Alignment of risk scores across the system,system integrated improvement plan in place. No change to risk score and risk score trend changed to same 20/11/24 - Angela Szabo
8	1,2,3	Sam Tilley	Emergency Planning, Resilience and Response (EPRR) If the ICB does not have system level plans in place to respond to emergencies, incidents, or disruptive events (e.g. adverse weather, cyber-attack, utilities failure, transport accidents, malicious attacks, industrial action, etc) impacting on the healthcare system and communities of Shropshire, Telford and Wrekin, there is a risk of an inadequate and/or uncoordinated response by the NHS, and the potential for a confused and/or misrepresented attendance at multiagency coordinating	Opportunity to work collaboratively across the STW ICS and the West Mercia LHRP footprint in our approach to Emergency Preparedness, Resilience and Response (EPRR), and with West Mercia Local Resilience Forum (LRF) partners.	•ICB EPRR Programme Group (with oversight of EPRR related risk register). •West Mercia Local Health Resilience Partnership (LHRP) with oversight of EPRR and health related risk register. •West Mercia Health Emergency Preparedness Operational Group (HEPOG) reporting to LHRP. •LHRP and HEPOG work programme. •Risks and risk registers linked to National Risk Register (NRR) and LRF Community Risk Register (CRR). •Reporting to ICB Audit Committee and Board. •Civil Contingencies Act 2004 (CCA) and National NHS EPRR Framework, NHS Act 2006, Health and Care Act 2022, and the NHS Standard Contract. •Attendance at LRF working groups, including an approved NHS Shropshire, Telford and Wrekin ICS West Mercia Local Resilience Forum Representation Agreement.	•Review of risk registers as a standing agenda item at every meeting for ICB EPRR Programme Group, LHRP, HEPOG. •Annual assurance of NHS Core Standards for EPRR. •Regular review of progress of work programmes at meetings for ICB EPRR Programme Group, LHRP, HEPOG. •Systemwide exercising schedule. •ICB holds monthly meetings with EPRR leads for each organisation.	Gaps in assurance: •Very limited ICB EPRR resource. •No existing system level EPRR frameworks, policies, plans for organisations to align own policies and plans to enhance a coordinated response. •Lack of documented Standard Operating Procedures (SOPs) for the System Coordination Centre (SCC). Gaps in Controls: •Recent combining of STW LHRP & HEPOG and Herefordshire & Worcestershire LHRP & HEPOG to form the West Mercia LHRP and HEPOG. •Low level of compliance with NHS Core Standards for EPRR.	Consequence: 4 (Major) x Likelihood: 4 (Likely) = 16 HIGH RISK	↔	1.ICB EPRR work programme has actions to produce system level EPRR policies, frameworks and plans for organisations to align own policies and plans. 2.ICB to continue with monthly meetings with EPRR leads for each organisation. 3.STW ICB EPRR lead to work closely with H&W ICB lead to drive the LHRP and HEPOG work programme ensuring links to system/locality risks, issues, and challenges. 4.Continue with systemwide exercising schedule. 5.Accountable Emergency Officers (AEO) for each organisation to review EPRR resourcing to ensure it is adequate for the size, type, and services of their organisation and duties placed on them under the CCA, NHS EPRR Framework, NHS Act 2006, Health and Care Act 2022, and the NHS Standard Contract.	Consequence: 3 (Moderate) x Likelihood: 3 (Possible) = 9 MODERATE RISK		Ian Bett, Interim Executive Director – Director of Delivery and Transformation / Accountable Emergency Officer (AEO) (NHS STW ICB)	Ian Bett, Interim Executive Director – Director of Delivery and Transformation / Accountable Emergency Officer (AEO) (NHS STW	ICB EPRR Programme Group – Audit Committee – Board.	7 Jan 25 Gareth Wright, Head of Clinical Ops / EPRR	19/01/24 Sam Tilley. 13/09/2024 - Stuart Allen, Senior EPRR Lead (NHS STW ICB) (Approved by Ian Bett 17/09/2024).	
9	3	Alex Brett	System CPO If we do not have a substantive CPO for the system then our ability to implement the people agenda in a timely and effective manner will be affected, resulting in a failure to deliver the 10 statutory People outcomes.	This is an opportunity to enable the ICS to meet its statutory and People Plan obligations and facilitate collaboration and organisational development across all system employers.	Ad hoc discussion at ICB Board , Remuneration Committee and Executive Team meetings Regional NHSE People Director engagement The system CEO SRO provides leadership for the four strategic portfolio's and from August 24 chairs the system People Collaborative a sub meeting of the system People Culture and Inclusion Committee. The Deputy CPO is on secondment and this role has been backfilled with a Head of People Programmes role providing a leadership function to operational delivery of the people priorities. The Head of People programmes reports directly to the ICB CEO for additional leadership. Head of People programmes attends regional CPO meetings and monthly 1:1 with NHSE regional workforce transformation lead. There is also additional leadership capacity with SRO's with accountability and delivery to each of the four strategic people priorities.	Ad hoc minutes of ICS CEO and ICS Board meetings. Minutes of Regional People Director and QSRM meetings. Minutes of system People collaborative, People Committee , ICB Senior Leadership team meetings, system Transformation Committee. People Committee report to Board . .	Gaps in Controls: 1) There is no routine control mechanism to understand the impact of the current model, or the necessary actions - this gap is now closed . 2) The System People Committee does not consider the system's CPO resource requirements - 3) The 23/24 People annual report evidences progress against the ICS People strategy with significant assurance provided to illustrate improved outcomes against agreed plans 4) Advert for CPO has gone out twice plus an additional reach out by the ICB CEO to identify opportunities to appoint to this role, with no success as CPO roles are difficult to fill nationally. 5) An alternative to a CPO role will be part of one of the recommendations proposed as part of the external review. Gaps in assurance: 4) There is inadequate evidence of this risk being identified and addressed - this gap is now closed. 5) There is evidence of this risk being addressed with an external review of HR/People/ ICB people team function and infrastructure commencing September 24. Gaps in resources to deliver the people strategy have been mitigated by SaTH supporting with infrastructure where there have been opportunities to do so .	Likely 4 x Major 4= High 16	↑	1) Interim CPO working with ICB CEO and system CEOs to finalise a collaborative approach to people structures, programmes etc. 2 and 3) Interim CPO working to refresh System People Committee, its ToR and its work programme - to include regular discussion of demand & capacity. 4)CEO's were not able to agree a collaborative approach to people structures either a proportionate investment across providers into the peopel team resources hosted by ICB or providers identifying necessary infrastructure from own resources . There is now an external review of HR/People / ICB eopel team commencing September 24.	Possible 3 x Moderate 3 = Moderate 9		Simon Whitehouse	Ellen Shaw	People, Culture and Inclusion Committee People Collaborative	Ellen Shaw 27/02/25	S Hayes 28/07/23 Existing key controls updated 04/09/34 - Alison Trumper Existing sources of assurance updated 04/09/34 Gaps in controls or assurance -Alison Trumper 04/09/24 Action plan updated - 04/08/24 -Alison Trumper Director risk owner - Alison Trumper 04/09/24 Risk owner -Alison Trumper 04/09/24 Risk Owner 24/12/24 Ellen Shaw	
10	3	Alex Brett	Deputy CPO capacity If the size of portfolio of the Deputy CPO (programmes, team management and People function for the ICB as an employer)is not more manageable then this will affect our ability to implement the people agenda in a timely and effective manner, resulting in a failure to deliver the 10 statutory People outcomes.	This is an opportunity to enable the ICS to meet its statutory and People Plan obligations and facilitate collaboration and organisational development across all system employers. This is an opportunity to strengthen the leadership of the People Function which is vital in supporting, enabling and leading the workforce transformation programmes.	Ad hoc discussion at ICS meetings Ad hoc discussion at ICS CEO meeting The current CPO is on secondment which has provided opportunity to pilot a different approach to this role which the Deputy has been instrumental in securing before secondment. To ensure capacity to deliver there is now a separate temporary resource for workforce planning and assurance, system leadership across the four external people programmes and the internal ICB facing HR resource and leadership. This has provided sufficient resource to effectively manage and lead these three areas.	Ad hoc minutes of ICS meetings. ECF approval of the addittional resource and visibility of the three roles/ post holders	Gaps in Controls: 1) There is no routine control mechanism to understand the impact of the current model, or the necessary actions. 2) The System People Committee does not consider the system's collaborative approach to people structure, priorities or resource requirements. 3) People Culture and Inclusion Committee has received regular updates on available capacity across the four strategic people portfolio's . Where there has been opportunity providers have identified some additional leadership capacity . Gaps in assurance: 4) There is inadequate evidence of this risk being identified and addressed. 5) There is assurance that this risk has been managed by the addittional leadership across the three areas of the CPO role to increase capacity	Likely 4 x Major 4= High 16	↑	1) Interim CPO working with ICB CEO and system CEOs to finalise a collaborative approach to people structures, programmes etc. 2 and 3) Interim CPO working to refresh System People Committee, its ToR and its work programme - to include regular discussion of demand & capacity. 4) The interim CPO has now left the role .The PeopleCommitte has reviewed itsToR, reviewed its governance reporting arrangements and has been subject to observation as part of the ICB's good governance assessment process - awaiting formal feedback with iniital review indiated as being positive . 5) Where there have been opportunities provider partners have provided some temporary infrastructure across one of the programmes. The People infrastructure is subject to a wider review and and will commence September 24 with anticipated recommendations to present to the system CEO's . This will also include opportunity to review Director leadership at the CPO level in response to the post being challenging to appoint too.	Possible 3 x Moderate 3 = Moderate 9		Alex Brett Simon Whitehouse	Sara Hayes Alison Trumper	People, Culture and Inclusion Committee People Collaborative	Ellen Shaw 27/02/25	S Hayes 28/07/23 Existing key controls - 04/09/24 -Alison Trumper Level of assurance 04/09/34-Alison Trumper Gaps in control -04/09/24 Actionplan - 04/09/24 Risk owner Director - 04/09/24Where there has been opportunity providers have identified some additional leadership capacity .owner - Alison Trumper 04/09/24 Risk owner Director - Alison Trumper 04/09/24 Risk Owner 24/12/24 Ellen Shaw	
11	3	Alex Brett	Capacity (including appropriate administrative capacity) to deliver the 10 People outcomes. If there is lack of clarity on the shape, size, priorities, structures and sustainable funding for system people collaboration, then this will impact on our system's ability to deliver the 10 statutory people outcomes, resulting in continuing capacity pressures in our primary community and acute settings: - Supporting the H&WB of staff - Growing the workforce for the future & enabling adequate workforce supply - Supporting inclusion & belonging for all & creating a great experience for staff - Valuing and supporting leadership at all levels and lifelong learning - Leading workforce transformation & new ways of working - Educating, training & developing people and managing talent - Driving & supporting broader social & economic development - Transforming people services & supporting the people profession - Leading coordinated workforce planning & intelligence - Supporting system design & development	This is an opportunity to support and enable our system employers and people to make progress towards our strategic ambition of one workforce and workforce transformation for patient service transformation.	Ad hoc discussion at ICB Executive Team meetings Ad hoc discussion at ICS CEO meetings. Updates on available infrastructure reported to People collaborative and to People Culture and inclusion Committee Additional temporary capacity (up to March 25) to deliver the workforce planning, monitoring and assurance requirement as part of the REFORM portfolio. Where there has been opportunity , additional temporary capacity has been identified by Sath to support one of the portfolio's .	Minutes of Executive Team and CEO meetings. Minutes of People Committee . Papers to ICB Board The annual report for 23/24 People Programmes evidences delivery of programmes against the people strategy with clear indicators of success and outcomes	Gaps in Controls: 1) The ICS does not have an appropriate mechanism to discuss and agree the shape of people services and structures for the future. 2) The System People Committee does not consider the system's collaborative approach to people structure, priorities or resource requirements.3) People Culture and Inclusion Committee has received regular updates on available capacity across the four strategic people portfolio's . Where there has been opportunity providers have identified some additional leadership capacity . 3) People Culture and Inclusion Committee has received regular updates on available capacity across the four strategic people portfolio's . Where there has been opportunity providers have identified some additional temporary leadership capacity . 4) There is growing evidence of this risk being identified and addrressed through the commissioning of an external review or HR/ICB People infrastructure across the ICB, SCHT and SaTH commenced September 24 5) There is assurance that this risk has been managed by the addtiional leadership across the three areas of the CPO role to increase capacity. Gaps in assurance: 3) There is inadequate evidence of this risk being identified and addressed.	Likely 4 x Major 4= High 16	↔	1) Interim CPO working with ICB CEO and system CEOs to finalise a collaborative approach to people structures, programmes etc. 2) Interim CPO working to refresh System People Committee, its ToR and its work programme - to include regular discussion of people services and structures across all ICS employers. 3a) Focus current People Team resources on programmes that enable the greatest value to be added 3b) Explore all opportunities for collaborating and sharing workload with system partners. 4)Where there has been opportunity providers have identified some additional temporary leadership capacity . 5) Additional temporary resource has been funded to provide capacity for workforce planning and assurance, internal ICB HR function and leadership across the people Programmes and at this item this has been identified as being cost neutral from vacant posts. 6) Await outcomes of external review commenced September 24	Possible 3 x Moderate 3 = Moderate 9		Alex Brett Simon Whitehouse	Ellen Shaw	People, Culture and Inclusion Committee People Collaborative	Ellen Shaw 27/02/25	S Hayes 28/07/23 Existing key controls - Alison Trumper 04/09/24 Existin sources of assurance - Alison Trumper 04/09/24 Gaps in control - AlisonTrumper 04/09/24 Action plan - Alispn Trumper 0409/24 Director /risk owner - Alison Trumper 04/09/24 Risk Owner - AlisonTrumper 04/09/24 Risk Owner Ellen Shaw 24/12/24	
12 (SQG9)	2 & 3	Vanessa Whatley Chief Nursing Officer, NHS STW	If there is not an effective acute paediatric pathway for Shropshire Telford and Wrekin including clear access to the wider KIDS Network and assurance that there are not inequalities in access with health and care partners then Children requiring the support of their health needs may experience harm or delays in accessing treatment.	To have assurance of a sustainable, safe and effective paediatric health and social care for the population of Shropshire Telford and Wrekin.	1) SaTH incidents are reviewed in line with the Patient Safety Incident Response Framework and policy (PSIRF) (June 24) 2) Paediatric sepsis pathway is audited monthly at SaTH (June 24) 3) SaTH have provided assurance on immediate actions from Quality visit and immediate actions from incidents in Sept and Oct 23 (June 24) 4) Chid death cases are shared with the SaTH patient safety Specialist (June 24) 5) SaTH are members of the quarterly child mortality meetings (June 24)	1) Monthly joint meeting to oversee risk and actions and liaise with SaTH/other partners to support progress including continuous oversight in line with National Guidance on Quality Risk Response and Escalation in Integrated Care Systems, NQB,22. (ICB and Regional NHSE team, (June23) 2) There is a plan in place to progress current ICB action plans which is on track (June 23) 3) A Rapid Quality Review has been undertaken with appropriate stakeholders (June 23). 4) The Sepsis Trust Paediatric tool has been launched at SaTH with education and training in May 23 (June 23). 5) SaTH have completed and presented a thematic review on 3 cases (June 23) 6) Sath have reviewed Sepsis pathway and implemented the Sepsis Trust's padiatric assessment tool in May 23(June 24) 7) Sath are reviewing all actions relating to Paediatric Pathways via PTAC meeting with ICB rep(June 24) 8) SaTH delivered action plan addressing immediate actions and actions identified in the Quality visit undertaken on 1st February, Assurance to be given at PTAC (June 24) 9) SaTH have identified senior medical leadership for paediatrics for July 23(June 24) 11) Rapid Quality Review Action Plan delivered (June 24)	1) There is no efficient system for GP's to communicate with Paediatricians for advice and support.(June 24) 2) There is a lack of assurance on the timeliness of response from the KIDS Team. (June 24) 3) There is a gap in the reporting against newly signed contractual quality measures in paediatric dept (June 24) 4) There is a gap in the reporting of paediatric sepsis audit and training in the emergency department(June 24)	3 possible x 5 catastrophic = 15 High	↓	1) SaTH to continue to review all paediatric actions via PTAC and they are completed and assured (SaTH, June 24) 3) KIDS /NHSE teams to provide assurance on the response to children in STW. (KIDS/NHSE specialist commissioning NHSE, June 23) 5) Await sign off of the Review of Paediatric Commissioning oversight at system level (ICB, Dec 23) Completed 6) Await findings of CQC inspection Oct/Nov 23 (ICB/SaTH March/April 24) Completed 7) Sath to present paediatris quality metrics as per contract (June 24) 8) Sath to provide infomraitno relating to the succesful introufction of electronic PEWs in line wth Nov 23 published version 9) Clinical lead for STW to work with clnical director at SaTH to identify improved communcation for piloting (ICB, June 24)	catastrophic 5x Rare 1= 5 Low		Ian Bett PTAC, SaTH, ICB Group TBD.	Vanessa Whatley Director for Safety and Quality/ Chief Nurse ICB	Quality and Performance Committee	Sharon Fletcher 07/01/25	21.06.23 Reviewed at QPC July 24 Reviewed at QPC and SQG next review and consideration for de-escalation and removal from SORR - devision at November SQG was to update in Feb and leave risk at the same score	
13 (SQG 10)	1	ICS IPC Meeting 07/23	If Clostridioides difficile cases continue to increase at the current rate there will be increased harm to patients, resulting in poorer outcomes, loss of reputation and inefficient in best use of resources.	To bring new C diff cases back in line with monthly trajectory	1) IPC resources for all parts of the system with implementation of policies including the below(June 24) : 2) National guidance supporting best practice (Mar 24) 2) Quality Walk arounds (June 24) 3) Commode audits (June 24) 4) HPV cleaning of side rooms and equipment (June 24)	1) Surveillance is in place to monitor infections (June 24) . 2) C. diff policies have been read across for reflection of national guidance (June 24) 3) Local action plans in each NHS organisation have been merged into one so there is consistency of action in sept 23 (June 24) 4) System oversight of primary care prescribing indicates that STW is not an outlier in high risk antibiotics(June 24) 5) RJAH back on monthly trajectory (June 24) 6) SCHT back on monthly trajectory (June 24) 7) Quality visits focussing on C diff have been undertaken which has shown good IPC practice in areas visited (June 24) 8) System antimicrobial prescribing guidelines have been reviewed in line with rising C diff and action on community prescribing is underway (June 24)	1) There is a gap in controls as Sath are unable to report on deep clean programme completion due to UEC pressures (June 24)	Likely 4 x Major 4 = High 16	↔	2) System action plan to be delivered to regain monthly trajectory (July 24) 3)AMR sub group of IPC AMR group to deliver plan to address prescribing in high risk antibiotics for CDI (Sept 24) 4) SaTH Developing revised plan in line with regonal lead visit (May 24).	Unlikely 2 x Moderate 3 = Low 6		ICS IPC/AMR Group Chair: Vanessa Whatley	ICS IPC/AMR Group Chair: Vanessa Whatley	ICS IPC/AMR Group	Sharon Fletcher 07/01/25	Vanessa Whatley Jan 24 Vanessa Whately Mar 24 Reviewed QPC July 24 QPC review November 24	
14	2	Tristi Tanaka	Without a system digital operating model, there is an increased likelihood of material delays to vital digital programmes to enable priority clinical and care services that support improved patient outcomes - failure to provide integrated clinical and care digital services	Develop a digital operating model framework to join up core and enabling capabilities development across ICS partners to underpin the ICS Digital Strategy	* BAF Strategic Risk 5 * ICS Digital Strategy * ICS Digtial Portfolio	*Strategy Committee *ICS Digital Delivery Group .	Gaps in controls: 1) Resources are limited 2) It is currently unclear how many ICS have a 'system digital operating model' Gaps in Assurance: 3) External sources for assurance are limited.	Likely 4 x Major 4 = 16 High	↔	1& 2 Initiate discussions on a system digital operating framework	Possible 3 x Moderate 3 = 9 Moderate		Lorna Clarson CMO	David Maruta	Strategy Committee	David Maruta 01/08/2025	30.01.2024. Tristi Tanaka 08/01/2025 David Maruta - risk score remains the same until the newly created ICS Digital Operations Group begins working on the ICS' target operating model	
15	5	Tristi Tanaka	Patients/users harmed due to difficulty of finding information across different systems within and across settings (Self-referral, Primary Care, POD, Community Services, Mental Health, Specialist Acute Services, Acute Services, Social Care and Children's Services	Review the value, benefits and gaps of the One Health & Care (integrated care record) platform for direct care.	* BAF Strategic Risk 5 * ICS Digital Strategy * ICS Digtial Portfolio entry for Shared Care Records	* Quality Committee * Clinical Leadership groups * ICS Digital Delivery Group * STW OHC Group	Gaps in Controls: 1) Resources are limited Gaps in Assurances: 2) Sources are assurance are limited as part of Group reporting up to the ICS Digital Delivery Group.	Likely 4 x Major 4 = 16 High	↔	1a) Complete the STW OHC Review with the purpose of enabling the integrated care record to 1b)Connect our staff and organisations to one source of truth for citizen information" and support "Support better multi disciplinary working, as clinical data follows the patient and encourages a collaborative approach to care" 1c) Review OHC overnance, stakeholder involvement and communications, finance and budget Change management, Supplier management and OHC roadmap and strategic alignment 1d) Ensure clinical and care digital solutions are selected for integration, funded for development and ongoing support for user training, quality improvement and aligned to use cases that support patient safety and improved health and care outcomes	Possible 3 x Moderate 3 = 9 Moderate		Lorna Clarson CMO	David Maruta	Quality and Performance Committee	David Maruta 01/08/2025	30.01.2024. Tristi Tanaka 08/01/2025 David Maruta - risk score reduced as OHC development has progressed with the implementation of data sharing capability, and will further reduce when the CarePlanning module goes live in 25/26	
16	5	Tristi Tanaka	Lack of a system digital inclusion framework increases the likelihood that digital transformation programmes may exacerbate digital inequalities, not only affecting access health and care services as well as the ability to achieve the desired patient outcomes	Develop a system digital inclusion framework to guide the prioritisation, design, implementation and evaluation of digital health and care services	* ICS Strategic Commissioning Intentions * ICS Digital Strategy * ICB Prevention and Health Inequalities Board Quarterly Highlight report	*STW Equality Impact Assessment (EQIA) * STW ICS Full Integrated Impact Assessment (IIA) *ICB Investment Panel	Gaps in controls: 1) Resources are limited Gaps in Assurances: None	Likely 4 x Major 4 = 16 High	↔	1a) Develop a system digital inclusion framework for digitally-enabled health and care services 1b) Update the STW ICS Full Integrated Impact Assessment 1c) Update the STW Business Case requirements 1d) Update commissioning requirements for the procurement of digital health and care products and services 1e) Ensure supplier contracts include mechanisms for monitoring, reporting, improvement metrics and assurance 1f) Update the prioritisation guidance for the Investment Panel	Possible 3 x Moderate 3 = 9 Moderate		Lorna Clarson CMO	David Maruta	Strategic Commissioning Committee	David Maruta 01/08/2025	30.01.2024. Tristi Tanaka 08/01/2025 David Maruta - risk score remains the same until the newly created ICS Digital Inclusion Group begins working on the ICS' Digital Inclusion Framework	
17	5	Tristi Tanaka	Lack of system capacity and funding to support digital clinical risk management increasing likelihood of non-compliance with compliance with NHSE digital clinical risk management standards	Develop a system-wide approach to clinical safety including the integration of incident management	* ICS Strategic Commissioning Intentions *ICS Clinical Leadership development programmes * ICS Digital Strategy * ICS Digtial Portfolio	* Quality Committee * Clinical Leadership groups * ICS Digital Delivery Group * STW OHC Group	Gaps in controls: 1) Resources are limited Gaps in Assurances: 2) Sources are assurance are limited a part of Group reporting up to the ICS Digital Delivery Group	Almost Certain 5 x Major 4 = 20 Extreme	↔	1a) Develop a fund to enable the development of the role of clinical safety officers and the tools for clinical risk management 1b) Develop a programme of training and support 1c) Review existing clinical incident management processes for opportunities to align incident reporting related to digital clinical risks 1d) Identify opportunities to align the clinical risk management framework and alignment with compliance with best practice technology standards to commissioning and procurement processes for digital health and care tools and solutions e.g. DCB0129 (developers) and DCB0160 (adopters), DTAC, NICE TA recommendations, MHRA Approval, TCoP 1e) Ensure link to clinical risk management in the development of the SCC and EPRR 1f) Develop guardrails for emerging technologies like AI for risk stratification, automated or embedeeded clinical decision support tools, etc.	Likely 4 x Major 4 = 16 High		Lorna Clarson CMO	David Maruta	Quality and Performance Committee	David Maruta 01/08/2025	30.01.2024. Tristi Tanaka 08/01/2025 David Maruta - risk score remains the same	
18 (SQG 11)	1	Vanessa Whatley CNO NHS STW (Interim CNO when risk was added to register Nov 23)	**Update 14th March 25 please note the change in risk narrative/description due to completion of procurement/mobilisation** 1) The current waiting list is 2999 as of February 2025 2) There is currently no approved pathway to manage adult ADHD coexisting with mental health co-morbidities. Co-morbid patients as of February 25 is 470 3) Shared care (link to SQG 13) 4) Patients can request to go through the Right To Choose option if they wish . .	1) The ICB have completed a procurement o commission a list of accredited providers to offer the provision of ADHD Adult Assessment service and reduce the waiting times. 2)To develop an agreed pathway for people with co-morbidities	1) The ICB have completed procurement under direct award B for an ADHD adult assessment service. 2) Three providers have been awarded a contract. One of which is mobilised with a second provider due to commence April 2025 3)Patients currently have option of Right to Choose (RTC) 4)Weekly mobilisation meetings with 2/3 providers. 5) ICB representation at Midlands ADHD Community of Practice 6) Ongoing collaborative work with MPFT around patients with comorbidities	1)Procurement completed 2) RTC remains a patients constitutional right	1) Update March 25 continued position no control on the number of people being referred for an adult ADHD assessment . 2) No control on the clinical assessment prior to referral - consideration of a screening tool as part of a new service. 3) Limited control over the quality of the right to choose process (March 25) (ICB are not host commissioners) ICB now hold contract service specifications for a number of RTC providers high on agenda for Midlands ADHD Community of Practice 4) No control over the associated costs following the right to choose process (March 25)	Likely 4 x Major 4 = High 16	↔	1) No control on the number of people being referred for an adult ADHD assessment (March 25). 2) No control on the clinical assessment prior to referral (March 25) - consider screening tool 3) Limited control over the quality of the right to choose process (March 25) (ICB are not host commissioners) high on agenda for regional task and finish group. ICB now holds contract service specifications for a number of RTC providers. 4) No control over the associated costs following the right to choose process (March 25) - however ICB have a locally commissioned provision of service this may reduce patients choosing RTC as an alternative option. 5) ongoing discussions regarding shared care (link to SQG 13)	Likely 4 x Moderate 3 = High 12		Vaness Whatley	Tracey Slater/Helen Rowney	QPC	Tracey Slater/Helen Rowney 14/03/25	Entered onto quality RR December 23 Updated January 24 - risk score remains the same until impact and outcome of triage and assessment is known. Updated 16th February 24 (TS & HR) risk score remains the same (as above) Updated 24th April 24- risk score remains the same , awaitng transfer of people with co-morbidities and limited control over RTC August update completed to SQG 4th November 2024 update completed to SQG by risk owners TS/HR Update Jan 25 Helen Rowney & Tracey Slater Update Feb 25 Tracey Slater & Helen Rowney **Update March 25 Tracey Slater & Helen Rowney**	
20	1, 2, 3	Angela Szabo, Director of Finance	**Revenue Financial Plan 24/25** Failure to deliver 24/25 ICS revenue financial plan limit, delivery of the financial improvement programme and management of risk. **Capital Financial Plan 24/25** Failure to deliver plans within the capital limit in year	Opportunity to create a financially sustainable system Adherence with the Financial Frameworks, Revenue and Capital	**Revenue and Capital** System financial principles and risk management framework in place across the system as part of development of system financial recovery plan approach as set out within the financial strategy. System governance arrangements in place through finance committee and system strategic committee and commissioning working group to ensure that new investments are not made unless recurrent resource is available. **Revenue** System workforce programme and agency reduction group implemented, weekly agency reporting and action plan to reduce agency expenditure in line with system cap Financial Improvement Programme and System Transformation Group Organisation self assessments of plan conditions/financial controls in place - Triple Lock, vacancy controls, HFMA sustainability and NHSE Grip and Control. System vacancy panel in place. Workforce monitoring of vacancies in place. Triple lock process for non pay expenditure **Capital** Capital Prioritisation Oversight Group	First Line Monitoring of financial performance by System Finance Group Standing Orders, Standing Financial Instructions and Delegated Financial Limits Financial Accounting Performance Metrics HFMA Financial Sustainability and NHS Grip and Control checklist self assessment Better Payment Practice Code System productivity and FIP group in place for efficiency. FIP reports into System Transformation Group which provides Assurance to the Board. System agency reduction group implemented, weekly agency reporting and action plan to reduce agency expenditure in line with system cap. System Vacancy Assurance Panel in place. Triple Lock in place. Second Line Regular Finance Report and Efficiency Report to Finance Committee Integrated Performance Report to the Board Third Line Monthly Integrated (Care System) Finance Return and Provider Finance Returns reporting to NHSE External review of HFMA financial sustainability and NHSE Grip and Control self-assessments.	**Gaps in Control:** STW 12th June Revenue Financial Plan Limit £90m deficit, Key areas of risk to delivery are: 1.a Efficiency delivery risk 1b Escalation costs due to UEC pressure and links to discharge 1c Costs and inflation pressures 1d New NICE appraisals with significant implementation costs 1e Income Risk if NHSE Income assumptions in the forecast are not supported **Gaps in Assurances:** A forecast that does not have risks fully mitigated means that there is limited assurance that the financial forecast can be met.	**Almost Certain 5 x Major 4 = Extreme 20**	↔	**Revenue Financial Plan/Limit Note - Boards approved System and organisational expected FOT M10.** Efficiency: Action 1) Review of most likely expected FOT on a regular basis through financial governance, specifically for high risk and medium risk schemes to identify potential slippage, mitigation actions/schemes. [In place] - ASz Completed monthly - ongoing. Action 2) Ensure sufficient PMO capacity is allocated to support recovery of medium/high risk efficiency schemes and the development of the pipeline mitigation schemes to support de-risking the overall efficiency programme. [In place] - IB Completed M6-M8 - closed. Action 3) Support the implementation of the actions recommended in the System PMO report including changes to financial governance, efficiency documentation and processes and the utilisation of PMO resources across the System. [In progress] - IB Due date for completion of actions 31/03/25. Cost: Action 1) As part of the Monthly Financial Review processes interpret current financial performance: 1a) analyse special variation changes in the run-rate trend of spend for Pay and Non-Pay. 1b) analyse key drivers of overspends and underspends. This will inform accurate forecasting and identification of risks and risk mitigations. [In place] - ASz Updated in System Financial Reporting M9 - in place. Action 2) Review all requests for pay through the existing Vacancy Control Panels ensuring the completion of the benefits/benefit realisation supports financial delivery and recovery. [In place] ASz Updated SVAP TOR under review in Feb for implementation in Mar 25. Action 3) Review all discretionary non-pay over £10k though the existing financial governance processes including the Triple Lock and reduce discretionary spend. [In place] - CS Ongoing. Action 4) Review all contingencies, provisions and prior year accruals. [In place] - ASz Completed M10. Income: Action 1) ICB/SaTH formally requested a National Payment Variation from NHSE in October 2024. Agreed in principle; awaiting formal written confirmation. - ASz Completed M10. Action 2) ICB to support providers to recover all income paid under previous income agreements/arrangements or where funding may be accessed. [In place] - ASz Completed Month 10. Action 3) System providers to maximise all commercial income and non nhs income opportunities. [In progress] – HT/SL/CM Ongoing. **Capital Financial Plan/Limit** Action 1) All organisations review their priorities in line with current agreed strategies for estates, digital, clinical, workforce etc. Ongoing monthly review is undertaken through the Capital Prioritisation Oversight Group (CPOG) and reported to the System Finance Committee as appropriate. – HT/SL/CM/CS Reviewed Month 8 - Closed. Action 2) Use the System prioritisation framework to prioritise requirements based on key system criteria including equality of population health outcomes, value for money, broader socio-economic factors and health inequalities including Equality Diversity and Inclusion (e.g. DDA compliance and digital inclusion IT software and hardware). Initially completed July 2024 and updated as at Month 8 FOT by all organisations. Review of prioritisation at CPOG continues as required. - ASz Completed in M8 - closed. Action 3) Complete business case requests for NHSE approval as required ensuring full system governance and sign off is applied. - ASz Closed - completed. Action 4) All organisations to review IFRS16 operating lease commitments with a view to reducing the overcommitment in year – reviewed monthly at CPOG. - ASz Closed - additional funding allocated by NHSE M10. Action 5) If required - Agree mitigations for potential overspends with budget holders - ie, deferral of uncommitted capital scheme expenditure. Organisational senior finance team and CPOG to review monthly. – HT/SL/CM/CS Ongoing. Action 6) If required - Agree mitigations for potential underspends with budget holders -i.e. bring forward pipeline schemes - reviewed monthly by organisational senior finance team with budget holder and via CPOG. – HT/SL/CM/CS Ongoing. Action 7) Submit business case proposals for replacement capital schemes to NHSE asap as required - organisational senior finance team review/CPOG review monthly. – Asz Closed.	**Possible 3 x Major 4 = High 12**	4/29/2025	Claire Skidmore	Angela Szabo	Finance Committee	Angela Szabo, 05/03/25	22/04/2024 Angela Szabo 23/07/2024 Angela Szabo 21/10/2024 Angela Szabo 20/11/2024 Angela Szabo 27/12/2024 Angela Szabo 05/03/2025 Angela Szabo	Alignment of risk scores across the system,system integrated improvement plan in place. Fully identified efficiency plan. 20/11/2024 - Detail updated to match SIIP/RSP and Finance Report Risk Reporting. No change to risk score, risk trend changed to the same. Angela Szabo
21 (SQG 13)	1	Clare Stallard Medicines Management and Dr Priya George	If the increasing numbers of rejections for shared care prescribing which would otherwise be suitable for Primary Care prescribing is maintained then this will lead to further capacity pressures at specialist provider level and impact on patients accessing their medicines in a timely way, creating inequity of access where some practices accept prescribing and others do not. MHWB ADHD services have reported a 25-30% rejection rate which is further increasing.	Address the concerns of primary care through the LMC, GP board with the support and oversight of Nick White (CMO) to improve uptake of share care prescribing particularly for MH/ADHD services	1)Implementation of National Documents to standardise approach across all specialties 2) specialist provider led with GP input for approval via IMOC 3) working group in place to ensure clear pathways for MH and ADHD services 4) safe prescribing of medicines LCS with exisiting funding reinvested to support MH and ADHD prescribing 5) Communication of implementation process via newsletter and formulary newsfeed/update e.g. routine review or proactive	1)Decline to prescribe process and data 2) EPACT-2 prescribing data 3)National documents implementation programme and progress against plan	1) Absence of clear pathway for support for Primary Care from specialist teams MH ADHD services and how the services interlink (MDT approach) 2) inconsistent use of language/terminology relating to discharge and continued specialist oversight 3) growth being seen in ADHD/MH services and prescribing- additional funding considerations/drug budget impacts/primary care capacity 4) Knowledge/competency gap for primary care 5)lack of assurance of adoption and communication at provider level of agreed shared care documents and specialist responsibilities due to absence of operational management input in development, approval and circulation 6) Limited practice sign up to LCS due to ongoing discussions with LMC and Primary Care	4 Likely x 4 Major = 16 High	↔	1) comorbidities pathway developed to outline patient pathway, GP support/escalation and ongoing care/supervision- changing language avoiding discharge and reframing acute specialist oversight--> community specialist oversight when prescribing transferring to primary care. Contract negotiations being held with MPFT- ongoing 2) operational management involvement in shared care document development and clinical lead MH representative on future relevant IMOC- complete 3) New decline to prescribe process in place for provider reporting and identification of trends to allow for addressing any issues-complete May 4) as part of ADHD assessment and diagnosis service, consider capacity and funding/budget impacts for primary care increasing prescribing numbers, consider as part of procurement process. CWG paper presented 4) met with LMC and issue joint statement from commissioning, medicines, LMC to practices with CMO sign off/endorsement to provide current assurances of the above financial uplift for LCS once approved- July/Aug 5) specialist education/networking/support session for primary care -24/25 6) User guide for new shared care documents format approved to present to GP board on 19th June and circulate following this 7) position statement to clarify position of non-medical prescribers in shared care prescribing - to present to GP board 19th June 8) Meeting held with Primary Care and LMC, follow up actions with Nicola Williams in Primary Care- update to be provided July 24.	3 possible x3 moderate = 9 Moderate		Task and Finish Group ADHD Lorna Clarson CMO	Andrew Riley, Senior Pharmaceutical Advisor	Quality and performance committee	Reviewed Sharon Fletcher 07/01/25	Accepted onto RR March 24 Reviewed QPC July 24 QPC reviewed Nov 24	
22	1, 2, 3	Tristi Tanaka, interim Head of Digital	System-wide Cybersecurity Operating Model and Strategy The ICB does not have a cyber operating model, system-wide cybersecurity strategy or ICS plan in place for cyber reslience for known vulnerabilities and attack methods proportionate to the risk profile, with all operators of essential services (OESs) in the sector and across the ICS digital and technology supply chain, making ICS partners vulnerable in meeting their statutory obligations	Opportunity to work collaboratively across the system in our approach to cybersecurity	Each ICS partner has cybersecurity capabilities Working action plan from November 2023 Cyber Resilience event	Each ICS partner has a cybersecurity plan or strategy	Gaps in Controls: 1) Unclear funding to develop a ICS Cyber Target Operating Model (TOM) and ICS Cybersecurity Strategy 2) Unclear resources and capabilities to achieve functional Cyber Assessment Framework outcomes 3) Unclear commitment from ICS partners to develop an ICS TOM Gaps in Assurance: 1) The ICS Cyber Operations working group has not been re-established. 2) ICB Cybersecurity services are wholly outsourced and reporting through Information Governance 3) Existing reporting does not have Digital involvement or oversight	4 Likely x 4 Major = 16 HIGH	↔	1) Confirm ICS Cyber Lead who will attend NHSE/Midlands Cyber meetings, promote NHSE Cyber service offer and agree to participate in any study 2) Deliver Board approved ICS Cyber Strategy by April 2025 3) Deliver and integrate ICS Cyber Risk Register 4) Produce and issue ICS Cyber Allocation Quarterly Reports From our ICS Digital Strategy's "Cyber Security Portfolio" and "Collaborative Ways of Working" • Respond to identified need and risk/gap that the ICS are not providing Cyber security support to organisations on a 24/7 basis. • Review options and agree solutions to protect medical devices. • Increase capabilities in office 365 and enhancing licensing within the specialty area. • Respond to need for all organisations to work together to achieve collective goals... establishing key groups where lessons can be learned and where sensible the joining up of resources can be utilised. From our ICS Digital Strategy's pledge "Upskilling workforce and communities in data literacy" • Conduct current capability analysis across ICS workforce and community digital, data and cyber security literacy via surveys. • Support all staff to attain a basic level of data, digital and cyber security literacy, followed by continuing professional development. • Address BAF Strategic Risk No.2: Risk of not delivering sustainable services within available resources and Strategic Risk No.5: Lack of capacity and strategy to develop and use digital and data systems to enable efficient and effective care across the ICS	Possible 3 x Moderate 3 = 9 Moderate		Lorna Clarson	David Maruta	Strategic Commissioning Committee	David Maruta 01/08/2025	30.01.2024. Tristi Tanaka 08/01/2025 David Maruta - risk score remains the same until the newly created ICS Cyber Security Group begins working on the ICS' Cyber Strategy	

1
2
3
4
5
6
7
8

NHS STW - ICB Strategic Operational Risk Register (ICBSORR) 2024/25

Appendix B

ICB Statutory Purpose:

1 Improve outcomes in population health and healthcare

2 Tackle inequalities in outcomes, experience and access

3 Enhance productivity and value for money

4 Help the NHS support broader social and economic development

1 Risk ID	2 Strategic Objective	3 Opened / added by	4 Risk and description	5 Opportunity	6 Existing key controls	7 Existing sources of assurance	8 Gaps in controls or assurances	9 Risk score (consequence x	10 Risk score trend	11 Action plan / cost / action lead /(target date) /sufficient mitigation	12 Target risk score for end of	13 Target date for closure	13 Director or Risk Owner	14 Risk Owner	15 Committee/ICB oversight	16 Last Review: name and	17 Amendments: name and date	18 Rationale for amendments/increasing or decreasing risk levels
1	1, 2 ,3	Angela Szabo, Director of Finance	**Financial Sustainability** **Failure to deliver long term system financial sustainability and exit NOF4 arrangements**	Opportunity to create a financially sustainable system	Strategies and Plans - System Financial Strategy, incorporating: Healthcare Financial Management Association (HFMA) Financial sustainability checklist , Strategic Decision Making Framework, Capital Prioritisation Framework, Financial Revenue Plan, Financial Capital Plan , Joint 5 year forward plan, Financial Recovery Plan inclusive of the Financial Improvement Programme and Efficiency, Productivity and Strategic Transformation Plans, ICS Infrastructure Estates Strategy, General Practice Estate Strategy /Programme. Partnerships and Services – ShIPP, TWIPP, ICS Digital Delivery Group, Strategic Estates Group, People Board, Strategic Transformation Group supported by delivery boards for all major programmes e.g. Planned Care Board, UEC Delivery Board. Governance & Engagement Structures - Finance Committee, Commissioning Working Group, Strategic Commissioning Committee, Audit Committee, Provider Collaborative Committees in Common.	First Line - Monitoring delivery of System Financial Strategy and Financial Plan by System Finance Group and System Finance, Planning and Performance GroupSecond Line - Finance Report to Finance Committee, Integrated Performance Report to the Board. Third Line - Monthly Integrated (Care System) Finance Return and Provider Finance Returns reporting to NHSE, Quarterly NHSE Financial Stocktake, NHSE Annual planning process (and triangulation of Finance, Activity and workforce planning)	**Gaps in assurances:** **Long term financial plan and system financial strategy now out of date** **System transformational projects in place but at varying stages of maturity.** Existing transformation plans do not fully address the target savings position. **Gaps in assurances:** None	**Almost Certain 5 x Major 4 = Extreme 20**		Action 1) Agree detail of the Financial Recovery Plan and refresh and agree with System partners the System financial strategy by Mar 25 aligned to the SIIP delivery action timescale - ASz. Target completion date Mar 25 on track. Action 2) System partners will agree the detail of the three to five-year strategic transformation plans (quality and inequality impact assessments will be carried out on the impact of equality of population health outcomes and health inequalities as a result of any transformation plans) - to be reported through Financial Improvement Programme Board, known as 'the Recovery Plan' by Mar 25 aligned to the SIIP delivery action timescale - IB. Update provided in MTFP paper Feb 25. Action 3) Refresh the medium and long-term financial plan for latest financial projections and HTP by Mar 25. (Including developing the 25/26 operational plan inclusive of efficiency plans (quality and inequality impact assessments will be carried out to confirm the impact to equality of population health outcomes and on health inequalities as a result of any efficiency plans). [Links to SBAF entry 2b] - ASz. Target completion date Mar 25 on track.	**Possible 3 x Major 4 = High 12**	TBC one the trajectory has been agreed for the MTFP	Claire Skidmore	Angela Szabo	Finance Committee	18/02/2025 Angela Szabo	27/10/23 Laura Clare 17/01/2024 Laura Clare 22/04/2024 Angela Szabo 23/07/2024 Angela Szabo 21/10/2024 Angela Szabo 20/11/2024 Angela Szabo - No Change 27/12/2024 Angela Szabo 18/02/2025 Angela Szabo	Alignment of risk scores across the system,system integrated improvement plan in place. No change to risk score and risk score trend changed to same 20/11/24 - Angela Szabo
24	1, 2, 3	Stuart Allen, Senior EPRR Lead	Emergency Preparedness, Resilience and Response (EPRR) If the ICB does not have plans in place to respond to emergencies, incidents, or disruptive events (e.g. adverse weather, cyber-attack, utilities failure, transport accidents, malicious attacks, industrial action, etc) impacting on the ICB and/or local healthcare system, the ICB will not meet its statutory obligations and therefore fail in the duties placed on the organisation under the Civil Contingencies Act 2004 (CCA), NHS EPRR Framework, NHS Act 2006, Health and Care Act 2022, and the NHS Standard Contract.	Opportunity to work collaboratively across the STW ICS and the West Mercia LHRP footprint in our approach to Emergency Preparedness, Resilience and Response (EPRR), and with West Mercia Local Resilience Forum (LRF) partners.	•ICB EPRR Programme Group (with oversight of EPRR related risk register). •ICB EPRR work programme. •ICB EPRR Training and Exercise Programme. •Reporting to ICB Audit Committee and Board. •Civil Contingencies Act 2004 (CCA), National NHS EPRR Framework, NHS Act 2006, Health and Care Act 2022, and the NHS Standard Contract. •West Mercia Local Health Resilience Partnership (LHRP) with oversight of EPRR and health related risk register. •West Mercia Health Emergency Preparedness Operational Group (HEPOG) reporting to LHRP. •LHRP and HEPOG work programme. •Risks and risk registers linked to National Risk Register (NRR) and LRF Community Risk Register (CRR).	•Review of risk registers as a standing agenda item at every meeting for ICB EPRR Programme Group, LHRP, HEPOG. •Annual assurance of NHS Core Standards for EPRR. •Regular review of progress of work programmes at every meeting for ICB EPRR Programme Group, LHRP, HEPOG. •ICB exercising schedule. •Systemwide exercising schedule. •ICB holds monthly meetings with EPRR leads for each organisation.	Gaps in controls: •Very limited ICB EPRR resource. •Lack of documented Standard Operating Procedures (SOPs) for the System Coordination Centre (SCC). Gaps in assurance: •Rated non-compliant with NHS Core Standards for EPRR. •Recent combining of STW LHRP & HEPOG and Herefordshire & Worcestershire LHRP & HEPOG to form the West Mercia LHRP and HEPOG. •The ICB does not currently have a permanently employed EPRR Practitioner in post; role is currently provided by an Interim on a fixed term contract to end September 2024.	Consequence: 4 (Major) x Likelihood: 5 (Almost Certain) = 20 EXTREME RISK		1.Continue with newly established ICB EPRR Programme Group to provide strategic level oversight of EPRR function and compliance with NHS Core Standards for EPRR. 2.Recently reviewed and updated key EPRR policy and plans; consulted with NHSE, Providers, and reviewed as part of annual assurance of NHS Core Standards for EPRR. 3.ICB EPRR work programme has actions to further develop existing policy and plans and introduce new documentation to improve compliance with NHS Core Standards for EPRR. 4.ICB EPRR work programme has actions to produce system level EPRR policies, frameworks and plans for organisations to align own policies and plans. 5.ICB to continue with monthly meetings with EPRR leads for each organisation. 6.STW ICB EPRR lead to work closely with H&W ICB lead to drive the LHRP and HEPOG work programme ensuring links to system/locality risks, issues, and challenges. 7.Continue with ICB and systemwide exercising schedule. 8.Accountable Emergency Officer (AEO) to review EPRR resourcing to ensure it is adequate for the size, type, and services of the ICB and duties placed on the organisation under the CCA, NHS EPRR Framework, NHS Act 2006, Health and Care Act 2022, and the NHS Standard Contract. 9.Accountable Emergency Officer (AEO) to undertake recruitment campaign for a permanent EPRR Practitioner; and extend current Interim to cover recruitment and onboarding/handover period.	Consequence: 3 (Moderate) x Likelihood: 3 (Possible) = 9 MODERATE RISK		Ian Bett, Interim Executive Director – Director of Delivery and Transformation / Accountable Emergency Officer (AEO) (NHS STW ICB)	Ian Bett, Interim Executive Director – Director of Delivery and Transformation / Accountable Emergency Officer (AEO) (NHS STW ICB)	ICB EPRR Programme Group – Audit Committee – Board.	07/01/2025 - Gareth Wright, Head of Clinical Ops / EPRR	13/09/2024 – Stuart Allen, Senior EPRR Lead (NHS STW ICB) (Approved by Ian Bett 17/09/2024).	
28	1,2,3	Gemma Smith	Provider Accrediation - Independent Sector. There are existing national statutory duties around Patient Choice set down by the DoHSC, with a growing emphasis on patient choice, empowering patients and expanding the range of options available to patients, which all forms part of enabling elective recovery through accessing additional capacity. In parallel there is a growing need for greater provider accreditation and listing of additional providers, which all presents a complex and changing financial and sustainability landscape for the ICB.	Reduction of waiting times, improved choice and access.	At present, the legal guidance in relation to choice provides significant challenge in being able to put controls in place as providers can be accedited should they be able to meet the ICB service specification. Where they are also commissioned and hold an NHS contract via another ICB, they can also acept referrals for consultant led services from any ICB in the country. Legal advice has been sought.	West Midlands discussion in relation to collective management. Escaltion of the issue to SLT. Active discussions with NHSE in relation to the parameters of acceditation.	Gaps in controls 1) At present, the ICB does not have service specifications for each of the services that providers are requesting accrediation for. 2) Financial Risk due to additional providers and capacity entering the system which the ICB does not have additional funding for. 3) Chnages to ERF and any further changes within the Operational Planning Guidance. 4) No Accrediation policy in place. Gaps in Assurance 1) The issue is currently being managed via commissioning and contracting but require wider visability within the ICB via SLT and Strategic Commissioning Committee. 2) NHSE are not clear in terms of their guidance and offer varied advice. 3) Unknown impact on the acute sector due to movement of activity.	Possible 4 x Possible 4= 16 High		1) Service specifications for all elective pathways to be written and signed off by February's CWG. These will be all age and reflect all conditions which are currently commissioned via our acute contracts. This will ensure that high cost, low complexity procedures cannot be cherry picked by the independent sector. 2) Legal advice from Mills and Reeves to be finalised so that the ICB has a clear position in terms of accrediation and the Independent Sector. 3) Accrediation Policy and Process to be drafted and submitted to February's CWG for review and subsequent sign off via SCC. 4) Continue to work with the wider West Midlands ICB's in terms of a wider approach to managing this challenge. 5) Paper to be prepared in terms of the potential options for the ICB to consider in how to manage the risks associated with this challenge. 6) Full risk appraisal re the impact on SATH to be completed.	Possible 3 x Major 4 = High 12		Gemma Smith	Barrie Reis Seymour and Meryl Flaherty	SLT Strategic Commissioning Committee	Gemma Smith 8-1-2025	Gemma Smith 08/01/25	

Appendix B

RISK MANAGEMENT MATRIX

	Likelihood				
Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5 LOW	10 MODERATE	15 HIGH	20 EXTREME	25 EXTREME
4 Major	4 LOW	8 MODERATE	12 HIGH	16 HIGH	20 EXTREME
3 Moderate	3 VERY LOW	6 LOW	9 MODERATE	12 HIGH	15 HIGH
2 Minor	2 VERY LOW	4 LOW	6 LOW	8 MODERATE	10 MODERATE
1 Negligible	1 VERY LOW	2 VERY LOW	3 VERY LOW	4 LOW	5 LOW

	1 – 3	Very Low risk
	4 – 6	Low risk
	8 – 10	Moderate risk
	12 – 16	High risk
	20 – 25	Extreme risk

	Consequence score (severity levels) and examples of descriptions				
Domains	1. Negligible	2. Minor	3. Moderate	4.Major	5. Extreme
Impact on the safety of patients, staff or public (physical/psychological harm).	Minimal injury or illness, requiring no/minimal intervention or treatment. No time off work.	Minor injury or illness, requiring minor intervention. Requiring time off work for >3 days. Increase in length of hospital stay by 1-3 days.	Moderate injury requiring professional intervention. Requiring time off work. Increase in length of hospital stay by 4-15 days. RIDDOR/agency reportable incident. An event which impacts on a small number of patients.	Major injury leading to long-term incapacity/disability. Requiring time off work for >14 days. Increase in length of hospital stay by >15 days. Mismanagement of patient care with long-term effects.	Incident leading to death. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.
Quality/complaints/audit	Peripheral element of treatment or service suboptimal. Informal complain/injury.	Overall treatment or service suboptimal. Formal complaint. Local resolution. Single failure to meet standards. Minor implications for patient safety unresolved. Reduced performance rating if unresolved.	Treatment or service has significantly reduced effectiveness. Formal complaint. Local resolution (with potential to go to independent review). Repeated failure to meet internal standards. Major patient safety implications if findings are not acted on.	Non compliance with national standards with significant risk to patient if unresolved. Multiple complaints/independent review. Low performance rating. Critical report.	totally unacceptable level or quality of treatment/ services. Gross failure of patient safety if findings not acted upon. Inquest/ombudsman inquiry. Gross failure to meet national standards.
Human resources/organisational /development/staffing/ competence	Short term low staffing that temporary reduces services quality (1< day).	Low staffing level that reduces the services quality.	Late delivery of key objectives/service due to lack of staff. Unsafe staffing level or competence (>1 day). Low staff morale. Poor staff attendance for mandatory/key training.	Uncertain delivery of key objective/service due to lack of staff. Unsafe staffing level or competence (>5 days). Loss of key staff. Very low staff morale. No staff attending mandatory/key training.	Non-delivery of key objectives/service due to lack to staff. On-going unsafe staffing levels or competence. Loss of several key staff. No staff attending mandatory training /key training on an on-going basis.
Statutory duty/inspection	No or minimal impact or breach or guidance/statutory duty.	Breach of statutory legislation. Reduced performance rating if unresolved.	single breach in statutory duty. Challenging external recommendation/improvem ent notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low performance rating. Critical report.	Multiple breaches in statutory duty. Prosecution. Complete systems change required. Zero performance rating. Severity critical report.
Adverse publicity	Rumours. Potential for public concern.	Local media coverage. Short term reduction in public confidence. Elements of public expectation not being met.	Local media coverage - long-term reduction in public confidence.	National media coverage with >3 days service well below reasonable public expectation.	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions raised in the House). Total loss of public confidence.
Business objectives/projects	Insignificant cost increase/schedule slippage	<5 per cent over project budget. Schedule slippage.	5-10 per cent over project budget. Schedule slippage.	Non-compliance with national 10-25 per cent over project budget. Schedule slippage. Key objectives not met.	Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met.
Financial Risk in relation to CCGs	Insignificant cost increase	1-2% over plan/target	2-5% over plan/target	5-10% over plan/target	>10% over plan/target
	On assessing impact, consideration will also be given to other key financial objectives including but not limited to cash management and receivables/payables control				
Service/business interruption/environmental impact	Loss/interruption of >1 hour. Minimal or no impact on the environment.	Loss/interruption of >8 hours. Minor impact on environment.	Loss/interruption of >1 day. Moderate impact on environment.	Loss/interruption of >1 week. Major impact on environment.	Permanent loss of service or facility. Catastrophic impact on environment.

Agenda Item

ICB 26-03.135

Refreshed Joint Forward Plan

Appendix A. 25-30 Joint Forward plan

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Shropshire, Telford & Wrekin

Joint Forward Plan

2025-2030

Date: 4th March 2025
Owner: Emma Pyrah

Version	Editor	Status of document	Date
1.0	E Pyrah	First review and amends for refresh	17.1.25
2.0	E Pyrah/C Parker	Revised format and amends following joint Review	25.1.25
3.0	E Pyrah	Narrative updated by lead officers and Amendments to improve digital accessibility Submission to Strategic Commissioning Cttee	6.3.25
4.0	E Pyrah	Amendment following feedback from SLT	17.3.25

Executive summary

The Shropshire, Telford and Wrekin (STW) Integrated Care System (ICS) has developed this Joint Forward Plan to outline how our health and care system will work together to deliver the priorities we have jointly agreed over the next five years.

This plan has been developed through a collaborative approach with all system partners and wider stakeholders in this diagram (right) and is based on engagement with our local communities. It is not set in stone, and we will continue to engage with our communities beyond the publication of the plan.

Since March 2020, when the COVID-19 pandemic was declared, our health and care system has been through some of the most challenging few years in its history. The pandemic changed the way we worked, lived and how our health and care was delivered. As a system, as partners and as individuals, we learned a lot about working together and the importance of community and wellbeing. However, the pandemic has also exacerbated our challenges and the demand for services.

For example, we are seeing unprecedented demand for mental health and wellbeing services, particularly for our children and young people (CYP). The backlog of planned operations and medical interventions has grown, and we have experienced challenges in delivering several constitutional standards. Our whole system also faces significant challenges in recruitment and workforce shortages, particularly in relation to restoring elective inpatient and cancer activity.

In July 2021, our system was formally placed in the national Recovery Support Programme (RSP) due to serious, complex, and critical quality and finance concerns that required intensive support.

Our system is currently spending more than its allocated finances and, therefore, our plan is set in the context of a financial recovery trajectory. Rather than spending more, we need to allocate resources based on creating health value – implementing innovative financial flows and payment mechanisms and considering allocation of resources to provider collaboratives and 'Places'. We need to think and work differently to meet these challenges, including working more closely together.

The three key elements of our plan are:

1. ***Taking a person-centred approach (including proactive prevention, self-help, and population health to tackle health inequalities and wider inequalities).***

We are committed to working with service users, carers, and partners to support our citizens to live healthy, happy, and fulfilled lives. This will mean supporting people to proactively look after their own health, putting a greater emphasis on preventing illness and staying well, but also providing the right care when and where they need it. Chapter 2 talks about person-centred care, what it is and how we will deliver it.

2. ***Improving place-based delivery, having integrated multi-professional teams providing a joined-up approach in neighbourhoods, supporting our citizens and providing care closer to home, where possible.***

The STW Local Care Transformation Programme (LCTP) brings together a collection of transformation initiatives that will deliver more joined-up and proactive care closer to home, supporting improved health and wellbeing for our population. This is encompassed by the local care vision of “adding years to life and life to years”. Details of the LCTP are set out in Chapter 3 of this plan.

3. ***Providing additional and specialist hospital services through our Hospital Transformation Programme (HTP).***

The HTP is putting in place the core components of the acute service reconfiguration, agreed as part of the Future Fit consultation. It is helping us to address our most pressing clinical challenges and establish solid and sustainable foundations upon which to make further improvements. Details of the HTP are set out in Chapter 4 of this plan.

In conclusion, this plan highlights the work that we are undertaking across the ICS to improve the care we provide for the citizens of Shropshire, Telford and Wrekin. We understand that this is an ambitious plan which faces significant challenges. But while there is much work to be done, we believe that it is achievable. We must deliver our plan to improve the health and care services for our population through the strong commitment of our partner organisations and by talking to and working with our communities.

Integrated Care System
Shropshire, Telford and Wrekin

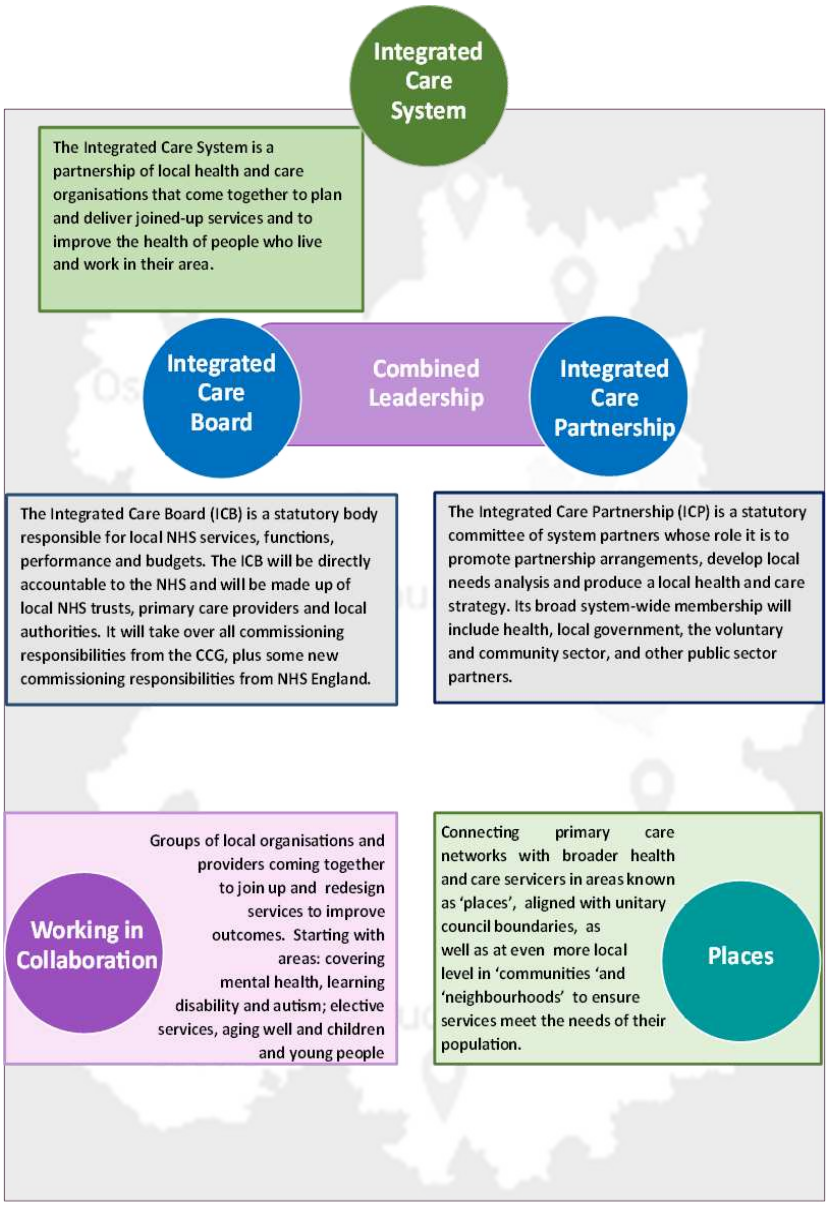
NHS
Shropshire, Telford and Wrekin

Chapter 1:

Our Integrated Care System (ICS)

1.1 Background

Our Joint Forward Plan has been developed through a collaborative approach with all system partners and wider stakeholders, including our Health and Wellbeing Boards. We will be held to account for its delivery by our population, patients and their carers or representatives and, in particular, through the Integrated Care Partnership (ICP), Healthwatch and the local authorities' Joint Health Overview and Scrutiny Committees.



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. We have been working with our two Healthwatch organisations to hear what our residents are telling us.

Residents have asked for "a person-centred approach to our care". People must be at the heart of everything we do and by delivering joined-up services in both acute and community settings, we can give everyone the best start in life, create healthier communities and help people age well.

1.2 Our population

Our approach to population health management and business intelligence, and our understanding of our population and their needs, will ensure that as a system, we are working on the right priorities. Furthermore, it will then provide the in-depth analysis to support commissioners in facilitating work with providers, community assets and our population to find solutions to our 'wicked[1]' issues.

[1] Wicked issues – A problem that is difficult or impossible to solve because of its complex nature

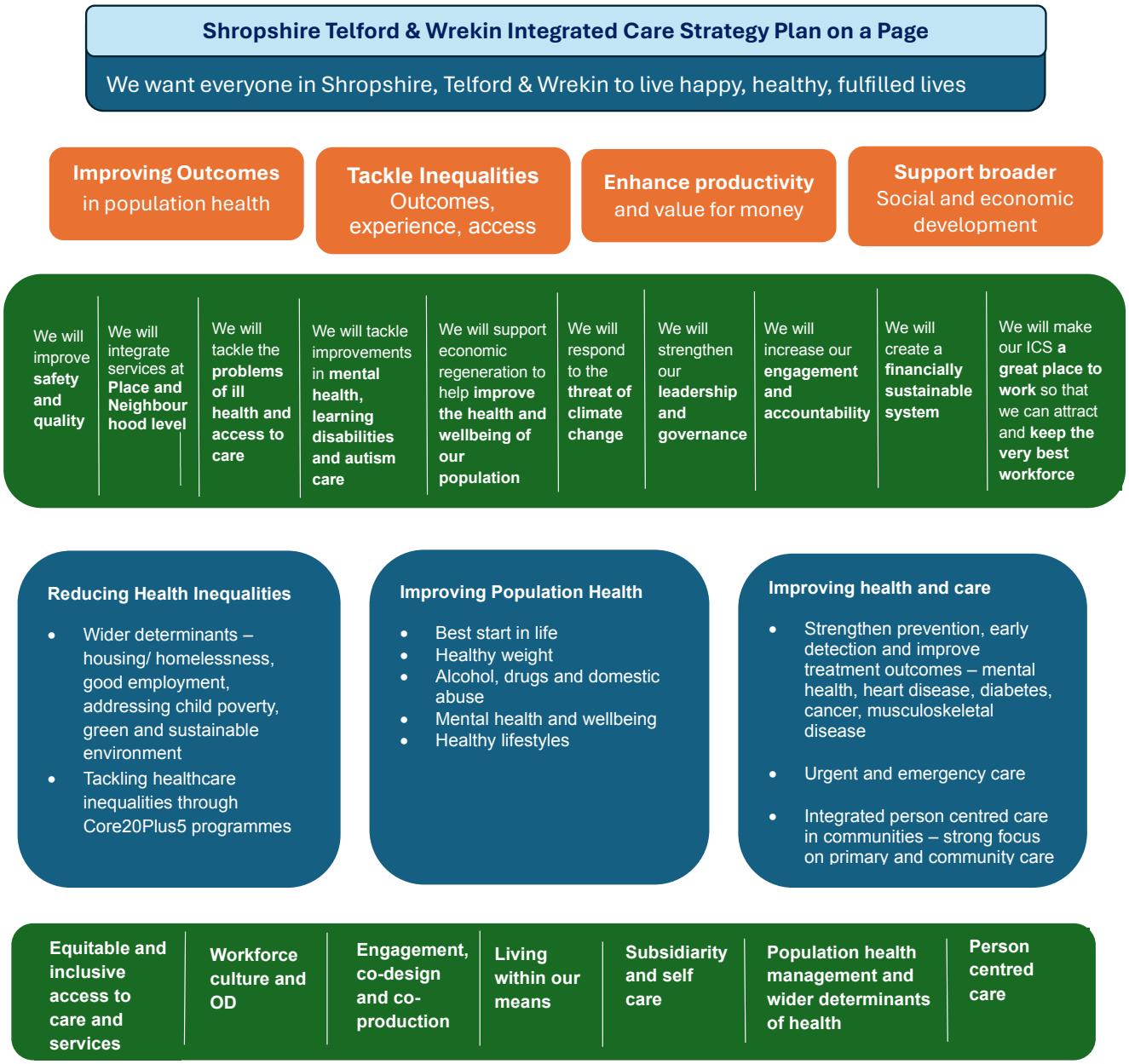
Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Our councils provide the Joint Strategic Needs Assessments (JSNAs) for our populations and communities. These inform the Health and Wellbeing Strategies for each of our Places and, subsequently, our interim Integrated Care Strategy, was approved in March 2023 by the Integrated Care Partnership with the final version approved in October 2024.

1.3 What we want to achieve

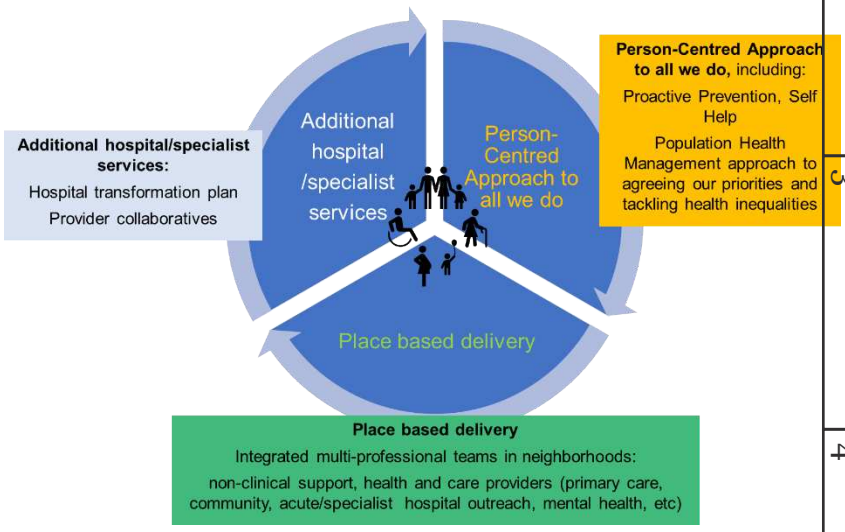
Within the context described above, our ICS vision, pledges and strategic priorities are summarised in the diagram below:



1.4 How we will deliver these priorities

There are three key components of our plan which will help us achieve our priorities and our model of care. These are shown in the diagram on the right.

Our two Places will play a major role in delivery of our priorities. The table below shows how the ICS priorities align with our Place priorities.



1.5 Our operating model

Although we are a challenged system, we are an ambitious one. Our operating model outlines how we plan to deliver our statutory duties and our ambitious plans. The operating model has our purpose at its foundation:

NHS Shropshire, Telford & Wrekin Integrated Care Board			
Our goal as an organisation is to lead and support delivery of the four Integrated Care System (ICS) aims across Shropshire, Telford & Wrekin:			
Improving outcomes in population health and healthcare	Tackling inequalities in outcomes, experience and access	Enhancing productivity and value for money	Helping the NHS to support broader social and economic development
Our purpose reflects our roles through the lenses of Strategic Commissioner, System Convenor, System Oversight and as a System Partner:			
Strategic Commissioner – • commissioning of health and care services to reduce the health inequalities that exist. • leading engagement with local communities and all our staff to shape how services are developed.	**System Convenor –** • leading on the development of system-level strategies and plans to transform health and care services across our system. • focussing on effective joint working arrangements with all partners.	**System Assurance –** • providing the first line of oversight of health providers across our ICS. • adding value and focus on improving the experience of local people.	**System Partner -** • playing an influential role in the development of strategic solutions that are implemented with partners. • focussing on reducing duplication and improving collaboration. • playing an active role as a local employer to support the local economy

In combination with our purpose and goals – our values, behaviours and leadership approach shape the design principles for our ICB teams and functions, our relationships within and beyond our organisation and how we design our processes. This includes how we commission and how we support our providers of care to collaborate.

We undertake our unique role in the Shropshire, Telford and Wrekin health and care system with compassion, respect, drive and integrity. This means that we value diverse contributions, drawing on the expertise and experience of local people, staff and partners, alongside high-

quality intelligence to make choices which best serve the people of Shropshire, Telford and Wrekin. You can expect to see and experience:

These values form one of the pillars of our recruitment and retention processes and shape our behaviours.

We have worked with our staff to develop design principles which underpin how we design our functions to deliver our purpose:

- **Outcome focussed –** design for our 4 purposes and unique role in the ICS
- **Positive future mindset** – Design for how we want to work in the future
- **Affordable** – Clear roles and functions, aligned to the commissioning cycle to ensure clear relationships and contributions within and beyond the ICB
- **Collaborative** – Do once what can be done once for all (ICB or ICS, or prepare for that in the future) Support colleagues to be intelligent consumers of specialism and design to service our colleagues and partners
- **Challenge assumptions** – Find new ways of working, support others to hold their responsibilities
- **Compliant** – Fulfil our statutory obligations
- **Enabling** – Design for: expertise and freedom to act; efficiency; the ability to flex and change, developing talent; and transition through pain points supported by governance which supports us and keeps us safe

These design principles, along with our values, behaviours and leadership models, form the principles of how we design our operating processes:

- Strategy will be grounded in population health management approaches, with equitable targeting to reduce inequalities, and measurable outcomes, clearly laid out contributions to its implementation, draw on experience and insight from across the ICS and align resources to clinical priorities
- Our relationships within the ICS will be grounded in mutual support and our shared success will make Shropshire, Telford and Wrekin a great place to work
- We will place our people in roles that they have the skills and experience for, create clear career pathways and ensure that every member of the team understands how they can make decisions and contribute to the delivery of our purpose

- We will set out clear accountability and ensure collective responses to any challenges we face
- Our record keeping will ensure transparency in our decision-making process and how we prioritise.

1.6 Our approach to working together

In 2024, working with the Good Governance Institute, the ICB developed a governance improvement programme. The aim of the programme was to develop a simplified corporate divisional structure for the ICB with fewer, more efficient meetings that strengthen assurance, management of processes and board oversight.

A core principle of these proposals is to recognise the distinctive role of the board and management. In particular:

- The ICB board sets the strategy and receives assurance
- ICB committees provide and receive assurance on risks to the ICB strategy and support continuous improvement
- ICB executives develop and implement plans and actions.

ICB Board

The board of our ICB is a unitary board at the centre of the ICB governance framework. It is accountable for the performance and assurance of the NHS and the wider Integrated Care System (ICS) within Shropshire, Telford and Wrekin in both operational delivery and to ensure progress towards its four aims. To discharge this, the board also sets the strategy for the NHS within the ICS and supports the delivery of the Integrated Care Partnership (ICP) Strategy.

The board provides leadership for the transformation of the NHS in Shropshire, Telford and Wrekin, and oversees the activities carried out by the ICB, in Place and in the ICP, ensuring good corporate, financial, clinical and quality governance throughout the ICS. The board convenes committees within the ICB or across the ICS to assure these activities.

All members of the board are jointly and equally responsible for the decisions and actions of the board and, whilst drawing on their experience in undertaking their ICB role, do not represent the particular interest of any organisation, community or group.

Our non-executive directors provide leadership of the key assurance functions of the board including chairing the committees of the ICB. Our partner members lead ICS delivery portfolios.

Our Places

Telford and Wrekin Integrated Place Partnership (TWIPP) and Shropshire Integrated Place Partnership (ShIPP) are our system's two Place-based partnership boards. They are based on the well-established relationships across the NHS and with our local authority and community and voluntary sector partners. Our Joint Forward Plan describes the actions and ambitions to deliver the Place-based strategies over the coming five years.

Both Places have strategies that are based on delivery of their respective Health and Wellbeing Board strategies and the Integrated Care Strategy (a joint strategy originally developed in March 2023 and subsequently refreshed in and signed off by the ICP in October 2024).

Our Place delivery model recognises that neighbourhoods are key to having thriving communities that support people to keep well, prevent ill health, and manage long-term conditions closer to their homes, schools, or primary care.

Our Provider Collaborative

Collaboration between providers forms a cornerstone of the ICS's approach to delivering better outcomes for our population. The ICB will continue to support the development of formal collaboratives between provider organisations with which it can commission a range of joined up services.

As the Provider Collaborative landscape develops a key step will be the inclusion of a wider set of partners in formal collaborative arrangements to ensure we are embracing collaboration and the opportunities this presents, in its widest sense.

1.9 Our approach to Commissioning

Delivering the NHS Commissioning Cycle

The ICB works to deliver its four purposes through the three phases of the commissioning cycle:

- Strategic planning – co-assessment of ICS needs, planning of services, engagement with stakeholders
- Procuring services – service specification development, provider selection, engagement with stakeholders, contract development
- Monitoring and evaluation – contract compliance, oversight of delivery, feedback from stakeholders.

In combination, this enables our ICS to respond and transform delivery. The ICB will not undertake every part of each phase of the commissioning cycle, but it will hold the responsibility for ensuring that all activities happen. The fundamentals of commissioning (in its fullest sense) remain crucial in structuring health services. However, how we commission is being transformed. The introduction of the provider selection regime requires a new function within the ICB that can collaborate with partners in a different way. We will use the commissioning cycle to align the efforts and contributions of each function in the ICB to achieve our commissioning objectives.

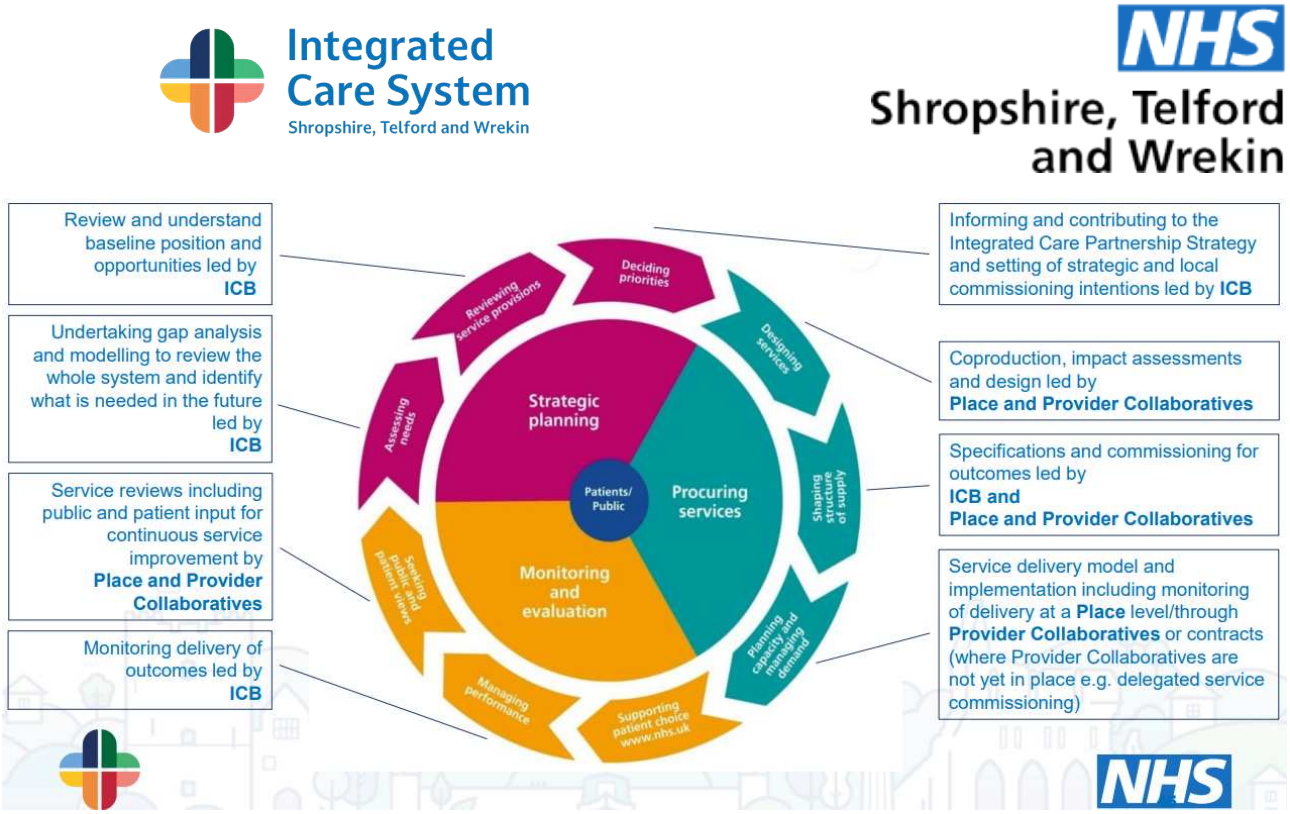


FIGURE 1: HOW WE WILL WORK TOGETHER TO DELIVER OUTCOMES

Our approach to Commissioning Intentions

Commissioning intentions describe how the organisation intends to shape local services to meet the needs of the population.

As well as ensuring we continue to meet our historic mandatory requirements for commissioning intentions and contract negotiations, the ICB has begun considering how it will evolve to focus upon outcomes.

As the ICB's attention and focus is shifting to the role of becoming the Strategic Commissioner within the ICS, with the ambition of starting to delegate tactical commissioning and transformation to Place and Provider Collaboratives as our key delivery vehicles over a period of time, a new approach to the development of Commissioning Intentions is required.

The approach will form a key element of the Planning process and our Commissioning Intentions will be co-produced working with all health and care partners across the system focusing on a number of high level priorities already agreed through the Joint Forward Plan and Clinical Strategy underpinned by the Joint Strategic Needs Assessments across Shropshire, Telford and Wrekin turning actions into deliverable outcomes that can be quantified from an activity and finance perspective and also deliver demonstrable patient/pathway improvements. These intentions may also span a number of financial years.

In addition, the Commissioning Intentions will also provide the framework to facilitate the ICB to lead, develop and embed an outcome-based commissioning approach which is a data driven and evidence based reflecting the needs of the population and providing strategic direction without specifying ways of delivering services.

This approach will also support the development of a robust, integrated commissioning framework delivering the ICB's statutory duty with a focus on the alignment of commissioning priorities, strategic market development, delivery of outcomes and maximisation of financial

resources including the joint commissioning of services through pooled or aligned budget arrangements.

The golden threads that run throughout the development of the Commissioning Intentions are as follows:

- System Strategies – the Commissioning Intentions take the relevant strategies and aim to develop a high-level set of deliverables and measurable outcomes against each of the areas
- The system overarching Integrated Strategy (IS) - The four aims of the IS run through the Intentions with clear links to how the successful delivery will contribute to one or more of the following:
    - Financial Improvement and the Medium Term Financial Plan
    - Operational Planning Rounds submissions
    - Darzi review and high level ambitions of the upcoming 10 year plan's 3 shifts i.e. hospital to community, illness to prevention, analogue to digital.

Our Commissioning Intention principles

- Wherever possible we will do things only once but with flexibility
- Reducing inequalities by tackling the wider determinants of health and inequity in access, experience and outcomes, including poverty and rural exclusion
- Drive efficiency and productivity, delivering best value, effective use of resources
- Committed to working with people with lived experience and coproduction
- Decision making will be devolved to the most appropriate place
- Risk with be shared – clinical, financial and operation
- Be ambitious in our approach, recognising the challenges we have alongside the breadth of opportunities
- Fully embed evidence based shared decision making and contracting for outcomes
- Commissioning for outcomes; giving freedom for design and coproduction across sectors

Our approach to integration and joint commissioning

Joint commissioning refers to arrangements in which public bodies look to undertake the planning and implementation of services collaboratively. This could be for a whole population or in relation to people with particular needs (such as those with a complex disability). We believe that commissioning collaboratively as a system enables benefits for everyone, including improved outcomes and experiences for people, reduced duplication, best use of resources and improved access to services.

We will use joint commissioning to deliver integrated services.

Integration focuses on the strengths of people and communities as a cornerstone of how we will work. As described in our model of care – people, communities and public services work together to support people to build the foundations for a healthy and fulfilling life.

The diagram on the right demonstrates this people and community-centred approach that is echoed throughout this plan and the ICS's work.

Specifically, we will work together to design and invest in pathways which are person-centred and hold organisations jointly accountable for the overall experience of individuals and families. We will also engage people with lived experience, communities, and professionals in setting the overall priorities for an area and designing pathways that reflect local needs and opportunities. We will develop performance management frameworks which consider not only quality of individual services, but also the extent to which people experience integrated, high-quality care. We will use the financial and workforce resources available across our organisations to support local populations in the most effective means possible. The Better Care Fund (BCF) enables this joint working and focuses on local priorities at place-based level.

1.10 Our approach to taking specialist and clinical advice

We strongly believe that our Clinical and Care Professional leaders should be at the centre of our system planning and decision-making. We start from a strong foundation, with dedicated ICB Clinical Leads for each of our system portfolios who are responsible for convening and chairing multi-disciplinary and multi-organisational Clinical Advisory Groups (CAGs) which provide clinical/specialist advice into each programme of work. Individuals from within these groups lead work on clinical pathways and transformation, using the CAG to engage, inform, check and challenge.

The CAGs feed into four specialist delivery groups that support the ICS. These are:

- Mental Health and Learning Disabilities and Autism Delivery Group
- Children and Young People, SEND and Families Delivery Group
- Urgent and Emergency Care Delivery Group
- Planned Care Delivery Group.

We also have a well established Local Maternity and Neonatal System which is clinically-led and involves a range of multi-disciplinary clinicians from a variety of organisations, and focuses on transformation, quality, governance and assurance.

Our Clinical Cabinet brings together our Clinical and Care Professional leaders for strategic discussion, and our Health and Care Senate, acts as a wider forum for clinicians to share learning, information, and challenges across our system.

We have also developed a collaborative peer learning network for Maternity and Neonatal Care with Staffordshire & Stoke-on-Trent ICB and system partners, in order for us to maximise our ability to take clinical and specialist advice from outside our own system. We plan to utilise a similar model of cross system collaborative learning across other clinical priorities.

We will continue to build on this solid foundation to ensure that clinical and/or specialist advice is embedded throughout all levels of the ICS, through visible multi-professional leadership and strong professional networks, supported by clear governance structures.

Specialist advice is also supported by NHS England through the clinical and specialist networks.

1.11 Our approach to quality

As a system, we commit to using all available resources, including Right Care Opportunities, to deliver improved quality by removing unwarranted variation and improving outcomes at a population health level.

It is our ambition to create outstanding quality by:

- Committing to patient-centred, personalised care where patients have ownership of their own care, but also routinely inform development and delivery of future services based on the learning of their lived experiences
- Strengthening integrated multi-disciplinary working across our organisations to ensure our population receives care in the right place at the right time
- Streamlining care with robust pathways to ensure sufficient capacity for planned care, designed to improve patient experience and outcomes
- Making sure people can navigate a simplified urgent care system to meet both physical and mental health needs
- Supporting our health and care providers to achieve improved CQC ratings where appropriate.

Key areas where we need to improve quality of services:

- **Children and young people's (CYP) services**
  - We want to strengthen the multi-agency approach to the prevention of poor mental health and improve access when services are needed
  - We want to ensure children's acute services are safe and effective, and waiting lists are tackled in line with adult services
- **Urgent and emergency care (UEC)**
  - We want to improve timely access to urgent and emergency care
- **Diabetes care**
  - We want to focus on prevention of diabetes and ensuring healthy lives for people with diabetes
- **Maternity care**

- We want to continuously improve our maternity services and sustain improvements made in response to the Ockenden reports.

As a system, we will fully prepare for the CQC framework to monitor the quality of services for integrated care systems.

Our plans to continuously improve the quality of our services are outlined below:

How will we monitor quality?

- Listening to those with experience of care
- System quality risk register
- System risk escalation
- System quality metrics at Place
- System Quality Group with clear terms of reference and feed to Regional Quality Group
- The Quality and Performance Committee seeking assurance against the risks with the partnership of key agencies across the ICS, in line with national guidance
- Learning from deaths, child death overview panel (CDOP), infant mortality and people with a learning disability and autistic people (LeDeR)
- The co-ordinated introduction of a Patient Safety Incident Response Framework (PSIRF) and learning from incidents as a system and beyond, driven by patient safety specialists and patient safety partners
- Receiving and discussing quality exception reports monthly at ICB Board

How will we measure and sustain quality?

- Executive champions of quality health and social care coming together at System Quality Group to drive quality services forward across the ICS and beyond
- Contracts and local quality requirements
- Clearly defined system quality metrics
- Themed quality visits
- Partnering with Healthwatch and the voluntary sector
- Co-production with those who experience care
- Feedback from our residents
- Quality accounts

How will we improve quality?

- Integration of quality improvement expertise into system priority programmes
- Research and innovation
- Rapid learning from incidents and themes across partners
- Finding out what works through quality improvement projects with partners across the ICS
- Focus on personalised palliative and end-of-life care

- Aging well though the support of care homes and domiciliary care to deliver the highest possible care they can
- A focus on early years
- Ensuring quality care is accessible to all though strategic integration of quality and Core20PLUS5.

1.12 Our approach to engagement with communities

In line with our values, we have built our Joint Forward Plan through a process of genuine engagement with our local communities, stakeholders, and our staff.

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' voices at Place and system levels. We have engaged with groups who are seldom heard and those who have the greatest health inequalities, in relation to access to services and health outcomes, to ensure they are not excluded from the dialogue.

We have developed a set of principles for involvement which have been shaped with input from people across our health and care system and communities. They have been informed by the knowledge and experience of a diverse range of people, including those with lived experience of using our services and those for whom involvement is already embedded into their working practices.

Read our full Involving People and Communities Strategy.

To support staff to plan and undertake the appropriate level of involvement of people and communities, we have established an Equality and Involvement Committee into our governance arrangements. The role of the Committee is to provide assurance to the Board that our strategies, plans, service designs and developments have adequately and appropriately:

- considered and addressed the health and care needs and aspirations of residents in Shropshire, Telford and Wrekin who do, or may, experience inequalities in access to health services and health outcomes,
- involved people who do, or may, use the services under consideration.

Read more about the role of the Committee and its membership.

In 2023, we launched the Big Health and Wellbeing Conversation asking people who live, work or access health and care services in Shropshire, Telford and Wrekin how the care they receive could be improved. The Big Health and Wellbeing Conversation aimed to understand local views on what is affecting their health and wellbeing and what could make the biggest difference to improve experiences of local health and care services. The feedback gathered is helping NHS Shropshire, Telford and Wrekin to develop future plans. We also continue to engage and listen to the views of people and communities through individual programmes of work to support the delivery of our Joint Forward Plan, for example the Children and Adolescent Mental Health Service, GP Out of Hours Service, and more broadly the Think Which Service Campaign and Change NHS.

The key recommendations from the Big Health and Wellbeing Conversation included the following:

- Improve communication with patients and between services.
- Improve access to appointments including increasing virtual appointments.
- Raise awareness of services to help people to live well.
- Support patients to minimise digital exclusion.
- Sharing learning from patient experience of poor-quality services.

1.13 Our approach to Climate and Green planning

Climate change presents an immediate and growing threat to health. The UK is already experiencing more frequent and severe floods and heatwaves, as well as worsening air pollution. Up to 38,000 deaths a year are associated with air pollution alone, disproportionately affecting the most deprived and further exacerbating health inequalities.

In October 2020, the NHS became the world's first health service to commit to reaching carbon net zero, in response to the profound and growing threat to health posed by climate change.

The "Delivering a Net Zero Health Service" report sets out a clear ambition and two evidence-based targets.

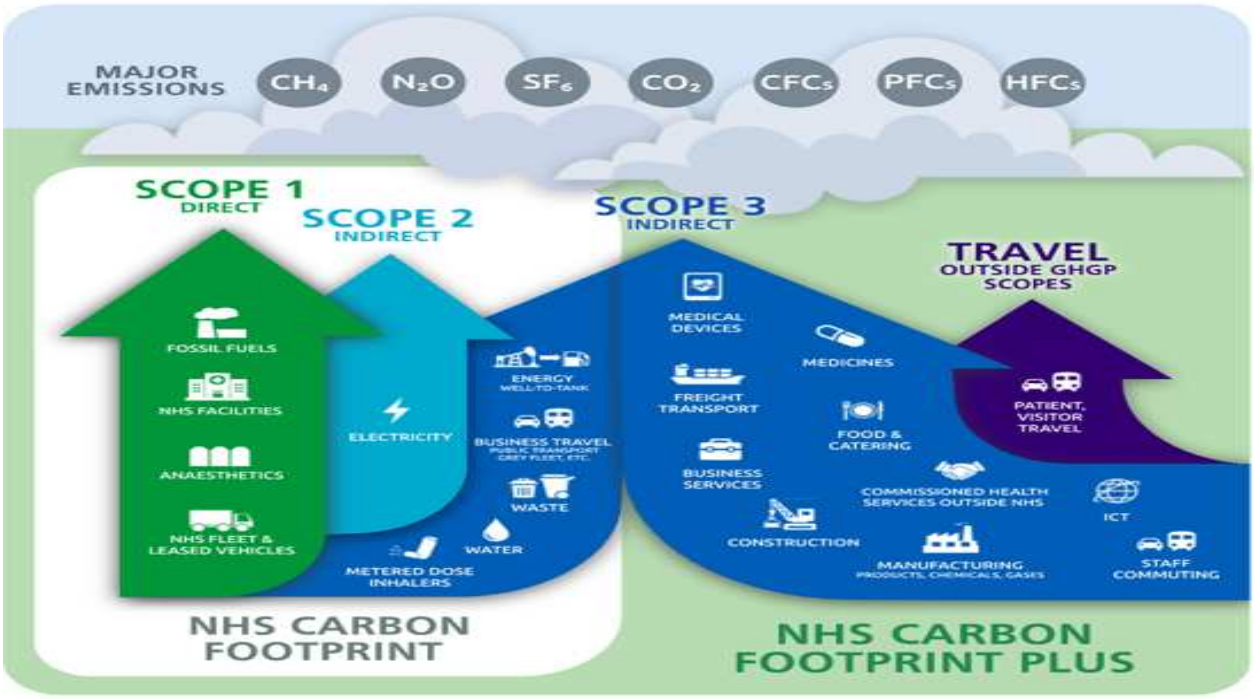
- For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032; These are the areas shown in scope 1 below.
- For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039. These are shown in the indirect scope 2 and 3 of the diagram.

Each Provider has a carbon reduction plan that looks to reduce carbon emissions in direct and indirect carbon emissions. This is achieved through implementing the delivery across key areas of focus detailed below

The system works collectively on achieving the net zero objectives across providers through a climate change group co-chaired by Shrewsbury and Telford Hospital (SaTH) and Robert Jones and Agnes Hunt (RJAH).

Examples of work to date has included

- Heat Decarbonisation Projects: Successful applications for funding and in the process of implementation at SaTH
- Installation of electric ambulance charging points at SaTH, and increased staff charging points installed in RJAH carpark
- Use of solar power and renewable energy sources/tariffs
- RJAH recognised as Exemplar status for catering – particularly for work around reduction of single use plastic in catering, recently winning Gold Award for Excellence in Waste Management (NHSE) for reusable food container projects
- Reduction emissions from nitrous oxide and mixed nitrous oxide waste through capped use and not including use in new estate builds at SaTH and RJAH
- Staff active travel schemes with Aviva and increase of use of Park and Ride
- Introduction of system wide fleet policy in 2024 re low emission and zero emission vehicles
- Greener Trainer hub at Midlands Partnership Foundation Trust
- Biodiversity schemes across a range of providers
- LED lighting at RJAH with plans for funding submitted across providers to national funding pots.
- Providers across system adopting and following the Total Roadmap for Greener Procurement
- Improvements made in reducing carbon emissions from inhalers, a significant contributor to the NHS carbon footprint. Key initiatives have included awareness campaigns among clinicians and patients to promote lower-emission alternatives, including dry powder inhalers (DPIs), where clinically appropriate.
- Collaborations with GP practices and pharmacy teams have focused on optimising prescriptions, with an emphasis on reducing unnecessary short-acting beta-agonist (SABA) inhaler use.



The Health and Care Act 2022 placed new duties on NHS organisations to consider statutory emissions targets in their decisions, making the NHS the first health system in the world to embed net zero in legislation. STW delivers these duties through considering the impact of climate change as part of the summary documentation in reports to key committees and Boards and in ensuring compliance with adherence to procurement regulations when awarding contracts for new services.

A Greener NHS Refresh Plan was published in February 2025 which re-emphasised the NHS's commitment to achieving NET zero in line with the Darzi Independent Review of the NHS:

> "Given the global health imperatives, the NHS must stick to its net zero ambitions. There is no trade-off between climate responsibilities and reducing waiting lists. Indeed, often health and climate are mutually reinforcing goals: cleaner air is good for the environment and good for respiratory health."

Independent investigation of the NHS in England, Lord Darzi, September 2024

The Greener NHS Refreshed Guidance (2025) retains the focus on delivery of Net Zero in the NHS through:

- supporting high-quality, preventative and low-carbon care, in line with the NHS's goal to boost out-of-hospital and digitally enabled care, improve prevention of ill health and reduce health inequalities
- reducing air pollution by decarbonising the NHS fleet, which is set to save the NHS over £59 million every year and deliver a range of health benefits valued at over £270 million.
- modernising and decarbonising the NHS estate, which is expected to reduce energy costs while creating a better environment for patient care
- minimising waste through circularity – where reusable, remanufactured or recycled solutions are used – which is often cost-saving and helps protect against external supply disruptions

In response, Shropshire, Telford and Wrekin ICB will produce a refreshed system Green Plan covering the next 3 years (2025-2028) for Board approval in July 2025. This system plan will reflect the contents of individual provider plans as well as new duties on the ICB to cover as a minimum the ICB's role in:

- providing system leadership on emissions reduction and engaging with wider system partners – for example, by working with local authorities on travel and transport initiatives
- supporting partner trusts to deliver their green plan objectives and overseeing progress, including through contract monitoring (NHS Standard Contract service conditions, section 18)
- supporting primary care providers to contribute to system-wide emissions reductions – for example, by working with and through overarching structures such as primary care networks and primary care committees

- sharing best practice across partner organisations, supporting collaboration and facilitating engagement with relevant research and innovation activities, such as through health innovation networks
- maximising opportunities to reduce emissions and improve population health when planning and commissioning NHS services
- ensuring that green plan priorities are aligned with and reflected in the ICB Joint forward plan, Integrated care system (ICS) infrastructure strategy and capital plans, and other relevant system-wide plans in line with the 4 core purposes of the ICS
- delivering a limited set of priority actions at system-level, as set out in areas of focus

1.14 Our approach to measuring what we have achieved

Shropshire Telford and Wrekin ICS has developed a system Accountability and Performance Framework (SAPF) during the later part of 24/25 which is to be implemented from April 25 and provides a governance structure across the system to ensure successful delivery of operational plans, national standards and effective reporting of improvement where recovery is required. It will be an integrated model that takes account of individual organisational accountability and performance governance but ensures delivery across the whole system. This framework is a key deliverable (4.2) for the System Integrated Improvement Plan agreed at the Integrated Care Board in November 24 and signed off by NHSE in December 24.

The SAPF sets out the systems and processes through which the system will support organisations/ teams and manage the delivery of our strategic and operational goals, as well as ensuring that the regulatory and statutory requirements that apply to the system and its Trusts are met (including those outlined in the NHS Constitution).

The SAPF drives the implementation of best practice performance assurance processes throughout the system, aligned to organisational and IC Board committees, ensuring that:

- **Accountability arrangements** are in place across the system and individual Trusts to drive the delivery of all agreed objectives, targets, and standards. Performance is seen as a continuous process which is embedded in all aspects of organisational activity.
- **Agreed performance objectives** and targets are Specific, Measurable, Agreed, Realistic and Time bound (SMART) and transparent measurements are set to monitor performance.
- **Timely information** is available to enable appropriate understanding, monitoring, and assessing of the System and individual Trust's quality and performance, prompting appropriate action to be taken if performance is forecast to fall below set objectives and targets at both organisation and system level as required.
- **All system partners** and their respective Committees **understand their roles and responsibilities** and are supported and motivated to deliver, with a clear line of sight between their contributions and the overall success of the Trust and wider system.
- **Action plans are developed** as soon as risks to the achievement of required targets or standards and/or barriers to effective performance are identified within individual trusts and then, if necessary, aggregated by the ICB where system performance is affected.

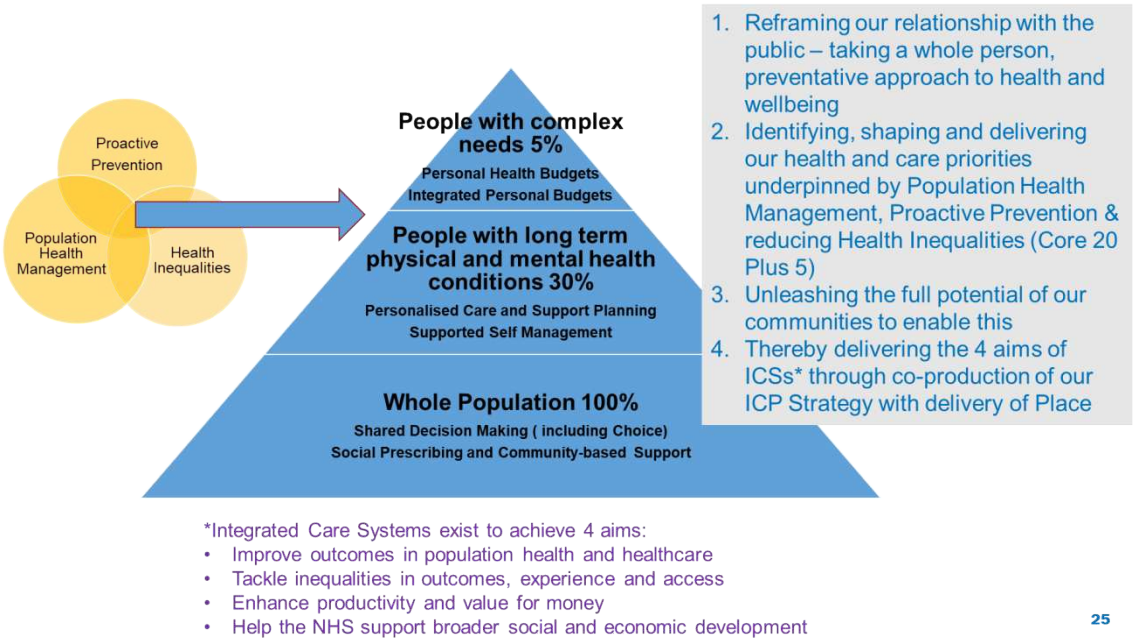
To deliver the SAPF a stepped approach to performance management is required which clearly specifies roles, accountabilities, and responsibilities. It is essential that key targets, programmes, projects, and actions are disaggregated throughout the System and within Trusts and hierarchy to ensure delivery of targets at every level and across the system/organisation as a whole; to understand what is expected of them and the part they play in the overall success of the system and Trust.

Chapter 2:

Delivering person-centred care

2.1 How we will implement a person-centred care approach

The diagram below summarises how we will implement our person-centred approach.



2.2 What we mean by a 'person-centred approach'

Person-centred care moves away from professionals deciding what is best for patients or service users, and places the person at the centre, as an expert in their own experience and lives. The person, and their family where appropriate, become an equal partner in the planning of their care and support, ensuring it meets their needs, goals, and outcomes.

With an emphasis on 'doing with' rather than 'doing to', person-centred care runs through both individual and group settings, allowing users of services to be active not only in their own care but also in the design and delivery of services. This approach can improve both the experience and quality of care.

Person-centred care relies on several aspects, including:

- People's values and putting people at the centre of their care, considering people's preferences and chosen needs
- Ensuring people are physically comfortable and safe
- Emotional support involving family and friends
- Making sure people have access to appropriate care that they need, when and where they need it
- Ensuring people get all the information they need, in a way that is accessible for them, to make decisions for their care and support.

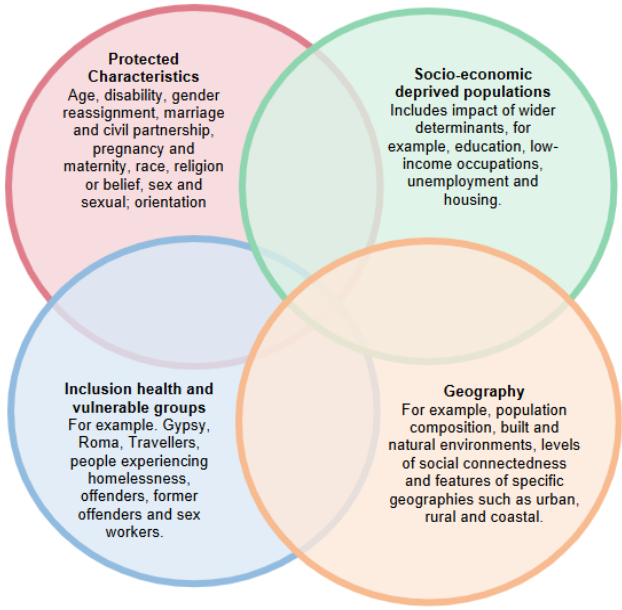
Person-centred care also recognises the strong and evidenced link between non-clinical, community support, and improvement in health and wellbeing.

We will facilitate a strengths-based approach in our communities to utilise non-clinical resources, recognising that the wider determinants of health affect 90% of our health and wellbeing, with health and care services impacting only 10%.

2.3 Our approach to tackling inequalities/duty to reduce health inequalities

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. Healthcare inequalities can arise from differences in access, experience and outcomes achieved from health care services. At a fundamental level this will result in a reduction in life expectancy and healthy life expectancy for those who experience health care inequalities.

Whilst the ICB recognises its duty to address access to, experiences of and outcomes related to directly provided health services, we also wish to recognise and work with partners to tackle the causes of the wider determinants of health inequalities, including preventable causes of ill health. These wider determinants can include discrimination of the basis of protected characteristics, socio economic factors as well as wider geographical impacts.



NHSE National Healthcare Inequalities Improvement Programme provides guidance to the ICB in relation to the evidence-based areas of targeted interventions that will make the most impact on reducing healthcare inequalities.

This approach is referred as the Core20PLUS5 approach, where Core 20 refers the population living in the m20% most deprived areas , PLUS refers to inclusion health groups and 5 to the clinical areas where evidence indicates worse health outcomes that can be addressed through system actions

To enable co-ordinated delivery across our system, a Prevention and Health Inequalities Group has been established which will monitor progress against our system high level implementation plan which addresses these mandated areas. To recognise partner working this Group is chaired by the Director for Public Health from Telford and Wrekin Local Authority with membership consisting of the ICB lead for health inequalities and SRO leads for health inequalities from across main provider organisations.

As part of the refresh of this JFP in February 2025, a review of the newly launched NHSE guidance documents that inform our healthcare inequalities focus as a system has been undertaken to assess areas for continued focus over the upcoming period.

2.4 Our approach to Population Health Management (PHM)

Population health management (PHM) is a person-centred, data-driven approach that seeks to improve the physical and mental health of people over their lifetime. PHM allows our system to use all the digitally-collated data, intelligence and insight from our area to make collective decisions and prioritise key issues and specific populations of people, depending on need and equity. It requires clinicians, professionals, and frontline workers to expand their focus from treatment and/or assessment to considering the whole person and their health risk.

System leaders, in conjunction with local stakeholders and the public, have set our ambitions and priorities for PHM over the next five years. We expect our priorities to evolve and respond to conversations with the public over the next five years. Our six population health priorities are:

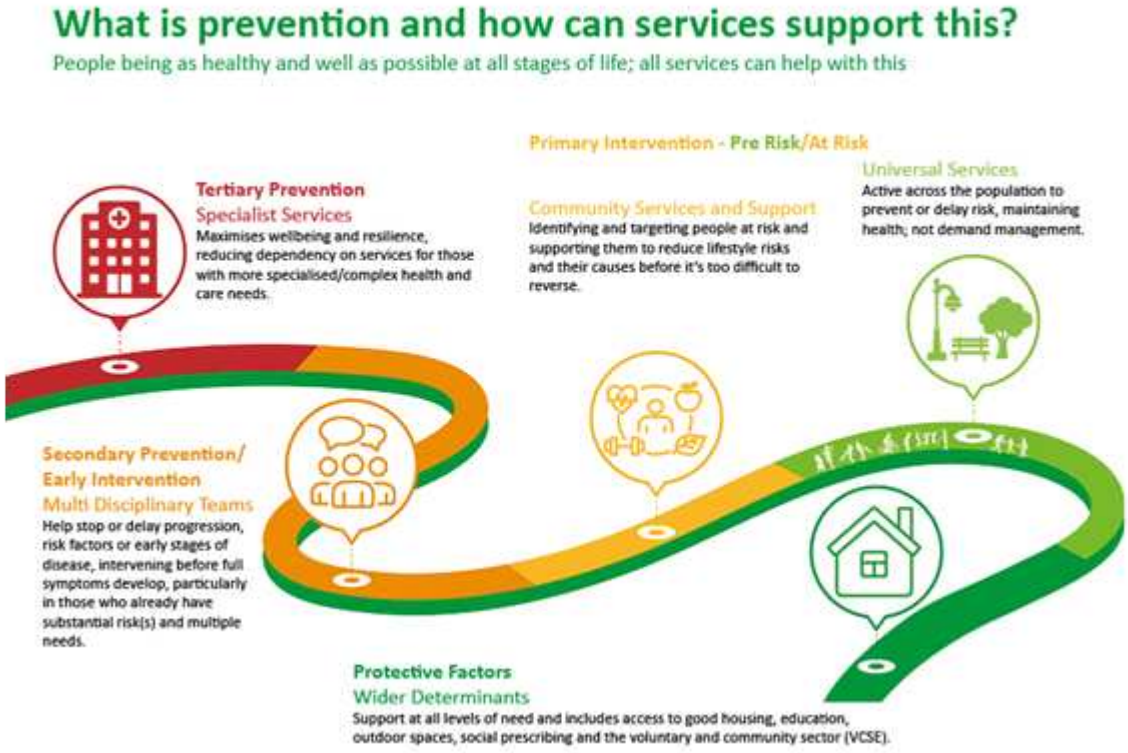
- Give every child the best start in life (including healthy pregnancy)
- Encourage healthier lifestyles with a priority focus on unhealthy weight and smoking
- Prevention, screening, early detection of preventable illness e.g. cancer and heart disease
- Improving peoples' mental wellbeing and mental health
- Dementia
- Reduce the impact of drugs, alcohol, domestic abuse on our communities

2.5 Our approach to Prevention

The Shropshire, Telford and Wrekin Integrated Care Partnership Strategy have confirmed its ambition and vision that a greater emphasis on prevention is crucial, to improve the quality of people's lives and the time they spend in good health. STW ICS recognised that not everyone has an equal chance of a happy, healthy long life and therefore we need to do more to improve health and wellbeing and tackle all inequalities.

In January 2024, the Shropshire Health and Wellbeing Board (HWBB) approved its prevention framework and action plan and in the October 2024, at its Integrated Care Partnership meeting, STW ICS agreed our ambition to focus on prevention, specifically to consider how the pathway reflects the prevention shift outlined in the national and local direction and strategy.

An agreement was reached to develop and clarify the STW system prevention priorities aligned to the "three shifts" which will underpin the NHS 10 Year Plan. During 2025 this work will be further developed into a systemwide framework, priorities, action plans for each Place and metrics to monitor delivery aligned to the ICP Strategy to demonstrate our ambition to shift from treatment to prevention. A draft framework is in development based on the ICP Strategy, HWBB frameworks and best practice.



2.6 Proactive preventative care

Proactive care is personalised and co-ordinated multi-professional support and interventions for people living with complex needs.

The specific aims of proactive care are to improve health outcomes and patient experience by:

1. delaying the onset of health deterioration where possible
2. maintaining independent living
3. reducing avoidable exacerbations of ill health, thereby reducing use of unplanned care.

Proactive care is not a new service or pathway, the focus is on using existing resources to support the defined group within local priorities. It is a model of care, delivered in the community, to a targeted cohort of patients with multiple long-term conditions who would benefit from integrated care to support management of their conditions. A successful model will result in reductions in the use of unplanned care, reductions in morbidity, addressing health inequalities, improved patient experience and supporting people to stay well for longer.

A pilot begun in 2024, in line with national guidance, in 2 Primary Care Networks. The learning from these pilots and other multi disciplinary team developments will be captured to inform an approach working in partnership with system providers, the voluntary and community sector, the public and patients, to embed a system-wide model that is flexible enough to meet the needs of the population for delivery at a local level.

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Chapter 3:

Place, neighbourhood health and collaboration

3.1 Our approach to Place and Neighbourhood health

Neighbourhood working is not new, it is something that has existed for many years both locally, regionally and nationally. There is no single or accepted blueprint for a Neighbourhood, but some definitions/descriptions include:

- An approach that strengthens and re-designs community services to meet local needs, to include better coordination and communication locally.
- An approach that supports teams and services to work in a more integrated way across health, local authorities, VCSE and the community.
- Level of locality or neighbourhood that tends to be between 30,000 - 50,000 people

In January 2025, NHSE published Neighbourhood Health Services guidance as part of its NHS Planning Guidance for 2025. This guidance recognises there is an urgent need to transform the health and care system and to move to a neighbourhood health service that will deliver more care at home or closer to home, improve people's access, experience and outcomes, and ensure the sustainability of health and social care delivery. More people are living with multiple and more complex problems and the absolute and relative proportion of our lives spent in ill-health has increased.

All parts of the health and care system – primary care, social care, community health, mental health, acute, and wider system partners – will need to work closely together to support people's needs more systematically, building on existing cross-team working, such as primary care networks, provider collaboratives and collaboration with the voluntary, community, faith and social enterprise (VCFSE) sector.

Neighbourhood health aims to create healthier communities, helping people of all ages live healthy, active and independent lives for as long as possible while improving their experience of health and social care, and increasing their agency in managing their own care.

As described below, STW has already made progress in developing an integrated local approach to NHS and social care delivery in advance of the full vision for the health system which will be set out in the 10 Year Health Plan to be published in Spring 2025.

3.2 Our Places

In STW there are two Place areas (coterminous with the local authority administrative boundaries of Shropshire and Telford & Wrekin), with neighbourhoods aligned currently to our 9 Primary Care Networks.

Both of our Places have strong Place-based integration boards – Telford and Wrekin Integrated Place Partnership (TWIPP) and Shropshire Integrated Place Partnership (ShIPP). Both ShIPP and TWIPP are committees of the Shropshire, Telford & Wrekin Integrated Care Board.

The role of Place, delivered through the two place boards, is to agree and drive the delivery of proactive, preventative, high quality, community centred health and care integration at place to improve their residents' outcomes. They have a key focus upon reducing health inequalities,

improving place-based proactive prevention and delivering seamless, accessible, safe, high quality community centred health and care services for all residents.

In addition, Place:

- Champions the needs and voices of local people
- Ensures that local voices, (people, elected members, local services, primary care), are part of developments and decision making
- Ensures that the voluntary and community sector (VCSE) play a central role in the health and wellbeing of local populations and integration work
- Assesses need and develops ongoing needs assessments (JSNAs and regular feedback loops)
- Understands how effectively the improvements in quality and safety are being driven forward.
- Works with partners to align strategic priorities with need through strategic plans and actions
- Works with the ICB on developing governance and delegation of decision a and finances to place and neighbourhood
- Understands, influences and develops local implementation of strategy and transformation programmes, that take into account need and local voices.

Both ShIPP and TWIPP membership comprise of senior officers from Telford and Wrekin Council, NHS Shropshire, Telford and Wrekin, Primary Care Networks (PCNs), Midlands Partnership University NHS Foundation Trust, Shropshire Community Health NHS Trust, Shrewsbury and Telford Hospital NHS Trust, Healthwatch, Shropshire Partners in Care and the Voluntary, Community and Social Enterprise Sector (VCSE).

ShIPP and TWIPP reflect the identity of each of the Places and benefit from the assets and strengths of the communities within that Place. However, the Places ensure that standards of access and quality do not vary. They connect across STW to ensure that the evidence of the most effective prevention, population health and care models are applied in every neighbourhood.

Our Integrated Strategy is overseen by the Integrated Care Partnership and is informed by the Health and Wellbeing Board strategies of our two Places. This plan sets out how we deliver the strategy across the system, ensuring that organisational strategies understand how they will contribute and impact on this delivery. The HWBB strategies for both Places will be reviewed in 2027/28 and will inform the integrated strategy and delivery, and set out the further ambition of the system in 2029.

Telford and Wrekin Health and Wellbeing Strategy

Telford and Wrekin Health and Wellbeing Board refreshed its priorities during 2022 and its updated strategy in June 2023. The priorities are defined through engagement and insight with local residents and intelligence from the Joint Strategic Needs Assessment (JSNA) on local the wider determinants of health, health and wellbeing outcomes and inequalities gaps.

Delivery of these health and wellbeing strategy priorities is steered and overseen by various partnerships including TWIPP, Domestic Abuse Local Partnership Board, the Alcohol & Drugs Partnership Board the Community Safety Partnership. The Council's Cabinet approved the Telford & Wrekin Children & Young People's Strategy in February 2025, this overarching strategy includes the following aims: start well, stay well, keep safe and enjoy and achieve.

TWIPP Priorities for 2024-2026

In addition to the Health and Wellbeing Strategies TWIPP has identified 3 key priorities that it will focus on up to March 2026. These are:

1. **Supporting General Practice** by working together to reduce and manage demand for GP services/appointments
2. **Improving all-age mental health provision** (prevention, early intervention and specialist services)
3. **Preventing, reducing and delaying frailty** (with a focus on healthy ageing)

The outcomes TWIPP will achieve will be defined by each priority area within their Programme Initiation Documents.

In addition to its priority areas, TWIPP will:

- Work with the system to devolve decision making and resources to place and neighbourhood where appropriate;
- Act in an oversight capacity for the Better Care Fund Board, the Ageing Well Partnership, the Mental Health Partnership, Learning Disability Partnership, Autism Partnership. This will include at least annual updates to TWIPP along with providing where needed an escalation route.

Shropshire Health and Wellbeing Strategy 2022-2027

The Shropshire Health and Wellbeing Board acts to ensure that key leaders from the health and care system work together to improve the health and wellbeing of Shropshire residents. Board members collaborate to understand their local community's needs, agree priorities and work together to plan how best to deliver services. Shropshire's Health and Wellbeing Board has produced its Joint Health and Wellbeing Strategy based on the needs of local people, setting out the long-term vision for Shropshire and identifying the immediate priority areas for action and how the Board intends to address these.

The priorities of the Joint Health and Wellbeing Strategy are developed in response to the Shropshire Joint Strategic Needs Assessment (JSNA). The JSNA fulfils a statutory duty to identify areas of health and wellbeing need through the examination of national and highly localised data. In Shropshire, the JSNA is considered a dynamic assessment that is regularly updated as new understanding and data come to light. In addition to thematic assessments, we have developed Locality Needs Assessments, which demonstrate the need in our very local communities (based on 18 Place plan areas). To support delivery of the strategy, the Shropshire HWBB has developed a Prevention Framework, which supports the system to prioritise prevention activity, working through our local communities and with our statutory partners and voluntary and community sector colleagues.

Shropshire Joint Health and Wellbeing Strategy priorities 2022-2027

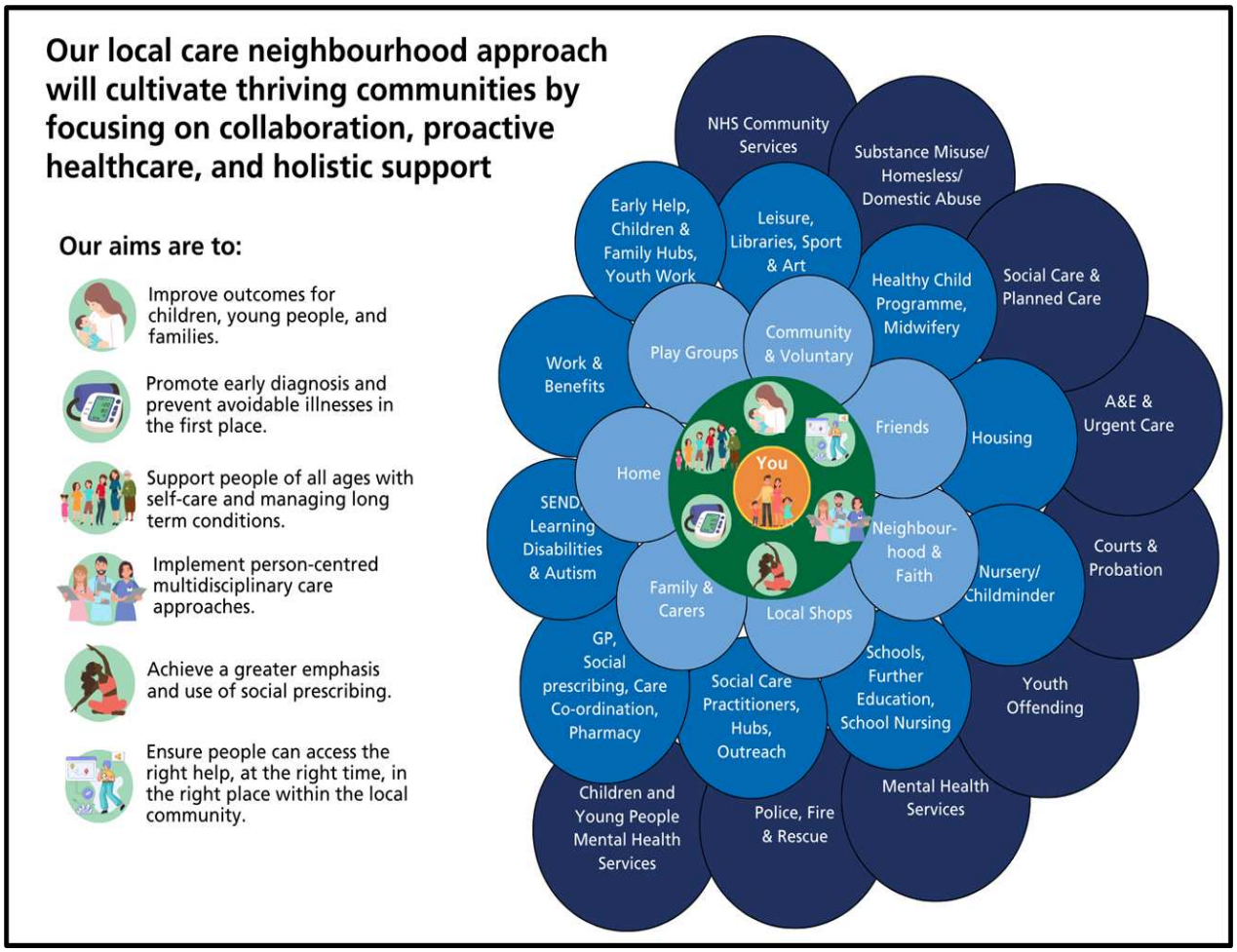
Strategic Priorities Long-term aims and how we will achieve them		**Key areas of focus** Identified areas of health and wellbeing need in Shropshire	
Joined up working		Workforce	
Working with and building strong and vibrant communities		Healthy Weight and Physical Activity	
Improving Population Health		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			

3.3 Our approach to Neighbourhoods and Integrated Neighbourhood Teams (INT)

Our neighbourhood approach is about joining up local services in the community and fostering community connections so that everyone in a neighbourhood can thrive. Providing more services closer to home and taking a neighbourhood approach to prevention is at the heart of our wider vision to improving wellbeing and preventing illness and poor health and reduce inequalities.

In Shropshire, Telford and Wrekin we are taking a proactive, preventative, person-centred neighbourhood approach to care as we have listened to and understand that people require joined up care and support as close to home as possible. We know that local areas have different needs and our neighbourhoods will develop in a tailored way to reflect this, e.g. what's needed in Lawley in Telford, may not be the same as the priorities for Ludlow in South Shropshire.

By adopting an intelligence-led approach and being focused on understanding local health needs, neighbourhood approaches will contribute to reducing inequalities.



Local Principles for Neighbourhood Working

In neighbourhoods, we are committed to strengthening and evolving existing networks, while forging new connections and fostering collaboration. By bringing together teams and services across health, care, the voluntary and community sector, businesses, schools and education settings and other key partners -including police, housing, and education - we will adopt the following principles:-

- ### Proactive Population Health Management

Working in a proactive, preventative, assets based, population health way that maximises health, wellbeing, independence and self care in or as close to people's homes as possible, in order to reduce their need for health and care services.

- ### Person Centred Approach

Ensuring that we take a person centred approach, putting people at the centre of what we do.

- ### Learning and Evidence

Building on what already works and using learning and evidence to develop a more comprehensive community based prevention offer which includes universal, early help, targeted and specialist system services.

- Integration

Working across service areas, integrating where possible, embracing partnership and collaborative working, creating a culture of working jointly across professions, organisations and teams for the benefit of our communities.

- Time

Adopting a test and learn approach allowing projects time to evolve and deliver outcomes, embedding evaluation in all development programmes from the start.

- Leadership

Collaborative local leadership with a shared vision, culture and values to support transformation.

The configuration of our Neighbourhoods can be found at Appendix C.

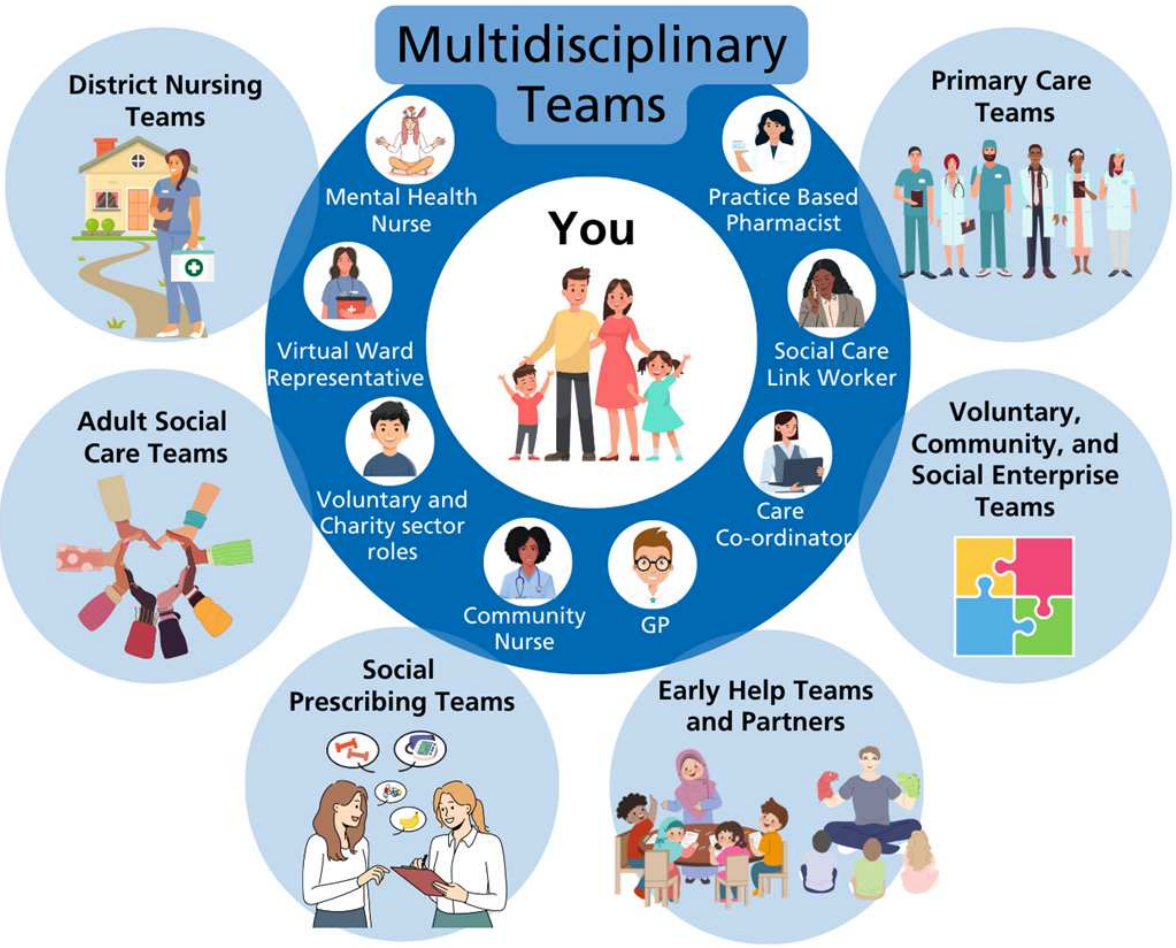
- 'Team of Teams' working in Neighbourhoods

'Teams of teams' work in neighbourhoods, they are not restricted by geographical boundaries and link together providing personalised care, centred around individual needs.

Various teams, sometimes referred to as 'a team of teams,' will operate within neighbourhoods with a range of different remits, for example multi-disciplinary teams (MDTs) supporting people with specific needs, one example is an MDT approach for people with frailty and multiple long-term conditions, as well as specialist teams focused on tackling local issues such as widening the range of activities available for local children.

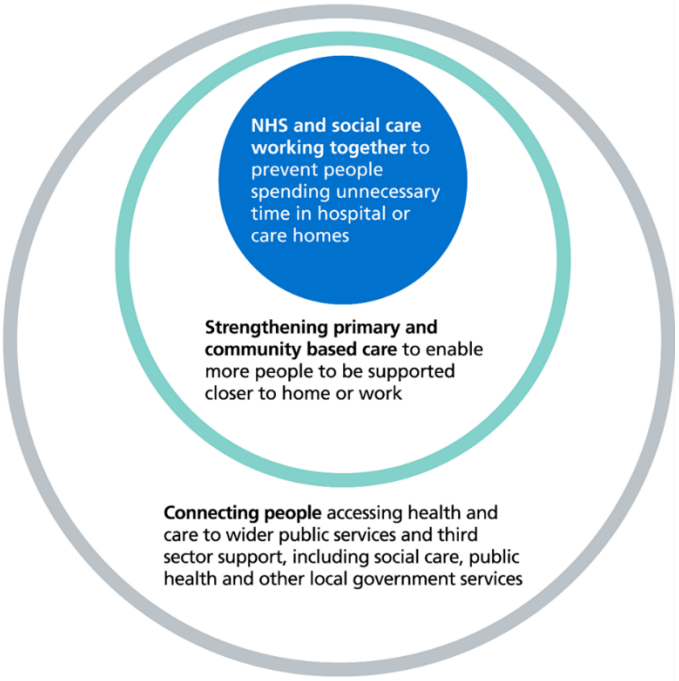
Through resource pooling and information sharing, these teams can streamline access to services and provide more proactive, preventative and personalised approaches.

'Teams of teams' is not only about professionals working better together, it is about empowering residents to come together to create thriving communities.



Next steps for Neighbourhood health services

The diagram below shows the national aims for all neighbourhoods over the next 5 to 10 years. For 2025/26, systems are primarily to focus on the innermost circle to prevent people spending unnecessary time in hospital and care homes.



Whilst we await the 10 Year Plan and to strengthen the existing foundations for scaling and expanding the neighbourhood approach over the coming years, STW will continue to build on current momentum for a neighbourhood health approach by making further progress to:-

- **standardise the 6 core components of existing practice** to achieve greater consistency of approach:-
  - Population Health Management
  - Modern General Practice
  - Standardising community health services
  - Neighbourhood multi-disciplinary teams (MDT's)
  - Neighbourhood intermediate care with a 'Home First' approach#
  - Urgent neighbourhood services
- **bringing together the different components into an integrated service offer** to improve coordination and quality of care, with a focus on people with the most complex needs
- **scaling up** to enable more widespread adoption
- **rigorously evaluating** the impact of these actions, ways of working and enablers both in terms of outcomes for local people and effective use of public money

We will work with our NHSE regional team, and local government and our other Place partners, informed by the evidence generated from our existing work, to agree locally what specific impacts are to be achieved during 2025/26. We expect these to include, as a minimum, **improving timely access** to general practice and urgent and emergency care, **preventing long and costly admissions** to hospital and **preventing avoidable long-term admissions** to residential or nursing care homes. The primary focus will be on:-

- supporting adults, children and young people with complex health and social care needs who require support from multiple services and organisations.

- Integrated neighbourhood teams for children and young people

The Neighbourhood Health Guidelines for 2025/26 include several prevention programmes aimed at improving health outcomes and reducing inequalities. Key prevention initiatives include:

1. **Health Literacy and Education:** Programs to enhance public understanding of health issues, encouraging healthier lifestyles and informed decision-making.
2. **Early Intervention:** Initiatives to identify and address health issues at an early stage, preventing them from becoming more serious.
3. **Chronic Disease Management:** Support for managing long-term conditions such as diabetes, hypertension, and respiratory diseases to prevent complications.
4. **Mental Health Support**: Programs to promote mental well-being, including early detection and intervention for mental health issues.
5. **Vaccination Campaigns**: Efforts to increase vaccination rates and prevent the spread of infectious diseases.
6. **Healthy Living Initiatives**: Encouraging physical activity, healthy eating, and smoking cessation through community-based programs.

These prevention programmes are designed to create healthier communities by addressing the root causes of health issues and promoting overall well-being.

The Neighbourhood Health Guidelines for 2025/26 outline several strategies to tackle health inequalities:

1. **Integrated Care:** Encouraging collaboration between the NHS, local government, social care, and other partners to provide seamless and coordinated care.
2. **Community-Based Care:** Shifting care from hospitals to community settings, making it more accessible and closer to home.
3. **Prevention Over Treatment:** Focusing on health literacy, early intervention, and preventive measures to reduce the incidence of health issues.
4. **Digital Solutions:** Utilizing digital tools to improve care delivery, accessibility, and patient empowerment.
5. **Targeted Interventions:** Implementing specific programs to address the needs of the most deprived and vulnerable populations, such as the CORE20PLUS5 approach.

3.4 Our approach to Women's Health Hubs

The Women's Health Strategy for England sets 10-year ambitions for boosting the health and wellbeing of women and girls, and for improving how the health and care system listens to women. The strategy encourages the expansion of women's health hubs across the country to improve access to services and health outcomes.

Women's health hubs bring together healthcare professionals and existing services to provide integrated women's health services in the community, centred on meeting women's needs across the life course. Hub models aim to improve access to and experiences of care, improve health outcomes for women, and reduce health inequalities. Women's health hubs are models of care working across a population footprint and are not necessarily a single physical place.

We introduced our Women's Health Hub model in 2024. The approach encompasses specific needs of women and young women, with a focus on inequalities and rural inequalities including sustainable, community-based Women's Health Hubs, ensuring equitable access to clinical

and non-clinical support by building on family & community hubs within PCN areas and other clinical offers informed by the JSNAs, population health and clinical data.

Following expressions of interest from Primary Care Networks and one practice, we have 10 hub offers with a specific focus on the NHSE core specification and additionally all 9 PCNs chose to develop specific projects focusing on health inequalities. The key objectives of the model are: -

- Increasing uptake of cervical screening especially with women who haven't or don't often attend.
- Increasing access to menopause advise and treatment.
- Increasing access to Long-Acting Reversible Contraception (LARC) consultations and fittings
- Women's Clinics during extended hours offering both clinical and non-clinical advice & guidance for a range of Women's health services including contraception, menstruation, pessary fitting & removal, menopause & breast pain.
- Developing awareness & understanding

Health inequality initiatives include: -

- Transgender and Non-Binary Opt-In for Cervical Screening Call/Recall
- Targeted approach to working with girls and younger women within communities.
- Working with women and girls with learning difficulties to understand and access cancer screening, especially breast and cervical screening.
- Increase awareness of Women's health related services, cervical cancer screening, breast cancer screening and safeguarding support for Afghan women and girls registered with PCN practices, part of Operation Lazurite.
- Work with the community teams and the Job centres to host information events and promote women's health in the community.
- Developing a "smear buddy" system linking women who are due to have their cervical smear. e.g. A patient that only speaks Japanese could be paired with a patient that speaks both Japanese and English. They could be booked back-to-back appointments, offering each other support and translating for each other.

In 2025, the Government will publish an update following its rapid review of the Women's Health Strategy focusing on identifying keys priorities and areas of focus. Our plans for Women's Health Hubs over the coming years will be approached through the development of integrated neighbourhood teams at place, building on embedding a digital approach and supported by the increased knowledge and skills of the workforce. Importantly the interdependencies with system work and collaboration with existing commissioned and noncommissioned providers will enable a system wide approach with a focus on meeting need and improving experiences for women and young women in STW.

Key Deliverables for Integrated Neighbourhood Team Development

- **Year 1** - Phase 1 – Foundations and integrated practice – functioning integrated teams in place.
- **Year 2** - Phase 2 – Population Health Management with supporting infrastructure – PHM fully established, digital interoperability and estates solutions confirmed.
- **Year 3** - Phase 3 – Integrated and intelligence led practice – INTs plan their workforce to meet needs.
- **Year 4** - Phase 4 – Full delegation for STW Neighbourhood delivery – INTs delivering demonstrable system benefits and outcomes.

3.5 Our approach to Provider Collaboratives and Collaboration

Provider collaboratives are partnerships that bring together two or more NHS trusts (public providers of NHS services including hospitals and mental health services) to work together at scale to benefit their populations. While providers have worked together for many years, the move to formalise this way of working is part of a fundamental shift in the way our health and care system is organised, continuing to move from an emphasis on organisational autonomy and competition to collaboration and partnership working. The rationale for providers working together in this way comes down to improving efficiency, sustainability and quality of care.

Collaborative arrangements see providers coming together to consolidate services for greater efficiency, increase sustainability by making better use of a limited workforce and improving quality of care by standardising clinical practice to tackle variations in care across different sites. It also supports joint accountability for service delivery in the areas where formal collaboratives have been established as the delivery vehicle with which the ICB will commission services.

In STW, provider collaboratives are still developing and have been referred to in various sections of this plan. The main focus is how a provider collaborative will drive improved patient outcomes and quality while supporting the following areas:

- Addressing unwanted variation across service delivery
- Improving resilience on delivery
- Improving productivity
- Developing the right Governance and accountability
- Leadership development.

STW is committed to the development of its collaborative arrangements and has commenced a programme of work to develop this approach further to ensure it forms a cornerstone of our delivery approach going forwards.

Each of STW's provider trusts (Shrewsbury and Telford Hospital NHS Trust, Shropshire Community Health NHS Trust, Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust and Midlands Partnership University NHS Foundation Trust) have agreed to develop the provider collaborative approach.

This will encompass both the development of a provider collaborative infrastructure to support the approach across STW, as well as the oversight of a number of collaborative programmes of work and will broaden to include a wider set of partners as it develops

Collaboration will occur at three levels:

- Collaboration between STW providers (as a whole group or in combinations of providers depending on the field of delivery and outcomes to be achieved)
- Collaboration between STW providers and commissioners (where there are tangible benefits of including the ICB in a collaborative partnership)
- Collaboration with partners outside of STW ICS boundaries where it delivers increased efficiency, productivity and/or improved patient outcomes

We have a number of established and formalised collaboratives already, for example, Shrewsbury and Telford Hospital NHS Trust and University Hospital of North Midlands NHS Trust collaborating in the provision of a range of speciality services, a number of collaboratives are still in stages of development towards formalisation and there is opportunity to build on this further

Currently, STW providers have collectively identified 5 key workstream areas of focus:

- Urgent and Emergency Care
- Musculoskeletal Services
- Workforce
- Mental Health, Learning Disabilities and Autism
- Shared Services Efficiencies

The identified areas are those where there is potential for providers to deliver better outcomes for patients through more formalised collaborative approaches and work will continue to evolve to define the collaborative outcomes to be achieved for each workstream

In addition to these priority programmes, mapping work continues to establish pipeline areas for collaboration.

Future plans

We will continue the development of both our local provider collaborative infrastructure and collaborative programmes focusing on developing effective partnerships and working collaboratively to provide seamless, well integrated services whilst bringing the design and provision of care closer together for the benefit of our communities. The provider collaborative will focus on the delivery of outcomes in relation to specific programmes set by the ICB acting as the strategic commissioner for the STW population.

Over the period covered by this plan, we will seek to ensure that the provider collaborative works across statutory and non-statutory organisations and use co-production with the wider communities involved with service delivery.

Local provider collaboratives (LPC) under integrated models would see delegation of functions to the provider collaborative from the ICB, pooled budgets for areas agreed by the collaborative as being within the scope and a focus on adding value, increasing efficiency, and improving quality of care.

3.6 Support social and economic development

Telford and Wrekin's Health and Wellbeing Strategy refresh proposals have been developed based on Joint Strategic Needs Assessment (JSNA) intelligence and informed by

engagement with residents as part of the development of the 'Vision 2023 – Building an Inclusive Borough'.

Shropshire's 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 brought together the available intelligence from the HWBB strategies to inform the priorities for the Integrated Care Strategy and Joint Forward Plan. The refresh of the Joint Forward Plan continues to use the HWBB strategies and Integrated Care Strategy as its anchor points and reflects wider determinants and health inequalities.

The JSNAs, population health intelligence and the Integrated Care Strategy informs system partners about areas of health and social need and inequalities gaps within our communities. In Shropshire, the Social Task Force meets bimonthly to address wider socio-economic development and the wider determinants that impact health, care and wellbeing and reports into the HWBB. In Telford and Wrekin, the HWBB covers health and care including socio-economic factors and priority areas are reported back through the board. Areas of delivery for the partnership are reported through the Place partnerships to deliver and give assurance on. This process is evolving.

Healthy life expectancy for males and females is unfortunately getting worse, and health inequalities are widening, so our partnerships focus on the root causes of health inequalities, the wider determinants of health, and addressing 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, and we are taking a person-centred approach to do this. We are using this approach to deliver our Women's Health Hubs across STW.

We are tackling the wider determinants of health, such as homelessness, healthy homes, poverty and the cost of living, through positive work and employment of the social task force and HWBB. This includes warm spaces, access to leisure, road and transport reports, and warm housing being made available through VCSE organisations. We also aim to give every child the best start in life which will influence a range of outcomes throughout people's lives.

We are improving equity of access to healthcare for those living in our most deprived areas, including rurally excluded locations, as well as other forms of exclusion. This includes Core20PLUS5 and a focus on preventable health conditions. For adults, this includes hypertension, early cancer diagnosis, health checks for severe mental illness (SMI) and LDA, vaccinations, continuity of carer in maternity. For children, this includes epilepsy, diabetes and asthma.

As the partnership develops our five-year plan, we are considering broader system working. Programmes of work need to demonstrate how they will deliver against the Integrated Care Strategy.

This includes:

- Local planning and regeneration including transport

- Housing and employment
- Education
- VCSE and community partners, police and fire service
- HTP
- Local Care Integration Programme including Integrated Neighbourhood teams.

3.7 Voluntary, Community and Social Enterprise

Our system has a wealth of experience as well as knowledge, professional expertise and skills in our voluntary, community sector (VCSE). During the COVID-19 pandemic, the VCSE delivered an unprecedented level of services to our communities.

The VCSE across STW is committed to supporting the delivery of the priorities within our plan and to joint working that has, and will continue to, shape and improve services in STW from a grassroots perspective. As a system, we need to support the VCSE ambition to deliver well-resourced services to our places, neighbourhoods and communities. With the knowledge of the communities and populations they serve, sustainable community services will underpin the person-centred approach to delivery of prevention, self-care and keeping well throughout a person's health and care journey.

Our strong VCSE sector underpins healthy communities, supports wellbeing and specialist services. Our VCSE already contributes to our neighbourhood working in communities and at place.

We recognise that, to reduce inequalities, we will need to draw on the knowledge of the local authorities, voluntary, community and social enterprises (VCSEs) 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. Our partnership working has previously been formalised within two Memorandum of Understandings (MOUs) with the VCSE and Healthwatch. These MOUs set out why the ICS values the role of the VCSE and Healthwatch in improving health, social care and wellbeing in this area.

As a system we are further developing our working with the VCSE to develop a joint framework with some key principles underpinning our work together across the system. These principles include:

- Leadership and Governance
- Financial sustainability
- Contractual arrangements
- Market development
- Data analysis
- Operational understanding and delivery

The VCSE is impacted by changes to government legislation in relation to minimum wage increase and National Insurance increases that are impacting on, particularly, smaller charitable and voluntary organisations. Our system commitment is to continue to work closely in collaboration with the VCSE, our local authorities, who have developed their own

partnerships with the VCSE such as the Shropshire Accord and align the framework to a way of working to deliver prevention, support, early help and other services such as supporting care closer to home and early discharge from hospital.

ICB Commissioning Ambition

- **Preventative Proactive Person Centred** care delivered through multi-disciplinary Integrated Neighbourhood Teams
- To commission a **sustainable community bed model** that is cost effective, meets need and focuses on rehabilitation and reablement to deliver optimum outcomes for the residents of STW.

Key Commissiong Intention Deliverables

Year 1

- Using a Population Health Management approach **model designed for a targeted and sustainable model to proactively support adults, children and young people with complex health and social care needs** who require support from multiple services and organisations.
- **Integrated Neighbourhood Team for Children and Young People.**
- **Model designed for the community nursing service** delivering preventative proactive care through integrated neighbourhood teams wrapped around General Practice with a
- **Implement a VCSE framework** to ensure impact, delivery, assurance and sustainability
- **Scheme of delegation from the ICB in relation to Place** based decision making and budgets and a timeline for implementation
- **Model redesigned for the whole wound care pathway** utilising a provider collaborative approach
- **Completion of the review of the Community Bed Model** including sub acute following any required public engagement, staff engagement and due process via NHS including sub acute following any required public engagement, staff engagement and due process via NHSE

Years 1-2

- **Implement at scale the Proactive Care model** designed in Year 1
- **Implement the revised community nursing service model**
- **Continue to develop the integrated neighbourhood teams** delivery model, aligning existing LA, NHS and community assets/meeting places informed by the needs of local populations
- **Expanded range of services delivered through provider collaboratives/collaboration** delivering shared efficiencies
- **Implement the revised wound care pathway**

Chapter 4:

Improving Access to Services

4.1 Primary Care Networks (PCNs) and General Practice

The current model of contracting for and providing general medical services has not changed in decades, despite changes to the way modern healthcare is accessed and delivered. Despite the huge amount of demand and work delivered in general practice, there have been increasing levels of dissatisfaction in primary care access and care for both patients and staff, and these challenges are now threatening the sustainability of our primary care services. General practice is suffering the same challenges in workforce and resources as the rest of our system. In particular, there are challenges related to the development of GP estates, and primary care estates need to be incorporated into the wider enabler of the system estates plan.

Primary care networks were set up to support groups of practices to deliver the Primary Care Network Direct Enhanced Service (PCN DES). Some PCNs are more mature than others and are using resources aligned to PCNs to develop and work with neighbourhood models of care and influence the local care programme as members of the place partnerships. Primary care will be at the heart of healthcare and must be appropriately resourced to support and enable true integration.

In May 2023, a delivery plan for recovering access to primary care was published by NHS England (NHSE). The aims of this plan are to tackle the 8am rush in general practice, to enable people to know their needs will be met when they contact the practice and to widen the scope of services available from community pharmacy. There are four areas this plan focuses on:

- Empowering patients
- Implementing modern general practice access
- Building capacity
- Cutting bureaucracy.

There is a need for evolution in the way primary care is delivered, protecting its core strengths, such as continuity of care, and placing it at the heart of new health and social care systems. Primary care is the ideal deliverer of person-centred care with the need for patients to be invested in their health planning through the use of personal health plans. We propose to have an integrated, collaborative primary care strategy and delivery models, providing streamlined access to care and advice, that is straightforward to navigate, more proactive, provides personalised care and support from an MDT based around neighbourhoods, and helps people to stay well longer.

Primary care cannot achieve this alone. It will need system support to provide the conditions for locally led change and a supporting infrastructure to implement change. Primary care clinicians will be engaged to co-develop, provide clinical leadership and support any changes proposed, ensuring we maintain stability in primary care.

4.2 Community pharmacy, optometry and dental

In April 2023, the contractual services for pharmacy, optometry and dental (POD) services were delegated to ICBs. The management of the contracts is undertaken in partnership with the Office of the West Midlands (OWM) through joint governance arrangements.

These primary care services are becoming increasingly important, never more so than through the COVID-19 pandemic.

Community Pharmacy Expansion

Community pharmacy services have expanded through the Recovering Access to Primary Care Delivery Plan and new national clinical services provided through community pharmacy. There are opportunities to deliver additional services to alleviate pressure in general practice but there are also challenges. Workforce in community pharmacy is under the same challenges as other healthcare services. From 2025/26, newly qualified pharmacists will be independent prescribers, this provides a training challenge within the system to support this, but also opportunities to further expand the role of community pharmacy and integrate this sector within primary care delivery.

Dental Recovery Plan

There is a national lack of NHS dentists, and this is particularly an issue across STW. The Dental Access and Equity audit published earlier in 2024 identified seven key priority areas across Shropshire and Telford for additional dental access and investment. These are our focus for improving dental access, especially within our most deprived communities.

ICB Commissioning Ambition

Commission a sustainable primary care model for STW

Key Commissioning Intention Deliverables

Year 1

- **Primary Care commissioning framework** –alternative models for primary care commissioning at practice level and at scale which aligns services across Shropshire and Telford
- **Refreshed Primary Care Strategy**
- **Demand and Capacity Workforce Assessment and Planning Model for General Practice**
- **Dental Recovery Plan implementation** targeted to improving access for most ‘at risk’ patient groups
- **Evaluation of the Community Pharmacy pathfinder sites** to inform the development of future clinical services that incorporate prescribing from within community pharmacies

Year 1-2

- Development **support programmes for Primary Care Networks and GP Provider Collaboratives**
- Ongoing **expansion and integration and optimal use of community pharmacy** to support primary care recovery and capacity
- **Education and support models for trainee and foundation pharmacists** and 'catch up' for existing workforce with respect to independent prescribing
- Continued work to **improve dental access** to pre-covid levels and beyond

4.3 Elective Care Recovery

Elective care covers a broad range of planned, non-emergency services – from tests and scans to outpatient appointments, surgery and cancer treatment.

Performance is measured by the constitutional standard: 92% of patients should wait no longer than 18 weeks from referral to treatment by March 2029. STW partners and staff have worked extremely hard in the aftermath of the pandemic to tackle the elective backlog – reducing long waits and treating the most clinically urgent cases – this system along with the wider NHS is a long way from meeting the required standards but are making good progress against milestones of 'no patients waiting over 65 weeks by April 25. Waiting lists have risen for the last decade. Continuing to do what we have been doing will not work: the Government plans major reform to elective. New and innovative ways of working and a number of improvement initiatives are part of STW's plan to reduce waiting times for our local population.

In January 2025, NHSE published new guidance outlining its ambitious strategy to tackle long-standing challenges in elective care. In STW (December 2024 data) there were 81,454 STW patients in total awaiting appointments, procedures, or operations, on an Referral to Treatment Target (RTT) Waiting List and 50.5% of these waiting more than 18 weeks. STW are experiencing increasing demands for elective care, this demand correlates with the growing demand nationally for elective care.

This reform plan focuses on empowering patients, improving service delivery, and aligning resources with care priorities. STW are committed and working with system partners to deliver this plan to ultimately improve patient access and waiting times, ensuring that our population are provided with the right care first time, in the right healthcare setting.

To deliver these commitments, the guidance includes a comprehensive set of priorities covering four areas, which involve collaboration between NHSE, ICBs, and NHS elective care providers:-

- **Empowering Patients**: Digital tools like the NHS App will become the default route for elective bookings, with new standards and leadership roles to enhance patient experience.
- **Reforming Delivery**: Partnerships with the independent sector, expanded community diagnostic centres, and new surgical hubs will boost capacity and reduce waiting times and support care closer to home.
- **Delivering Care in the Right Place**: Enhanced GP services, tech-driven solutions, and patient-initiated follow-ups aim to streamline care and reduce unnecessary delays.
- **Aligning Funding and Standards:** Updated funding schemes, performance oversight, and workforce programmes will drive improvements in care delivery and efficiency.

Reforming Diagnostic Pathways

Elective, cancer and diagnostic standards are interrelated and so must be improved together. The Government's plan is for existing and new planned Community Diagnostic Centres (CDCs) to be able to take on more of the growing diagnostic demand within elective care.

By providing a wider range of and capacity for tests and more consulting rooms, CDCs can improve elective pathways for both urgent cancer pathways and routine diagnostic pathways. They can reduce pathway length and make care more productive by providing multiple same-day tests and consultations where possible, as well as significantly reduce the need for lower clinical value outpatient appointments.

To improve the NHS Constitution standard for diagnostics, the cancer waiting time standards and the RTT standard, NHSE plans that all CDCs and hospital based diagnostic services to:

- be open 12 hours a day, 7 days a week
- be for adults and children
- deliver the optimal standards of tests per hour – such as 4 CT scans per hour – to use system diagnostic capacity productively
- remove low value test referrals to maximise capacity
- develop and deliver at least 10 straight-to-test pathways by March 2026, focusing
- on the diagnostic tests patients are waiting the longest for locally
- identify local opportunities to improve performance against the Faster Diagnosis Standard to reduce the number of patients waiting too long for a confirmed
- diagnosis of cancer
- Increase Primary Care provision straight to test.

NHSE plans also include a boost for bone density scanning (DEXA) capacity by investing in up to 13 DEXA scanners to support improvements in early diagnosis and bone health, particularly in the highest priority locations.

All of the above must be implemented in a way that upholds patients' rights to choice. Details of how the ICB fulfils its duty in relation to patient choice can be found in Appendix B.

ICB Commissioning Ambition

92% of patients receive their treatment within 18 weeks of referral by March 2029

Key Commissioning Intention Deliverables

Year 1

- **65% performance against the 18 week standard**
- Enable patients to view appointment information via the **NHS App**
- **Named Director within each ICB and Provider** for improving patient experience
- **Clear ICB local vision on how elective care reform will reduce health inequalities**
- **Advice and Guidance (A&G) service expanded** allowing patients increased access and avoiding the elective waiting list
- **Patients and their carers are aware of the new experience** expectations for elective care and their right to choose their care
- **"Collective care"** deployed including group appointments, one-stop clinics and super clinics
- **Patient Initiated Follow Up (PIFU) is offered as standard** in all appropriate pathways
- **Customer care training available to non-clinical staff** with patient-facing roles

Year 1-3

- **Increase in % performance** in line with the trajectory in the system's operational plan

- **NHS App significantly expanded** to improve information for patients in elective care, as well as their parents and carers through proxy access
- **Optimal use of the new diagnostic capacity** with new standards for Community Diagnostic Centres: extended opening hours, increased same day tests and consultations and the range of tests offered, **with increased direct referrals and rolling out at least 10 straight-to-test pathways**
- **A range of options are in place for patients to have more responsive and accessible follow-up care,** including standardising remote consultations, remote monitoring and digital support for patient initiated follow-up (PIFU) across all major specialties
- **Transformed pathways to deliver activity in the community in the priority specialties;** ENT, gastroenterology, respiratory, urology and cardiology
- **Remote monitoring expanded across all long-term conditions** where clinically appropriate, helping to remove lower value follow-up appointments
- **Reduced variation in discharge processes** and expanded opportunities for self management through shared decision-making tools

Year 4

- **92% of patients receive their treatment within 18 weeks of referral**
- **Patient-initiated follow-up (PIFU) increased to at least 5% of all out patient appointments**

4.4 Urgent and Emergency Care

Demand for our urgent & emergency care services have increased year-on-year from 2021 onwards and are back to or above pre-pandemic levels in terms of Attendances and Emergency Admissions to our hospitals. This has been aligned to national and regional trends. This has brought considerable challenge to meet this demand, requiring process improvement to provide alternatives to emergency departments for our patients; and by coordination of hospital discharge with system partners working together collaboratively. This has been with some success, but not sufficient to decompress our emergency departments to deliver the quality of care, patient experience and operational performance we are committed to providing.

Therefore, we intend to transform the way our urgent and emergency care services are delivered with increased focus upon delivering the urgent care our patients require away from hospital settings.

ICB Commissioning Ambition

- To transform our services into an improved, simplified and financially sustainable 24 hour/7-day Urgent and Emergency Care model; delivering the right care, in the right place, at the right time for all our population.
- To commission a highly effective Integrated Out of Hospital Community model incorporating Virtual Ward, Rehab & Recovery, and Rapid Response services delivered via the UEC Provider Collaborative.

Key Commissioning Intentions Deliverables

Year 1

- To **redesign and recommission an Integrated Urgent Care Service** across STW incorporating GPOOH, SPA, CCC, Care Transfer Hub, MIUs and UTCs through a system wide Provider Collaborative model. (contracting form to be explored).
- **Full review of the current Virtual Ward service** to assess against the original business case in terms of staffing, finance, step up vs step down assumptions, activity and caseload and clinical pathways. This will be completed alongside the review of Rehab & Recovery, Rapid Response, Outpatient Antibiotic Treatment (OPAT) and Diagnostics, Assessment and Rehabilitation and Treatment (DAART).

Years 1-2

- Transformed, Integrated Care Coordination centred model that delivers on the Reform to improve urgent and emergency care objective within the government's 'Road to recovery' mandate to NHS England issued in January 2025.
- Aligned to our Hospitals Transformation Programme.

4.5 Cancer

Cancer services remain a priority for this system and we are committed to working across organisational boundaries to collaboratively deliver significant improvements within cancer, recognising that improving cancer outcomes is a system wide responsibility. Improvement requires sustained collaborative action towards:

- Prevention,
- Improving early diagnosis,
- Increasing screening uptake,
- Optimising treatment modalities, and
- Strengthening services for those living with and beyond cancer.

In 2019 NHS England published the Long-Term Plan with a target that by 2028, 55,000 more people would survive more than 5 years after being diagnosed with cancer. To achieve this 75% of people diagnosed would be in the early stages of cancer (Stage 1 and 2) and would start and receive their treatment faster. STW is currently achieving this target in 59% of patients and we recognise that more targeted interventions are needed to reach the national ambition by 2028.

To support delivery of this, stakeholders from across the system have committed to convene to develop and deliver a plan of targeted interventions to achieve earlier diagnosis with a focus on reducing deprivation-related inequalities. Membership includes clinical and operational leads from primary and secondary care, public health teams, health inequalities leads and screening teams. Efforts relating to this area of focus includes, but not limited to, targeted case finding of patients within primary care who are at greater risk of developing cancer e.g. black males at higher risk of prostate cancer, understanding variation and addressing the reasons behind low uptake of cancer screening services and community

outreach initiatives to educate and empower patients on cancer symptoms to promote timelier presentation in primary care.

STW has a strong background of community-centred approaches to help build connected and empowered communities and is committed to putting communities at the heart of everything through meaningful engagement and co-production. This patient-centred approach will continue over the coming years to support reducing health inequalities.

ICB Commissioning Ambition

To commission and deliver cancer pathways to meet the Long Term Plan ambitions of diagnosing 75% patients at early stages and reduce long term mortality, focusing on levelling up for those in Core20plus5 cohorts by continuing engagement and co-production across all system partners. Support delivery of performance to meet national operational standards.

Key Deliverables

Year 1

- **Commissioned STW teledermatology service** to support skin referrals
- **Investment in Artificial Intelligence (AI) technologies** to support diagnostic reporting capacity
- **Commissioned service in General Practice for surveillance of prostate-specific antigen** (PSA) levels to detect prostate cancer in specific patient cohorts
- **Non Specific Symptom (NSS) Pathway**
- **Pathway for the referral of patients at suspected risk of Lynch Syndrome** from Shrewsbury and Telford Hospital NHS Trust (SATH) to a specialist centre
- Redesigned model for **psycho social care provision for cancer patients**
- **New diagnostic sites** identified
- **Baseline assessment of access and equity disparities**
- Start **targeted recruitment and training programs** to enhance workforce capacity
- **Identify and trial new technologies**
- Develop **collaboration agreements across sectors**
- Strengthened **public awareness campaigns**

Year 1-2

- **New diagnostic sites operationalised** and evaluated
- Improved **workforce stability and satisfaction.**
- Full **roll out of validated technologies**
- Implement and **evaluate shared diagnostic resources**
- Expand **preventative diagnostic services** (Years 1-3)

Chapter 5:

Our key clinical transformation programmes

5.1 Hospital Transformation Programme (HTP)

Our Hospital Transformation Programme (HTP) is our second major system transformation programme and is a key part of the bigger picture for our patients and communities. We are trying to address the following critical issues:

- Our workforce challenges:
  - We are overly reliant on agency and temporary staff because we are unable to recruit and retain the high calibre staff we need. This is mainly due to the current configuration of services which means that staff must work across sites and are unable to access multi-disciplinary support when they need it for our sickest patients. Our clinical environments also do not currently provide the capacity, space or layout needed to provide modern-day healthcare. All these factors impact negatively on our people, resulting in them leaving and impacts our ability to attract the number and skill mix of the substantive staff that we need.

- Our clinical model challenges:
  - The clinical model is not fit for purpose because of the outdated service configuration that prevents us from addressing quality and operational issues. This becomes more impactful as more and more hospital trusts across the UK reconfigure their services to better meet the needs of their citizens, patients, and staff.
  - Our greatest areas of risk are the sustainable provision of critical care and emergency medicine services, and consistently providing uninterrupted planned care capacity to ensure we can treat the many patients who are waiting for planned procedures, many of which are life changing.

- Our infrastructure challenges:
  - Our infrastructure does not support the delivery of modern-day healthcare, our digital aspiration, or the capacity we need to care for our patients in a safe and dignified way.
  - The configuration of our buildings does not lend itself to robust infection prevention processes as we need more single rooms and better ventilation.

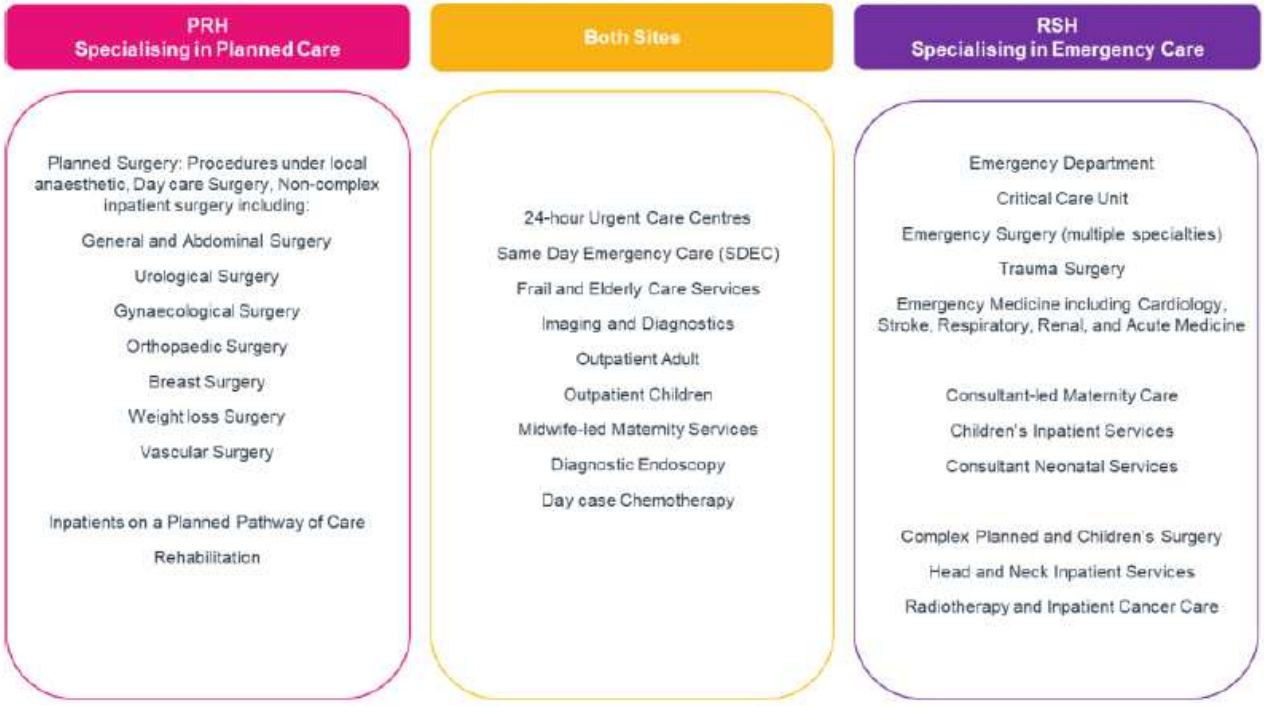
- The needs of our population are changing – our systems, processes and estate need to be able to meet those changing needs.

To address these challenges, the HTP is transforming services across our acute hospital sites and putting in place the core components of the acute service reconfiguration agreed as part of the Future Fit consultation. Key benefits include:

- A dedicated emergency department with immediate access to medical and surgical specialities
- Ring-fenced planned care services supporting the needs of our population
- A much better environment for patients, families, and staff
- Improved integration of services for local people.

The diagram below demonstrates what we are moving towards:

Figure S-07: High level outline of services on each site



Key HTP deliverables

Year 1

- **Complete phase 1 of the Emergency Department expansion** and to prepare grounds and commence building of the new facility on RSH site
- **Produce master delivery programme** and commence pathway development work.
- **Review workforce models** and prepare for the Management of Change process.
- **Continue with Stakeholder engagement** with the support of communications and patient engagement team.
- **Continue working collaboratively with the system partners** to implement the Local Care Transformation Programme

Years 2-3

- **Complete phase 2 of the Emergency Department expansion** ready for the implementation of the new clinical model in 2028.
- **Complete the clinical pathways for the new model** of care on both sites.
- **Complete the development of the 24 hour Urgent Treatment Centre** (UTC) on both sites
- **Communicate the UTC model** with key stakeholders and public.
- **Workforce model to be implemented** and recruitment, retain and reform process completed.
- **Complete transition plan to include transport model**, and the safe transfer and occupancy of the healthcare facility at RSH

Year 4

- **Complete Benefits realisation** exercise to include patient experience, estate, clinical quality and safety and workforce benefits workforce.
- **Post project evaluation** to be completed 6 months after occupancy.
- **Officially open the building at the end of Q3 2028**

5.2 Local Care

Local Care is a system wide commitment to a range of community-based transformation programmes and initiatives that aim to reduce the need for unplanned health care, keep people safe, well, and independent at home, and contribute to improved population health and wellbeing.

Local Care involves:

- **Integrating health and care at place and neighbourhood** levels to deliver more joined up, proactive, and personalised care in local communities and in people's homes
- **Expanding the range of community-based services** available to citizens
- **Health and care professionals working together in a joined-up way** across different settings focused on the person's goals, needs, and wishes and as part of wider teams with partners including the Voluntary Sector

The programme consists of initiatives that will deliver more care in the community achieving improved outcomes and experiences for patients, while also helping to relieve pressure on our acute hospital services so that those services are able to deliver quality services when people need them.

The programme was established in 2022 and focused on three key initiatives:

- **Implementing alternatives to hospital admission**, providing 2-hour rapid response in the community
- **Setting up of a Virtual Ward** providing sub-acute care in the place people call home that would otherwise need to be provided in an acute hospital, thereby providing an improved experience for patients. Initially, there has been a focus on the frailty pathway including enabling referral to the Virtual Ward from care homes and rapid response teams.
- **Implementing an integrated discharge team (IDT)** to support timely and appropriate discharge from hospital with the necessary community support in place

The above services are now in place and in 2024 the Local Care Programme undertook a review to determine the scope of its next phase of initiatives. The outcome of this review was guided by the following:-

- In totality the community-based care agenda is too significant in breadth and depth to treat as a single traditional programme under single leadership and delivery arrangements
- Harness the opportunities for more 'diverse and disperse' leadership including clinical and professional leadership
- Delivery needs to recognise the role of multiple teams and organisations across the system architecture

- ICB new organisational structure enables a wider set of resources aligned to Place
- Both the Hospital Transformation Programme and Local Care are moving into next phase of pathway development – opportunity to align/join up

The next phases of Local Care consists of two elements:

Design of integrated clinical pathways

- aligned with the Hospital Transformation Programme
- initial focus on end-to-end pathway design for diabetes, cardiovascular and frailty;
- building a strong foundation of 'NHS to NHS' integration as part of the core service offering of Integrated Neighbourhood Teams
- Senior Responsible Officer: Community Trust Chief Executive, ICB Strategy and Development Team providing resource for programme and project management working with partners

Delivery through Integrated Neighbourhood Teams and wider neighbourhood approaches

- through ShIPP and TWIPP
- neighbourhood sub-groups continuing to provide the 'engine room' for delivery
- priorities for INT development
- Local Authority CEO leads, ICB resources aligned to place to 'wrap around' place resource; providing strategic and technical support to complement the role of Place.

Governance of the continued delivery of the objectives of the first phase of Local Care and the next phases described above is through a new group established in November 2024. The Hospitals and Care Models Transformation Programme brings together the Hospital Transformation Programme (excluding the build programme) and the Local Care Transformation Programme clinical models and pathway design work programme to ensure they align.

The role that our community hospitals play is front and central to the delivery of Local Care, providing crucial facilities in which to develop vibrant health and care hubs serving the local population's needs in our rural communities. Whilst our ambition for the existing community hospital sites is clear and demonstrated with the reopening of Bishops Castle Community Hospital in 2024, the system recognises that there will be difficulties in terms of the lack of available capital and staffing challenges across both bed and community-based services and close working will be required with all stakeholders in designing services that are co-produced and sustainable moving forwards.

By delivering Local Care we will:

- Expand community-based services and provide suitable alternatives to hospital-based care.
- Support people with long-term conditions and those with a range of health and wellbeing needs to be empowered in the delivery of their care.
- Respond swiftly to those in crisis to avoid unplanned hospital admissions.
- Ensure a focus on proactive care and early intervention that promotes good health and wellbeing.

- Develop a deeper understanding of the needs of our population and make demonstrable progress in tackling health inequalities.
- Focus rehabilitation services to help people maximise their functional outcomes and independence, focusing on the personal goals that matter most to patients.

Enable our staff to work flexibly across organisational boundaries in more integrated and joined up ways that enables staff to deliver high quality care for their patients; thereby supporting staff wellbeing and job satisfaction.

5.3 Cardiovascular Disease (CVD)

CVD is the cause of a quarter of all deaths in the UK, and the largest cause of premature mortality in deprived areas. This is the single biggest area where the NHS can save lives over the next 10 years.

In January 2023, the ICB developed a Cardiovascular Disease (CVD) High-level Recovery Strategy which describes the current context behind health outcomes related to CVD in STW and identifies key priorities to recover and improve those outcomes.

STWs CVD Recovery Strategy further takes into account the high-impact objectives identified by the National CVD Prevention Recovery Plan 2023/24, to restore detection, monitoring and treatment of high-risk conditions. These are:

- Monitoring and targeting unwarranted variation in care and outcomes.
- System leadership to co-ordinate action to drive CVD recovery.
- Supporting general practice to recover the management of key risk factors in atrial fibrillation, hypertension, and hypercholesteremia.
- Accelerating making every contact count (MECC) interventions such as commissioning non-NHS providers, high street pharmacies and vaccination centres to undertake BP checks.

Around 66,000 people in STW are living with heart and circulatory diseases. These heart and circulatory diseases cause 110 deaths each month in Shropshire Telford and Wrekin. Around 81,000 people in Shropshire Telford and Wrekin have been diagnosed with high blood pressure and 13,000 with Atrial Fibrillation.

Moving forward our clinical priorities are:-

- **CVD Prevention –** embed and align system wide initiatives which identify at risk populations and support people to live a healthier lifestyle
- **Cardiology Transformation** – reduce non-elective heart failure presentations in acute settings, improve cardia rehabilitation services and explore out patient transformation.
- **Stroke Improvement** – ensure early and rapid diagnosis, best practice treatment and improve rehabilitation and life after stroke.

ICB Commissioning Ambition

- Enable people to live healthier longer lives through prevention and proactive management of CVD

- To provide high-quality integrated cardiology services for our patients, carers, and their families in the right place, at the right time, in the right location; delivering excellent patient experience.

Key Commissioning Intention Deliverables

Year 1

- Recruit a **CVD Clinical Lead**
- **Relaunch of the Cardiology Transformation Programme** to redesign integrated cardiology pathways & processes that are more effective and efficient with an initial focus on Cardiac Rehab and Heart Failure
- Evaluation of the Heart Failure @ Home Pilot to inform further roll out

Years 1-3

- **Deliver the CVD Prevention Strategy** focusing on targeted case-finding and management interventions across all areas (Community Outreach, Primary Care and Secondary Care) to improve prevention and accelerate Make Every Contact Count (MECC) interventions.
- **Continue embedding National programmes for Smoking (**including a system wide approach to Smoke Free), **Alcohol and Weight Management,** including the initiation of the NHS Low Calorie Diet Programme and working with LAs to design connected community tobacco cessation pathways
- **Enhanced use of digital technologies** in prevention inclusively
- **Improved pharmacological management** of lipids, heart failure rapid dose titration, atrial fibrillation anticoagulation management

5.4 Diabetes

One million people in UK with Type 2 Diabetes are currently undiagnosed. Prevention and early diagnosis is essential as complications such as neuropathy (nerve damage), nephropathy (kidney damage), retinopathy (eye damage) can begin 5-6 years before some people actually find out that they have diabetes.

In January 2025, there were 34,322 registered diabetic patients in STW.

- **93% of those people have Type 2 Diabetes** (T2D). T2D tends to happen later in life, as the ability to produce insulin declines at a time when the body becomes resistant to the effects of insulin, resulting in reduced glycaemic control.
- **7% of people those people have Type 1 Diabetes** (T1D). T1D is an autoimmune condition that leads to the pancreas being able to produce little or no insulin. People with T1D rely on manufactured insulin to regulate their glycaemic control.

Outcomes for some patients with diabetes in Shropshire, Telford and Wrekin are significantly poorer than the rest of the country and there is unwarranted variation in outcomes across the county. In January 2025, we launched our Diabetes Transformation Programme which aims to ensure a **consistent offer for every patient with, or at risk of diabetes wherever they live in STW, that is:**

- Based on scientific evidence and best practice
- Aimed at empowering patients to take control of their health

- Easy to navigate, with support for those who may struggle
- Digitally enabled, with alternatives to prevent exclusion
- Focused on prevention as well as treatment
- Focused on outcomes as well as processes
- Delivered by one team, working across organisational boundaries

The programme will have 4 areas of focus:-

1. **Prevention of diabetes** – identification of risk and a prevention offer
2. **Optimising care** – Care process delivery, treatment targets achievement, medicines management, self management including digital assets
3. **Reduction in complications** – prenatal/antenatal advice, CVD, Chronic Kidney Disease, Neurovascular, Ocular
4. **Collaboration** – digital access to data for patients, professionals and commissioners, digital delivery/enablers, care navigation, peer networks.

This is a multi year programme delivered in phases. The prioritisation of the phases of the programme will be undertaken in Year 1.

ICB Commissioning Ambition

A consistent offer for every patient with, or at risk of diabetes wherever they live within STW which empowers people to manage their diabetes or risk of diabetes effectively, by making them aware, educated and able to access high quality and equitable care as close to home as possible.

Key Commissioning Intentions Deliverables

Year 1

- **Strong foundation for management of diabetes in General Practice** through revised commissioning arrangements
- **Improved outcomes** for diabetes patients through:-
- **More patients receiving the nationally recommended 8 care processes, 3 treatment targets** and an annual review
- Model for improved **targeted services for young people in transition between CYP and Adult services**
- **Established Clinical Network**
- **Established Expert Patient Network**
- Prioritisation of future phases of the programme

Years 1-2

- **Implement the agreed model for services for young people in transition from CYP to Adult**
- **Transformation Programme Plan** for Phase 3 and beyond

5.5 Musculoskeletal (MSK)

The population of STW continue to experience variation within the system and in comparison to other regions. For instance, a person from the most deprived quintile is 41% more likely to be readmitted as an emergency following surgery than a person from the most affluent quintile.

We also know that there is an underrepresentation of specific population groups on our waiting lists and our rates for diabetic amputations are significantly higher than other regions. We have ambitions to improve safety and quality, integrate services, tackle health inequalities and access to care, and create a great place for staff to work. The ICS has an opportunity to demonstrate an efficient and sustainable way to fulfil these ambitions by taking a population-based approach to meet the needs of patients facing musculoskeletal (MSK) concerns.

Key Commissioning Intention Deliverables

Year 1

- **Lead provider model in place in shadow form to implement one whole system MSST, Orthopaedic, Rheumatology and Pain Management service**. Contract between NHS STW ICB and Robert Jones and Agnes Hunt Orthopaedic Hospital.

Years 1-2

- Full lead provider contract formally in place

5.6 Mental Health, Learning Disabilities and Autism

Our priorities include an ambition to prevent mental disorders in young people (and by default adults) through effective mental health promotion and prevention, as well as transforming current services to ensure they are accessible, integrated and reflect the best available evidence.

ICB Commissioning Ambition

- To enable adult and older adults with severe mental illness to have greater choice and control over their care and support.
- Through coproduction children and adults with LD&A have the right support locally to thrive

Key Commissioning Intention Deliverables

Year 1

- Implement **the Assertive and Intensive Outreach programme**
- Recommissioning of the **TCP Management Oversight service**
- Reduce patients requiring bed based care and support through **delivery of a non clinical community crisis support team**
- Development of a **system all aged joint Neurodiversity pathway**

Years 1-2

- Implement the approved programme of work to **enable local repatriation of individuals receiving community rehabilitation** away from their family and home area.
- **Community Mental Health Rehabilitation -** funds released from the above reinvested into community rehabilitation services.

Year 1-5

- **Learning Disabilities and Autism (LDA) - Reduce reliance on inpatient care** and address unwarranted variation/gaps in autism care.

5.7 Maternity services

Maternity transformation was highlighted as a key area at the establishment of the ICB in our System Development Plan, based on the findings of the first Ockenden report. We have already made significant improvements in the quality and safety of maternity care since then.

In March 2023, NHS England (NHSE) produced a three-year delivery plan for local maternity and neonatal services. The plan encompasses four themes:

- Listening to and working with women and families with compassion
- Growing, retaining and supporting our workforce
- Developing and sustaining a culture of safety, learning and support
- Standards and structures that underpin safer, more personalised, and more equitable care.

Based on this vision, we will, together with local transformation and partners across the system such as providers, commissioners and system users, deliver a plan to transform our Local Maternity Neonatal System (LMNS).

We will also work with 'Maternity Voices' to engage with parents and families about services to ensure co-production of services is at the heart of pathways.

5.8 Our approach to meeting the needs of Children and young people (CYP)

Our system is committed to focusing on the needs of children and young people in our population. We know that children need to live happy, healthy and fulfilled lives and the pandemic has impacted on them in many ways. Throughout this plan, we consider children and young people and their families and carers, including those children with complex needs and the support their families need. The offer starts before conception and through to adulthood. We are committed to engaging children and young people in the development, review and delivery of our service offer to them.

Some of the key priorities we have identified for children and young people are to:

- develop transformative care pathways for asthma, epilepsy, diabetes and obesity.

- work with partners in education, mental health, and safeguarding to ensure that, no matter how complex, our children's needs are met.
- hear the voices of children as we plan and deliver their care.
- use Core20PLUS5 children's model to drive improvement and reduce inequalities.

We will establish a CYP Joint Commissioning plan. Working collaboratively with partners, we will develop a joint commissioning plan that meets the needs of CYP and supports them to achieve their full potential. This will include SEND, mental and physical health, safeguarding and CYP with complex needs.

Specifically for CYP Mental Health services we will achieve a shared and coherent vision across our system, to drive forward our transformation programme, including a full review across a number of service elements, alignment of pathways, and expansion of services where needed.

ICB Commissioning Ambition

- That CYP get the right help at the right time to ensure they meet their potential, able to self-manage and are resilient

Key Commissioning Intention Deliverables

Year 1

- Via procurement a **recommissioned Children and Young People Mental Health Service (CAMHS)** ensuring the inclusion of our approach towards prevention and trauma informed care.
- A collaboratively developed CYP Joint Commissioning Plan that meets the needs of CYP at a local level and supports them to achieve their full potential, including SEND, mental and physical health, safeguarding and CYP with complex needs.

Years 1-5

- Using the national CYP Core20PLUS5 framework **drive improvement action led by Place across CYP services; asthma, diabetes, epilepsy, oral health and mental health.**

5.9 Our approach to Healthy Ageing and Frailty

Frailty is a loss of physical and mental resilience, leaving a person vulnerable to declining health and the inability to recover well from adverse events such as illness, injury or bereavement. Frailty is important because it compromises quality of life for the individual and increases the risk of death, disability, dementia, hospital admission, falls and the need for long-term care. The likelihood of frailty increases as we get older, but it is not inevitable, and at various stages along the spectrum it can be prevented, delayed, reversed and managed. Conversely, frailty can occur at a younger age for those with an accumulation of health risks, and the risk of early frailty is higher among those living in deprivation, some ethnic minorities and those with chronic health conditions.

Frailty is a national priority because the number of people at risk of frailty is growing, and with it an increase in the need for health and care services. Years – or decades – spent in ill

health mean personal suffering, strain on families, and use of health and social care services. Delaying the onset of frailty, and managing frailty well, to slow progression and reduce the need for unplanned care, are crucial for the long term financial and environmental sustainability of health and care services.

In Shropshire, Telford and Wrekin we have a larger proportion of people aged over 65 than nationally (22% compared to 18% across England), along with significant numbers at risk of poor health in later life, such as people who live in deprivation and those from Pakistani and Bangladeshi communities. On average our residents live the final 17-22 years of life in poor health, and there is a gap of up to 12 years between the healthy life expectancy of the most and least deprived. Reducing the number of years lived in poor health, particularly for the most deprived who live the longest in poor health, is where the opportunity lies for improving quality of life for our residents whilst slowing the growth in health and care costs.

As an Integrated Care System, we have an urgent need to develop plans that reduce the impact of frailty on the quality of life of our population and on the demand for health and care services. This will be achieved through implementation of a strategy to delay the onset of frailty and deliver best-practice frailty management.

The ICB is developing a Healthy Ageing and Frailty Strategy for approval and implementation in the autumn of 2025. A multistakeholder Steering Group has been established to oversee the development and implementation of the strategy, chaired by the ICB Chief Nursing Officer.

This three-year system-wide strategy will comprise five pillars that reflect the trajectory of frailty: educate, prevent, identify, manage and care.

The diagram below shows how this strategy aligns with other system and ICB strategies:

ICB Commissioning Ambition

- A fully integrated falls pathway focused on prevention
- deliver collaboratively with system partners the new dementia vision and service model which was developed and co-produced with people living with dementia and their carer's

Key commissioning intention deliverables Ambition

Year 1

- **Implementation of the Dementia Vision** including multi-disciplinary teams, shared care model with patients receiving annual reviews and sufficient service capacity achievement of the national Dementia Diagnosis to Treatment rate (DDR)
- Improved performance in **the national Dementia Diagnosis to Treatment rate** (DDR)
- **Approved Ageing Well and Frailty Strategy** with supporting implementation plan
- Fully functional **provider collaborative providing end to end falls pathway** including a single point of referral
- Service in place for **urgent response and assessment to a person who has fallen at home/in the community**

Years 1-3

- Deliverables for Years 1-3 will be determined as part of the strategy development

5.10 Our approach to End-of-life care

It is the commitment of Shropshire, Telford and Wrekin (STW) ICS that people nearing the end of their life receive high-quality, compassionate care and are supported to live well and to die with dignity in a place of their choosing. Across STW, we know that this is provided for the majority of people. However, we also know that we can do more, particularly for those that do not access, or have difficulty accessing, services. We want to identify people in their last journey of life earlier and anticipate care needs that can be planned for in advance.

The National Ambitions for Palliative and End of Life Care states that caring for people at the end of their life is everyone's responsibility and it is for this reason that our Providers are keen to develop a collaborative approach to care.

ambitions-for-palliative-and-end-of-life-care-2nd-edition.pdf

- The ICB will facilitate the developments needed to establish a Palliative and End of Life Care Provider Collaborative.
- The ICB will work with providers and the public to understand the anticipated requirements and impact of the Terminally Ill Adults (End of Life) Bill as it goes through the legislative phases.
- We will seek to ensure that safeguards and protections are in place to enable the statutory obligations of the bill and to support individuals rights and choice.

Babies, children and young people with life-limiting or life-threatening conditions

The number of babies, children or young people (BCYP) with life-limiting or life-threatening conditions in our region is, thankfully, low – with an average of 11 expected to die each year. The specific and often very complex needs for BCYP who require palliative and end-of-life care means that an all-age strategy is not appropriate, and the Shropshire, Telford and Wrekin Integrated Babies, Children and Young People Palliative and End of Life Care Strategy will be developed.

Key deliverables

Year 1

- **Palliative and End of Life Care Provider Collaborative** established
- Proposal and **action plan agreed**
- **BCYP Strategy approved** and implementation plan developed
- Plan in place to **monitor progress of the Terminally Adults (End of Life) Bill**

Years 2-3

- **Collaborative arrangements achieved** for year one and refined for years 2 -3
- **Adult PEoLC Strategy refresh**
- **Requirements of the Terminally Adults (End of Life) Bill implemented** and monitored

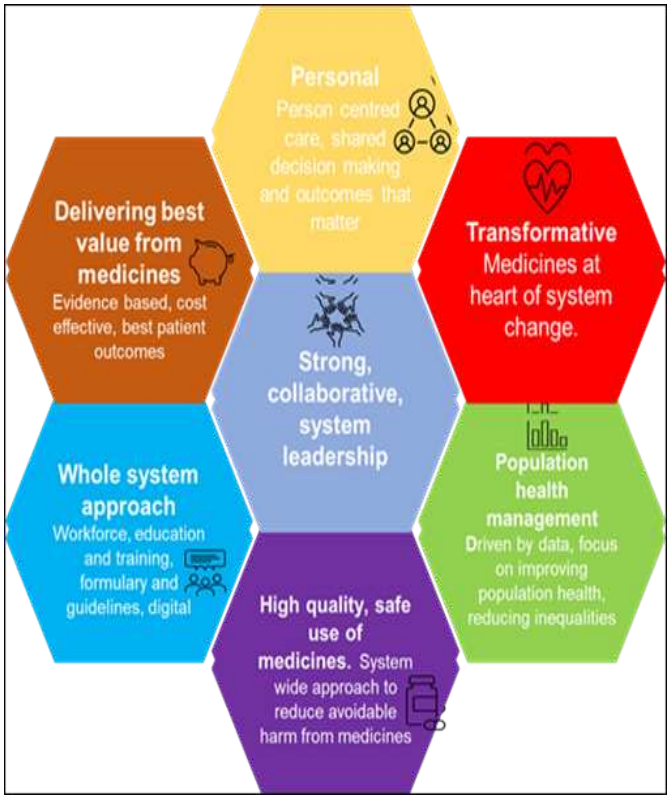
Years 4-5

- Deliverables for years 4 -5 will be determined by Provider Collaborative arrangements and ICB statutory requirements

5.11 Our approach to medicines

Medicines play a crucial role in maintaining health, preventing illness, managing chronic conditions and curing disease. In an era of significant economic, demographic and

technological challenge, it is crucial that patients get the best quality outcomes from the medicines that they are prescribed.



Our vision for medicines optimisation within STW ICS delivers a patient-focused approach to getting the best possible health benefits from the investment made in medicines. This requires a holistic approach, an enhanced level of person-centred care delivery, and partnership between clinical professionals and patients. Our aim is to ensure that the right patient gets the right medicine, at the right time. We will focus on wider health outcomes including improved clinical outcomes for patients, reducing avoidable hospital admissions related to medicines (HARMs), reducing health inequalities and utilising a population health management approach. A patient-centred approach will, in turn, ensure we get the best from our investment in medicines, and that patients live longer,

healthier lives. It will also support the system to achieve its aims in

transforming care by improving capacity through admission avoidance, earlier discharge and supporting high-quality access to care in alternative settings.

Over the next five years, our strategy will focus on six key themes:

Person centred care

- Holistic approach to shared decision making
- High-quality prescribing to improve patient outcomes and reduce health inequalities. Currently, we have a focus on cardiovascular, diabetes and respiratory disease
- Equity of access to medicines and a standardised approach with shared guidelines to best practice in all settings
- Supporting patients to self-care where appropriate.

Delivering best value

- Making best use of available resources by:
- Shared system evidence-based and cost-effective formulary – 90% adherence in all settings
- Best value biologics (high-cost drugs) – 90% use of best value biologics
- Reduce prescribing of low-priority medicines
- Reduce waste
- Reduce environmental impact of medicines and inhalers (working towards NHS net zero in 2040)

Medicines Quality and Safety

- System approach to improving medicines safety across primary and secondary care. Aim to align incident report system across all providers, improving safety by reporting and learning from medication errors whilst encouraging an open culture
- Reducing hospital admissions related to medicines (HARMS) – World Health Organisation challenge to reduce this by 50%
- Improving performance against national and local targets – currently, our focus is anticoagulation, sodium valproate in pregnancy and prescribed dependence performing medicines (opioids)
- Deprescribing to reduce inappropriate polypharmacy
- System Antimicrobial Resistance Strategy by July 2023.

View the Medicines Strategy.

Key deliverables

Year 1

- **Medicines and Waste Campaign**
- **Antimicrobial Stewardship** - appropriate durations of antibiotic course lengths - appropriate antibiotic prescribing for children with acute respiratory tract infection (RTI)
- Review of **Diabetes Optimal Treatment targets**
- Pilot use of **Continuous Glucose Monitoring (CGM) for Type 1 and Type 2 diabetes patients** in one of the PCNs
- **Medicines Governance Assurance Plan** agreed
- **Medicines Safety Plan** agreed

- **High-Cost Medicines (NICE)** current compliance scoped
- **Manage uptake of biosimilars and incentivise** with gain share
- **Tirzepatide implementation -** plan agreed with providers
- **Diabetes hybrid closed loop -** plan agreed with providers

Years 1-2

- Following Year 1 review, **optimising of all 3 diabetes treatment targets** through the use of structured medication reviews, individualised care and annual diabetic reviews
- **Implementation and rollout of CGM in Care setting** following evaluation of pilot.
- **Optimisation of anti-hypertensive therapy** in line with NICE guidance to achieve the national ambition of 80%
- **Enhanced lipid modification therapy** for primary prevention to improve cardiovascular outcomes.
- **Medicines Governance Assurance Plan** consolidated
- **Medicines Safety Plan** consolidated
- **High-Cost Medicines (NICE) -** confirm and challenge report

5.12 Duty to address the needs of survivors of abuse

We have a duty to address the needs of survivors of abuse in our area. People can be survivors of a range of different types of abuse, such as domestic abuse, sexual abuse, child sexual exploitation (CSE), criminal exploitation, neglect, financial or emotional abuse. Our approach and actions to delivering this duty are summarised below.

Preventing abuse

- Effective multi-agency working though safeguarding partnerships
- Delivering the requirements of the Serious Violence Duty
- Commissioning services based on existing resources and robust population information
- Linking with the voluntary sector
- Linking local and NHSE commissioned services
- Participation in the Criminal Justice Partnership
- Engaging those with lived experience in our plans and actions, including co-production
- Implementing the Liberty Protection Safeguards in line with national timescale
- Engaging CYP and their carers in our plans and actions

Supporting those who have suffered abuse

- Listening to victims and their needs
- Implementing a trauma-informed approach to relevant commissioned services
- Building pathways based on knowledge and information about the effectiveness of interventions
- Focusing on the prevention of ill mental health
- Working with schools and education establishments
- Meeting the needs of looked-after children
- Engaging CYP in our plans
- Delivering the actions required in the Independent Inquiry into Child Sexual Exploitation in Telford (IITCSE).

How will we know our approach is working?

- Robust multi-agency datasets to triangulate crime, social care and health data
- Working with Healthwatch and those with lived experience
- Working in safeguarding partnerships to gain intelligence on changing themes in abuse and the prevention measures needed as a dynamic process
- Benchmarking with other areas and engagement in regional and national improvements
- Audit of services
- Gaining feedback from service users to ensure the approaches are working

Chapter 6:

Enablers

6.1 People

Our system workforce has been working collaboratively for many years, an approach underscored during the system's response to the COVID-19 pandemic. During this time, relationships have formed between NHS, local authority, ICB (formerly CCGs), primary care, social care and voluntary sector partners to tackle the workforce pressures at a system level.

Our ICS People, Culture and Inclusion committee draws its membership from a broad range of stakeholder organisations and continues to build on our collaborative approach towards delivering the national guidance for ICB people functions to support a sustainable 'One Workforce' within health and care – creating a compassionate and inclusive culture and working collaboratively as a system to address our workforce challenges.

People Strategy

Our People Strategy sets out our ambition for the circa 23,000 people who work with us across health and social care. Our strategy is focused on the delivery of the NHS People Plan, underpinned by the NHS People Promise and the ambitions set out in the Future of NHS Human Resources and Organisational Development

Our refreshed People Strategy is designed to help bring our integrated care strategy and operational plan to life through the following strategic drivers:

- Improve outcomes in population health and healthcare.
- Tackle inequalities in outcomes, experience, and access
- Support broader social and economic development.
- Enhance productivity and value for money.

These strategic drivers are translated into a small but focused number of workstreams to deliver our commitments to those we serve through effective and efficient models of delivery. Our priorities include:

- the reduction of unavailability of substantive workforce
- continued reduction in use of agency and bank staff
- maximisation of national programmes such as the national bank
- enhanced career pathways through apprenticeship and T levels for hard to fill and scarce skill professions
- transformation of our UEC and elective care workforce to support pathway redesign
- move towards more integrated and collaborative corporate services

Working collaboratively with system partners we are identifying areas for improvement in how we can support and value diversity even further and create an inclusive workforce and culture. Our aim is to have a workforce profile that is more representative of the communities we serve. To support this we will expand apprenticeship opportunities, T-levels and alternative routes into a career in health and social care, and we will continue to develop more diverse leaders across the system through our involvement in schemes like the High

Potential Scheme. Furthermore, we will work with system partners to ensure delivery of the six high impact actions to improve equality, diversity and inclusion throughout all that we do.

Finally, to prepare for the introduction of the national leadership and management competencies, we are investing in our leadership team to drive a culture of courage, compassion and continues improvement. These skills and knowledge will support the ICS to navigate the challenges and capitalise on the opportunities, as well as supporting the development of an engaged and motivated workforce who deliver high quality patient outcomes.

With the evolving landscape in terms of a new 10 year plan, annual operational planning guidance and the likelihood of a new People Operating Model being published we will refresh our priorities regularly in collaboration with system partners to ensure they remain relevant to the context within which we are operating.

Key deliverables

Year 1

- Delivery of commitments within the operational plan relating to workforce
- Development of an **Equality Diversity and Improvement strategy** / plan
- Engagement with **cohort 2 of the high potential scheme**

Years 2-3

- Delivery of **efficiencies in corporate services**

6.2 System procurement

National priorities

Nationally the NHS launched the NHS Commercial Portfolio and the Strategic Framework for NHS Commercial during 2023. This outlines how the NHS and government functions will work together to transform public procurement. The NHS Commercial Portfolio has seven main service offerings:

- People and Community
- Technology and data
- Commercial strategies
- Governance, assurance, and processes
- Sourcing and management
- Commercial capability/best practice
- Sustainability and innovation.

The Strategic framework builds on several of the national commercial function service offers but goes further to provide a centrally driven blueprint for whole system commercial and supply chain transformation across four thematic areas.

- Our People
- Digital and Transparency
- How we work
- Influence and scale

The introduction of the 2023 Procurement Act in October 2024 will necessitate significant changes to NHS procurement practices.

Local governance

The System Director of Procurement chairs a bi-monthly Procurement Working Group encompassing NHS and local authorities within STW which will enable future collaboration within procurement. A monthly System Product Evaluation Group has been introduced to look at standardisation of products and suppliers linked to patient pathways. Standardised use of products will assist with better knowledge and safer usage of products leading to a better patient experience. Other benefits include efficiencies, standardised training, and equity for patients.

Local function

The Shropshire Healthcare Procurement function has focussed on training to support the demands of the changing ICS landscape and has embedded several apprenticeship positions to grow our own procurement workforce.

The function has developed and matured over recent years and is well advanced in terms of partnership working as an ICS with proactive engagement to deliver as a system.

The procurement function has embedded the use of national benchmarking tools (Spend Comparison) and workplan pipeline (Artamis) to enable the system to understand system spend profiling, transparency of expenditure and to assist with identifying opportunities.

Key Deliverables

Year 1

- Procurement awareness and training
- Review strategic supplier management options
- Identify collaborative Trust project opportunities
- Increase procurement profile in trusts
- Clinical Nurse Procurement Speicalists
- Review and reduce the use of waivers
- Review e-procurement strategy and progress against it
- Income generation supplying GPs
- Review of items held in stores and cost improvement opportunities
- System procurement key areas: workforce/estates/digital

Years 2-3

- All procurement via one department ICB/SATH/SCHT/RJAH
- All contactive via procurement – digital/estates/pharmacy/GP
- One supply chain and logistics service for all providers
- Manage key suppliers to drive reciprocal benefits and gain share
- Reduce number of products and suppliers used within the Trust
- Totally electronic P2P system impelemented and managed by procurement
- Update e-procurement strategy in line with national guidance

- Increase supply to GPs/voluntary organisations

Years 4-5

- Drive efficiencies and saving via full contract
- Collaboration across Shrosphire and West Midlands where appropriate
- Demonstrate best value for money for all strategic products
- Reivew logisitics provision
- Hospital Transformation Programme review procurement and logistics implications
- Tender transport logistics provision
- Review procurement structure/skill mix and succession planning
- Review procurement strategy/1-5 year plan

6.3 Digital as an enabler of change

Digital transformation is fundamental to improving service delivery, addressing health inequalities, and enhancing patient outcomes across STW ICS. The latest NHS England 2025/26 Operational Planning Guidance prioritises digital as a key enabler for elective recovery, UEC reform, and tackling inequalities, aligning national expectations with our local strategic objectives. The ICS continues to embed a digital-first, but not digital-only approach, ensuring equitable access to services while supporting digital inclusion efforts.

To support elective recovery, we will maximise digital tools such as the NHS App, Patient Initiated Follow-Ups (PIFU), and virtual wards, reducing unnecessary outpatient visits and enabling self-management of care where clinically appropriate. Enhanced use of Shared Care Records (ShCR) will ensure seamless information sharing across providers, improving efficiency in clinical decision-making. Additionally, OrderComms and digital diagnostics will streamline test ordering and results management, accelerating diagnostics and triage. The modernisation of PACS (Picture Archiving and Communication Systems) will further enhance access to imaging, reducing delays and improving clinical workflows.

In urgent and emergency care, we will drive the Electronic Patient Record (EPR) rollout programmes at the acute trusts, ensuring that clinicians have real-time access to patient information, improving decision-making, and reducing duplication. The implementation of the Federated Data Platform (FDP) will enable system-wide data integration, allowing for better resource allocation, operational efficiency, improved patient flow across care settings, and enhanced population health insights.

Reducing health inequalities remains a core objective, with efforts focused on mitigating digital exclusion through initiatives such as loaned digital devices, digital literacy training, and local authority partnerships. Expanding remote monitoring and econsultation services will improve access for underserved communities, particularly in rural areas, while ensuring that those unable to engage digitally have alternative pathways.

STW ICS will continue to align its digital portfolio with national funding opportunities, ensuring sustainability in Microsoft 365 adoption, Windows 11 implementation, cybersecurity enhancements, and supplier management. The integration of AI-driven tools such as NHS

Copilot will streamline administrative processes, freeing up clinical capacity and supporting workforce efficiency.

By embedding digital solutions into every aspect of care delivery, STW ICS is committed to achieving a modern, efficient, and patient-centred healthcare system, addressing the critical challenges outlined in the Elective Recovery, UEC Reform, and Health Inequality frameworks.

Our current position and the future desired state of our ICS are described below:

Current position

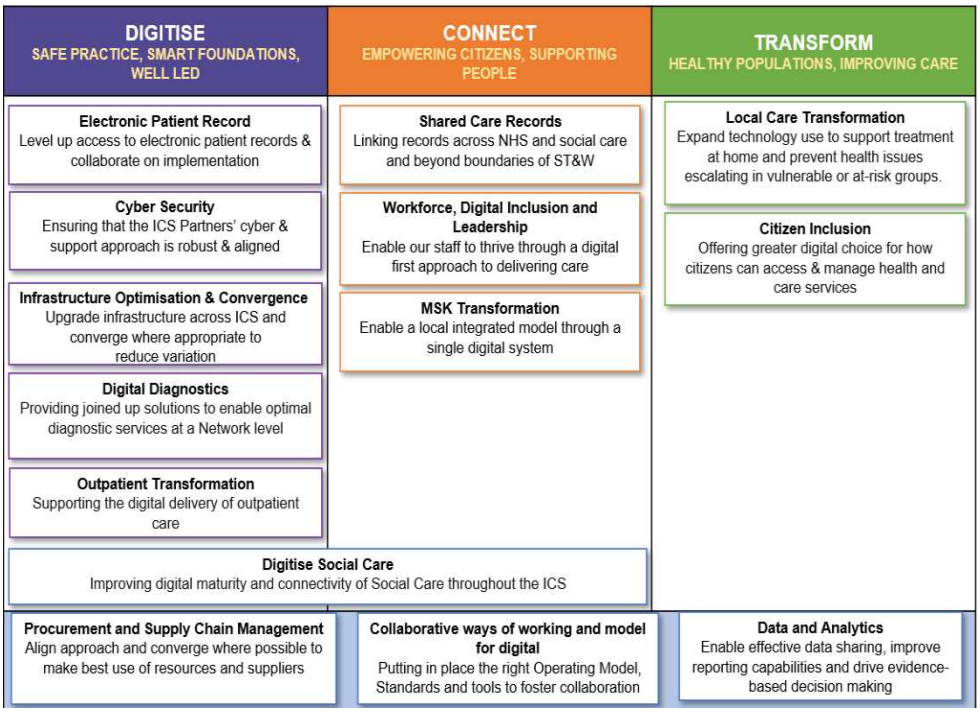
- A 'digitally immature' system with variation in digital capabilities across organisations.
- Digital inclusion across communities is worse than the national average, limiting access to digital health services.
- Ageing IT infrastructure and estate, including outdated hardware and software across community hospitals, primary care, SaTH, and local authorities.
- Fragmented and siloed digital services, with each organisation managing digital projects in isolation.
- Limited system-wide interoperability, leading to delays in data sharing and decision-making.
- Inconsistent use of Microsoft 365 tools, limiting collaboration and efficiency.
- Cybersecurity risks due to legacy systems and inconsistent compliance measures

Desired future state

- A digitally enabled ICS that meets national expectations and delivers against local priorities through strategic investment and system-wide collaboration.
- Proactive digital inclusion initiatives supporting patients and staff, including loaned digital devices, training programmes, and local authority partnerships to bridge the gap.
- Upgraded IT estate with Windows 11 deployment, modern network infrastructure, and cloud-based services, ensuring a future-proofed digital environment.
- A unified digital strategy underpinned by the Federated Data Platform (FDP), Shared Care Records (ShCR), and system-wide governance, enabling better coordination and resource sharing.
- Full integration of EPR systems at acute trusts, OrderComms and digital diagnostics, EPMA, and modernised PACS, ensuring seamless access to patient data across all care settings.
- Optimised Microsoft 365 adoption, including Copilot AI integration, improving productivity and automating routine tasks for staff.
- Enhanced cybersecurity framework, ensuring compliance with NHS DSPT standards, threat monitoring, and proactive risk management across all ICS organisations.
- Streamlined supplier management with a structured digital investment plan, ensuring cost-effective procurement and maximised return on digital investments.

Our Digital Pledges

To deliver our ambitions and pledges, we will embed sustainable ways of working to ensure we are best set up to successfully deliver our digital portfolio.



ICB Commissioning Ambition

To drive digital transformation across STW, ensuring technology is a key enabler of improved health outcomes, equity of access, and operational efficiency. This includes digital inclusion, interoperability, and local and integrated care pathways.

Key deliverables

Year 1

- **Electronic Patient Record (EPR) rollout** at acute trusts
- **Shared Care Record** (ShCR) enhancement
- **Windows 11 transition** across ICS organisations

Years 2-3

- **Federated Data Platform** (FDP) implementation
- **OrderComms and digital diagnostics** implementation
- **Copilot AI** deployment
- **PACS**
- **EPMA**
- **Virtual Wards Remote Monitoring**

6.4 Data and Information

There is an ambition to develop a system-wide approach to the management and visibility of linked data in place to inform Strategic Commissioning and outcome-based approaches to pathway redesign.

Our reliance on data to inform and drive decisions is becoming more inherent to our everyday needs along with the ability to make decisions and support our development of a Population Health Management approach to health and care commissioning and a coordinated reduction in the Health Inequalities across our population.

We are developing a system data strategy which will allow us to drive the necessary improvement in both the quality and coordination of our data across all partners. This will enable us to make better informed decisions which are key to supporting the delivery of our strategic aims.

There have been several publications over the recent years including the Hewitt Review, What Good Looks Like Framework and Data Saves Lives to name a few. Contained within these it is evident that we need good quality, timely and accurate data to inform data driven decision making.

The data strategy will support the development of a record level linked dataset for secondary uses by all system partners and include datasets from all system partners. This will be used to identify areas of poor outcomes and allow us to monitor their improvement over time.

The strategy will also look into how we can include advanced tools and techniques to support strategic analytics. This will include, for example, the use of innovative coding languages like “R” and advanced forecasting techniques through machine learning. This will be heavily dependent on the investment of upskilling our current workforce and linking with digital colleagues.

Critical to the success of our system will be allowing our analytical workforce to grow and thrive. Working with the developing recognition nationally of analysts, we will look to implement the benefit of the National Competency Framework as well as using APHA (Association of Professional Health Analysts and FEDIP (Federation for Informatics Professionals in Health and Care) to professionalise the analytical community.

Key deliverables

Year 1

- **Data Strategy developed** and agreed by all system partners.
- Aims of national planning guidance delivered

Years 2-3

- Adoption of the Federated Data platform
- Agree and implement governance to support system wide working
- Review partner infrastructure for reporting
- Develop workforce in line with national competency framework

Years 4-5

- **Adopt Machine Learning** tools and techniques
- **Apply Data Science** principles

6.5 Estates – System Physical Infrastructure, Estates Strategy and Planned Delivery

In line with NHSE requirements, all ICSs need to draft their Estates and Physical Infrastructure Strategies. This process will need to be fully integrated into all system, clinical and non-clinical workstreams. The development of the strategy will aid system thinking and alignment across the infrastructure components and core objectives, and must fully integrated with all elements of the forward plan. We aim to deliver an estate which is fit for purpose and provides high-quality care environments which enable the safe delivery of services for our communities. This means an estate which is compliant and functionally suitable, environmentally sustainable, accessible, flexible, and designed around changing service needs.

ICS Estates and Physical Infrastructure Strategies will be used to inform future NHS Treasury Funding.

The Estates and Physical Infrastructure Strategy will be comprised of the following components:

- Estates physical infrastructure with specific focus on the shift from acute to community and from treatment to prevention.
    - Primary care estate
    - Community estate
    - Acute
    - Mental health
- Other physical infrastructure including analog to digital to support estate utilisation priorities.
    - Energy
    - IT physical infrastructure
- Medical equipment
- Zero carbon roadmap.

The strategy will also support the system priorities of the Hospital Transformation Programme, Local Care Programme, MSK Transformation and Outpatient Transformation as well as existing physical infrastructure workstreams and projects like Community Diagnostic Centres, Community Hubs including Integrated Neighbourhood Teams and non-clinical estates rationalisation.

Key deliverables

Year 1

- **Implement Strategic Estates Group** and associated Governance
- Finalise **ICS Infrastructure Strategy**
- **10 year capital investment plans** that underpin delivery of the Strategy

Years 2-3

- Creating **integrated and flexible clinical estate**
- **Improving utilisation** and sharing of estate non clinical and clinical
- **Integrating digital access** and workforce as key enablers to supporting estate utilisation

Years 4-5

- **Reduction in VOID space**
- **Reduction in Critical Infrastructure Backlog Maintenance**
- **Increased Primary Care Estate** to support expected population growth

6.6 Financial sustainability

The Shropshire, Telford and Wrekin system has a significant underlying financial deficit which is one of the reasons that we are part of the Recovery Support Programme (RSP). The system and ICB is therefore subject to significant scrutiny around finances and financial decisions, with a specific requirement to develop an approach to recovering and making sustainable our financial position.

A system financial framework was therefore developed in 2020/21 and agreed by all organisations and all system partners, working closely together to deliver a roadmap for financial recovery.

All organisations have:

- approved the approach of 'one model, one consistent set of assumptions' and recognise that the position of each organisation will evolve and change transparently
- agreed to mobilise and deliver the plan to enable the development and delivery of the financial strategy and Financial Improvement Framework as part of an Integrated System Strategy
- ensured that the transparent and agile approach to financial planning and management continues across the system
- recognised the initial financial control totals in the Financial Improvement Framework with a commitment to agree organisational control totals within that
- agreed to work together to use our resources flexibly and effectively, to deliver the system vision.

To ensure that all decision-making is open and changes are understood and approved by all, the system has been operating under the 'triple-lock' process and using a principle of 'moving parts.' This means that decisions are made at local, ICS and regional NHS England level (triple lock) and that new expenditure can only be committed if it is backed by new income, productivity or efficiency ('moving parts'). The principles are designed to ensure decisions are owned by each organisation and at system level, with oversight from NHSE. All investment decisions are made using a system-wide Strategic Decision-Making Framework to ensure allocative efficiency and that all decisions take into account the ICS core aims - Improving outcomes in population health and healthcare, tackling inequalities in outcomes, experience, and access, enhancing productivity and value for money and helping to support broader social economic development.

The System Integrated Improvement Plan provides the mechanism by which the ICB will come out of NHSE oversight level NOF 4. Delivery against monthly milestones within the plan is reported to ICB and ICS Executives through the System Transformation Group and System Finance Committee. Evidence of delivery is collated and submitted to NHSE, and then formal progress is presented at our national Recovery Support Meeting which are quarterly. Formal

changes to the RAG status of our exit criteria are agreed at the regional NHSE Recovery Support Oversight group (RSOG). The formal sign off of exit criteria is agreed through the national Quality and Performance Committee based on the recommendations from the regional RSOG.

In 2023/24, the impact of the first-year strategies have supported the delivery the 2023/24 £129m underlying exit deficit.

In 2024/25, the impact of the second-year strategies have reduced the underlying exit recurrent deficit to an expected £115m.

For 2025/26+ the financial planning principles adopted are as follows:

- Year on year improvement in the recurrent underlying position.
- Total efficiency targets including productivity of between 4-6%.
- Prioritisation of limited growth funding and investments, unless essential for generating income, delivering productivity or efficiency or meeting agreed waiting time targets
- Workforce monitoring and controls, reducing agency spend and escalation costs
- Controls on expenditure through the Triple Lock process for transactions of £10k across the system
- Reviewing cost pressure drivers to ensure effective controls and monitoring systems are in place
- A system-wide approach to efficiency, transformation, and productivity.

The medium to long term plan has been developed during 2024/25 setting out the recovery trajectory for the system showing the route to breakeven, including a detailed multi-year revenue and capital (strategic and operational), workforce, efficiency, and transformation plan.

A system-wide approach to efficiency and transformation is in place. We use a project management approach to ensure effective monitoring of achievement using business intelligence data and financial analysis. System-wide transformation programmes address the key system excess spend drivers and productivity opportunities and include Continuing Healthcare, Urgent and Emergency Care, Workforce including Temporary Staffing and Corporate Services, Local Care Programme and Elective Care which includes MSK and Outpatient transformation.

All ICB contracted services will be reviewed to ensure value for money is achieved. Where this is not the case, decommissioning and disinvestment will be considered alongside any 'Hard Decisions', using the Strategic Decision-Making Framework to further support allocative efficiency.

Key deliverables

Year 1

- **Improvement in the underlying recurrent financial performance**
- Refresh of the **System Financial Strategy and Medium-Long Term** Plans

Years 2-3

- **Delivery of the Medium Term Financial Plan** Capital and Revenue inclusive of the Recovery Plan via the System Transformation Programmes

Years 4-5

- **Delivery of the remaining Medium Term Financial Plan** Capital and Revenue priorities including the Hospital Transformation Programme and Local Care Programme

6.7 Productivity

A system productivity oversight group has been in place since June 2023 and meets monthly to coordinate and oversee delivery of the system level improvement in productivity and efficiency. It will work with regional leads to ensure our systems and processes are aligned to regional and national priorities and allow all parts of the system to share ideas and best practice for improvement. Intelligence on the opportunities for productivity will be drawn from benchmarking sources NHS Futures, Model Hospital, GIRFT, NHS England productivity reports and local benchmarking with other ICB's and providers. The productivity oversight group will be supported by system resources across finance, business intelligence, clinical and operational leadership and project management to ensure the delivery of productivity improvements. Providers will have their own individual plans, but the impact and learning will be shared at the oversight group to ensure our plans are delivering the required improvement. It reports to the System Finance, Productivity and Planning Group and into the System Finance Committee.

The Hewitt review of ICSs outlined the need to focus on the creation of health value and implementation of innovative financial flows and payment mechanisms. As the system matures, opportunities to understand the cost of whole care pathways and intelligence through population health management approaches will allow consideration of resource allocation to provider collaboratives and places.

ICBs have been notified that baseline running cost allowances (allocations to fund the running costs of an ICB) will reduce by 30% in real terms by 2025/26, with at least 20% to be delivered by 2024/25. This provides us with an opportunity to review how we deliver the core business of the ICB alongside the development of our models for provider collaboratives and place.

In 2024/25 NHS England commercial directorate produced standardised productivity packs for all ICB's setting out efficiency opportunities for Continuing Healthcare and Prescribing. Provider packs detailed productivity and efficiency opportunities in Corporate Services, Temporary Staffing, Urgent and Emergency Care, Elective and Outpatients, Medicines and Commercial opportunities. These productivity and efficiency opportunities will form a key part of the financial recovery plan aligned the medium-term financial plan.

Key deliverables

Year 1

- Validation of **ICB and Provider efficiency and productivity opportunities**.
- **Development of efficiency plans** to deliver productivity and efficiency opportunities

Years 2-3

- **Delivery of agreed productivity and efficiency improvement plans** to support cash releasing efficiencies and performance improvements

Years 4-5

- **Delivery of agreed productivity and efficiency improvement plans** to support cash releasing efficiencies and performance improvements.

6.8 Our commitment to research and innovation

Duty in respect of research

The ICS developed a research and innovation strategy agreed through the Staffordshire and Stoke-on-Trent, Shropshire Telford and Wrekin Health and Care Research Partnership (SSHERPa) – signed off at the STW ICS Research and Innovation Committee in November 2023.

The key pillars of the research strategy are as follows:

1. Developing collaborative integrated research that addresses the health and care priorities of our region, expanding the range and diversity of research undertaken in our region
2. Fostering a culture of collaborative research and innovation with strong leadership championing the strategy
3. Developing the capacity and capability for evidence-based health and care
4. Increasing the opportunity for our region's population to engage in research
5. Developing a collaborative infrastructure for research and innovation in our region to support and grow an increased research portfolio
6. Supporting the implementation of best evidence into practice – commissioning and provision of services.

Our strategic objectives provide the framework for how we will achieve our vision and realise our principles through:

Workforce Development

- Championing a research culture where everyone is valued and able to contribute to, and benefit from, research
- Developing innovative career pathways, embedding research into health and care professional roles
- Sharing knowledge and expertise, developing research professional roles across the partnership

People, Places and Communities

- Creating opportunities for inclusive research across diverse communities
- Enhancing the opportunity for people to shape research, reducing health inequalities across our diverse urban and rural geography

- Enhancing the opportunities to engage in research – championing the people and teams that support this
- Developing infrastructure that supports wider engagement in research

Impact

- Creating an eco-system where research outputs can be rapidly adopted into practice/policy
- Developing co-production strategies that support the mobilisation of knowledge
- Transforming health and care through high quality research
- Supporting sustainability through new approaches to health and care research delivery
- Supporting economic development through income generation

All of the above supported by high quality research, empowering all to engage, improving outcomes through partnership and leadership.

Executive leadership and hosting of SSHERPa is now in place along with a provider executive sponsor and programme management support. We have a dedicated ICB lead for research (Chief Medical Officer) who provides senior leadership between SSHERPa and the ICB.

Work has also continued to develop and enhance partnerships across the health, care and the VCSE sector to advance research and innovation to support the four core purposes of the ICS. Development of our research engagement activities to reach wider communities has been supported through the establishment of voluntary and community sector research coordinators and the development of a research connector's network across our region. These links provide routes by which we can engage with under-served communities by taking research to those who do not currently have the opportunity to engage in research.

As part of developing the local research infrastructure, members from the voluntary, community and social enterprise (VCSE) sector are now key partners of SSHERPa and a dedicated patient, public and community involvement and engagement work stream is in place. This draws together those working in public engagement across all settings and community engagement with VCSEs, to ensure that new studies are in development, and established NIHR portfolio studies are shared across the widest population. Since February 2024, just under 5,000 people have been recruited to take part in a research study in NHS Shropshire Telford and Wrekin ICS, and through our community networks we are seeking ways in which we can extend these opportunities further.

Through working with communities, we have established voluntary and community sector research coordinators, hosted by the VCSE and funded through the NHSE REN programme, developed a research connectors network across our region and supported individual community research champions. We will continue to work with all health and care research partners to seek ways in which we can engage with under-served communities by taking research to those who do not currently have the opportunity to engage in research. Partners include NHS trusts, local authorities, VCSE organisations, universities, National Institute for

Health and Care Research (NIHR), Clinical Research Network West Midlands (CRN WM) and the West Midlands Health Innovation Network.

Developing collaborative integrated research addressing the health and care priorities of our region: Examples of how we are supporting this agenda include the successful application to be part of a national programme around dementia biomarkers, developing applications to establish a NIHR Mental Health Research Group (led by Keele University but with VCSE as co-applicants) and the development of a dementia study across rural locations.

We were delighted to secure NHSE research engagement network funding and to have delivered the NHSE Touchpoints programme as part of SSHERPa, where more than 11,000 people were directed to the NIHR Be Part of Research website. We work closely with our university partners to support 'home grown' research, and work with our NIHR CRN WM to ensure portfolio studies come to our region. Our priority is to work with partners to better understand how participation in these programmes can influence evidence-based service transformation in our region.

On a regional level, SSHERPa partners form part of West Midlands Secure Data Environment (WM SDE) Network workstreams, and have strong links with local research infrastructure and stakeholders to ensure that we support staff, organisations and our local population to be involved in research to support health and care priorities. We are working closely with NIHR CRN WM as it transitions to the new NIHR Regional Research Delivery Network to understand implications for support for wider settings including primary care and community settings.

Across our ICS research partners, we are driving collaborative working, actively sharing best practice. We have an established research governance work stream whereby we are streamlining processes with the aim of establishing one 'SSHERPa' check for studies that operate across organisational boundaries. Through this, workstream organisations are sharing knowledge and expertise to support organisations without research and development infrastructure – for example, VCSE. SSHERPa partners work closely to share training and workforce opportunities (STARs and research practitioners), develop research engagement approaches targeting different health and care professionals (for example, evidence based practice groups such AHP/GPNs, CENREE, NMAHP, LENSE, criminal justice settings, SCREEN for social care, PRIDE for public health); and seek innovative ways to build the capacity and capability for research, through joint clinical academic appointments, shared training opportunities and innovative research and innovation roles.

We were delighted that our work in driving research and innovation through SSHERPa, and the progress we have made in embedding research within the ICS, was recognised at the NIHR CRN WM annual awards 2023, with SSHERPa winning the 'Shining Research Star' award.

Innovation

We want to be an innovative and learning healthcare system to help improve the lives of patients. On this basis, we will work with a range of partners, including primarily the local Academic Health

Science Network (AHSN), which is the innovation arm of the NHS. The voluntary and community sector can be a particularly rich source of innovation and new ideas.

Key deliverables

Year 1

- **Research collaboration between system partners** established
- **Research Strategy co-designed**

Years 2-3

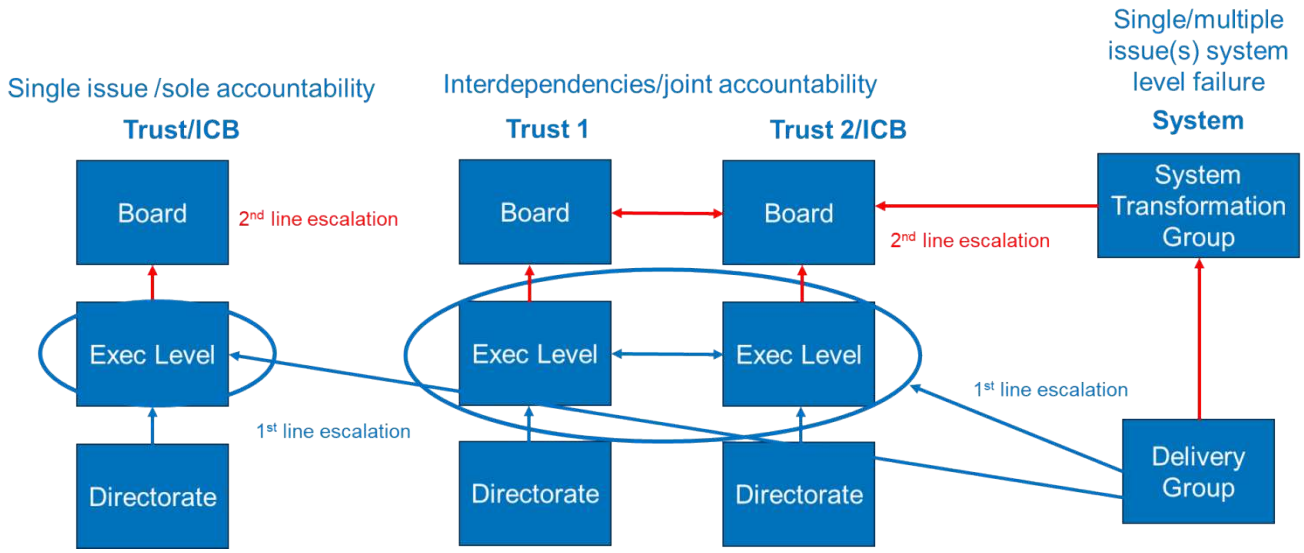
- **Shared approach to research governance** and infrastructure developed
- **Development of collaborative funding bids** for research infrastructure and grants
- **Development of partnerships with HIWM**

Years 4-5

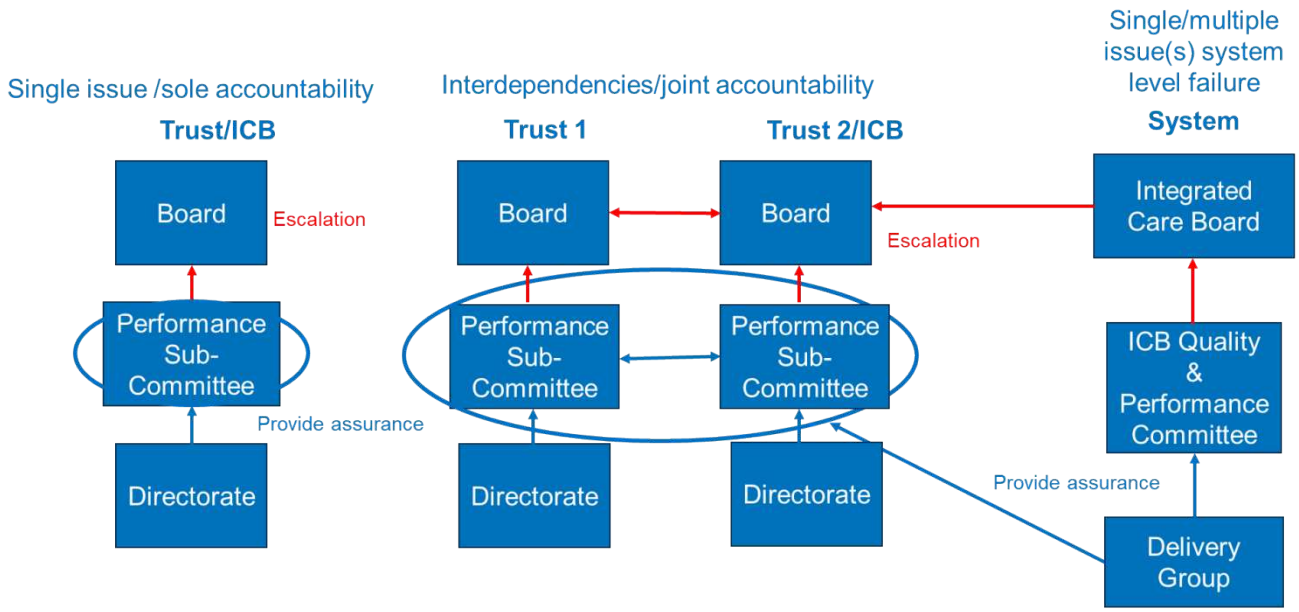
- **Embedding of collaborative approach** to research infrastructure and bids
- Increased number of **successful collaborative research bids**
- **Increased participation** in research across all communities
- **Implementation of innovations relating to clinical priorities** in partnership with HIWM

Appendix A:

Schematic of the delivery governance



Schematic of Assurance governance:-



Appendix B

Duty to offer patient choice

As standard ongoing practice, processes are in place to ensure NHS STW honours its statutory obligations in ensuring patient choice, as per the National Choice Framework set out by the Department of Health and Social Care (DHSC).

While GPs and referring clinicians can offer choice by utilising the e-Referral Service (eRS) at the point of referral, in STW we have a Referral Interface Service which processes all routine and urgent referrals. This means the majority of the choice conversation with patients, and ensuring the provision of patient choice, is provided by this team. It is an embedded standard working practice for this team to offer a minimum of five possible provider options to choose from when a patient has been referred into consultant-led care.

Mapping of referral pathways, whether in their current or future state, also forms a standard part of any review, redesign and transformation of services, service change or development. This would always include the need to ensure the provision of patient choice as part of that commissioned pathway.

Even with the recent move towards developing and implementing direct referral pathways as per the GP Access Recovery Plan, and areas of innovation like the implementation of electronic eyecare referrals from optometry to secondary care, we are still ensuring pathways are in place and that the referral goes via the Referral Interface Service to ensure patients are informed, involved and empowered in their own care, options and decision making.

Although patient rights and the National Choice Framework are already well established, further work is happening currently in STW to enhance public and staff communications and awareness. The aim of this work is to raise the profile of these statutory rights, and what patients should expect, through various communications tools. These include the development of a public-facing Choice Policy Statement that will be published on the ICB and ICS website, use of posters, leaflets, and social media channels to promote the messaging, as well as providing links to the national 'easy read' leaflets around these patient rights.

An Integrated Impact Assessment was completed on our patient choice work and supported by the Equalities and Involvement Committee, the outputs from which informed a bolstered range of public FAQs for publishing.

There is a local communications plan in place, aligned with the national communications toolkit on patient choice which was made available in December 2023. This plan was developed to inform and raise awareness and understanding among key stakeholders including staff from provider trusts, primary care and the ICB, along with the public, Healthwatch, MPs and councillors.

Strategically over the coming year, we will be working with primary care and provider colleagues as part of all transformation and service programmes, to start working towards encouraging patients to be more actively involved and manage their own appointment choices through things like My eRS and the NHS App.

Work is underway on the development of a robust accreditation framework and process for the listing of other providers, which will broaden the range of provider options that can be made available to patients to choose from. This work will be completed in the coming months.

Finally, as per the request issued by central Government in May 2023, the ICB actively participates in the national rollout of Patient Initiated Digital Mutual Aid. Through this, and aligned with the national phased rollout programme, long waiting patients are proactively identified and validated, before being offered the opportunity of changing to an alternative provider who has a shorter waiting time than where they are currently.

The national toolkit suggested that minimal communications were required as patients will be contacted directly where they have been identified as eligible to change provider, however we continue to ensure patients are aware of their right to choose.

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Appendix C

Our Neighbourhoods

Shropshire Neighbourhoods

Total registered patients – 318,279 *(April 2024)*

Rural Alliance

Population –26,312

Community Hubs
Links with North, Shrewsbury and Southwest

GP Practices
Clive, Knockin, Shawbury , Pontesbury & Worthen, Westbury

North

Population – 91,434

Community Hubs - NE & NW

NE - Raven House

NW – Oswestry Library

GP Practices
Churchmere Medical Group, Market Drayton, Plas Ffynnon, The Caxton Surgery, Wem & Prees, Cambrian Hodnet Medical Practice (LCS)*

South East

Population – 59,605

Community Hub

Bridgnorth Library

Highley Health & Well-being Centre

GP Practices
Albrighton, Alveley, Bridgnorth, Brown Clee, Cleobury Mortimer , Much Wenlock & Cressage, Broseley, Ironbridge

South West

Population – 36,571

Community Hub

Ludlow Youth Centre

GP Practices
Bishops Castle, Church Stretton Craven Arms, Portcullis Surgery Station Drive Surgery, The Meadows

Shrewsbury

Population 104,357

Community Hub

Sunflower House

GP Practices
Belvidere, Marden, Marysville Riverside, Severn Fields, South Hermitage Surgery, Radbrook Green Surgery, Mytton Oak, Claremont Bank Surgery, The Beeches, Prescott Surgery

Partners involved in Neighbourhood Care – Local Authority, Voluntary Community and Social Enterprises (VCSE), Community Trusts; Midlands Partnership MHS Foundation Trust (MPFT), Shropshire Community Health Trust (SCHT)

Telford & Wrekin Neighbourhoods

Total Registered patients – 196,605 *(April 2024)*

Wrekin

Population – 32,725

Community Hubs
Evergreen Family Hub

GP Practices
Hollinswood & Priorslee Surgery , Wellington, Dawley

TELDOC

Population – 65,151

Community Hubs
Oak Family Hub
Cherry Blossom Family Hub
Hazel Family Hub

GP Practices
TELDOC is a Medical Practice that operates out of 6 sites across Telford and Wrekin:

- Malinslee
- Lawley
- Oakengates
- Madeley
- Hadley
- Leegomery

Shifnal & Priorslee Medical Practice (chosen to be part of Telford PCN)

South-East Telford

Population – 38, 675

Community Hubs
Live Well Hub Madeley
Walnut Family Hub
Silver Birch Family Hub

GP Practices
Court Street, Stirchley
Woodside, Ironbridge *(part of South-East Shropshire PCN)*

Newport and Central

Population – 60, 054

Community Hubs
Coming soon – Live Well/Family Hub

GP Practices

Wellington Road Surgery
Linden Hall Surgery
Shawbirch, Donnington
Charlton Medical Practice *(not part of PCN)*

Partners involved in Neighbourhood Care – Local Authority, Voluntary Community and Social Enterprises (VCSE), Community Trusts; Midlands Partnership MHS Foundation Trust (MPFT), Shropshire Community Health Trust (SCHT)

Appendix D: List of acronyms

Acronym	Meaning	Acronym	Meaning
BAF	Board Assurance Framework	MH	Mental Health
ACE	Adverse Childhood Experience	MIU	Minor Injury Units
AHP	Allied Health Professional	MOU	Memorandum of Understanding
AHSN	Academic Health Science Network	MPFT	Midlands Partnership University NHS Foundation Trust
ARC	Academic Research Council	MSK	Musculoskeletal
BAME	Black, Asian and minority ethnic	MSST	Musculoskeletal Service Shropshire and Telford
BAU	Business as Usual	MTAC	Maternity Transformation Assurance Committee
BCYP	Babies, Children or Young People	NHSE	National Health Service England
BI	Business Intelligence	NIHR	National Institute for Health and Care Research
BCF	Better Care Fund	NHSI	National Health Service Improvement
BTI	Big Ticket Items	NQB	National Quality Board
CCG	Clinical Commissioning Group	OD	Organisational Development
CDC	Community Diagnostic Centre	ODG	Operational delivery Group
CDH	Community Diagnostics Hub	ORAC	Ockenden Report Assurance Committee
CDOP	Child Death Overview Panel	PCN	Primary Care Network
CEO	Chief Executive Officer	PHM	Population Health Management
CL	Clinical Lead	PL	Programme Lead
CQC	Care Quality Commission	PMO	Project Management Office
CRN	Clinical Research Network	POD	Primary, Optometry and Dental
CVS	Council for Voluntary Service	PSIRF	Patient Safety Incident Response Framework
CYP	Children and Younge People	QIP	Quality Improvement Plan
DHCS	Department of Health and Social Care	QSC	Quality and Safety Committee
DTOC	Delayed Transfers of Care	RJAH	The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
ED&I	Equality, Diversity and Inclusion	ROS	Readiness to Operate Statement
FREED	First Episode Rapid Early Intervention for Eating Disorders	ROP	Recovery Oversight Programme
G2G	Getting to Good	RSP	Recovery Support Programme
HARMs	Hospital Admissions Related to Medicines	SaTH	Shrewsbury and Telford Hospital NHS Trust
HBPOS	Health Based Place of Safety	SDP	System Development Plan
HCSW	Health Care Support Worker	SEEDS	Support and Education on Eating Disorders

HI	Health Inequality	SFH	Sherwood Forest Hospitals NHS Foundation Trust
HTP	Hospital Transformation Programme	ShIPP	Shropshire Integrated Place Partnership
IAPT	Improving Access to Psychological Therapies	SCHT	Shropshire Community Health NHS Trust
ICB	Integrated Care Board	SMI	Severe Mental Illness
ICP	Integrated Care Partnership	SOAG	SaTH Safety Oversight and Assurance Group
ICS	Integrated Care System	SOF4	Segment 4 of the System Oversight Framework
IDC	Integrated Delivery Committee	SOP	Standard Operating Protocols
IG	Information Governance	SRO	Senior Responsible Officer
IITCSE	Independent Inquiry into Child Sexual Exploitation in Telford	SSHERPa	Staffordshire and Shropshire Health Economy Research Partnership
INT	Integrated Neighbourhood Teams	STW	Shropshire, Telford and Wrekin
JHWBB	Joint Health and Wellbeing Board	TWC	Telford and Wrekin Council
JSNA	Joint Strategic Needs Assessment	TWIPP	Telford and Wrekin Integrated Place Partnership
KLOE	Key Lines of Enquiry	UEC	Urgent and Emergency Care
LCTP	Local Care Transformation Programme	UHNM	University Hospitals of North Midlands NHS Trust
LDA	Learning Disability and Autism	UTC	Urgent Treatment Centres
LeDeR	Learning from Life and Death Reviews of people with a learning disability and autistic people	VCSE	Voluntary, Community and Social Enterprise
LMNS	Local Maternity and Neonatal System	VCSA	Voluntary and Community Assembly
LTP	NHS Long Term Plan	WMAHSN	West Midlands Academic Health Science Network
LTP	Local Transformation Plan	WMAS	West Midlands Ambulance Service
MDT	Multi-Disciplinary Team		

Appendix E: How we engaged our different stakeholders

To inform our Joint Forward Plan, we launched the Shropshire, Telford and Wrekin Big Health and Wellbeing conversation programme of engagement with our communities, staff, and partners. It was essential that our engagement activity was accessible and as visible as possible, using all established methods of communication and engagement such as a range of printed materials, online and face-to-face contact through a variety of meetings and events, as well as embarking on new channels of digital engagement.

Partnerships were formed with VCSE organisations, Healthwatch and local media organisations to maximise reach and raise awareness about the activity. Activity was tailored to ensure it is appropriate for the local population and those with specific protected characteristics. New technology and social media were used to communicate and engage with citizens.

Our approach was to collaborate extensively with local people who use health and care services, their families and any carers, local political stakeholders as well as members of the public, including seldom heard groups to ensure that our residents help inform our decisions.

Listening Events

To launch the Big Health and Wellbeing conversation, we organised six listening events for the public and our stakeholders. Locations for the public events were selected based on the intelligence of our partners and stakeholders, based on current local issues and existing activity. Six locations in Shropshire, Telford and Wrekin were identified. These were:

- Telford – Sutton Hill
- Bishops Castle
- Telford Centre
- Ludlow
- Market Drayton
- Shrewsbury.

Those that attended the sessions were taken through a short presentation about the Shropshire, Telford and Wrekin ICS, the challenges that exist within the system, and how their feedback would feed into the development of the Joint Forward Plan.

Big conversation survey

An online survey was launched to support the 'conversation,' enabling us to capture qualitative and quantitative data. We encouraged people to complete the survey, as well as capturing important demographic data and data for future engagement and follow up.

STW citizen pledges

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

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

We used this opportunity to promote the STW pledges. The public were asked to suggest some pledges, things they could 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.

Community outreach

A community engagement team conducted on-street, opportunistic engagement at prime locations within communities, such as supermarkets, GP practices and outpatient clinics. Street teams focussed on areas of high deprivation and targeted groups of people who would not normally contribute to engagement activity.

Stakeholder engagement

A series of stakeholder engagement sessions were held throughout the period, including with 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. This also meant they had an early opportunity to view our priorities and proposals.

Stakeholders were provided with opportunities to:

- Input and share ideas about how they, or their organisations, could contribute to local delivery
- Describe what they would like to see in the health and care system over the next five years
- Identify ways we could transform, plan or commission services differently to increase access and reduce inequalities.

Establishing a people's network

We have been recruiting a system-wide citizen network of local residents to enable 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 be engaged on a wide range of local issues and offer their opinions.

Engagement with community groups

We attended several existing community groups and meetings to engage with protected characteristics and equality groups. The format depended on the demographics and needs of the group. The aim of this engagement was to gain insight into the experiences of marginalised groups in order to improve access and reduce inequality.

Our community group outreach work approach has included:

- Ethnic minority groups
- Faith groups
- Families
- Veterans
- Ex-offenders
- Carers
- Patient groups
- Older people
- LGBT communities
- Substance misusers
- Looked-after children
- Children and young people
- Farmers' groups
- Parent groups
- Homeless/rough sleeping people
- People with long-term conditions
- Disability groups
- People experiencing domestic abuse
- People living in deprived areas
- People living in rural communities

PR and media engagement

We launched a proactive PR campaign to help us reach a large audience without the expensive cost of traditional advertising and marketing. This increased the viability of the ICS and the engagement exercise.

Digital activity

To ensure maximum reach, we needed our digital campaign to be varied and wide ranging. The digital campaign consisted of a mixture of interactive website content, social media sharing and interaction, consistent and frequent e-newsletters to staff in all partner organisations, and utilising existing channels. Photo and video content generated during the outreach activity was also shared on social media.

Agenda Item

ICB 26-03.136

Shropshire Integrated Place Partnership Committee Chair's Report

Appendix A – Youth Strategy – Report

Appendix B - Youth Strategy – Presentation

Appendix C - Youth Work Position Statement 2024

Appendix D - Draft Youth Strategy 2025 to 2027

Appendix E. Youth Support Team Survey Report 2024

SHROPSHIRE INTEGRATED PLACE PARTNERSHIP (ShIPP)
Report

Meeting Date	Thursday 16th January			
Title of Report	**Youth Strategy**			
Reporting Officer **(Please include email address)**	Helena Williams, Youth Support Team Manager helena.williams@shropshire.gov.uk Siobhan Hughes, Service Manager Early Help Siobhan.Hughes@shropshire.gov.uk			
Which strategic ShIPP priorities does this paper address? Please tick all that apply	Children & Young People	**X**	Community Capacity & Resilience with the VCSE	**X**
	Mental Health	**X**	Local Care and Person-Centred Care (incl. involvement)	
	Healthy Weight & Physical Activity	**X**	Supporting Primary Care Networks	
	Workforce		Integration & Better Care Fund	
	Tackling health inequalities	**X**		
What inequalities does this paper address? **How has safeguarding been considered?**	Social inequalities Economic inequality Education inequality Health inequality Cultural inequality Gender inequality			
In the development of this work who has been involved?	System Partnership Board	ShIPP Neighbourhood working & Hub Subgroup, HWBB		
	Voluntary Sector	**SYA** who provide infrastructure support to Voluntary and community Youth Sector		
	Other Individuals	Education, Early Help, Public Health Partnerships		

1. Executive Summary

The Youth Strategy aims to create a comprehensive Youth Offer for young people in Shropshire, prioritizing their wellbeing and helping them reach their full potential. The strategy is driven by the vision to provide opportunities and safe spaces for young people, ensuring their voices are heard and included in decision-making processes.

2. Report Recommendations

1. **Create a Local Youth Partnership**

- Establish a cross-sector organization to develop and sustain youth work provision.
- Collaborate with Youth Work Providers, the wider Youth Sector, community and voluntary sector, Town and Parish Councils, businesses, and young people.
- Ensure the partnership is youth-led, inclusive, respectful, and focused on quality, safety, and wellbeing.

2.**Enhance Communication and Outreach**

- Create a website and social media presence to advertise the local youth offer.
- Promote the training offer via the Shropshire Community and Safeguarding Partnership to the Voluntary and Community Sector.

3.**Support Local Strategies**

- Align the Youth Strategy with other local strategies, such as the Early Help Strategy and the Health and Wellbeing Strategy.
- Develop a joint commissioning plan that brings together police, health, local authority, Town and Parish Councils, and housing.

4.**Focus on Safe Spaces and Activities**

- Provide safe environments for young people to socialize and engage in activities that promote personal growth and development.
- Address the concerns of young people regarding safety, crime, and anti-social behaviour.

5.**Address Social and Mental Health Needs**

- Recognize the impact of social media and the need for a balance between face-to-face and digital youth work.
- Provide accessible clubs and activities that appeal to all young people, especially those with social, emotional, and mental health needs.

2. Main Report

Background and Context

- Since 2011, Shropshire has seen a reduction in youth services.
- New guidance from the Department of Culture, Media & Sport (DCMS) in 2023 emphasizes the statutory duty to improve young people's wellbeing and personal development.
- The strategy addresses the changing landscape for young people, including the impact of social media and the need for more physical and social spaces.

Key Findings from Surveys

- Young people desire more places to go, outdoor facilities, and spaces to meet friends.
- Concerns include boredom, isolation, safety, and crime.

- A significant number of young people do not leave their homes during free time, leading to social and mental health issues.

Youth Work and Curriculum

- Youth work focuses on personal, social, and educational development, helping young people gain a voice and place in society.
- The curriculum framework supports understanding youth work practice and provides an educational reference for stakeholders.

Alignment with the Shropshire Plan

- The Youth Strategy aligns with the Shropshire Plan's priorities: Healthy People, Healthy Environment, Healthy Economy, and Healthy Organization.
- Youth work contributes to tackling inequalities, early intervention, partnerships, self-responsibility, climate change, safer communities, and skills and employment.

Strategic Priorities

1. Create a Local Youth Partnership. Establish a cross-sector organisation to develop and sustain youth work provision.
2. Build the Workforce**: Strengthen the voluntary sector and ensure youth workers are well-trained and resources are targeted effectively.
3. Youth Voice and Participation**: Ensure young people are central to decision-making, fostering civic engagement and inclusivity.

Ambitions for the Next Three Years

- Establish a Youth Partnership Board.
- Develop a robust Youth Offer Plan.
- Create a participation structure for diverse youth involvement.
- Enhance communication through a website and social media presence.

Supporting Strategies

The Youth Strategy is supported by other local strategies, including the Early Help Strategy, Health & Wellbeing Strategy and ICB Joint Forward Plan.

This report summary encapsulates the main points and goals of the Youth Strategy, highlighting the commitment to improving the lives of young people in Shropshire.

Risk assessment and opportunities appraisal (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)

ESHIA to be completed and submitted with information to EMT and Cabinet.

Financial implications (Any financial implications of note) **There are no finances allocated to delivering this work.**
Appendices: **Appendix A - Shropshire Youth Work Position Statement 2024** **Appendix B - Youth Strategy 2025 to 2027** **Appendix C - Youth Support Team Survey Report 2024**

Shropshire Youth Strategy, Statutory Duty and Youth Offer

Helena Williams – Shropshire Council Youth Support Team Manager

Why are we developing a Youth Strategy in Shropshire

- In September 2023 – the new statutory guidance was issued to Local Authorities on Services and Activities to improve Young People's Well-Being
- The guidance was issued by the Secretary of State, Culture, Media and Sport under Section 507b of the Education Act.
- The duty relates to securing services and activities for young people aged 13-19 and those with learning disabilities up to the age 24.
- The duty refers to young people's recreational and leisure time activity recognising that 85% of a young person's waking hours are spent outside of school and formal education.
- In November 2024, the DCMS announced that there will be a National Youth Strategy. Making sure we have a Youth Offer that is fit for purpose for young people in today's society.

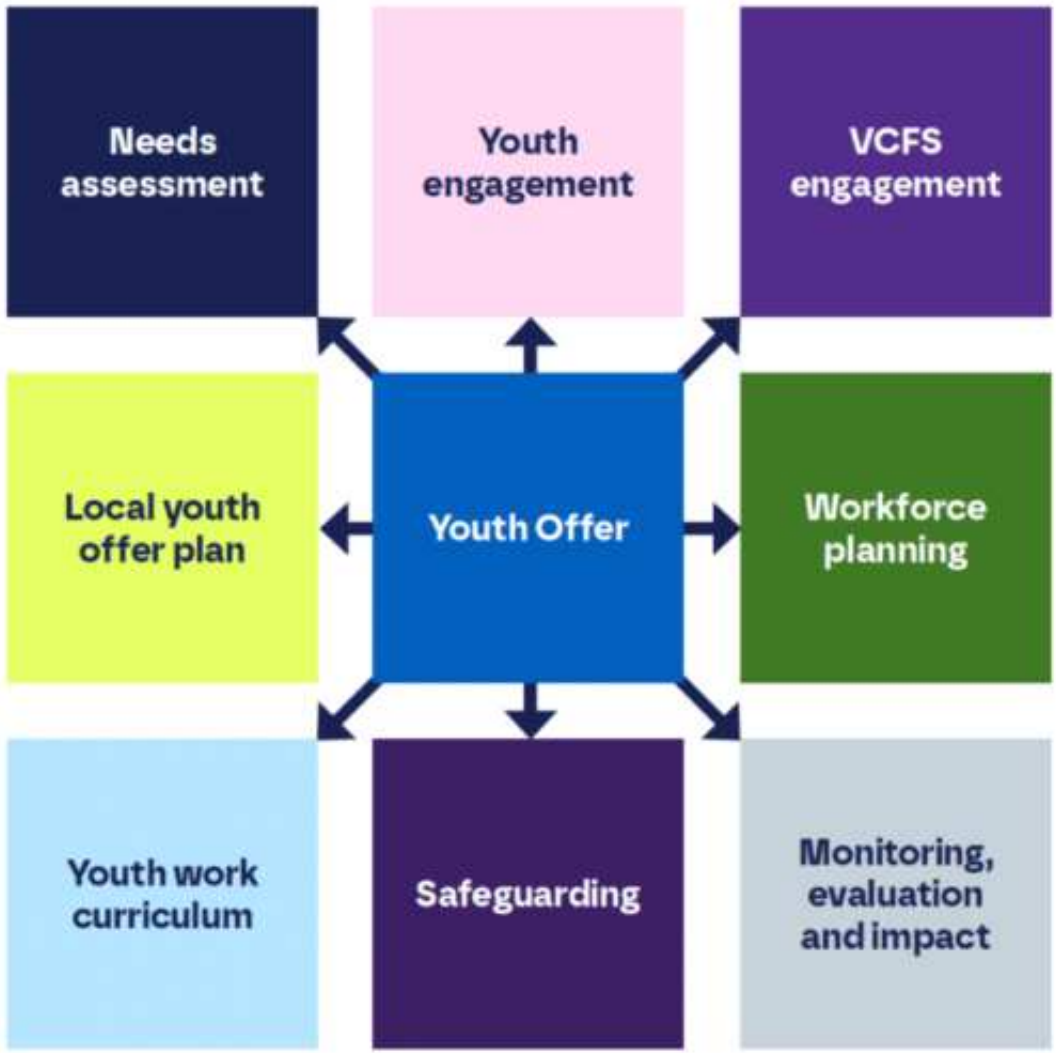
Nb Wellbeing defined as physical, mental and emotional well-being, protection from harm and neglect, education, training and recreation, the contribution made by young people to society and social and economic wellbeing

Key Points from Guidance

- To co-ordinate and promote a Local Youth Offer
- Provision MUST include leisure time activities which are for the improvement of young people's personal and social development (Youth Work).
- Local authorities MUST determine what activities, and associated facilities should be available to young people in their area.
- Under section 507b LA's Must consult with young people in their area on 1) current provision 2) the need for additional activities and facilities, access to activities and facilities.

Shropshire Council

The nine 'essentials' of a local youth offer



Shropshire Council

Definition of Youth Work

Occupational Standards for Youth Work 2019:

Engaging with young people to facilitate their personal, social and educational development and enable them to gain a voice, influence and a place in society. Youth Workers help young people to engage with their local communities, taking account of cultural diversity. They support the young person to realise their potential and to address life's challenges critically and creatively.

Youth work may take place in a variety of settings including community venues, uniformed groups, schools, youth cafés and on the street, whilst using numerous approaches such as outdoor pursuits, drama workshops, health initiatives, peer education and single issue and single focused gender work to engage with young people. Youth work may be carried out by volunteers or via paid employment in the sector.

Youth Work Curriculum Diagram

How are we doing…..

- Mapping of Services has been completed; however, this needs drilling down further to get an accurate picture of Youth Work in Shropshire
- Position statement has been completed
- A place-holder Youth Strategy has been written that focuses on collaboration of youth providers and young people's voice and partipcation.
- Needs Assessment work has started
    - Survey completed by 2021 young people in Shropshire
    - Focus Groups delivering workshops around ‘What is a Youth Offer’ to YP
    - Community profiling ongoing in the 18 JSNA areas.
- Baseline Assessment completed on the 9 essentials of a Youth Offer

Next Steps

- Working with the Youth Partnership Trust to develop a Shropshire wide Youth Partnership.
- Continue Assessing the needs of young people in Shropshire through community profiling.

What Young People are telling us……

- Lack of Facilities and purpose-built spaces for young people

Limited access to outdoor facilities and safe spaces within their communities.

- Feelings of Isolation and Safety Concerns

Young people feel isolated and unsafe, worried about crime and anti-social behaviour in their communities; however, this is quite often perception from what young people are seeing on social media sites.

- Social Emotional Mental Health (SEMH) Needs

Many young people have SEMH needs, are excluded from school, or are at risk of exploitation.

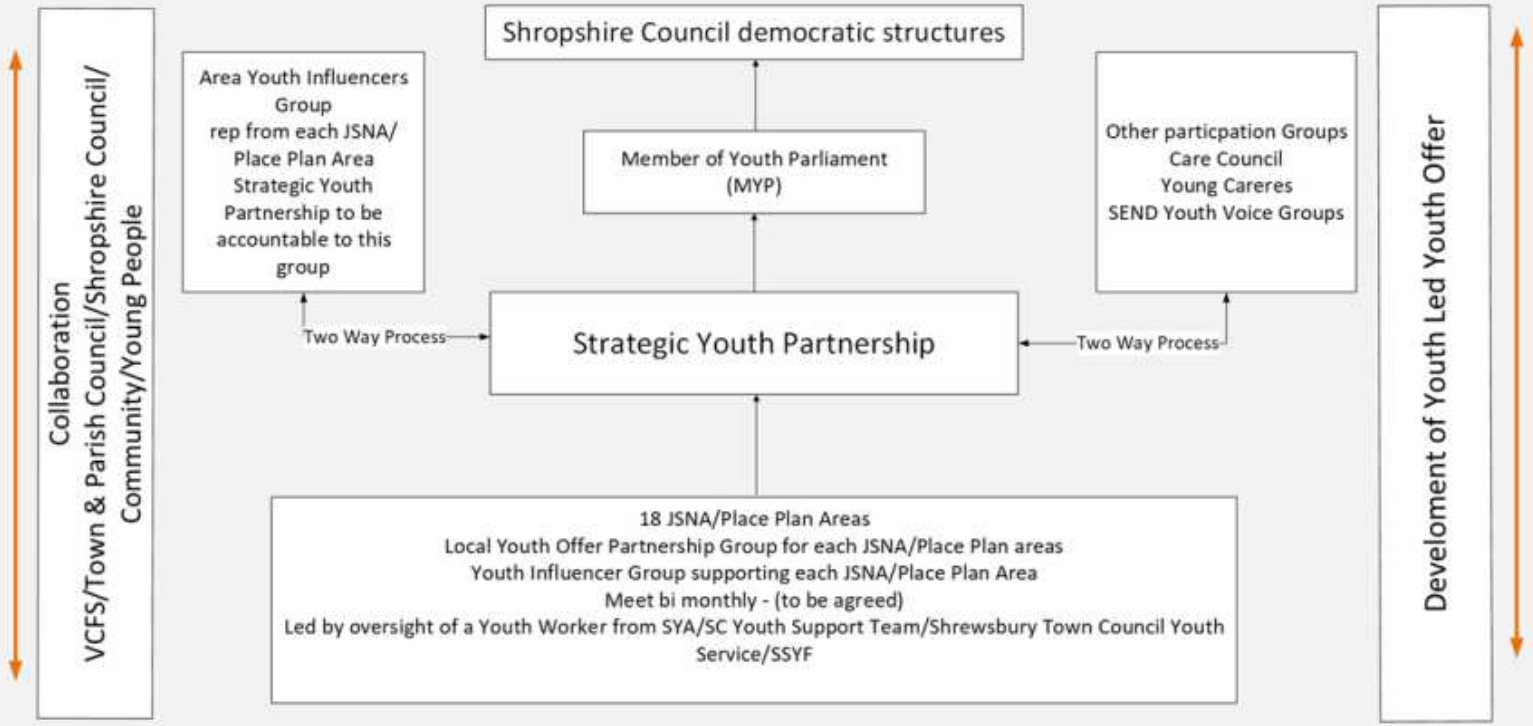
- Young people want health and wellbeing support from trusted and safe adults within their communities without having to wait for referral-based interventions.

- Young people want to be involved, included and empowered to make decisions and plans for their future.

Young People are experts by experience. They have first hand knowledge and insights derived from living through specific circumstances or challenges.

- Young people want to be part of shaping their communities to make them better places for everyone living in them.

Youth Partnership / Youth Participation Structure

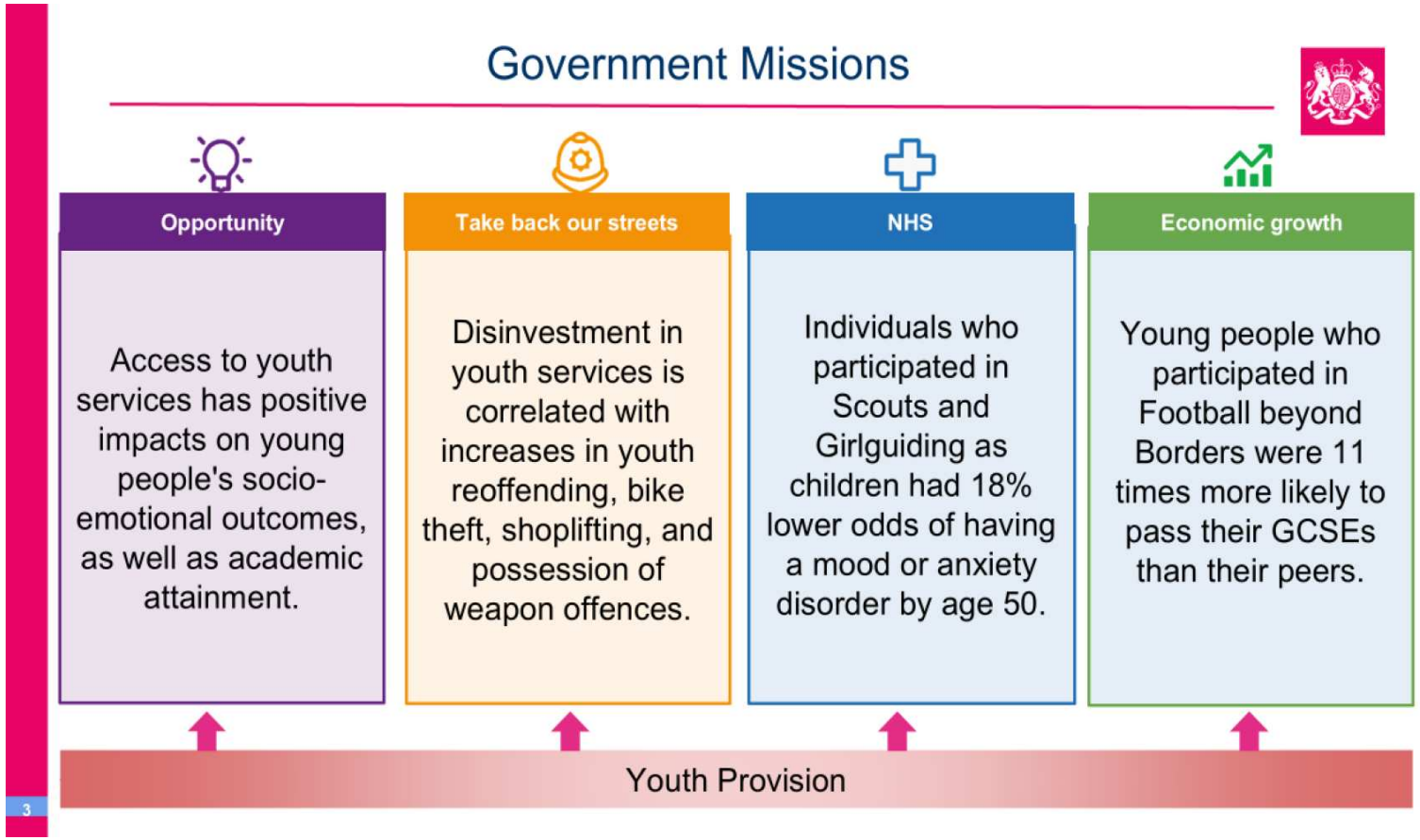


How can you help?

One of our biggest challenges is spaces and places for young people to access. We only have 2 purpose-built youth facilities within the county serving 2 communities. One run by a Town Council and the other by a VCS organisation. How can we work collaboratively with other organisations to create more spaces for young people to access.

Quite often getting external funding can be a challenge for VCS organisations. This is because funders are aware that Youth Work for the 13-19-year-olds is a statutory duty. This means that a high percentage of provision in the voluntary and community sector is for the younger age range of 8-13. Meaning that there is a limited youth work offer for the 13-19 age range.

What's coming down from government



Shropshire Council

Department for Culture, Media & Sport

National Youth Strategy

- **Timings:** Publication of the Strategy next year.
- **Scope**: England, c.11-18 (up to 25 for SEND) year olds, focused on policies within DCMS remit (e.g. youth spaces, out-of-school services, youth workforce, youth voice, etc) and better coordinating wider government's work on youth.
- **Co-production**: With young people, sector leaders, experts, academics and Other Government Departments.
  - Initial conversations with stakeholders and engagements with young people.
  - More in the new year, including survey, roundtables, focus groups, etc

Department for Culture, Media & Sport

Funding - what we know so far

- **NCS wind down in 2025.**
- **Increase in total funding for other DCMS Youth programmes in 25/26** (e.g. Million Hours Fund, YIF, Uniformed Youth Fund, iwill, DofE)
- **New Local Youth Transformation Fund and Better Youth Spaces (25/26).** Forthcoming Spending Review in Spring will set out funding after that.
- **Wider support:** Revised Stat Duty Guidance. NYA Officer Peer Network. NYA Youth Worker Bursaries.

SHROPSHIRE Youth Work Position Statement 2024

Where we've come from

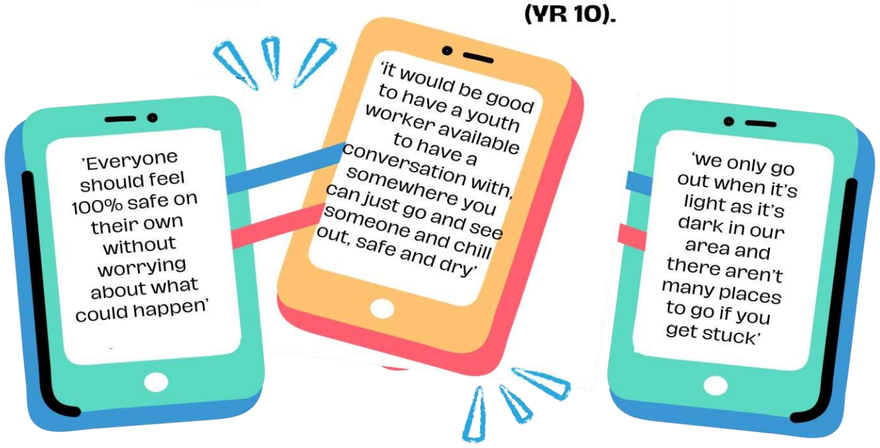
We want to improve services for Young People by listening and working together with them to find out what works and what doesn't in their local area. As one Young Person said:

'Young people want to be heard and continue to be heard…..to have their say on if things work or not' (YR 11)

Where we are at now

Young people live in ever changing communities; they play a big part in how their community feels to live in, for themselves and for other local people. One Young person stated they, '**Strongly feel a campaign to show young people in a positive light is important' (YR11) .**

Young people agree that it could be beneficial to show how aspects such as **'play, should be ageless and feel that working with both younger and older members of the community to show this could help everyone to understand each other better' (YR 10).**



Young people today experience a very different world to past generations. The economy, society and technology have changed, leading to a whole host of additional opportunities being available to them and with this comes a different set of challenges for young people. Young people also have more pressures and the availability of new media technologies have revolutionised the way they interact with the world. Young people face challenging times, especially around key transition stages such as, changing schools and preparing for and moving into adulthood.

If Shropshire were 100 young people, shows us the vast difference between what data collections are telling us in comparison to what young people are saying. This speaks volumes and emphasises the importance of listening to young people, not making assumptions and that their participation is integral to how a youth offer is developed.

SHROPSHIRE youth

SHROPSHIRE youth youth work team

Shropshire Council

30% of young people have told us they are not aware of any support services available to them locally.

51% of young people said that there are things they would like to improve about where they live.

reas not being well lit, concerns about bullying,
drug/alcohol use, and antisocial behaviour were the top areas for concern among young
people about going out in their communities.

40% of young people have told us they like their location precisely because it is rural,
citing the quiet or the beauty of where they live as positives.

going

Young people are telling us that they feel disenfranchised from their communities

and have lost their sense of place and belonging. This strategy aims to ensure that more young people have a say in the things that matter to them, helping to shape the service they need and taking ownership of leadership and
decision making. By working together with Local youth sector partners we can build an offer designed by young people and for young people, with coproduced local youth offer plans which lead to a responsive
youth offer. A youth offer that adapts and changes to the views, values and beliefs of Shropshire's young
people. We would like to thank the youth support team and Local youth sector partners who have engaged and enabled over 2021 young people to participate in the development of this youth position statement. It's
aim is to be the platform for which they can lead through meaningful participation and be **'the catalyst for positive change and a true representation of youth voice in their community' (YR 10)**

The Why...

In September 2023 The Department for Culture, Media and Sport published new guidance for Local
Authorities to meet the statutory duty S507B. Local authorities must determine what activities and associated facilities should be available to young people in their area. In doing so, local authorities should
aim to improve the local youth offer and be mindful of the needs of young people facing particular barriers to accessing sufficient provision, such as disadvantaged young people and vulnerable young people (DfCMS, 6:2023).
1873 young people took the opportunity to participate in a recent survey to find out how young people want us to help make their community a better place for them. The results and subsequent focus groups with a further 148 young people have helped produce this strategy and will guide us in the development of a
responsive local youth offer.

The survey and focus groups have provided valuable insights into the needs and opinions of young people in the county and shows that whilst 57% of Young People feel that there are enough opportunities in their area, 43% do not (Cited from Young People's survey September 2023). In the recent outcome from 'Make your mark', young people have told us that the most important topics were Health and Wellbeing, Crime and Safety, Youth Work and Young People's Services.

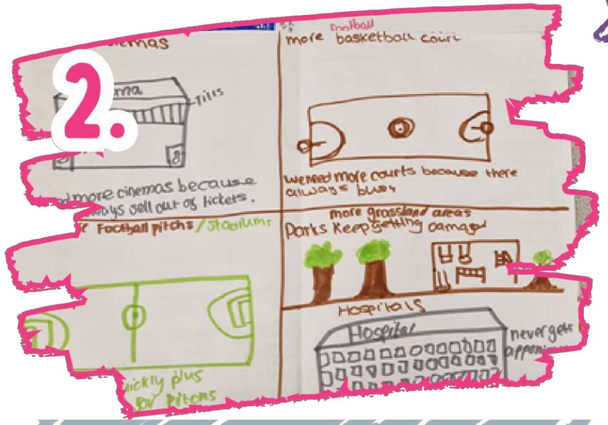
transport options such as buses and trains but, they
don't use them as they are unreliable. Many young people use bikes to get around.

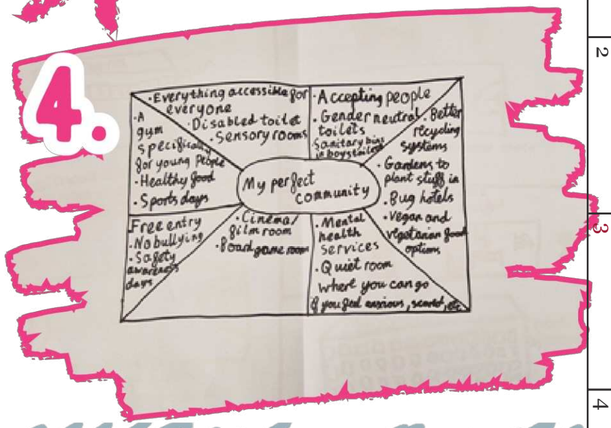
57% of young people have told us there are enough
opportunities for them in
their area however, 43% of young people have told us there are not enough.

79% of young people have told us that they felt they would not use a support
service or "didn't know" if they would use a support service if it were available to them in their area.

63% of young people either agreed with the statement
that they feel unsafe in their community or said that they "sometimes" agreed.

WHAT MATTERS TO YOUNG PEOPLE:





Safety in community:
'We want to feel safe in our communities'

This included aspects of traffic safety, having access to safe spaces that are well lit and consider prohibiting the use of alcohol in the areas they like to be in, feeling safer on public transport, having more police presence with better understanding of young people and being able to have responses to how their concerns have been dealt with.

Health and well-being support:
'We need people we can trust to talk to us about our emotional well-being'

This includes having the right trusted people at the right time to talk through how they are feeling, better training for other professionals to enable conversations, development of spaces to enable young people to get out into the community, having free or discounted accessible opportunities to engage with exercise or just being outside.

Empowering Young People:
'We want to be involved, included and empowered to make decisions and plans for our future'

To shape their own ideas and initiatives, be part of decision making and planning about what matters the most to them, create opportunities for young people to be involved because their opinions are important and they don't often feel heard, to empower them to take ownership of their youth offer because it's an offer for them and enable young people's voices to work with adults views to ensure priorities are achievable and realistic.

Being part of shaping their communities:
'We want to be part of shaping our communities to make them better for everyone living in it'

This includes working on local plans, projects and initiatives that develops social value within their communities that are reflective of what young people need to live their best lives. Develop restorative relationships with the whole community and work collaboratively with local partners to understand how young people play a vital part in enhancing their own communities.

THE HOW...

Engagement: We are committed to work with young people and local youth sector partners to develop a meaningful and responsive youth offer in Shropshire by leveraging resources, expertise, and networks, and maintaining transparency in our shared goals and objectives for the strategy.

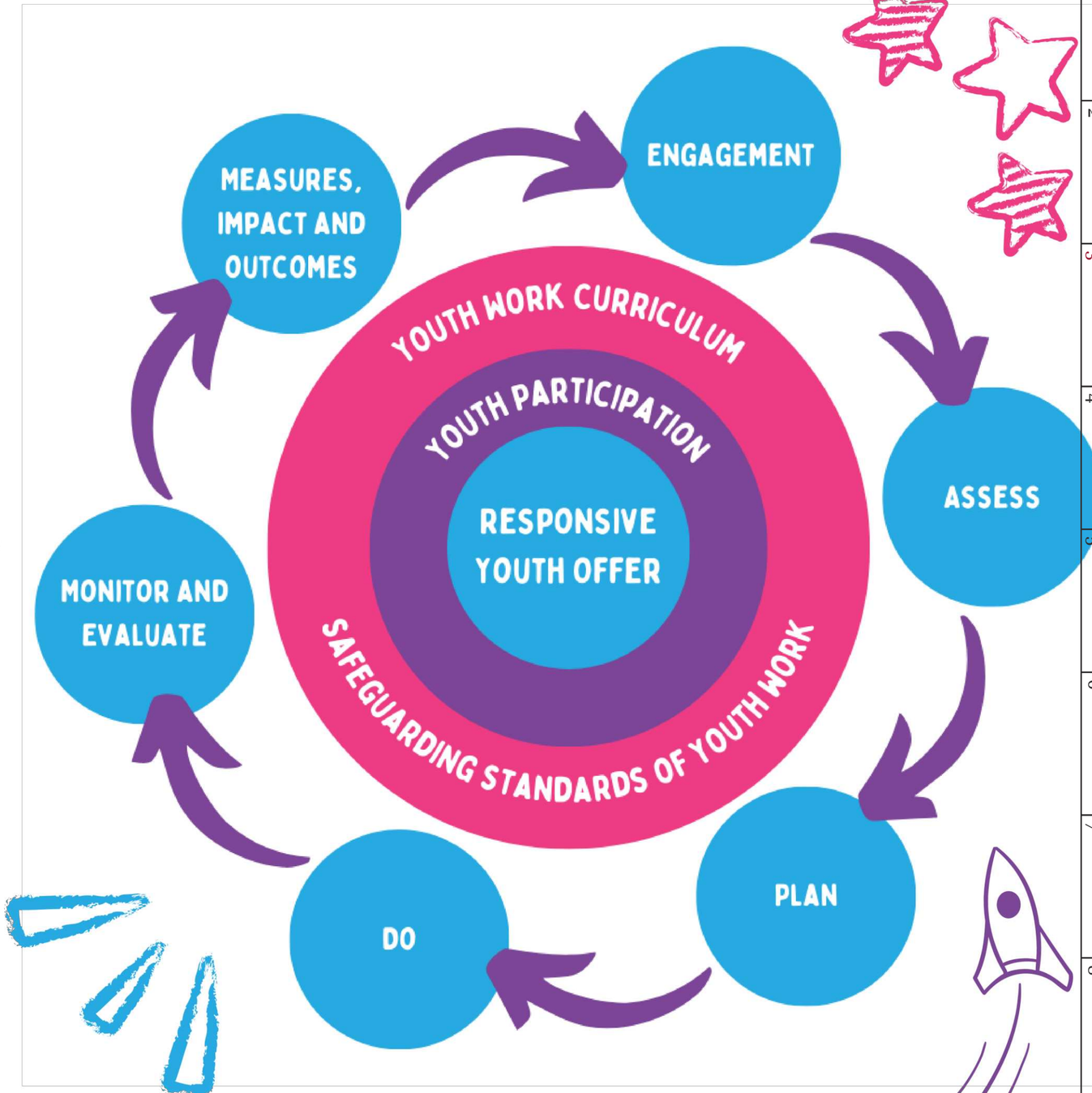
Assess: We will work with young people and local youth partners to complete a youth needs assessment, including mapping our current local youth provision. This will show us what the needs of young people are, what we have, what gaps we have and how we will work together to build a collective offer which meets need.

Plan: We will work with young people to coproduce a local youth offer plan to meet their needs and work in partnership with other stakeholders and local youth partners to implement this effectively.

Do: We will work with other stakeholders and local youth partners to secure a responsive youth offer that is reflective of young people's needs. We will consider the long term sustainability and adaptability including strategies for securing ongoing funding, resource, addressing emerging needs and responding to changing circumstances over time.

Monitor and evaluate: We will use a range of methods to regularly monitor and assess the effectiveness of the youth offer, primarily through direct feedback from young people to ensure voices are listened to and heard, and develop ways of working to enable the partnership to monitor and evaluate provision to ensure it meets the needs of young people.

Measures, Impact and Outcomes: We will determine measures to indicate positive outcomes and the impact the Youth Offer on the lives of young people. This will help us to reflect on what is working well and, where needs change, it will allow us to be responsive to adapt approaches and further developments to meet the needs of young people.

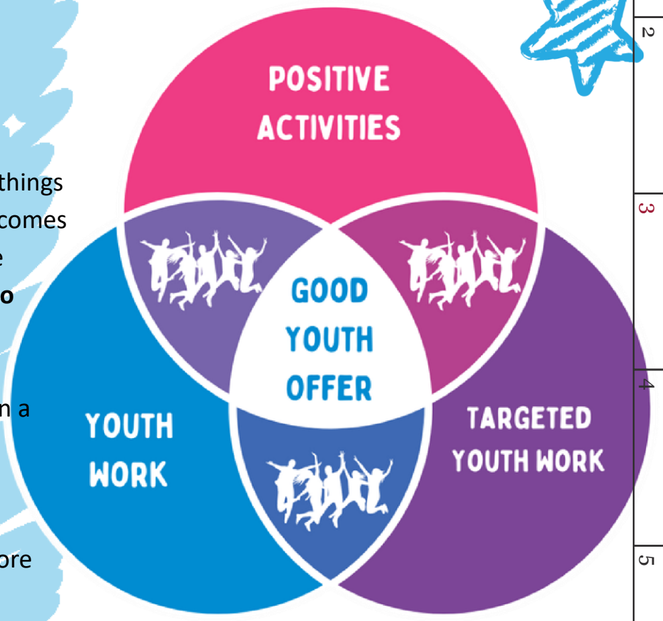


What does a good Youth Offer Look Like?

Positive Youth Activities: Opportunities for positive youth activities are an essential part of a good youth offer and can be delivered in a variety of ways. These may include youth clubs, sports and leisure, young voice and engagement, LGBTQ+, SEND, Arts and culture and informal social activities taking place in a range of spaces and places. Positive youth activities are an inclusive offer, accessible to all and should be developed and enhanced by the young people who access them. Access to positive youth activities that are fun will support young people to develop a sense of belonging and build confidence to create opportunities for the future.

Universal Targeted Youth Work: Specialist support services are there for when things in life get tough and you need a more focused plan to get the help you need to make things a little easier. Specialist support for a young person with a disability or additional learning need can help to maximise their development, social, educational and health outcomes and support them in their transition into adulthood. Young people reach out to people they trust and are consistent with them, reaching out for extra help can often be the hardest step and it is important to recognise the time and place for a more specialist approach. **'Open access provision that includes youth work should act as a gateway to specialist, targeted support for young people without stigma. This supports place-based, youth work in community settings'** (NYA Guidance, 2022).

Youth Work: Youth work is the golden thread which should be woven throughout any connection with a young person. It is a unique educational process that can be used in a range of environments to support young people. It is the facilitation of personal, social, emotional, and educational development which encourages creativity to explore values, beliefs and ideas. Youth work places the young person at the centre, starting with their map of the world inclusive of their feelings, perspectives and what really matters to them, influencing their place in the world by developing voices and empowerment.
Youth work is a partnership which a young person chooses to be involved with, it supports the development of lifelong skills and harnesses their passion to create and explore opportunities.



What we will do Next...

Over the next two years we will focus on developing Partnerships, the development of the workforce, participation and quality assurance.

We will develop youth partnerships to agree shared principles that reflect inclusivity, diversity and collaboration. The partnership will represent a cross sector of the local youth partners and will be the driving force to developing a youth offer that centres around young people and empowers them to have ownership of decision making and planning.

We will focus on workforce development and planning, to build on the strengths of existing youth work practice which in turn will enhance the open access youth offer and streamline pathways to more targeted youth work without stigma for young people, when they need this the most.

We will place participation at the core of the youth offer, inclusive of young people and empower them to drive their own initiatives for social change for the communities they live in and ensure there continues to be a consistent quality of youth work that is accessible to young people.

Youth Strategy 2025 to 2027

Our Ambition / Vision

'To create a Youth Offer for Young People in Shropshire which will put their needs at the forefront, and prioritises their wellbeing by creating opportunities that will help them reach their full potential and live their best lives'

Background Information / Context

Since 2011, Shropshire has seen a significant reduction in its Youth Services including dedicated spaces for young people to access.

In September 2023, new guidance was issued by the Department of Culture, Media & Sport (DCMS) to support Local Authorities in meeting their statutory duty under Section 507b of the Education Act on Services and Activities to improve Young People's Wellbeing and their Personal and Social development.

The purpose of the strategy is to make sure that young people in Shropshire have a fulfilled and balanced adolescence filled with opportunities, new experiences, and safe spaces to access. As a local authority we know that we need to collaborate with partners to enable us to meet this duty, Shropshire Council is fully committed to working with partners to deliver a co-ordinated approach to deliver youth services for young people based on their needs and interests and fully informed by their engagement and participation. We know that when young people feel heard and included in the decision-making process, it will lead to improved outcomes for them.

The landscape for young people has changed dramatically over the last 10 years. Social media has become a huge influence on how young people spend their social time, with young people often spending their free association/recreation time in their bedrooms on devices for gaming or accessing social media and other platforms to engage with their peers.

A survey undertaken by the Local Authority Youth Support Team in November 2023 highlighted that that young people in Shropshire would like

- more places to go.
- more access to outdoor facilities,
- spaces to meet their friends and access swimming pools.

What young people overwhelmingly said they don't like about the community they live is there:

- is nothing to do
- it's boring and they feel isolated from their peers.
- They also don't feel safe and are worried about crime and anti-social behaviour.

The same Youth Work Team are also concerned about the lack of young people using green spaces and parks to meet up with friends or enjoy social activities. The team also report that most groups they meet are vulnerable young people with Social Emotional Mental Health (SEMH) needs, have been excluded from school, involved in crime and anti-social behaviour identified as at risk of exploitation. Over 71% of young people in the survey said they don't not leave the house in their free association time.

A recent report from the Local Authority Infrastructure support provider (SYA) states 'young people's deteriorating social emotional mental health (SEMH) is of concern, many young people don't leave their bedrooms or homes in the evenings, and this is storing up problems for the future. To address this, we need more clubs that are easily accessible, offering activities that appeal to all. The voluntary sector as always attracted more junior clubs and younger adolescents. Where the real need is probably for senior clubs'

The National Youth Agency undertook a survey this year which some of the main themes highlighted are that young people are feeling disconnected from their community, with many – in the later teens – struggling with social anxiety.

However, we also must acknowledge that we are now living in a digital age and young people are living hybrid lives. This generation of 'digital natives' are now living a blended lifestyle of in person interactions and online interactions. A good Youth Offer will need to be a balance between meaningful face to face youth work and digital youth work.

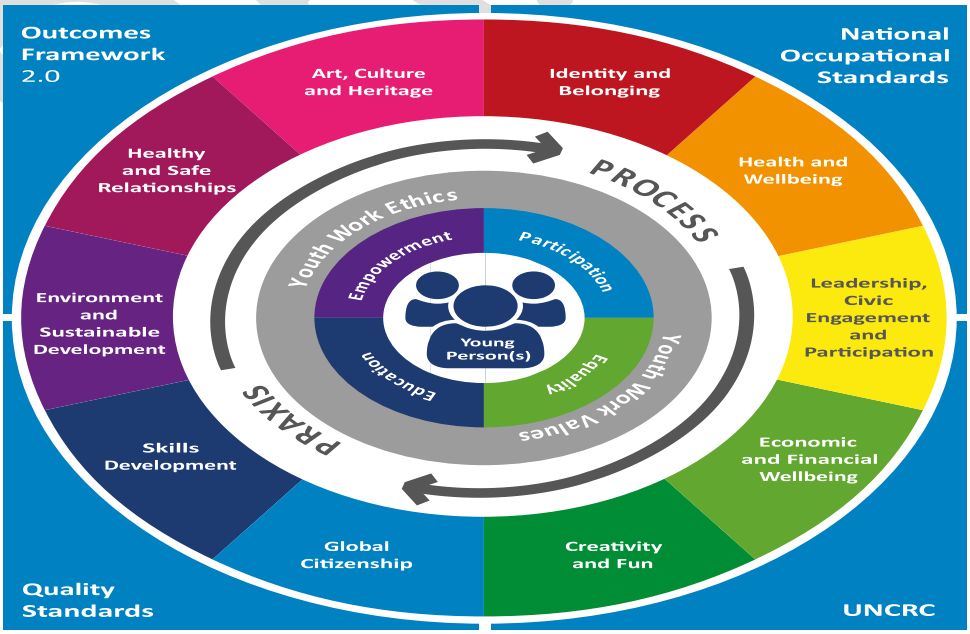
What is Youth Work and its Curriculum?

The youth work curriculum is underpinned by the description of youth work articulated in the National Occupational Standards for Youth Work 2019: *Youth Work is:*

'Engaging with young people to facilitate their personal, social and educational development and enable them to gain a voice, influence and a place in society. Youth Workers help young people to engage with their local communities, taking account of cultural diversity. They support the young person to realise their potential and to address life's challenges critically and creatively.

Youth *workers build voluntary, trusted relationships with young people, away from many of the other pressures they may be facing in their lives. They usually work with young people aged between 11 and 19, but may support young adults up to the age of 25 depending on their needs. (NYA)*

The Youth Work Curriculum



The above sets out the youth work curriculum framework for England. Its purpose is to enable a greater understanding of youth work practice, provide an educational framework and act as a reference tool to be used by decision makers, policy makers, commissioners, youth workers and young people.

The Shropshire Plan

Shropshire Council have set out an ambitious plan which outlines its direction over the next 3 years.

The Youth Offer aligns with the priorities set out in the Shropshire Plan.

The Shropshire Plan is underpinned by the 4 Healthies:

- Healthy People
- Healthy Environment
- Healthy Organisation
- Healthy Economy

Young people are an integral part of the Shropshire Plan and Youth Work can enable young people to live their best lives.

Mapping Youth Work to the Shropshire Plan

Become…..Healthy People

Shropshire Plan	Youth Work
Tackle inequalities	Youth Work helps to break down barriers between communities, it supports the empowerment of individuals and helps to educate young people about discrimination and injustice.
Early Intervention	Youth Work provides essential support to young people within their local communities by providing Safe spaces and trusted adults. This stops young people being drawn into negative situations which can reduce demand for higher level services.
Partnerships	The Youth Partnership will establish bringing together partner across the system to work together to meet the statutory duty for Youth Work
Self-Responsibility	Youth Work enables young people to take responsibility for their learning and development. Youth work enables young people to develop coping strategies for problems they face, learn where to go for information or support and build positive and healthy routines.

Live in a…….Healthy Environment

Shropshire Plan	Youth Work
Climate Change Strategy and Action	Youth work can help young people to consider the environment and sustainable development by: Enabling young people to consider their own impact on their environment.
Safer Communities	By taking a contextual safeguarding approach within Youth Work Practice we look at how we can best understand the risks posed to our young people and help to keep them safe, by

	listening to their experiences and working with them to meet their needs. We know when young people move towards adolescence they start spending time independently with friends, by creating safe spaces for young people to access and stay safe provides a safe community for those young people Living there.
Natural Environment	Youth work encourages and advocates the use of green/public spaces. We know increased levels of physical activity lower levels of obesity, and improvements in mental health and cognitive performance.

Help create a……..Healthy Economy

Shropshire Plan	**Youth Work**
Skills and Employment	Youth Work increases confidence and independence and helps young people realise their goals and raise their aspirations. A framework of Outcomes for Young People 3.0

contribute to a……Healthy Organisation

Shropshire Plan	**Youth Work**
Best Workforce	Internal Staff are all trained to JNC level 3 and above in Youth Work Practice. There is continuous professional development. Externally The voluntary and community sector are also enabled to gain qualification within the Youth Sector to support the delivery of a sufficient Youth Offer.
Align our resources	Local Authority Youth Workers will target their resources into the most deprived areas of the locality to make sure the Youth Offer is sufficient and Youth Work provision is developmental around the needs of local young people. We will work with the Voluntary and Community Sector to make sure our resources are targeted to enable us to meet our statutory duty by making sure our small rural communities also get good youth work provision.

The Youth Offer (Statutory Duty)

This is an exciting time for Youth Work, the update of the statutory duty has been a long time coming and gives Local Authorities a clearer understanding of what a sufficient offer should look like for young people within their Local Authority Area.

Over 85% of a young person's waking hours are spent outside of school and formal education. Recreational and educational leisure-time activities provided during those hours can have a significant effect on young people's development and well-being. Those activities can:

- support them to build their skills
- improve trust and tolerance
- help them become active members of society
- champion their voice

Not securing such leisure-time activities can mean young people miss out on opportunities to reach their full potential. Those activities can act as a supportive measure that can prevent costly interventions later on. This is true for all young people but is particularly important for the most disadvantaged and vulnerable young people who might need specific, additional, or early support.

Young people's involvement in such activities can also make an important contribution to other objectives, such as economic, social and environmental improvements, community cohesion, safer and stronger neighbourhoods, better health and increased educational attainment and employment.

In 2022, a review of spending on out-of-school youth programmes Youth Review found that youth services are a vital part of the response to the current challenges young people face. That review, as well as direct feedback from young people, highlighted the importance of prioritising regular clubs and activities, adventures away from home, and volunteering opportunities.

Local authorities are uniquely placed to coordinate a 'local youth offer' that answers those priorities. They are in a position to:

- set a vision for young people across the local authority
- establish whether the available provision meets their needs
- help direct support where it is most needed

They also hold a crucial role in engaging young people, parents and carers, youth providers and practitioners, other providers of activities for young people, educational settings, communities, and neighbouring areas to enhance and sustain provision. In doing so, they can identify valuable links and contributions and where appropriate help build the capacity and provision of public, private and third sector organisations to improve the local youth offer.

NYA

The nine 'essential' in creating a Local Youth Offer

The Youth Offer will focus on quality Youth Work and providing safe environments for young people where they can socialise and make new friends and take part if activities that enables their personal growth and development.

Creating a Youth Offer for Shropshire Young People

We will (Strategic Priorities)

1) Create a Local Youth Partnership

A locally established, cross sector organisation Local Youth Partnerships will be created for Shropshire that will seek to develop and sustain delivery of Youth Work provision over the County.

Shropshire Council is committed to the development of a local Youth Partnerships which will have oversight of the local youth offer within Shropshire to 'make sure' that there is a sufficient level of Youth Work in localities within Shropshire. This will be a collaboration of Youth Work Providers, wider Youth Sector, community and voluntary sector, Town and Parish Councils, business and Young People.

The Youth Partnership will share a set of principles (to be agreed by the partnership) that are based on the principles of youth work practice, these are……

- **Youth Led** – Young people's voices are central to the provision being offered to them
- **Inclusivity, Equality and Diversity** – Young people feel included in their local area and can access the support they need as they progress towards adulthood.
- **Respect –** Young people are valued and respected as part of their community.
- **Quality, Safety and Wellbeing –** Good Quality Services are provided and underpinned by the NYA Safeguarding Standards and Practice Standards
- **Empowerment** Services empower young people to progress and engage in employment, education and training, and to take an active role within their community.
- **Positivity –** services are strength-based and focus on developing the skills and attributes of young people rather than attempting to 'fix a problem'

(*principles taken from Brighter Futures: our vision for youth services, six key principles of effective Youth Servies*)

Ambition

Shropshire Council is committed to working with partners from the VCSA and Town and Parish Councils alongside our School Communities to make sure young people are actively involved in the process, development and maintenance of a local Youth Offer. For their local area.

The partnership will have a strategic group oversight, and a locality based working group; these could be in line with place plan area. This would need to be agreed by the partnership.

A joint commissioning plan that brings together Police, health, Local Authority, Town and Parish Councils and housing.

The partnership will look at local needs of young people to understand where best placed youth provision is situated.

2) Build the Workforce

Shropshire has historically and continues to have a strong and active voluntary sector that delivers Universal Youth Work Provision, alongside specialist youth work provision and targeted work.

Youth Work is mainly delivered by 3 organisations/sectors in Shropshire.

Shropshire Council

The current model of Youth Support within the local authority focuses on a Detached Youth Work Model, Youth Drop in for older Teenagers and Targeted Group Work Interventions. The team currently works countywide and directs services to the higher areas of need through the use of data, intensive reconnaissance and needs assessment work within communities to understand the needs and the lives of the young people living in them. The Team consists of 10.5 FTE equivalent staff.

- Youth Support Team Manager (JNC Professional Youth Work Qualified)
- 3 Full-Time - Youth Work Area Leads (JNC Professional Youth Work Qualified)
- 3 Full-Time Youth Support Worker (minimum JNC – Level 3) in Youth Work Practice Qualified)
- 2.5 FTE Assistant Youth Workers (working towards a level 3 in Youth Work Practice)

Restructure

The Youth Support Team are currently restructuring to focus their resource on the most deprived areas in Shropshire providing a locality Youth Worker for these areas, the Youth Workers will work closely with the Local Community, Young People and local businesses to create a developmental Youth Offer that will focus on a balance of universal and Targeted Youth Work Provision based on the identified needs, and in development with local young people. The team will then work with the VCFS and Town and Parish Councils to support the delivery of this Youth Offer and support/work with them to deliver the universal element of the Youth Offer

Town and Parish Councils

Over the last 9 years, Town and Parish Councils have been integral to continuing universal Youth Provision, with the 2 largest Town Councils increasing their precept in the Council Tax to include funding for Youth Services. Our largest Town Council, Shrewsbury, has developed its own Youth Service which delivers Youth Clubs for primarily the 8–13-year-olds from different local community venues around the Town. Oswestry Town Council have set up their own Youth Partnership and they commission a local youth provider to deliver its Youth Clubs. Many other smaller Town and parish councils commission Youth Clubs from Youth Work Providers.

The VCSA

Infrastructure Support The Local Authority currently contributes to SYA, who add this funding to their other resources to offer a comprehensive support package for youth clubs and organisations.

Youth Work Training

SYA are the National Youth Agencies designated trainers for the bursary scheme in this area and also train others to grow the sector.

Ambition

For Youth Work Training to be accessible to all providers delivering Youth Work including the Local Authority, Town and Parish Councils and the VCFS.

For the infrastructure support provider to work closely with the Youth Partnership to support local Youth Work Providers to develop their offer for the 13–19-year-olds (and up to 25 with SEND)

To create a network newsletter that is available to all the Youth Sector and promotes the National infrastructure organisation offering free training and resources to the Youth Sector.

To better promote the training offer via the Shropshire Community and Safeguarding Partnership. to the Voluntary and Community Sector.

Shropshire Council is committed to working closely with Youth Providers from the Voluntary, Community and Faith based sector and understands the importance of working closely with Town and Parish Councils that have local knowledge on their locality areas.

3. Make sure that Youth Voice and Participation is central to all decision making of the partnership; by making sure young people and their needs are the priority of the creation of a Youth Offer

Youth Voice, participation and engagement is a fundamental right included in the United Nations Convention of the right of the child

The right to be heard. Article 12 says that every child has the right to express their views, feelings and wishes in all matters affecting them, and to have their views considered and taken seriously.

Section 507b of the education act requires councils to engage, listen to and involve young people to engage, be listened to and involved in service design. Young People are 'experts by experience' and uphold the best insight into what personal, social, political and economic issues affect them'.

Youth participation is a fundamental part of Youth Work practice. We know that by involving young people in the process of Youth Work it enables practitioners to be responsive to young people's needs, therefore, leading to better outcomes.

Involving young people in decision making is important to

- Create Fresh perspectives and creativity
- To build young people's skills and confidence
- To empower the next generation of young people to take ownership of their futures and foster a sense of responsibility for their communities and the world around them.
- Enhancing relevance and inclusivity. Young people's involvement ensures that decisions are relevant to their needs and aspirations.
- Fostering Civic Engagement. This encourages young people to be active participants in their communities and democratic processes.
- Bridging generational gaps. Collaborating between generations helps to build mutual understanding and respect, creating more inclusive and effective policies and strategies.

- Long Term Impact. Decision made today shape the future. Young People's participation ensures that that their long-term interests are considered, leading to sustainable and forward-thinking solutions.

By involving young people in decision making, societies can harness their energy and innovation while ensuring decisions are equitable and inclusive.

The local Authority is currently working towards developing a Children and Young People's Participation Strategy.

Ambition

For the Local Authority to work alongside, SYA on the UK Youth Parliament Programme. This will embed the elected Members of Youth Parliament within the local government structure. The elected members of Youth Parliament represent their peers from within a certain geographical area. They represent their peers at a local level by campaigning on their behalf on issues that affect them.

For the Youth Partnership to become accountable to young people in Shropshire. This will be done through local youth forums that sit within the local Authority and outside of the Local Authority, for example, Shrewsbury Town Council Youth Committee.

To have a streamlined young people's participation structure that allows young people to be involved in local decision making.

The ambition over the next 3 years is to…..

- Create a Youth Partnership Board to oversee the Statutory Duty which reports to the Early Help Partnership Board and Health and Wellbeing Board.
- Have a robust Youth Offer Plan that outlines how we are going to get to a 'sufficient' level of Youth Services as collective group of services invested in the wellbeing of Shropshire Young People.
- A Participation Structure which allows a diverse range of young people to be involved with the development of the Youth Offer
- A Website and Social Media presence which advertises the Local Youth Offer to Young People in Shropshire.

Other strategies that support the development of youth services and provision

Local Strategies that impact or influence services and provision for young people are:

- Early Help Strategy 2023-2025
- Health and Wellbeing Strategy 2022-2027

Shropshire Council

Youth Support Team

Survey Report

January 2024 Year

www.shropshire.gov.uk
General Enquiries: 0345 678 9000

1 Background and Methodology

Shropshire Council's Youth Support Team provides support through working on the streets, interacting with young people, and running arranged sessions in schools. There are 11 youth workers across the county, serving over 28,000 young people aged 11–18.

The Team are primarily detached workers which means they mainly work without the use of a building or activity. Instead, their work takes place where young people are, both geographically and developmentally. For the most part, this means working on the streets, though not exclusively. They work to deliver personal and social education whether at school, at home or in town, by using everyday situations as educational opportunities in an informal way. This helps to address the needs of young people as they see them, or as young people tell them what those needs are. They help with personal, social, and educational development in an informal approach and in an environment that is structured around the terms of young people.

This survey, conducted between 7th November and 8th December 2023, built on the findings of a survey in 2022 of 459 young people. Where possible and appropriate, comparisons have been made between the 2022 and 2023 survey results.

The survey was produced and run using Survey Monkey with paper options also provided to boost participation. A huge range of methods were employed by the Youth Support Team to encourage survey uptake. These included, but were not limited to:

- Emails sent to headteachers and school staff to inform and help encourage uptake.
- Sending out via school Parentmail listservs and school newsletters.
- Using schools' Teams sites to send the survey link to all young people.
- Manually entering the data from paper questionnaires that students were given to complete.
- Using social media, including the Shropshire Council and school accounts.
- A QR code poster was put up in specific areas in the community such as community centres and retail establishments, as well as distributed through the Community Outreach Team.

In addition to ensuring wide population uptake, the team also sought to ensure good uptake from traditionally underrepresented groups through the following methods:

- Taking a sample from each year group and vulnerable students.
- The voluntary and community sector's VCS Assembly youth leads were engaged to inform their groups of young people to participate.
- Youth Work Teams engaged young people directly in their communities.
- Elective home educated young people were given information via the Education Access Team.

In the analysis of results, qualitative questions were considered, and common themes were identified from the feedback. Examples of comments grouped into themes are provided below, and any potentially identifying information has been

redacted from these quotes. For the presentation of quantitative data, percentages in tables are rounded to the nearest integer.

The report is broken down into the following sections:

- **Section 1: Background & Methodology** (this section) explains the purpose of the survey, the methods used to collect and analyse the data.
- **Section 2: Respondents** provides an overview of the demographics of those responding to the survey as well as what they reportedly do in their spare time.
- **Section 3: Use of Transport and Services** presents the results of questions aimed at ascertaining the use of various modes of transport as well as use and interest in youth support services across Shropshire.
- **Section 4: Opportunities, Activities and Facilities** details the findings around what young people feel are the opportunities (or lack thereof) in Shropshire, what activities and facilities they enjoy, and what activities and facilities they feel are missing from their area.
- **Section 5: Young People Evaluating Where They Live** provides an overview of the responses to open-ended questions that young people were asked about what they like about where they live, what they don't like, including issues around safety, and how their area might be improved.
- **Section 6 Summary and Conclusion** provides a brief summary of the key findings in the report and conclusions.

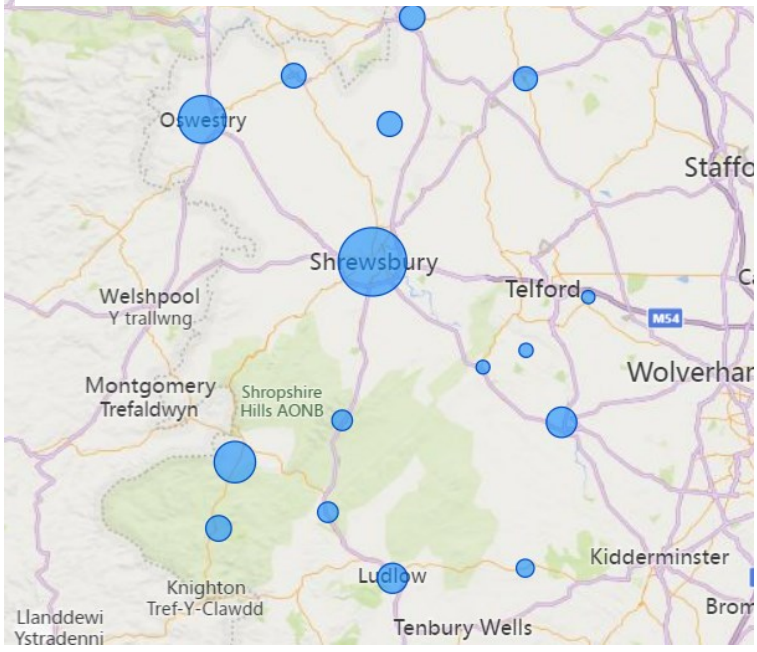
2 Respondent Characteristics

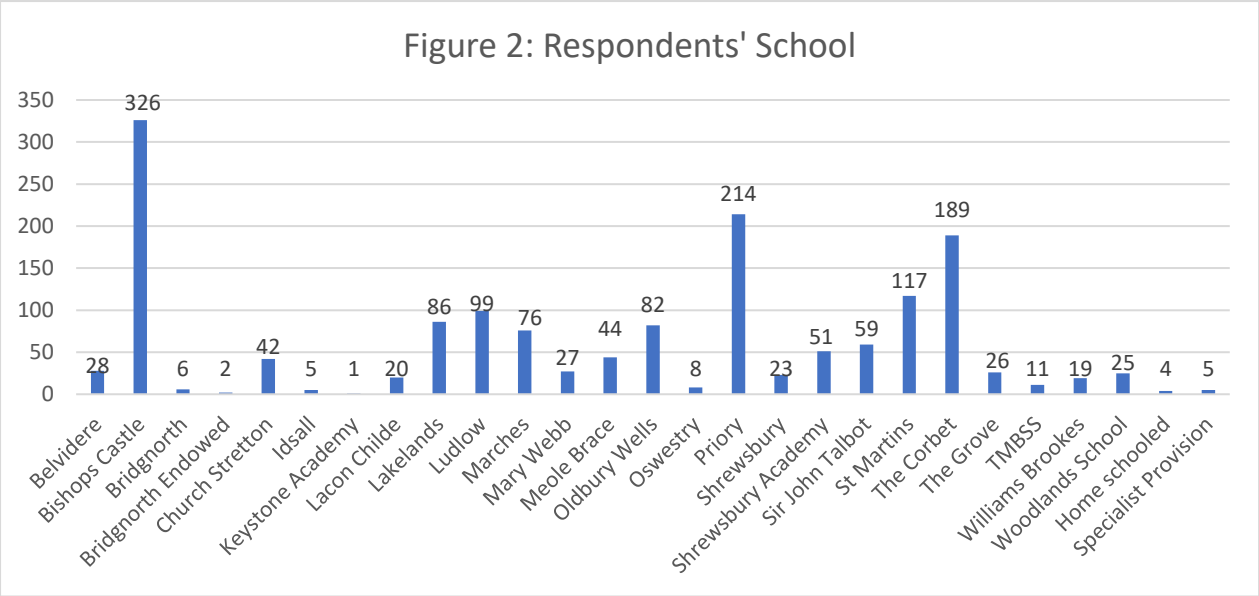
1,873 young people from around the county answered the survey. Demographic questions about the respondents' location, place of education/training, age, gender, ethnicity and disability status were asked.

Geographical Location:
Figure 1 shows the distributions of respondents by their nearest town and **Figure 2** by their school. The survey represents young people from both rural areas and larger towns such as Shrewsbury, Oswestry and Ludlow, and has a good distribution across both the north and the south of the county.

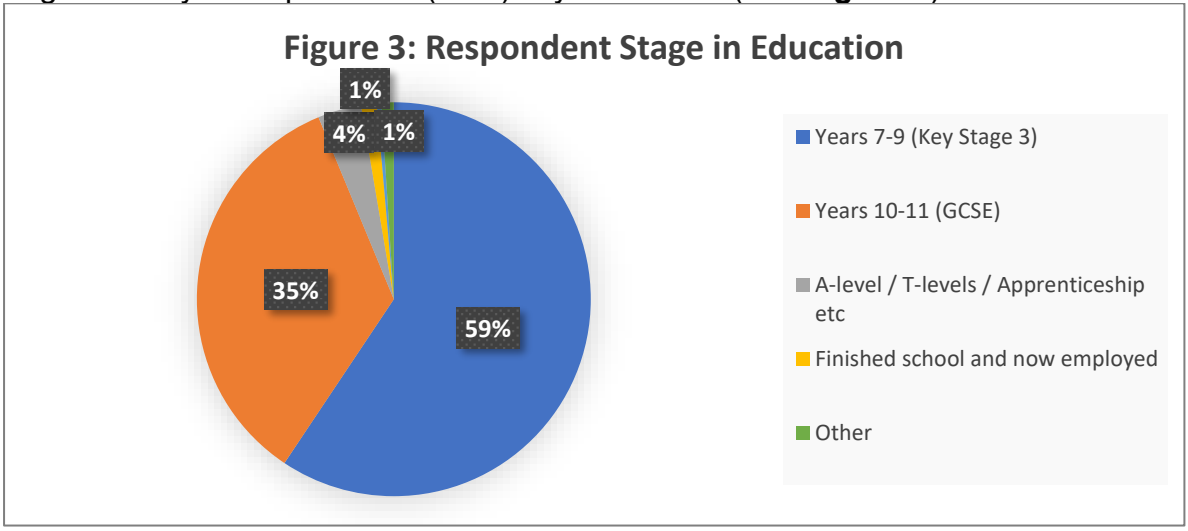
Bishop's Castle Community College, The Priory School in Shrewsbury, and The Corbet School in Baschurch were the schools with the highest numbers of respondents, again demonstrating a nice distribution across the county.

Figure 1: Respondents' Nearest Town





Age:
The majority of respondents (59%) were pre-GCSE students in years 7-9, with a large minority of respondents (35%) in years 10-11 (**see Figure 3**).



Gender:
Female identified young people made up a small majority of the respondents (52%) while male identified young people made up 43% (**see Table 1**). 1% of respondents identified as Transgender and 1% as Non-binary.

Table 1: Respondent Gender Identity	Count	%
Female	977	52%
Male	796	43%
Transgender	22	1%
Gender variant	7	Less than 1%
Non-binary	17	1%
Other	14	1%
Prefer not to say	33	2%

Ethnicity

Consistent with the ethnic makeup of Shropshire, the vast majority of respondents identify as white with British, Irish or Welsh background. A smaller percentage identify as white from other backgrounds, and only 6% identify as being from mixed or other ethnic backgrounds.

Table 2: Respondent Ethnicity	%
White (British, Irish, Welsh)	87%
White (Gypsy, Roma or Irish Traveller)	1%
White (Other - e.g., Bulgarian, French, Lithuanian, Polish, Portuguese, South African, or any other White background)	4%
Asian (e.g., Asian British, Bangladeshi, Indian, Pakistani, Japanese, or any other Asian background)	1%
Black (e.g., Black African, Black British, Black Caribbean, or any other Black background)	1%
Mixed (e.g., White and Asian, White and Black British, or any other mixed background)	3%
Arab	Less than 1%
Other ethnic group	1%

Disability:

The large majority (86%) of respondents said that they do not have a longstanding illness or disability that limits their daily activity, but 8% of respondents did identify as having a disability (**see Table 3**).

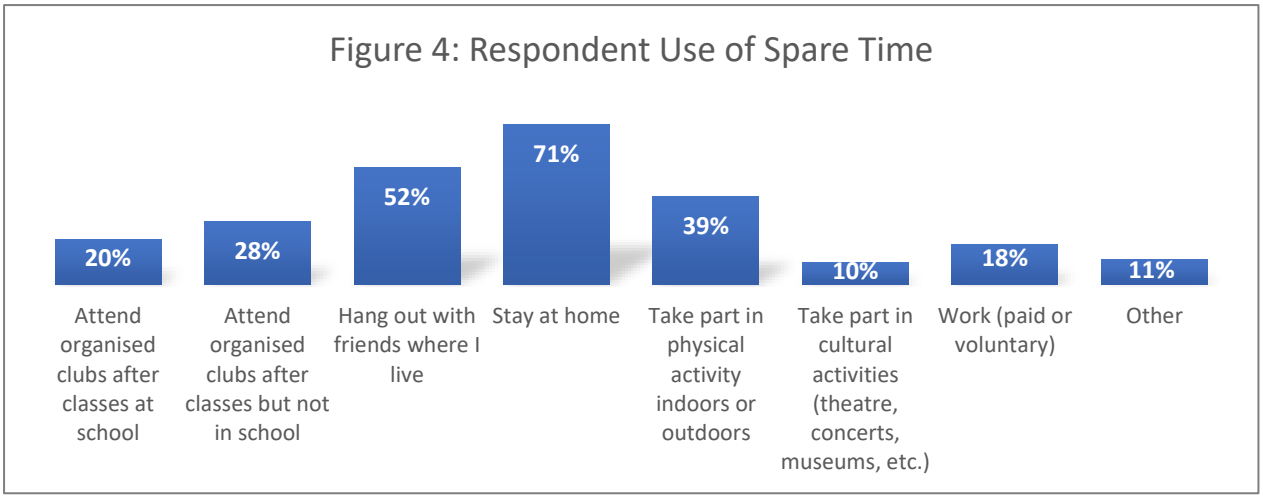
Table 3: Respondent Disability Status	Count	%
Yes	149	8%
No	1587	86%
Prefer not to say	108	6%

Use of Spare Time

When asked what respondents like to do in their space time outside of education/training, a majority of respondents said they stay at home (71%) and a majority also said they hang out with friends (52%) (**See Figure 4**).
Organised clubs (either in school or outside of school) and taking part in physical activity were also mentioned by large minorities of respondents.

These results are very similar to those from the November 2022 Youth Survey. One interesting difference is that this year a higher percentage of respondents reported that they take part in either paid or voluntary work (18% in 2023 compared to 10% in 2022).

Respondents were given the opportunity to specify other activities not listed and 11% (209) did so, with some young people listing more than one additional activity (**see Table 4** for more detailed breakdown).



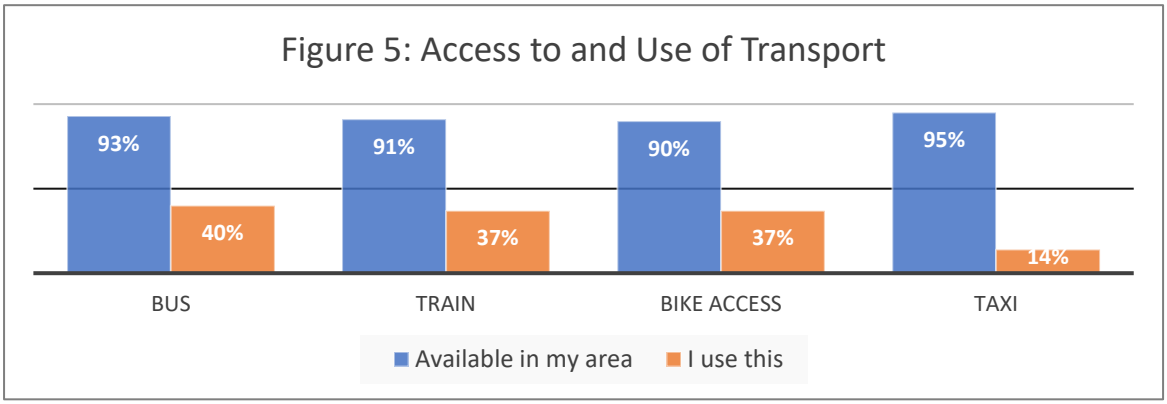
32% of the types of activities young people described participating in during their free time as "other" would actually fall under two of the categories offered in Figure 4 – that being attending organised activities and hanging out with friends.

However, some other relevant information does stand out from **Table 4**. Notably, 16% of respondents specifically identified riding their bike, taking walks, or going to the park as what they enjoyed doing with their spare time. Additionally, 10% of respondents discussed helping or spending time with animals or working on a farm as how they spend their spare time. Both of these activities received higher response rates than going out of the area, watching television, or playing video games.

Table 4: Use of Spare Time – "Other"	Count	%
Play video games	17	7%
Watch TV	3	1%
Ride bikes/go to park/take walks/run	36	16%
Spend time with animals/pets/help with farm	23	10%
Go to a shop or shopping/restaurant	9	4%
Go out of area	22	9%
Organised groups or lessons (e.g. youth clubs/cadets/church/guides/young farmers/instrument lesson/dance, etc.)	47	20%
Work with cars/race cars/car meets	8	3%
Go to friend/or bf/gf/family	28	12%
Go to gym	9	4%
Pub	2	1%
Music/art/reading/other solo hobbies	11	5%
Snooker	2	1%
Other	15	6%

3 Use of Transport and Services

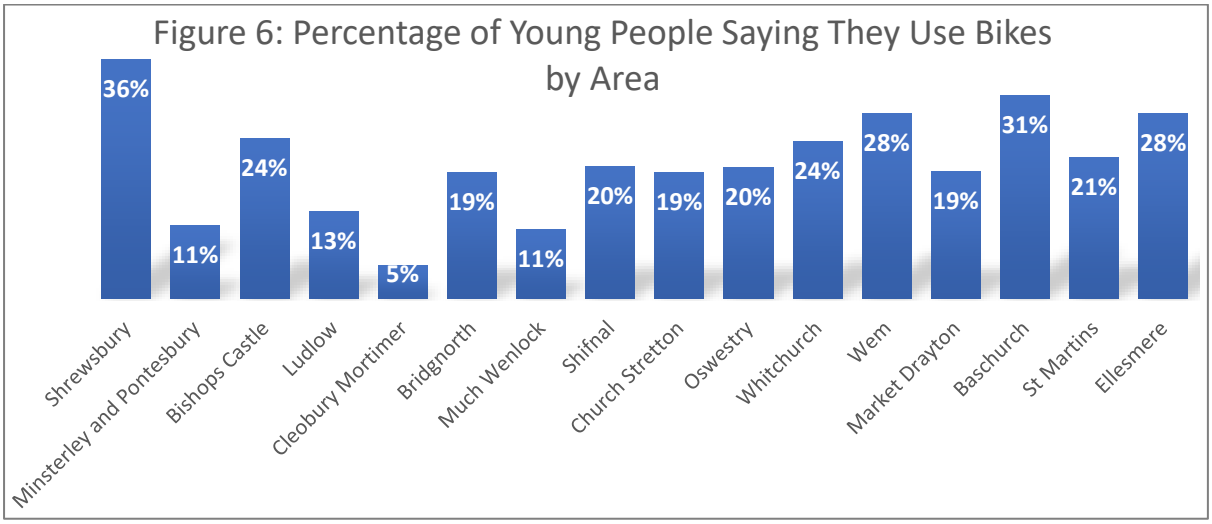
Transport Availability and Use
Respondents were asked whether various types of transport are available in their area and whether or not they use it (**see Figure 5**).



The vast majority of respondents said that all forms of transport are available in their area. However, no majority of respondents said they used any of these methods of transport. **Bus was the most common form of transport used by respondents, with 40% reporting that they use this method**. Both train and bike use were also used by large minorities of respondents as well (37% each) with taxis being the least common form of transport used (14%).

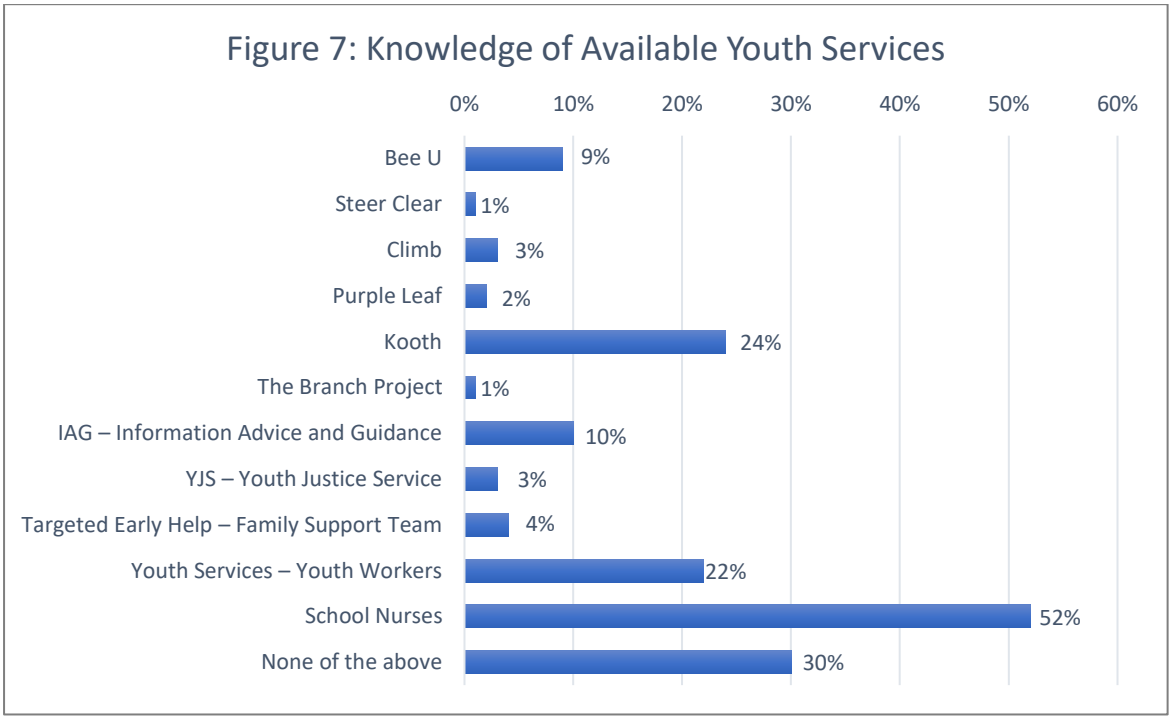
Bike access was high among respondents (90%) and 37% of respondents also said that they use their bikes for transport. However, understanding bike use by geographical area is important as well, since some areas of Shropshire may have more cycle lanes or bike paths that are accessible.

Figure 6 shows reported bike use by geographical area. Shrewsbury, Baschurch, Wem and Ellesmere were places where respondents were more likely to report using their bike as a form of transport. Cleobury Mortimer, Much Wenlock, Minsterley and Ponstesbury, and Ludlow, however, were places where smaller percentages of respondents reported using their bikes as a form of transport.



Awareness of Services

The survey asked questions about services available for young people and whether or not respondents are aware if these services are available in their area. Respondents' knowledge of services was fairly low overall, with 30% of respondents saying "none of these" are services they are aware of being available in their area. School nurses (52%) were the only service a majority of respondents were aware of being available in their area. There was an awareness among a sizeable minority of Kooth (24%) and Youth Service Workers (22%) (**see Figure 7**). 30% of respondents said that they were not aware of any of the services listed as being available in their area.



Respondents were also given the option of adding a comment to clarify their answer to this question about available youth services in their area and 92 did so. These responses were grouped into themes and are detailed in **Table 5**, below.

Table 5: Comments on Available Youth Services	Count	%
Don't think so/no/not in my area	11	12%
Don't know	54	58%
Childline	2	2%
The support is limited (e.g. only available irregularly, not enough) or not good	7	8%
Social prescriber/GP practices	3	3%
Other local charities/services	10	11%

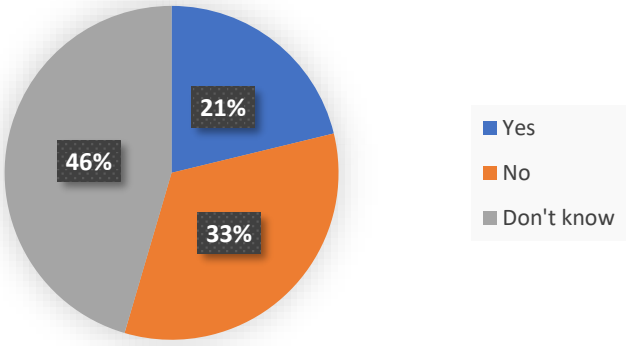
In this space, 65 respondents reiterated that they either don't know whether these services are available, or that they are not available in their area. A few additional services emerged among these responses. Some young people mentioned charities or local services not listed in the question, such as SYA, Crossroads Together, Childline, social prescribers, GP practices and school counsellors.

Overall, however, the results from this question makes it clear that few respondents are aware of services available in their area for young people.

Interest in Using Youth Services

When respondents were asked whether they would use a support service for young people were it available in their area, a majority either said they did not know or that they would not use one. Only 21% of respondents said that they would use a support service for young people (**see Figure 7**).

Figure 7: Would Respondents Use a Youth Support Service



An additional survey question also asked young people to offer comments to explain their answers, and 425 did so. These responses were grouped into themes and are detailed in **Table 6**, below.

Table 6: Comments on Potential Use of Youth Services	Count	%
Don't need it/wouldn't go	123	27%
Too uncomfortable/awkward/don't trust/don't like talking to strangers	33	7%
Had bad previous experience with support service	17	4%
If needed/it depends	72	16%
Want support but it isn't available/appropriate for my situation/it's not available	20	4%
Would use if available/would be beneficial/already use what's here	74	16%
Don't know / not sure what a support service can do	84	19%
Prefer to talk to parents/family/friends	11	2%
Other	16	4%

Of the 425 respondents who offered further comment on this question, 27% said that they don't need youth support services, or they simply wouldn't use them. 7% said that they would likely not go because they would find it too uncomfortable or awkward to use such a service, and 2% said that they preferred to find their support from parents, family or friends. A further 19% said that they are not sure what a support service is or could offer them.

Examples of these kinds of comments include:

- "I don't really like talking to people about personal things."

- “We as teens feel unsecure conversing with adults as they often relay it to our parents.”
- “I do not like opening up to people I don't know, I would only ever do that if I knew them beforehand.”
- “I’m not sure what it is like.”
- “I don’t know a lot about youth workers.”
- “I don’t really know what a support service is?”

Some respondents indicated that they might be interested in using a support service. 16% said that they think it would be beneficial to have youth support services available for people in their area and/or that they are already using such services. A further 16% said that they would do so if they needed it, or depending on their circumstances, or the type of support offered. Examples of comments such as these include:

- “I would as sometimes you need someone to talk to.”
- “Most people would benefit.”
- “Depends on what’s happening in my life.”
- “It depends what support and how accessible.”

4% of respondents commenting said that they would like to use a service, but that one is not available in their area that is appropriate for them. A further 4% said that they had already used services, but that these services were not appropriate, or they had had bad experiences with them. Examples of comments such as these include:

- “There is no support for young people who have disabilities.”
- “I reached out for support with Kooth but help was not provided well and other support services I tried to use I wasn’t old enough.”
- “Because I was recently involved with Bee U and I found my worker very rude.”
- “I have used CAMHS (before it was BeeU) but did not have a positive experience.”

4 Opportunities, Activities, and Facilities

Opportunities

Young people were asked whether they felt there are enough opportunities in their area for young people. While a majority **(57%) of respondents said that yes, there are enough opportunities, 43% do not feel that there are enough opportunities**.

In order to better understand whether there are particular areas where young people feel that opportunities are greater than others in Shropshire, this question was cross-analysed with the “nearest town” data provided by respondents (**see Table 7**).[1]

While not entirely falling into an even divide between more rural and more built-up areas, it was generally the most rural areas of the county where a majority of respondents were more likely to say that there are not enough opportunities for

[1] Although “nearest town” may not be the most accurate for many of the young people answering the survey, as many young people may not be aware of which town is geographically closest to them, this measure may be a still be a good indication of what opportunities young people perceive are nearby.

young people where they live. Cleobury Mortimer, Craven Arms, Ludlow, Market Drayton, Much Wenlock and Whitchurch all had majorities of respondents saying that there are not enough opportunities for young people in their area.

Table 7: Respondent Perception of Opportunities by Nearest Town

Bishops Castle	
No	37%
Yes	63%

Bridgnorth	
No	48%
Yes	52%

Broseley	
No	50%
Yes	50%

Church Stretton	
No	42%
Yes	58%

Cleobury Mortimer	
No	70%
Yes	30%

Craven Arms	
No	57%
Yes	43%

Clun	
No	27%
Yes	73%

Ellesmere	
No	36%
Yes	64%

Ludlow	
No	72%
Yes	28%

Market Drayton	
No	55%
Yes	45%

Much Wenlock	
No	75%
Yes	25%

Oswestry	
No	50%
Yes	50%

Shifnal	
No	43%
Yes	57%

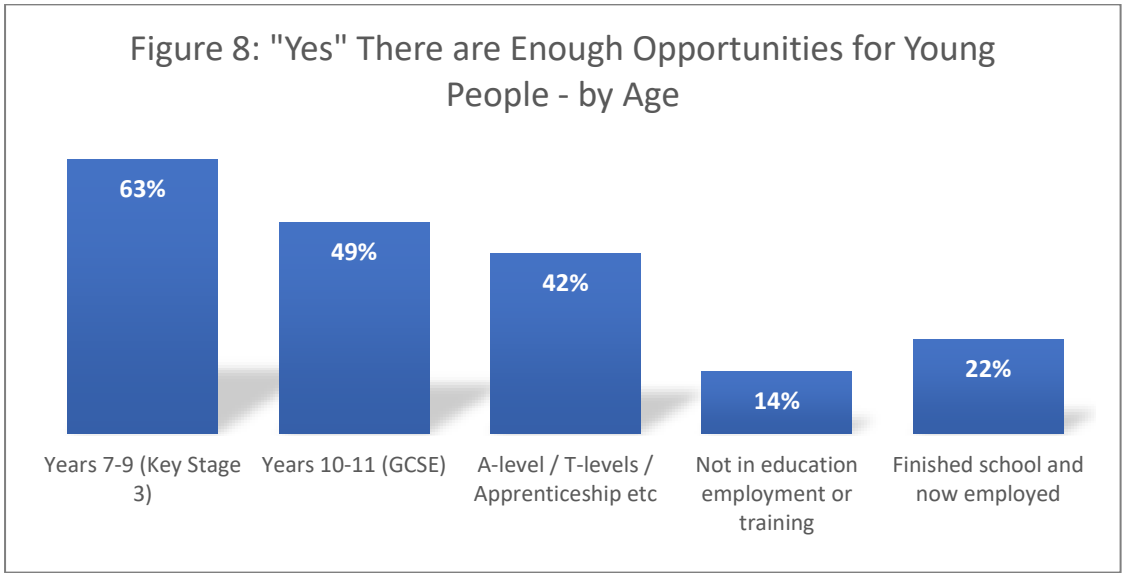
Shrewsbury	
No	36%
Yes	64%

Wem	
No	40%
Yes	60%

Whitchurch	
No	58%
Yes	42%

Interestingly, though, some more rural areas such as Bishops Castle and Ellesmere also had a majority of respondents saying that there are enough opportunities in their area. It is possible that young people do not perceive their opportunities to be limited by their geographical location because many work or educational opportunities are largely a future consideration of a majority of the respondents.

Interestingly, when analysed by age, the perception of opportunities for young people decreases considerably with an increase in respondent age. **See Figure 8**. While the total number of respondents is much lower among older young people in the sample, a comparison by percentage of respondents in that age group allows for a clear picture that, as young people get older, they are less likely to perceive that there are enough opportunities for them in the area.



Once again, respondents were given the opportunity to comment on their responses to the question, and 470 young people did so. Their comments were grouped into themes, and these are presented below in **Table 8.**

Table 8: Opportunities for Young People - Comments	Count	%
Need more job/apprenticeship/volunteer opportunities	68	12%
Not enough higher education/colleges nearby	17	3%
Need more age-appropriate activities/facilities/restaurants	165	30%
Nothing to do/boring	160	29%
Anti-social behaviour/not nice people/being told off	3	1%
Not enough public transport	19	3%
Too far from everything/rural	50	9%
Not a lot of other young people nearby	7	1%
Not enough affordable/free/costs too high	34	6%
Other	27	5%

Table 8 clarifies that respondents interpreted “opportunities for young people” in different ways. Some respondents (15%) talked about opportunity in terms of access to jobs or education. Examples of comments like this include:

- “Job opportunities for young people are low, entry level but skilled positions very hard to find. Seems to be either hospitality/retail or positions that young people don't have the skills and experience for. Graduate schemes in Shropshire could be beneficial.”
- “I feel that there is not enough jobs available and guidance for our age.”
- “Nothing here, we have to travel 1hr to an agricultural college.”
- “Educational options aren't great because only a hand full of people from round here make it to higher education such as university.”
- “There aren't many career paths after school that are local like apprenticeships.”

However, a higher percentage of respondents (30%) talked about opportunity in terms of activities or facilities available to them, and 29% of respondents commenting on this question simply talked about it in terms of “things to do”. Examples of comments such as these include:

- "The area is mostly based for people who are older and there is not much to entertain younger children and teens."
- "Things are either aimed at adults or young kids and restricts us from getting places."
- “"If there were enough, I would assume that kids would be busy doing those things rather than destroying our area and disturbing the peace."
- “No organised youth clubs for 11-12 year olds.”
- “Not much to do other than hang around. not really encouraged to participate in local community events.”
- “As it is a small village there isn’t much to do.”

Finally, a total of 12% of the comments that respondents made to this question also had to do with the way that isolation or a lack of good transport options limited their opportunities. Examples of comments like this included:

- “Very isolating. Not able to travel unless parents willing to drive.”
- “Opportunities are offered outside the area, but that may require transport that some young people do not have the ability to access & afford.”
- “There is nothing where I live. I need to go into town or out of area to access everything.”
- “Trapped into only a few jobs unless you want to travel away but it’s expensive.”

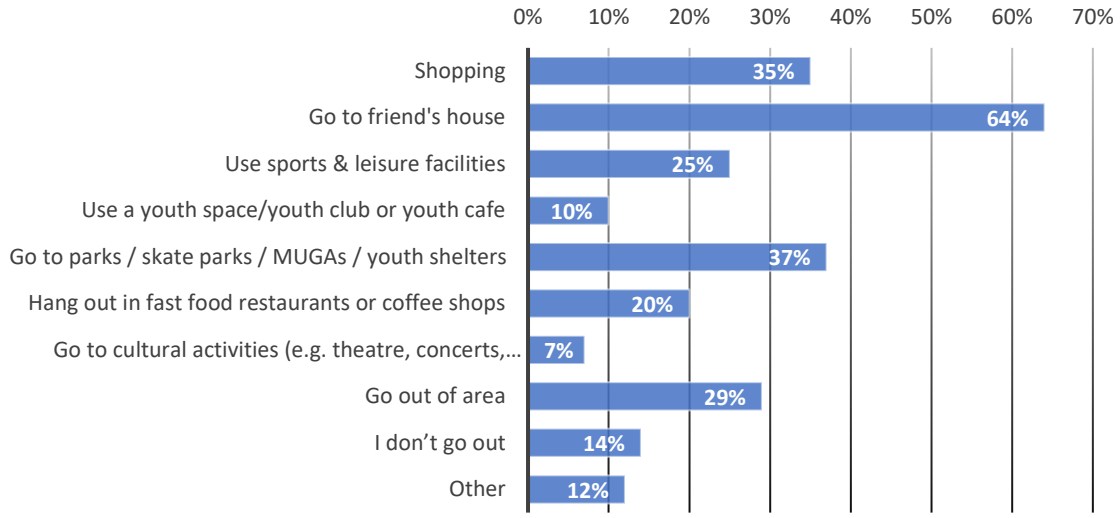
Activities in the Area

When asked whether there is enough for young people to do where they live, respondents were most likely to say “no” (49%) or that they “don’t know” (18%). **Only 33% of survey respondents feel that there is enough to do for young people where they live.**

Respondents were further asked what activities they and their friends take part in within the area they live (**see Figure 9**).

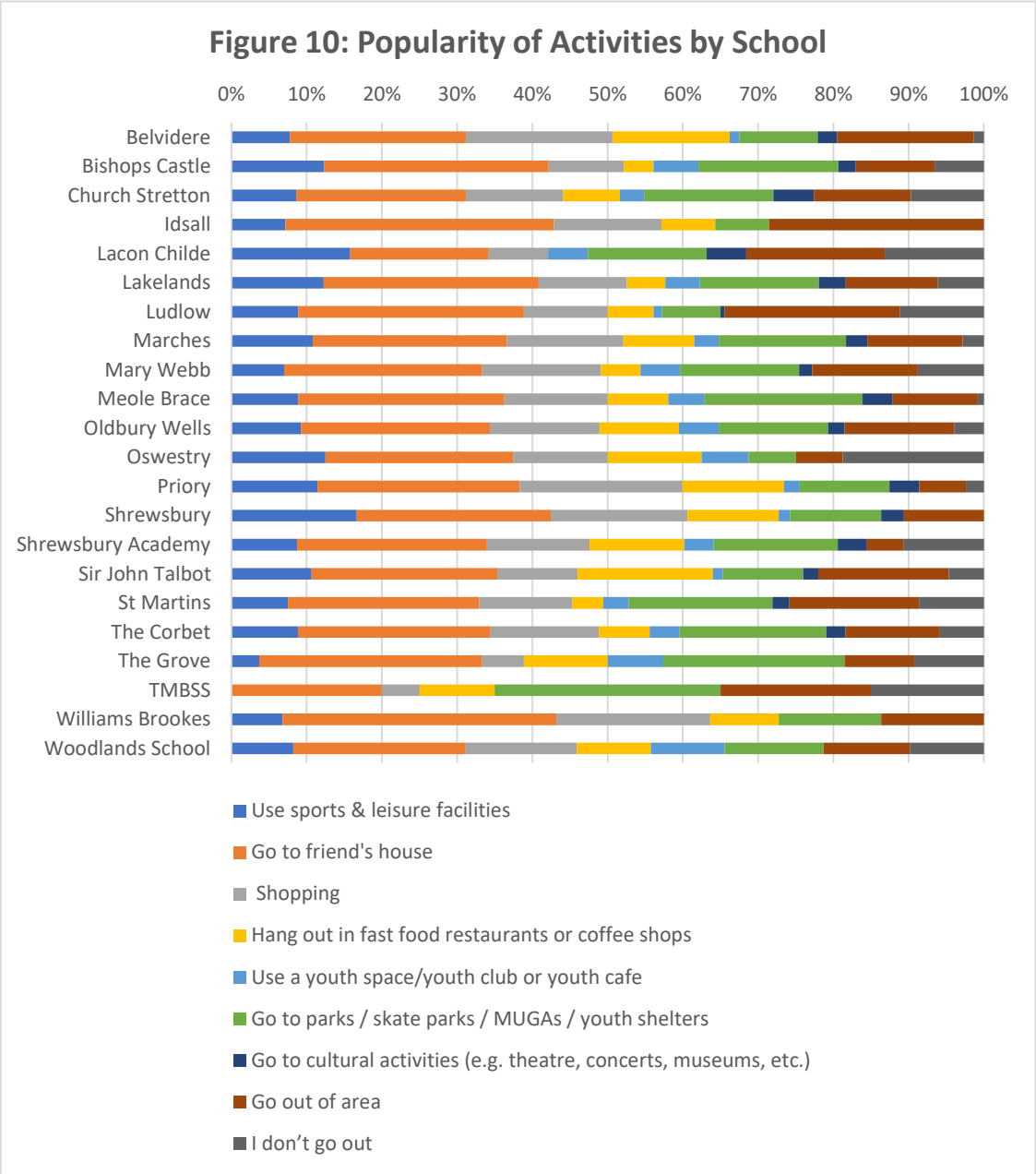
Going to a friend’s house was the most popular response, with a majority of 64% saying that they do this. While no other activity received a majority of responses, large minorities of respondents also said that they go to parks/skate parks/MUGAs or youth shelters (37%) or go shopping (35%). 29% of respondents said that they go out of the area when they go out.

Figure 9: Activities Respondents Do Within Their Area



Some additional analysis of activities by school was also performed in order to better understand which types of activities were more popular in which areas of the county.[2] The results of this analysis are presented in **Figure 10**.

[2] In this question, school was used as a more accurate gauge of locality as opposed to nearest town, due to activities often being very local in nature and going “out of area” for some respondents may mean going to their nearest town.



This analysis is fairly revealing about what kinds of activities are popular in more rural areas versus areas closer to greater population density, such as Shrewsbury and Oswestry-based schools. For example, Shrewsbury, Priory and Belvidere respondents are more likely than those attending Lacon Childe, The Grove, or Woodlands School to say they go shopping.

Perhaps more interesting might be the students who make more use of parks, youth cafes and sport and leisure facilities. For example, relatively fewer respondents attending Belvidere take part in these activities than students in Church Stretton.

Additionally, either going out of their area to participate in activities or not going out at all seems to be higher among respondents attending more rural schools such as Ludlow, Church Stretton and Idsall.

Other relationships between the school locations and the types of activities respondents participate in may occur to specialists in the Youth Services Team upon analysis of these data.

Respondents were given the opportunity to identify other activities and 177 respondents did so. Additional activities identified are detailed in **Table 9**, below.

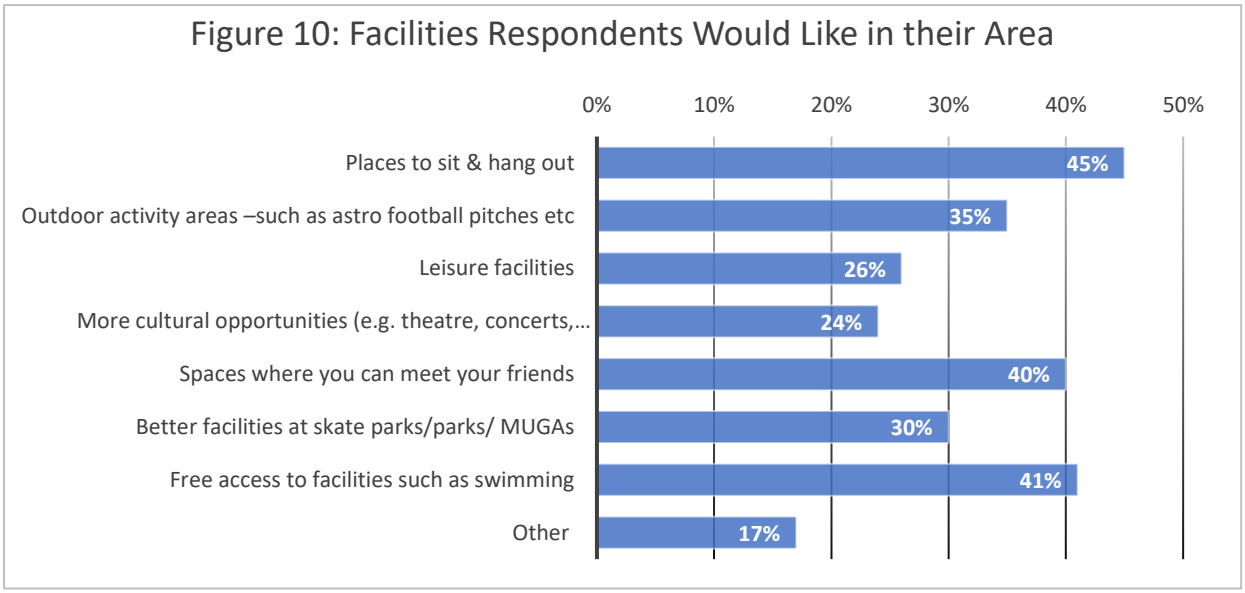
Table 9: "Other" Activities	Count	%
Play video games	11	6%
Ride bikes/go to park/take walks/run	52	27%
Spend time with animals/pets/help with farm	8	4%
Go to a shop/town or restaurant/café	14	7%
Football	11	6%
Organised groups or lessons (e.g. youth clubs/cadets/church/guides/young farmers/instrument lesson/dance, etc.)	28	14%
Work with cars/race cars/car meets/hang out in cars	3	2%
Hang out with friends/family	10	5%
Go to gym/leisure centre/swimming/library/bowling/snooker	6	3%
Pub	3	2%
No activities/don't have friends in area	27	14%
Other	23	12%

The largest theme to emerge under "other" activities was that 27% of respondents said that they enjoy spending time outdoors riding bikes, taking walks and hanging out in their local park. Another large theme was taking part in organised clubs, lessons or other groups such as cadets, young farmers, or playing musical instruments.

Unfortunately, another big theme was that respondents do not participate in any activities with their friends and/or don't have any friends in their area (14%).

Facilities

Respondents were asked what types of facilities might make where they live better for them and their friends. Respondents were given a range of possible options, and while no one option garnered majority interest, a few were popular among large minorities of young people responding to the survey (**see Figure 10**).



For example, places to sit and hang out, as well as spaces where you can meet your friends were popular with 45% and 40% of respondents respectively. Free access to facilities such as swimming was also popular with 41% of respondents.

Respondents were also given the opportunity to identify other types of facilities that might make where they live better for them and their friends and 200 did so. These were grouped into themes and are presented in **Table 10**, below.

Table 10: Facilities Respondents Would Like – "Other"	**Count**	**%**
More shops/better shops	59	26%
Fast food/café	24	11%
Parks/improved parks (e.g. mountain bike trails, skate park, more for teens, etc)/better lighting in parks	47	21%
Safe places to hang out indoors	6	3%
More activities (leisure facilities/pool/mini golf/bowling/cinema)	41	18%
Better public transport/cycle paths/improved roads	14	6%
More affordable activities (e.g. cheaper gigs, affordable transport)	3	1%
Clubs/social events/places to meet other young people	12	5%
Nicer people/safer area/less anti-social behaviour	8	4%
Other	12	5%

More shops (including any shop at all for some), as well as improved shopping that was of more interest for young people was a popular theme among respondents, with 26% of respondents saying something similar to this. Relatedly, 11% of respondents commenting in the "other" field said that they would like a fast food restaurant (specific preferences included McDonald's, KFC and Greggs) or a café near them.

Another large portion of respondents (18%) wanted some sort of facilities for activities they enjoy. There were a wide variety of facilities for activities that respondents mentioned, for instance bowling alleys, leisure centres, swimming pools, mini golf, and cinemas, to name just a few.

Some respondents had very strong ideas about what facilities should be brought into their area – so much so that they used multiple comment spaces to talk about their wishes for these facilities to be introduced. One respondent, for example, used every comment box to write "a basketball court in Baschurch." Another wrote something about wanting a Greggs near them in just about every comment box as well. Additionally, a few respondents said they want a "pump track" in more than one comment box. While they represent only a tiny number, it is worth noting the persistence of these respondents in trying to get across their particular interests.

5 Young People Evaluating Where They Live

What Respondents Like

Respondents were given the opportunity to discuss what specifically they like about where they live. 1,476 young people responded to this question with a comment, and their responses have been grouped thematically and presented in **Table 11**, below.

Table 11: What Young People Like About Where They Live	Count	%
Access to the great outdoors / outdoor activities /animals (e.g., walking, horse riding, etc)	94	6%
Rural, quiet, and beautiful location	618	40%
Facilities for young people (e.g., cinema, skate park, football stadium)	141	9%
Restaurants, shops and shopping	164	11%
Being able to see my friends and family	111	7%
The community /where I live / feel safe	207	13%
Close to school	24	2%
Able to get to places easily / good transport	62	4%
Nothing / don't know	65	4%
Local history/architecture	19	1%
Other	45	3%

A large minority of respondents (40%) liked their location precisely because it is rural, citing the quiet or the beauty of where they live as positives. 13% also noted that their community is a positive aspect of where they live, and 11% said that they like living near friends and family. 11% of respondents (likely those in more built up areas) said that they like the restaurants and shops available nearby and 9% said they think there are good facilities for young people where they live.

Examples of positive comments from young people about their area included:

- "Being close to lots of places to explore."
- "It's quite rural and calm but there's still enough things to do."
- "Good park for mountain biking."
- "The shops that are available in town."
- "It's a nice place to be to hang out with friends, and it's a nice place to walk around and do activities."
- "Living in Clun, it's quiet, small, peaceful, wouldn't have it any other way."
- "I'm close to school and my friends."
- "It's in walking distance to town centre."

In spite of these many positive comments, 4% of respondents (65) answering this question about what they **like** about where they live chose to say there is nothing that they like, or that they don't know what they like.

What Respondents Don't Like

Respondents were also given a separate opportunity to comment on what they don't like about where they live. 1,423 young people offered comments on this, which were grouped thematically, and these themes are presented in **Table 12**, below.

Table 12: What Young People Don't Like About Where They Live	Count	%
Nothing to do / boring / everything	174	13%
Crime / antisocial behaviour / litter / not feeling safe	181	13%
Live far away from my friends / family / feel lonely / isolated	128	9%
Other people / other children / neighbours, etc	107	8%
No shops/ restaurants near to where I live	109	8%
Not enough facilities / things for young people to do	144	10%
Poor transport / reliance on the car / can't get to where I want to go	87	6%
Weather / flooding / cold	63	5%
Nothing/ don't know / I'm happy	149	11%
State of the roads / traffic issues	102	7%
Don't like the nature/farms/history/architecture nearby	35	3%
Internet/phone limitations	12	1%
Too small/lack of diversity	14	1%
Noisy/crowded	17	1%
Lack of job/educational opportunities	7	1%
Other	48	3%

While there was no theme that stood out as prominently in this question as the rural/beautiful/quiet theme did in the positive comments, there were several themes where over 100 young people agreed. Moreover, some of these themes overlap into larger issues. For instance, 13% of respondents (174) said that what they don't like about where they live is that there is generally nothing to do or that it's boring. Similarly, 10% of respondents said more specifically that there are not things or facilities for young people where they live, and 9% said that what they don't like is that they live far away from people they want to be around such as friends or family, or that they feel isolated. 6% said that poor transport is an issue, and 8% said that there are not enough shops or restaurants where they live. All of these themes might be related to the rural nature of the county, over which young people have little control.

Another 13% of respondents said that they don't like that their area has crime or antisocial behaviour. Similarly, 8% had negative comments about people where they live, such as neighbours or other young people. A small number of respondents (14) also commented on the lack of diversity in their area being a problem. These themes seem to relate to discontent with the community (rather than the physical environment) that young people are living in.

Finally, it's worth noting that 11% of respondents commenting on this question said that there is nothing that they don't like about their community.

Things to Improve

About half of survey respondents (51%) said that there are things they would like to improve about where they live. 49% said there is nothing to improve about where they live.

When asked to provide comments on their responses, 855 young people did so. Their responses were grouped thematically, and these themes are presented in **Table 13**, below**.**

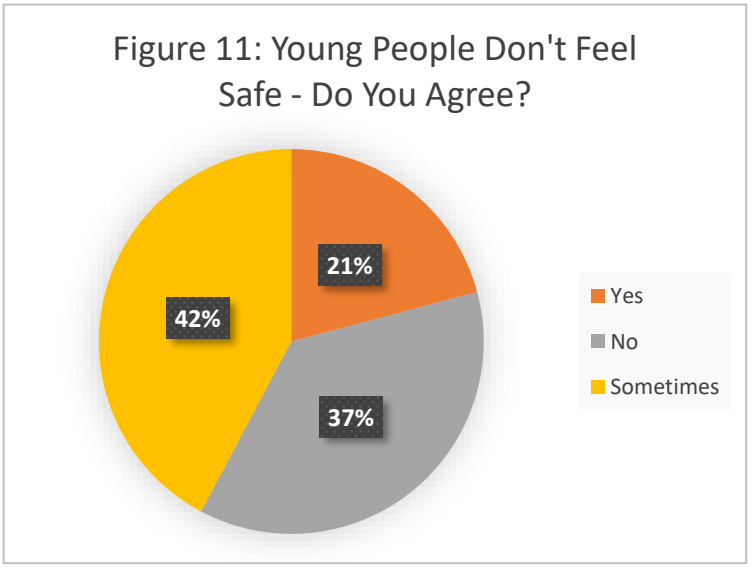
Table 13: Things to Improve	Count	%
Shops	160	19%
Parks and outdoor spaces (for young people)	97	11%
Sports, leisure and exercise facilities	97	11%
Places to hang out, spaces inside and outside (e.g. with seats)	94	11%
Things to do, activities to reduce boredom	192	23%
Safe and better public space (bins, toilets, lighting, crime reduction measures)	113	13%
Road crossings, safe paths, cycle routes and safer roads	44	5%
Too many new houses and building sites	6	1%
Cinema, bowling and other similar facilities	6	1%
Skate park, cycle track and mountain bike routes	38	4%
Places to eat out, fast food outlets and cafes	39	5%
Don't know	10	1%
Buses, trains, other public transport and car parking	60	7%
Other	92	11%

There was a very wide variety of suggestions for improvements to the area from young people. However, more shops and activities were some of the suggestions with the most support (19% and 23% respectively). Improvements to public areas such as lighting/toilets (13%), as well as parks (11%) and transportation (7%) were also popular suggestions.

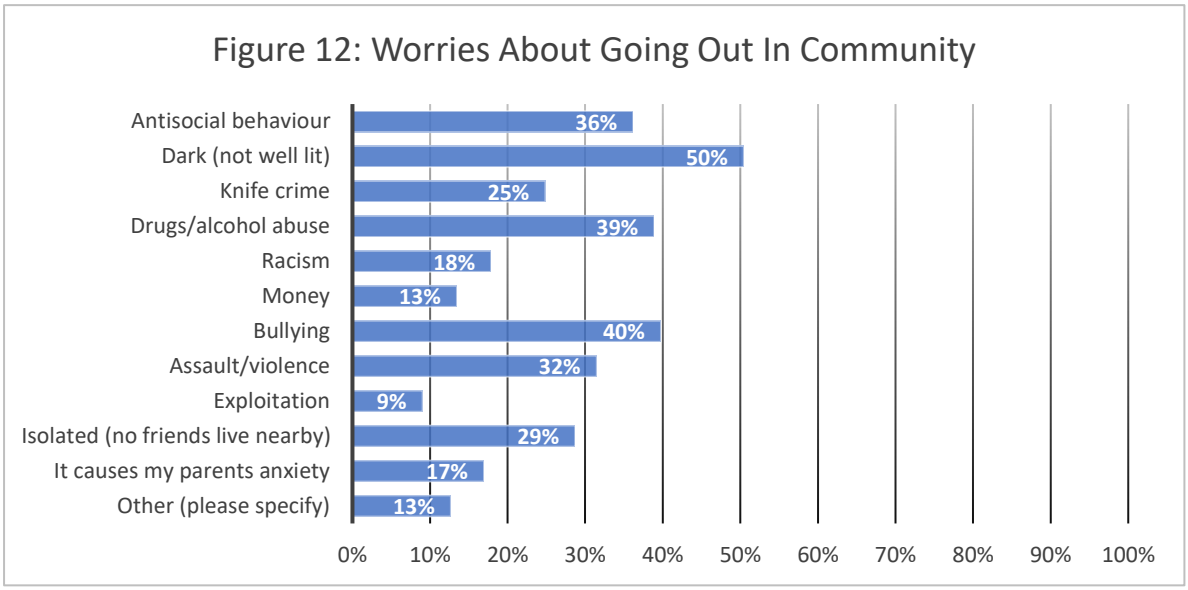
Worries About Safety

Young people were asked about whether they agreed with the statement that "young people do not feel safe in their community" (**see Figure 11**).

A majority of young people (63%) either agreed with this statement or said that they "sometimes" agreed. **Only 37% of young people disagreed, indicating that they always feel safe in their community.**



The survey then asked young people to identify what specific concerns they have about going out in their community. The results of this question are summarised in **Figure 12**.



Areas not being well lit, concerns about bullying, drug/alcohol use, and antisocial behaviour were the top areas for concern among young people about going out in their communities. Worryingly, nearly a third of respondents said they were concerned about assault and a quarter reported being concerned about knife crime.

Respondents answering "other" to the question of what worries they have about going out in their community were asked to clarify their response, and 82 respondents did so. Their answers were grouped thematically, and these themes are presented in **Table 14**.

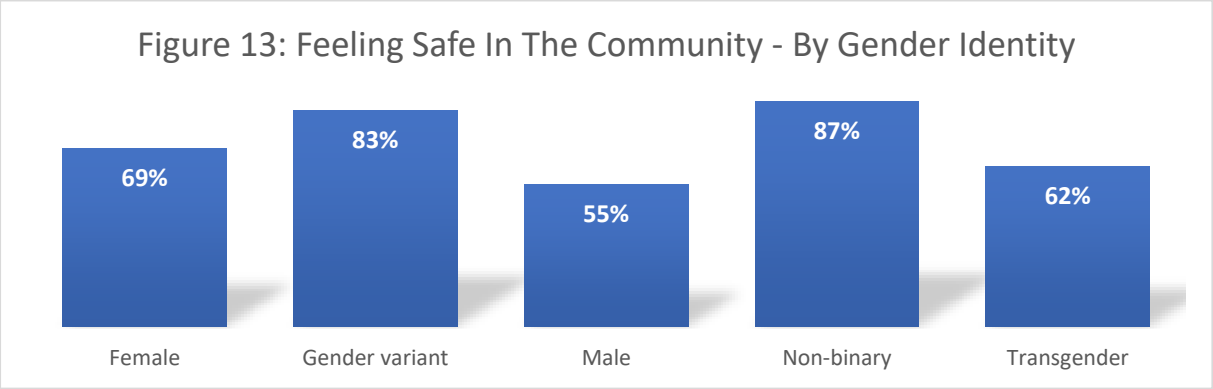
Table 14: "Other" Worries About Going Out In Community	Count	%
Gangs/groups of unsavoury people hanging around/homeless people	13	14%
General anxiety	19	20%
Not enough lighting	8	8%
Worried because theft, assault or other crime has recently happened nearby	11	11%
Worried about harassment (e.g. catcalling, transphobia, etc.)	13	14%
Fear of kidnapping	4	4%
Older people telling them off	4	4%
People vaping/smoking nearby	5	5%
People taking/selling drugs or drinking/acting drunk nearby	9	9%
Other	10	10%

19 of the respondents answering "other" identified their worries as a general anxiety. Another 13 respondents talked about gangs or groups of people hanging around that made them worried – some included the homeless in this theme. Another 13 respondents were worried about harassment such as catcalling, homophobia or transphobia. 11 respondents indicated that they were worried because of actual

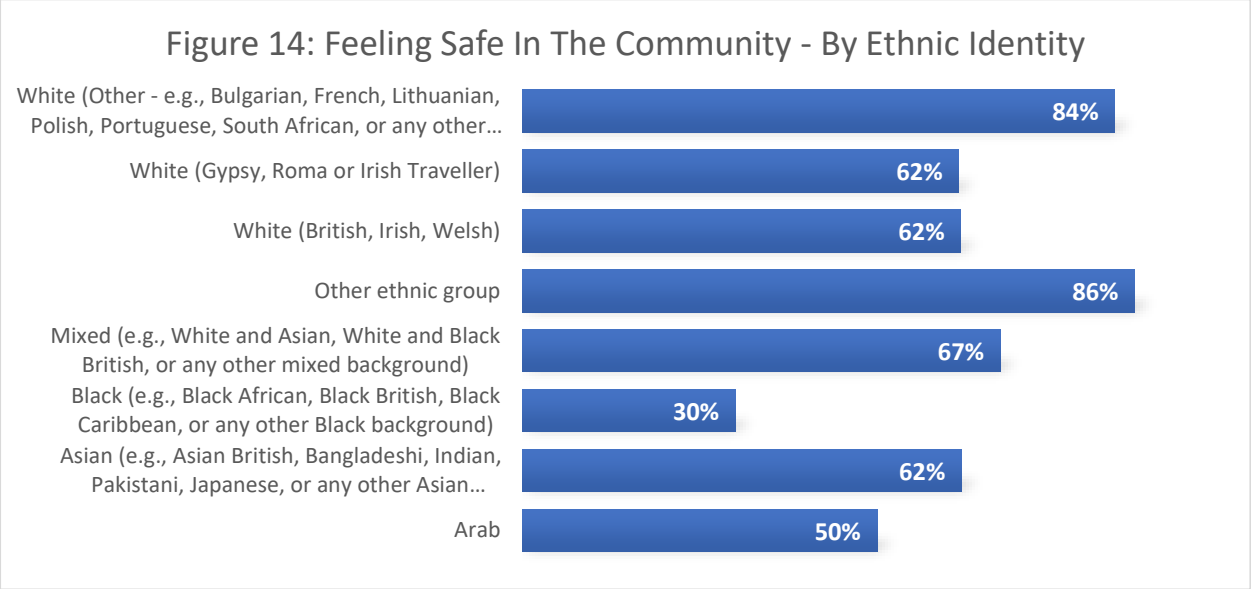
crime that had happened recently in their area. A handful of respondents, for instance, noted that there had been a shooting at a co-op near them recently.

It is helpful to break down some of the results from **Figure 12** along demographic lines to provide a clearer picture of what is driving some of these results. Perhaps unsurprisingly, for example, of those respondents who said going out in the community "causes my parents anxiety" a majority (51%) were the youngest age cohort in the sample (years 7-9).

Also perhaps unsurprising is the breakdown of feelings of safety in the community by gender identity (**see Figure 13**). A majority (55%) of respondents identifying as male said that they either felt unsafe or "sometimes" felt unsafe in their community. However, 69% respondents identifying as female reported these feelings, and respondents identifying as non-binary, transgender or gender variant were also more likely than those identifying as male to say that they felt unsafe or sometimes felt unsafe.



When broken down by ethnicity (**see Figure 14**), it is interesting to note that respondents identifying as Black are the least likely among self-identified ethnicities to report feeling unsafe or "sometimes" unsafe in their community, while "other ethnic groups" and "other white" ethnic groups report feeling unsafe or sometimes unsafe at higher percentages of their population than many other groups.



6 Summary and Conclusions

Summary

The key findings in the above report can be summarised as follows:

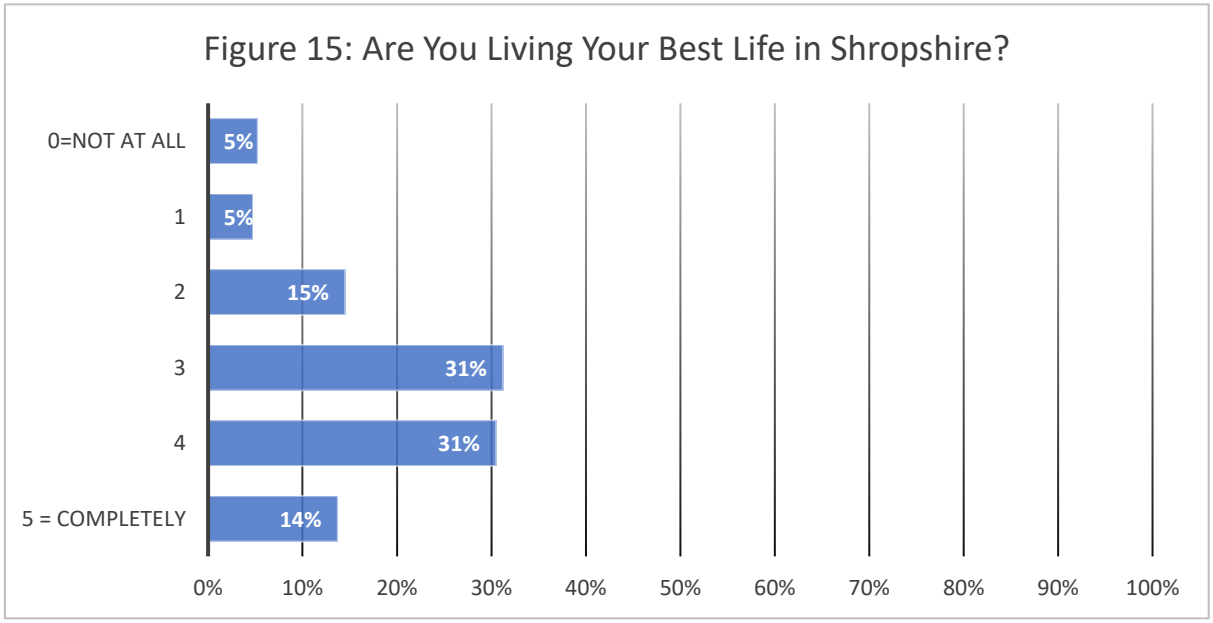
- Respondent Characteristics
  - 1,873 young people representing a good spread of locations across the county answered the survey.
  - A large majority (87%) of those responding to the survey identified as White (British, Irish, Welsh) and a majority of respondents were also in years 7-9 (59%) and identified as Female (52%).
  - 71% of respondents said they stay at home in their spare time, which is similar to the results of the November 2022 survey of young people in Shropshire.
    - One noteworthy statistic is that 18% of young people said that they spend their time taking part in paid or voluntary work in 2023, whereas in 2022 only 10% reported spending their time in this way.
- Use of Transport and Services
  - The vast majority of respondents said that all forms of transport are available in their area. However, no majority of respondents said they used any of these methods of transport. Bus was the most common form of transport used by respondents, with 40% reporting that they use this method.
  - School nurses were the only support service for young people that a majority (52%) of respondents said that they were aware of in their area.
  - A large minority of respondents (30%) said that they are not aware of any support services for young people in their area.
  - A majority of respondents (79%) said that they would not use a youth support service or "didn't know" if they would use a youth support service if it were available to them in their area.
- Opportunities, Activities, and Facilities
  - While a majority (57%) of respondents said that there are enough opportunities for young people in their area, 43% do not feel that there are enough opportunities.
    - The likelihood of responding "yes" to the question of whether there are enough opportunities for young people declines with the age of the young person responding.
  - Only 33% of survey respondents feel that there is enough for young people to do where they live.
  - The most popular activity for young people to engage in within their area if to go to a friend's house (64%).
  - Facilities that the most young people feel are needed in their area are places to sit and hang out (45%), free access to facilities such as swimming (41%) and spaces where they can meet their friends (40%).
- Young People Evaluating Where They Live
  - A large minority of respondents (40%) liked their location precisely because it is rural, citing the quiet or the beauty of where they live as positives.

- 13% of respondents said that what they don't like about where they live is that there is nothing to do, and 10% said that there are not enough facilities or things for young people to do in their area.
- About half of survey respondents (51%) said that there are things they would like to improve about where they live.
  - Improved or increased shops, activities and facilities for young people, as well as improved public spaces and services such as parks, outdoor lighting and transportation were all discussed as important improvements that could be made for young people.
- A majority of young people (63%) either agreed with the statement that they feel unsafe in their community or said that they "sometimes" agreed.
  - Areas not being well lit, concerns about bullying, drug/alcohol use, and antisocial behaviour were the top areas for concern among young people about going out in their communities.
  - Those respondents with a gender identity that is not male were most likely to respond that they feel unsafe or "sometimes" feel unsafe in their community.
  - "Other" ethnic groups and "Other White" ethnic groups were more likely than other self-identified ethnicities to feel unsafe or "sometimes" unsafe in their community.

Conclusion

At the end of the survey, young people were asked whether they are "living their best life in Shropshire". **Figure 15** shows that the majority of respondents think they are about a 3 or a 4 on a scale of 1-5 with 5 being "completely".

The response to this question makes sense in the context of the overall results of this survey. Young people in Shropshire overall seem to be happy with where they live, but they also have many things that they would like to see improve about where they live, and their responses offer some excellent and detailed ideas as to how the area might be improved to better suit the needs of young people.



Very many thanks are extended to the 1,873 young people who took part in the survey that produced this report, as well as to the Youth Support Team who worked tirelessly to ensure that the voices of as many young people as possible were heard as part of this research. Their extensive efforts to ensure survey uptake should be a model for other teams looking to achieve the kind of engagement that this survey yielded.

This report provides valuable insights into the needs and opinions of young people in the county. The survey results show that while a majority of respondents feel that there are enough opportunities in their area, a significant minority do not. Additionally, the survey highlights the need for better awareness of available youth services and the importance of providing accessible and affordable facilities and activities for young people.

By listening to the voices of young people and taking their feedback into account, the Youth Support Team can continue to improve their services and support the personal, social, and educational development of young people in the county.

January 2024

Analysis and reporting by:
Feedback and Insight Team, Communications and Engagement, Resources
Shropshire Council
Email: TellUs@shropshire.gov.uk

Shropshire Council Lead Department: Youth Support Team

Shropshire Council

Agenda Item

ICB 26-03.137

Telford and Wrekin Integrated Place Partnership Committee Chair's Report

Appendix A – TWIPP 30.01.2025 - Agenda

Integrated Care System
Shropshire, Telford and Wrekin

AGENDA

Meeting Title	Telford & Wrekin Integrated Place Partnership (TWIPP)	**Date**	30.01.2025
Chair	David Sidaway	**Time**	11:00 – 13:00
Minute/Action Taker	Kimberley Bailey	**Venue/ Location**	Walker Room, Meeting Point House, Southwater Square, Telford TF3 4HS

A=Approval R=Ratification S=Assurance D=Discussion I=Information

Ref	Agenda Item	Presenter	Purpose	Paper	Time
TWI30/01/25 – 01	Welcome, Introduction and Apologies	Chair	N/A	N/A	1 min
TWI30/01/25 – 02	Declarations of Interest	Chair	N/A	N/A	2 mins
TWI30/01/25 – 03	Minutes from the last meeting	Chair	A	Attached	2 mins
TWI30/01/25 – 04	Update on actions arising from last meeting	Sarah Downes	S & A	Attached	5 mins
TWI30/01/25 - 05	Energize Place Expansion Proposal	Jessica Bradbury / Pete Ezard	A	Attached	10 mins
Priority Focus: Supporting General Practice					
TWI30/01/25 – 06	**What's the current position and what's happening now?**				
	a) General Practice – a Clinical Director's view on the current challenges and opportunities	Dr Stefan Waldendorf	I	Verbal	10 mins
	b) Pharmacy First update	James Milner	I	Attached	10 mins
	c) Community Outreach (Community Blood Pressure and Family Hubs)	Louise Mills and Chris Thursfield	I	Attached and presenting on the day	10 mins

	d) Digital self-help asset updates (including use of NHS App) *(All to identify what would help to have more impact and improve outcomes)*	Not presented - report part of papers to inform discussions	I	Attached	N/A
TWI30/01 /25 – 07	**Discussion opportunity for members looking at:** a. Where are the gaps in what we've heard? b. What and where are the opportunities? c. What are the 3 priority actions that TWIPP should focus on? *(Group discussions with feedback)*	Sarah Downes	D	N/A	60 mins
TWI30/01 /25 – 08	**Plenary**	Chair / Vice-Chair	A	N/A	15 mins
Hot topics					
TWI30/01 /25 – 09	GP Out of Hours Procurement Update	Gemma Smith	S	Verbal	2 mins
TWI30/01 /25 – 10	Areas of risk identified and escalation needs	Chair	S	N/A	2 mins
TWI30/01 /25 – 11	Any Other Business	All	I	Verbal	3 mins
For information only items					
TWI30/01 /25 – 12	Telford & Wrekin Council's Children's Service Ofsted Outcome – 'Outstanding' Report available through this link at agenda item 'CAB 24'.	Jo Britton	I	N/A	N/A
Next Meeting Details					
19 March 2025, 1.30-3pm at Wellington Civic, Room 1					

Agenda Item

ICB 26-03.139

Delegated Specialised Commissioning

Appendix A – Collaboration Agreement Spec Comm 2025-26 FINAL

Appendix B - Delegation Agreement for Specialised Services 2025 FINAL

Appendix C - DPIA Delegation of SpecComm April 25_Midlands FINAL

Collaboration Agreement
For Delegated of Specialised Services
2025

Table of contents

Clause heading and number — Page number

THIS AGREEMENT is made on the first day of April 2024

BETWEEN:

(1) **NHS Lincolnshire Integrated Care Board** of Bridge House, The Point, Lions Way, Sleaford, NG34 8GG ("Lincolnshire ICB"); and

(2) **NHS Nottingham & Nottinghamshire Integrated Care Board** of Sir John Robinson House, Sir John Robinson Way, Arnold, Nottingham, NG5 6DA ("Nottingham & Nottinghamshire ICB"); and

(3) **NHS Leicester, Leicestershire & Rutland Integrated Care** Board of Room G30, Pen Lloyd Building, County Hall, Glenfield, Leicester, LE3 8TB ("Leicester, Leicestershire & Rutland ICB"); and

(4) **NHS Northamptonshire Integrated Care Board** of Francis Crick House, 6 Summerhouse Road, Northampton, Northamptonshire, NN3 6BF ("Northamptonshire ICB"); and

(5) **NHS Derby & Derbyshire Integrated Care Board** of Cardinal Square, 10 Nottingham Road, Derby, Derbyshire, DE1 3QT ("Derby & Derbyshire ICB").

(6) **NHS Birmingham & Solihull Integrated Care Board** of floor 8, alpha tower, Suffolk Street Queensway, Birmingham B1 1TT ("Birmingham & Solihull ICB"); and

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

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

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

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

(11) **NHS Staffordshire & Stoke-on-Trent Integrated Care Board** of Stafford Education & Enterprise Park, Weston Road, Stafford, ST18 0BF ("Staffordshire & Stoke-on-Trent ICB");

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

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 23 (*Termination & Default)* below.

2. PRINCIPLES AND AIMS

2.1 BACKGROUND

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

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

(C) Pursuant to section 65Z5 of the NHS Act, NHS England and the ICBs can establish and maintain joint arrangements in respect of the discharge of their Commissioning Functions.

(D) Under the Delegation Agreement made pursuant to section 65Z5, NHS England has delegated the Delegated Functions to each of the ICBs. NHS England has retained responsibility for the NHS England Reserved Functions and commissioning of the Retained Services.

(E) It is agreed that to exercise the Delegated Functions in the most efficient and effective manner, some of the Delegated Services are best commissioned collaboratively between multiple ICBs.

(F) This Agreement sets out the arrangements that will apply between the ICBs and NHS England in relation to the collaborative commissioning of Specialised Services for the ICBs' Populations.

2.2 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

2.2.1 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;

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

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

2.2.4 act always in good faith towards each other.

2.3 The Partners agree:

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

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

2.3.3 to act in a timely manner;

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

2.3.5 to act at all times, ensure the Partners comply with the requirements of the Delegation Agreements including Mandated Guidance;

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

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

2.4 The Partners' aims are:

2.4.1 to maximise the benefits to patients of integrating the Delegated Functions with the ICBs' Commissioning Functions through designing and commissioning the Specialised Services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim;

3. SCOPE OF THE ARRANGEMENTS

3.1 This Agreement sets out the Joint Working Arrangements through which the Partners will work together to commission Services. This may include one or more of the following commissioning mechanisms (the "Flexibilities") although this list is not exhaustive:

3.1.1 Lead Commissioning Arrangements: where agreed Commissioning Functions are delegated to a lead Partner (Lead Partner);

3.1.2 Aligned Commissioning Arrangements: where there is no further delegation of the Commissioning Functions. However, the Partners agree mechanisms to co-operate in the commissioning of identified Services;

3.1.3 Joint Commissioning Arrangements: where the Partners exercise agreed Commissioning Functions jointly;

3.1.4 the establishment of one or more Joint Committees;

3.1.5 the establishment of one or more Commissioning Teams;

3.1.6 the establishment of one or more Pooled Funds;

3.1.7 the use of one or more Non-Pooled Fund.

3.2 At the Commencement Date the Partners agree that the following Joint Working Arrangements shall be in place:

3.2.1 Delegation by NHS England of the Delegated Functions to each individual ICB in accordance with the relevant Delegation Agreement.

3.2.2 Establishment of the following Joint Working Arrangements:

- Establishment of a Commissioning Team in accordance with Clause 5.1 through which agreed Delegated Services may be commissioned as set out in schedule 10 of the Delegation Agreement
- Delegation of responsibilities by the ICBs to the two Joint Committees for the East and West Midlands established under existing multi-ICB Joint Working Agreements;
- Approval of the two schemes for the commissioning of delegated specialised services for the East and West Midlands multi-ICBs;
- Establishment of financial risk share and pooled budget arrangement as set out in Schedule 4.

4. FUNCTIONS

4.1 The purpose of this Agreement is to establish a framework through which the Partners can secure the commissioning of health services in accordance with the terms of this Agreement.

4.2 This Agreement shall include such Commissioning Functions as shall be agreed from time to time by the Partners and set out in the relevant Scheme Specifications.

4.3 The Scheme Specifications for the Individual Schemes included as part of this Agreement at the Commencement Date are set out in Schedule 3.

4.4 Where the Partners add a new Individual Scheme to this Agreement, a Scheme Specification for each Individual Scheme shall be completed and approved by each Partner in accordance with the variation procedure set out in Clause 13 (*Variations*).

4.5 The Partners shall work in co-operation and shall endeavour to ensure that all Services are commissioned with all due skill, care and attention irrespective of the Joint Working Arrangements utilised.

4.6 Where there are Lead Commissioning Arrangements in respect of any Individual Scheme, unless the Scheme Specification otherwise provides, the Lead Partner shall:

4.6.1 exercise the Functions of each Partner as identified in the relevant Scheme Specification;

4.6.2 endeavour to ensure that all Commissioning Functions included in the relevant Individual Scheme are funded as agreed by each Partner in respect of each Financial Year;

4.6.3 comply with all relevant legal duties and Guidance of all Partners in relation to the Services being commissioned;

4.6.4 perform all commissioning obligations with all due skill, care and attention;

4.6.5 undertake performance management and contract monitoring of all service contracts including (without limitation) the use of contract notices where Services fail to deliver contracted requirements;

4.6.6 make payment of all sums due to a Provider pursuant to the terms of any Services Contract; and

4.6.7 keep the other Partner(s) regularly informed of the effectiveness of the Joint Working Arrangements including any forecasted Overspend or Underspend where there is a Pooled Fund or Non-Pooled Fund.

5. COMMISSIONING TEAM

5.1 The Partners agree to establish a Commissioning Team(s) as set out in Schedule 6 (*Commissioning Team Arrangements*).

6. STAFFING

6.1 The staffing arrangements in respect of each Individual Scheme shall be as set out in the relevant Scheme Specification and/or the Commissioning Team Agreement and Standard Operating Framework.

7. JOINT COMMITTEE

7.1 Where Partners intend to form a Joint Committee then the arrangements for the Joint Committee shall be as set out in Schedule 2 (*Governance Arrangements*); and the relevant Joint Committee Terms of Reference.

8. GOVERNANCE

8.1 Overall strategic oversight of partnership working between the Partners shall be as set out in Schedule 2 (*Governance Arrangements*).

8.2 Each Partner has internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

8.3 The Governance Arrangements shall set out how the Partners shall provide overall oversight and approval of Individual Schemes and variations to those Individual Schemes.

8.4 Each Scheme Specification shall confirm the Governance Arrangements in respect of the Individual Scheme and how that Individual Scheme is reported to each partner.

9. POOLED FUNDS, NON-POOLED FUNDS AND RISK SHARING

9.1 The Partners may establish Pooled Funds, Non-Pooled Funds and agree Risk Sharing in accordance with Schedule 4 (*Financial Arrangements*).

10. REVIEW

10.1 Save where the Partners agree alternative arrangements (including alternative frequencies) the Partners shall undertake an Annual Review of the operation of this Agreement, any Pooled Fund and Non-Pooled Fund and the provision of the Services within three (3) months of the end of each Financial Year.

10.2 Annual Reviews shall be conducted in good faith.

11. COMPLAINTS

11.1 Complaints will be managed by the specialised commissioning team hosted by Birmingham and Solihull ICB in line with the agreed complaints process.

11.2 A report summarising complaints, actions and lessons learnt will be provided to the East Midlands Joint Committee and West Midlands Joint Committee annually.

12. FINANCES

12.1 The financial arrangements shall be as agreed between the Partners in the relevant Scheme Specification and Schedule 4 (*Financial Arrangements*).

12.2 Unless expressly provided otherwise in this Agreement or otherwise agreed in advance in writing by the Partners, each Partner shall bear its own costs as they are incurred.

13. VARIATION

13.1 The Partners acknowledge that the scope of the Collaboration Arrangements may be reviewed and amended from time to time.

13.2 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.

13.3 No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Partners.

13.4 Where the Partners agree that there will be:

13.4.1 a new Pooled Fund;

13.4.2 a new Individual Scheme; or

13.4.3 an amendment to a current Individual Scheme,

the Partners shall agree the new or amended Individual Scheme in accordance with the Governance Arrangements and, in respect of amendments, the Scheme Specification. Each new or amended Individual Scheme must be signed by each of

the Partners. A request to vary an Individual Scheme, which may include (without limitation) a change in the level of Financial Contributions or other matters set out in the relevant Scheme Specification, may be made by any Partner but will require agreement from all the Partners. The notice period for any variation unless otherwise agreed by the Partners shall be three (3) months or in line with the notice period for variations within the associated Service Contract(s), whichever is the shortest.

13.5 Partners may propose additional schemes to be added to this agreement via the Joint Committees.

13.6 The following approach shall, unless otherwise agreed, be followed by the Partners:

13.6.1 on receipt of a request from one Partner to vary the Agreement including (without limitation) the introduction of a new Individual Scheme or amendments to an existing Individual Scheme, the Partners will first undertake an impact assessment and identify the likely impact of the variation including those Individual Schemes and Service Contracts likely to be affected;

13.6.2 the Partners will agree any action to be taken because of the proposed variation. This shall include consideration of:

- governance and decision-making arrangements;
- oversight and assurance arrangements;
- contracting arrangements; and/or
- whether the proposed variation could have an impact on the Integrated Specialised Commissioning Team;

13.6.3 wherever possible agreement will be reached to reduce the level of funding in the Service Contract(s) in line with any reduction in budget; and

13.6.4 should this not be possible, and one Partner is left financially disadvantaged because of the proposed variation, then the financial risk will, unless otherwise agreed, be apportioned according to the financial risk share arrangement detailed in Schedule 4.

14. DATA PROTECTION

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

14.2 Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a need-to-know basis. If any Partner:

14.2.1 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

14.2.2 becomes aware of any security breach,

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

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

14.4 Any information governance breach must be responded to in accordance with the Information Governance 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 the other Partners of the information governance breach. This clause does not require the relevant Partner to provide information which identifies any individual affected by the information governance breach were doing so would breach Data Protection Legislation.

14.5 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.

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

14.7 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 third parties save as agreed by the Partners in writing.

14.8 Schedule 5 *(Further Information Governance and Sharing Provisions)* makes further provision about information sharing and information governance.

15. IT INTER-OPERABILITY

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

15.2 The Partners will each use reasonable endeavours to help develop initiatives to further this aim.

16. FURTHER ARRANGEMENTS

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

17. FREEDOM OF INFORMATION

17.1 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").

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

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

17.2.2 each Partner shall consult the other Partners as relevant regarding the possible application of exemptions in relation to the FOIA or EIA Information requested; and

17.2.3 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, or the ICB responsible for the geographical area the service sits if any correspondence is addressed to the commissioning team.

17.3 The commissioning team will respond to all FOIA requests on behalf of Partners as part of the administrative responsibility set out in Schedule 6 (Commissioning Team Agreement and Standard Operating Framework).

18. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY

18.1 The Partners must ensure that, in delivering the Joint Working Arrangements, 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.

18.2 Each ICB must maintain a register of interests in respect of all persons involved in decisions concerning the Joint Working Arrangements. 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.

19. CONFIDENTIALITY

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

19.2 Subject to Clause 19.3, the receiving Partner agrees:

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

19.2.2 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

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

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

19.3.1 in connection with any Dispute Resolution Procedure;

19.3.2 to comply with the Law;

19.3.3 to any appropriate Regulatory or Supervisory Body;

19.3.4 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 0;

19.3.5 to NHS bodies for the purposes of carrying out their functions; and

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

19.4 The obligations in Clause 19 will not apply to any Confidential Information which:

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

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

19.4.3 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.

19.5 This Clause 0 does not prevent NHS England making use of or disclosing any Confidential Information disclosed by an ICB where necessary for the purposes of exercising its functions in relation to that ICB.

19.6 This Clause 19 will survive the termination of this Agreement for any reason for a period of five (5) years.

19.7 This Clause 19 will not limit the application of the Public Interest Disclosure Act 1998 in any way whatsoever.

20. LIABILITIES

20.1 Subject to Clause 20.2, and 20.3, if a Partner ("First Partner") incurs a Loss arising out of or in connection with this Agreement (including a Loss arising under an Individual Scheme) as a consequence of any act or omission of another Partner ("Other Partner") which constitutes negligence, fraud or a breach of contract in relation to this Agreement then the Other Partner shall be liable to the First Partner for that Loss.

20.2 Clause 20.1 shall only apply to the extent that the acts or omissions of the Other Partner contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Partner acting in accordance with the instructions or requests of the First Partner. Clause 20.1 shall not apply in respect of Loss where an alternative arrangement has been agreed by the Partners and set out in the relevant Scheme Specification.

20.3 If any third party makes a Claim or intimates an intention to make a Claim against any Partner, which may reasonably be considered as likely to give rise to liability under this Clause 20, the Partner that may have a Claim against the Other Partner will:

20.3.1 as soon as reasonably practicable give written notice of that matter to the Other Partner specifying in reasonable detail the nature of the relevant Claim;

20.3.2 not make any admission of liability, agreement, or compromise in relation to the relevant Claim without the prior written consent of the Other Partner (such consent not to be unreasonably conditioned, withheld or delayed); and

20.3.3 give the Other Partner and its professional advisers reasonable access to its premises and Staff and to any relevant assets, accounts, documents and records within its power or control so as to enable the Other Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant Claim.

20.4 Each Partner shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a Claim against the other pursuant to this Agreement.

20.5 Unless expressly agreed otherwise, nothing in this Agreement shall affect:

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

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

20.6 Each ICB must:

20.6.1 comply with any requirements set out in the Delegation Agreement in respect of Claims and any policy issued by NHS England from time to time in relation to the conduct of or avoidance of Claims or the pro-active management of Claims;

20.6.2 if it receives any correspondence, issue of proceedings, claim document or other document concerning any Claim or potential Claim, immediately notify the other Partners and send each relevant Partner all copies of such correspondence; and

20.6.3 co-operate fully with each relevant Partner in relation to such Claim and the conduct of such Claim.

21. DISPUTE RESOLUTION

21.1 Where any dispute arises between the ICBs in connection with this Agreement, the Partners must use their best endeavours to resolve that dispute.

21.2 Where any dispute is not resolved under Clause 0 on an informal basis, any Authorised Officer may convene a special meeting of the Partners to attempt to resolve the dispute.

22. BREACHES OF THE AGREEMENT

22.1 If any Partner ("Relevant Partner") fails to meet any of its obligations under this Agreement, the other Partners (acting jointly) may by notice require the Relevant Partner to take such reasonable action within a reasonable timescale as the other Partners may specify to rectify such failure. Should the Relevant Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 21 (*Dispute Resolution*).

22.2 Without prejudice to Clause 22.1, if any Partner does not comply with the terms of this Agreement (including if any Partner exceeds its authority under this Agreement), the other Partners may at their discretion agree to:

22.2.1 waive their rights in relation to such non-compliance;

22.2.2 ratify any decision;

22.2.3 terminate this Agreement in accordance with Clause 23 *(Termination and Default)* below; or

22.2.4 exercise the Dispute Resolution Procedure in accordance with Clause 21 *(Dispute Resolution).*

23. TERMINATION AND DEFAULT

23.1 If an ICB wishes to end its participation in this Agreement, the relevant ICB must provide at least six (6) months' notice to the other Partners of its intention to end its participation in this Agreement and must have given prior notification to NHS England. Such notification shall only take effect from the end of 31 March in any calendar year and shall only take effect where alternative arrangements for the provision of the Delegated Services and effective exercise of the Delegated Functions are in place for the period immediately following termination.

23.2 Each Individual Scheme may be terminated in accordance with the terms set out in the relevant Scheme Specification provided that each Partner is assured that the relevant Services will continue to be appropriately commissioned.

23.3 The ICBs will work together to ensure that there are suitable alternative arrangements in place in relation to the Services.

24. CONSEQUENCES OF TERMINATION

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

24.1.1 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, to minimise costs and liabilities of each Partner in doing so;

24.1.2 where there are Commissioning Team arrangements in place the Partners shall discuss and agree arrangements for the Staff and any financial arrangements;

24.1.3 where a Partner has entered a Service Contract in exercise of the Functions of any other Partner which continues after the termination of this Agreement, all Partners shall continue to provide necessary funding in accordance with the agreed contribution for that Service prior to termination and will enter all appropriate legal documentation required in respect of this;

24.1.4 where there are Lead Commissioning Arrangements in place, the Lead Partner shall make reasonable endeavours to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place the Lead Partner in breach of the Service Contract) where the other Partner requests the same in writing provided that the Lead Partner shall not be required to make any payments to a Service provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment;

24.1.5 where there are Joint Commissioning Arrangements in place, the Partners shall co-operate with each other as reasonably necessary to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place any Partner in breach of the Service Contract) where a Partner requests the same in writing provided that no Partner shall be required to make any payments to a Service provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment;

24.1.6 where a Service Contract held by a Lead Partner relates all or partially to services which relate to the other Partner's Functions and provided that the Service Contract allows, the other Partner may request that the Lead Partner

assigns the Service Contract in whole or part upon the same terms as the original contract; and

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

24.2 The provisions of Clauses 14 (*Data Protection*), 170 (*Freedom of Information*), 19 (*Confidentiality*), 20 (*Liabilities*) and 24 (*Consequences of Termination*) shall survive termination or expiry of this Agreement.

25. PUBLICITY

25.1 The Partners shall use reasonable endeavours to consult one another before making any public announcements concerning the subject matter of this Agreement, the Joint Working Arrangements or any Services provided under the Joint Working Arrangements.

26. EXCLUSION OF PARTNERSHIP OR AGENCY

26.1 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.

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

27. THIRD PARTY RIGHTS

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

28. NOTICES

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

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

29. ASSIGNMENT AND SUBCONTRACTING

29.1 This Agreement, and any rights 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 Commissioning Function.

30. SEVERABILITY

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

31. WAIVER

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

32. STATUS

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

33. ENTIRE AGREEMENT

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

34. GOVERNING LAW AND JURISDICTION

34.1 Subject to the provisions of Clause 21 (*Dispute Resolution*) and Clause 32 (*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.

35. FAIR DEALINGS

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

36. COUNTERPARTS

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

This Agreement has been entered into on the Commencement Date

SIGNED by John Turner ..... (Signature)
for and on behalf of NHS Lincolnshire Integrated Care Board .....
(Date)

SIGNED by Amanda Sullivan ..... (Signature)
for and on behalf of NHS Nottingham & Nottinghamshire Integrated Care Board .....
(Date)

SIGNED by Dr Caroline Trevithick .....
for and on behalf of NHS Leicester, Leicestershire (Signature)
& Rutland Integrated Care Board .....
(Date)

SIGNED by Toby Sanders .....
for and on behalf of NHS Northamptonshire (Signature)
Integrated Care Board .....
(Date)

SIGNED by Chris Clayton .....
for and on behalf of NHS Derby & Derbyshire (Signature)
Integrated Care Board .....
(Date)

SIGNED by Philip Johns .....
for and on behalf of NHS Coventry & (Signature)
Warwickshire Integrated Care Board .....
(Date)

SIGNED by Mark Axcell .....
for and on behalf of NHS Black Country (Signature)
Integrated Care Board .....
(Date)

SIGNED by Simon Trickett .....
for and on behalf of NHS Herefordshire & (Signature)
Worcestershire Integrated Care Board .....
(Date)

SIGNED by David Melbourne .....
for and on behalf of NHS Birmingham & Solihull (Signature)
Integrated Care Board .....
(Date)

SIGNED by Peter Axon .....

for and on behalf of NHS Staffordshire & Stoke-on-Trent Integrated Care Board

(Signature)

.....

(Date)

SIGNED by Simon Whitehouse
for and on behalf of NHS Shropshire, Telford & Wrekin Integrated Care Board

.....

(Signature)

.....

(Date)

SCHEDULE 1: DEFINITIONS AND INTERPRETATIONS

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

“Agreement"	means this agreement between the Partners comprising these terms and conditions together with all schedules attached to it;
“Aligned Commissioning Arrangements”	means the arrangements by which the Partners agree to commission a Service in a co-ordinated and collaborative manner. For the avoidance of doubt, an aligned commissioning arrangement does not involve the delegation of any functions between ICBs;
“Annual Review”	means the annual review of the arrangements under this Agreement by the Partners;
“Area”	means the geographical area covered by the ICBs;
"Authorised Officer"	the individual(s) appointed as Authorised Officer in accordance with the agreed Terms of Reference;
“Claim”	means for or in relation to the Commissioning Functions (a) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal, or the Secretary of State, any governmental, regulatory, or similar body, or any department, board or agency or (b) any dispute with, or any investigation, inquiry or enforcement proceedings by any governmental, regulatory or similar body or agency;
“Clinical Commissioning Policies”	a nationally determined clinical policy sets out the commissioning position on a particular clinical treatment issue and defines accessibility (including a not for routine commissioning position) of a medicine, medical device, diagnostic technique, surgical procedure, or intervention for patients with a condition requiring a specialised service;
“Collaborative Commissioning Agreement”	means an agreement under which NHS Commissioners set out collaboration arrangements in respect of commissioning Specialised Services Contracts;
"Commencement Date"	[means 1 April 2024];

"Commissioning Functions"	the respective statutory functions of the Partners in arranging for the provision of services as part of the health service;
“Commissioning Team”	means a staffing arrangement for commissioning agreed Services through an integrated team structure. This can be either set up using: i. Lead Commissioning (one Partner hosts the Unit as Lead and all functions are delegated to that Partner); or ii. Joint Commissioning or Aligned Commissioning (one Partner may host but no functions are delegated). The Partners will need to agree whether decisions are taken via a Joint Commissioning arrangement such as a Joint Committee or whether each Partner is required to take decisions;
"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 Joint Working Arrangements made pursuant to it and: i. which comprises Personal Data or which relates to any patient or his treatment or medical history; ii. the release of which is likely to prejudice the commercial interests of a Partner; or ii. which is a trade secret;
“Contracting Standard Operating Procedure”	means any contracting standard operating procedure produced by NHS England in respect of the Delegated Specialised Services;
“Data Controller”	shall have the same meaning as set out in the Data Protection Legislation;
“Data Processor”	shall have the same meaning as set out in the Data Protection Legislation;
"Data Sharing Agreement"	means any data sharing agreement entered in accordance with Schedule 5 (*Further Information Governance and Sharing Provisions*);

“Data Guidance”	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement regarding information governance, confidentiality, privacy, or compliance with Data Protection Legislation to the extent published and publicly available or their existence or contents have been notified to the ICB by NHS England and/or any relevant Regulatory or Supervisory Body. This includes but is not limited to guidance issued by NHS Digital, the National Data Guardian for Health & Care, the Department of Health and Social Care, NHS England, the Health Research Authority, the UK Health Security Agency, and the Information Commissioner;
"Data Protection Legislation"	means the UK General Data Protection Regulation, the Data Protection Act 2018, the Regulation of Investigatory Powers Act 2000, the Telecommunications (Lawful Business Practice) (Interception of Communications) Regulations 2000 (SI 2000/2699), the Privacy and Electronic Communications (EC Directive) Regulations 2003 (SI 2426/2003), the common law duty of confidentiality and all applicable laws and regulations relating to the processing of Personal Data and privacy, including where applicable the guidance and codes of practice issued by the Information Commissioner;
“Data Protection Officer”	shall have the same meaning as set out in the Data Protection Legislation;
“Data Security and Protection Toolkit”	means the toolkit at: https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/data-security-and-protection-toolkit or as amended or replaced from time to time
“Delegation Agreement(s)”	means the Delegation Agreements under which NHS England delegate specific NHS England Specialised Services Commissioning Functions to each ICB;
“Delegated Functions”	means the Specialised Services Commissioning Functions of NHS England delegated to each ICB under a Delegation Agreement;
“Delegated Services”	means those Specialised Services commissioned in exercise of the Delegated Functions;

"Dispute Resolution Procedure"	the procedure set out in Clause 21 (*Dispute Resolution*);
"EIR"	means the Environmental Information Regulations 2004;
"Finance Guidance"	guidance, rules and operating procedures produced by NHS England that relate to these Joint Working Arrangements, including but not limited to the following: • Commissioning Change Management Business Rules; • Contracting Standard Operating Procedure; • Cashflow Standard Operating Procedure; • Finance and Accounting Standard Operating Procedure; • Service Level Framework Guidance;
"Flexibilities"	Mean the flexibilities that the Partners may use to work in a co-ordinated manner as set out at Clause 3 (*Scope of the Arrangements*);
"Financial Contribution"	means the financial contributions agreed by each Partner in respect of an Individual Scheme in any Financial Year;
"Financial Year"	means each financial year running from 1 April in any year to 31 March in the following calendar year;
"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;
"FOIA or EIR Information"	has the meaning given under section 84 of FOIA or the meaning given for "environmental information" under the EIR as applicable;
"Good Practice"	means using standards, practices, methods and procedures conforming to the law, reflecting up-to-date published evidence and exercising that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced commissioner;
"Governance Arrangements"	means the governance arrangements in respect of the Arrangements agreed by the Partners and as set out in Schedule 2 (*Governance Arrangements*);

"Guidance"	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the Partners have a duty to have regard (and whether specifically mentioned in this Agreement or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified by any relevant Regulatory or Supervisory Body;
"High-Cost Drugs"	means medicines not reimbursed though national prices and identified on the NHS England high-cost drugs list;
"ICB Reserved Functions"	Where there is any delegation of an ICB's Commissioning Functions or further delegation of Delegated Functions, those functions that remain reserved to each ICB;
"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);
"Individual Scheme"	means an arrangement in relation to how the ICBs will work together using one or more of the Flexibilities which has been agreed by the Partners to be included within this Agreement as part of the Joint Working Arrangements;
"Joint Committee"	means the joint committee(s) established by the partners that perform functions under this Agreement on the terms set out in their Terms of Reference;
"Joint Functions"	any Functions that are delegated to a Joint Committee;
"Joint Commissioning"	means Partners agreeing to jointly exercise agreed Commissioning Functions on behalf of each other in exercise of the functions of each Partner part of that Individual Scheme. This may, for example, be through agreeing to enter into the same contract or by use of a Joint Committee;
"Joint Working Arrangements"	means the Flexibilities that the Partners have agreed to use to work in a co-ordinated manner which, at the Commencement Date, are as set out in Clause 3;
"Law"	means: i. any statute or proclamation or any delegated or subordinate legislation; ii. 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 ii. any judgment of a relevant court of law which is a binding precedent in England;
"Lead Commissioning Arrangements"	means the arrangements by which one Partner commissions Services in relation to an Individual Scheme on behalf of another Partner or Partners in exercise of the Commissioning Functions of the ICB Partners;
"Lead Partner"	means the Partner responsible for commissioning under a Lead Commissioning Arrangement;
"Loss"	means all damages, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services) proceedings, demands and charges whether arising under statute, contract or common law;
"Managing Conflicts of Interest in the NHS"	means the NHS publication by that name available at: https://www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-guidance-for-staff-and-organisations/ or such publication that amends or replaces that publication;
"Mandated Guidance"	means any protocol, policy, guidance, guidelines, framework or manual relating to the exercise of Delegated Functions and issued by NHS England from time to time as mandatory;
"National Standards"	means the service standards for each Specialised Service, as set by NHS England and included in Clinical Commissioning Policies or National Specifications;
"National Specifications"	the service specifications published by NHS England in respect of Specialised Services;
"Need to Know"	has the meaning set out in Schedule 5 *(Further Information Governance and Sharing Provisions)*;
"NHS Act"	the National Health Service Act 2006;
"NHS England Functions"	NHS England's Commissioning Functions exercisable under or by virtue of the NHS Act;
"NHS England Reserved Functions"	those aspects of the Specialised Commissioning Functions for which NHS England retains commissioning responsibility;
"Non-Personal Data"	means data which is not Personal Data;

"Non-Pooled Funds"	means the budget detailing the financial contributions of the Partners which are not included in a Pooled Fund in respect of a particular Service as set out in the relevant Scheme Specification;
"Operational Days"	means a day other than a Saturday, Sunday, Christmas Day, Good Friday or a bank holiday in England;
"Partners"	means the parties to this Agreement;
"Personal Data"	has the meaning set out in the Data Protection Legislation;
"Pooled Funds"	means any pooled fund established and maintained by the Partners as a pooled fund;
"Population"	means the population for which an ICB or all the ICBs have the responsibility for commissioning health services;
"Provider Collaborative"	means a group of Providers who have agreed to work together to improve the care pathway for one or more Services;
"Provider Collaborative Arrangements"	means the arrangements entered in respect of a Provider Collaborative;
"Provider Collaborative Guidance"	means any guidance published by NHS England in respect of Provider Collaboratives;
"Regional Quality Group"	means a group set up to act as a strategic forum at which regional partners from across health and social care can share, identify, and mitigate wider regional quality risks and concerns as well as share learning so that quality improvement and best practice can be replicated;
"Regulatory or Supervisory Body"	means any statutory or other body having authority to issue guidance, standards, or recommendations with which the relevant Party and/or Staff must comply or to which it or they must have regard, including: i. CQC; ii. NHS England; ii. the Department of Health and Social Care; v. NICE; v. Healthwatch England and Local Healthwatch; *i*. the General Medical Council; ii. the General Dental Council; ii. the General Optical Council; x. 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?"*);
"Reserved Functions"	means NHS England Reserved Functions or ICB Reserved Functions;
"Retained Services"	means those Specialised Services for which NHS England shall retain commissioning responsibility, as set out the Delegation Agreement;
"Risk Sharing"	means an agreed arrangement for risk and benefit sharing between the Partners;
"Scheme Specification"	means a specification setting out the Joint Working Arrangements in respect of an Individual Scheme agreed by the Partners to be commissioned under this Agreement;
"Services"	means such health services as agreed from time to time by the Partners as commissioned under the Joint Working Arrangements and more specifically defined in each Scheme Specification;
"Service Contract"	means an agreement entered into by one or more of the Partners in exercise of its obligations under this Agreement to secure the provision of Services in accordance with the relevant Individual Scheme
"Single Point of Contact"	the member of Staff appointed by each relevant Partner in accordance with Paragraph 13 of Schedule 5 *(Further Information Governance and Sharing Provisions)*
"Special Category Personal Data"	has the meaning set out in the Data Protection Legislation;
"Specialised Commissioning Budget"	means the budget identified by NHS England in respect of each ICB for the purpose of exercising the Delegated Functions;

"Specialised Commissioning Functions"	means the statutory functions conferred on NHS England under Section 3B of the NHS Act 2006 and Regulation 11 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996 (as amended or replaced);
"Specified Purpose"	means the purpose for which the Relevant Information is shared and processed to facilitate the exercise of the Joint Working Arrangements as specified in Schedule 5 *(Further Information Governance and Sharing Provisions)* to this Agreement;
"Specialised Services"	means the services commissioned in exercise of the Specialised Commissioning Functions;
"Specialised Services Contract"	means a contract for the provision of Specialised Services entered in the exercise of the Specialised Commissioning Functions;
"Specialised Services Provider"	means a provider party to a Specialised Services Contract;
"Staff"	means the Partners' employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of any Partner (whether the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors' and their sub-contractors' personnel;
"Standard Operating Framework"	means the agreement(s) that sets out the arrangements for a Commissioning Team;
"Terms of Reference"	means the Terms of Reference for the Joint Committee agreed between the Partners at the first meeting of the Joint Committee;
"Triple Aim"	means 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: i. the health and well-being of the people of England; ii. the quality of services provided to individuals by the NHS; ii. efficiency and sustainability in relation to the use of resources by the NHS;

"Underspend"	means any expenditure from a Pooled Fund or Non-Pooled Fund in a Financial Year which is less than the value of the agreed contributions by the Partners for that Financial Year;
"UK GDPR"	means Regulation (EU) 2016/679 of the European Parliament and of the Council of 27th April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018.

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

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

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

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

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

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

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

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

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

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

SCHEDULE 2: GOVERNANCE ARRANGEMENTS

1. Joint Committees

1.1. The overall oversight and governance arrangements for these collaborative working arrangements will be discharged through the Joint Committees established by the ICBs through Joint Working Agreements between NHS Lincolnshire Integrated Care Board, NHS Nottingham and Nottinghamshire Integrated Care Board, NHS Leicester, Leicestershire and Rutland Integrated Care Board, NHS Northamptonshire Integrated Care Board and NHS Derby and Derbyshire Integrated Care Board (the "East Midlands ICBs") and NHS Birmingham and Solihull Integrated Care Board, NHS Black Country Integrated Care Board, NHS Coventry and Warwickshire Integrated Care Board, NHS Herefordshire and Worcestershire Integrated Care Board, NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire and Stoke-on-Trent Integrated Care Board (the "West Midlands ICBs")

1.2. The Terms of Reference and other detailed arrangements that support the operation of the Joint Committees are detailed in the Joint Working Agreements between the East and West ICBs. They set out that the two Joint Committees will have delegated authority on behalf of the East and West ICBs respectively to discharge the functions delegated to the ICBs by NHS England in respect of Specialised Services, including establishing appropriate subsidiary arrangements to enable effective decision-making and detailed oversight of performance, finance, and quality.

1.3. In recognition that effective collaboration may require aligned decisions from all the partners, the Joint Committees may consider meeting 'in common' where this is appropriate and will ensure that decisions by either the East or West Joint Committee that impact on the other are made having taken relevant views from the other committee into account.

1.4. The NHS England regional team will continue to work jointly with the Joint Committees on the commissioning of retained specialised services. This will include, where appropriate, discharging its authority (through accountable directors) in consultation with the Joint Committees.

1.5. The subsidiary arrangements established by the Joint Committees will include appropriate schemes of reservation and delegation in place to enable Sub-Groups of the Joint Committees and/or members of staff employed by Joint Commissioning Team to have the authority to make decisions. These arrangements will be developed in collaboration with NHS England to support effective working on both the delegated and retained services.

2. Joint Subgroups

2.1. There will be four joint subgroups established by the partners to support these arrangements, these being:

- **Midlands Acute Specialised Commissioning Group (MASCG)**
- **Mental Health Learning Disability & Autism Commissioning Group (MHLDACG)**
- **Specialised Commissioning Quality Group (Acute)**
- **Finance and Contracting Group**

2.2. Subsidiary arrangements established by the Joint Committees will include providing delegated authority to the **Midlands Acute Specialised Commissioning Group (MASCG)** and **[Mental Health Learning Disability & Autism Commissioning Group]** (MHLDACG) Joint Sub-Groups established by all the partners to make decisions on delegated services.

2.3. The role of MASCG and the MHLDACG will be to support the partners and the Joint Committees in ensuring that the delivery of the delegated and retained services is effective, efficient, and economical and in line with each partner's statutory responsibilities.

2.4. **Midlands Acute Specialised Commissioning Group** and the **Mental Health Learning Disability & Autism Commissioning Group** will report and make recommendations to the Joint Committees in respect of delegated services and to Midlands Commissioning Group in respect of the retained services and will always operate in accordance with its agreed terms of reference, and the relevant schemes of reservation and delegation and standing financial instructions for delegated and retained services.

2.5. Each of the partners will appoint one member to each of the **Midlands Acute Specialised Commissioning Group** and the **Mental Health Learning Disability & Autism Commissioning Group** who will be authorised to act as part of the group and participate in collective decision making on behalf of their organisation. **Midlands Acute Specialised Commissioning Group** and the **Mental Health Learning Disability & Autism Commissioning Group** will also ensure that its decisions are taken with the advice of suitable subject matter experts.

2.6. **Specialised Commissioning Quality Group –** This group, co-chaired by the Medical Director for Specialised Commissioning (MDSC) and Director of Specialised Nursing and Quality, will provide a forum to share and discuss potential and known issues which impact on the quality and safety of Specialised Commissioned services in the Midlands region and agree any remedial action.

2.7. The purpose of the Specialised Commissioning Quality Groups is to provide a forum for routinely and systematically bringing together partners from across ICSs and the region to share insight and intelligence in relation to quality concerns, to identify opportunities for improvement and to develop regional responses as required. The focus of the discussions will be on intelligence, learning, issues and risks that are recurrent and/ or have an impact wider than individual ICSs.

2.9 **Finance and Contracting Subgroup** – will have responsibility to oversee the management of the pooled fund on behalf of the Joint Committees.

2.10 The purpose of the Finance and Contracting Subgroup is to provide robust joint financial management of the pooled fund on behalf of the ICBs in line with the terms set out in schedule 4 of this agreement.

2.11 The Joint Committees will agree the terms of reference for the subgroups on behalf of the partners.

3. Clinical Governance

3.1. Clinical engagement and leadership will be secured at multiple tiers across the Midlands region and will draw upon established clinical networks including those formally commissioned plus the informal networks that have been recognised over time.

3.2. The Specialised Services Operational Delivery Networks (ODNs) will continue to be formally commissioned by NHS England. NHS England will retain the financial responsibility for the ODNs and will continue to play a key role in supporting understanding of clinical quality for the relevant services.

3.3. At a senior clinical level, the Collaborative Clinical Executive Forum (CCEF), a regional forum of Acute Provider and ICB Chief Medical Officers (CMOs), will continue to meet regularly and engage with the Midlands Commissioning Team. Advice offered via that forum will feed into the decision -making process via the Midlands Acute Specialised Commissioning Group (MASCG) and into the Joint Committees.

3.4. Governance and decision-making for high-cost drugs assurance for delegated services will be via Joint Committees and their sub-groups, with links to the Regional Pharmacy Leadership Board. The pharmacy team for High Costs Drugs employed by NHS England will work across ICBs and NHS England informed by other senior pharmacists across the region e.g., HCD pharmacists, regional cancer pharmacists,

3.5. High-cost tariff excluded drugs will continue to be reimbursed through a national process by NHS England irrespective of whether they are used for delegated services, meaning that ICBs will not bear the financial risk of new specialised drugs growth.

4. Quality Governance

4.1 The Specialised Commissioning Quality Group will provide a forum for oversight on quality matters relevant to their service areas, including where further assurance and remedial action may be required.

4.2. Key quality concerns requiring escalation relating to the delegated services will be reported monthly to the Joint Committees by the Specialised Commissioning Quality Group and the Mental Health, Learning Disability & Autism Commissioning Group. Furthermore, key quality concerns for specialised services will continue to be reported to and discussed at the NHSE led Regional Quality Group, of which all ICBs are members. These groups will ensure key quality concerns are fed back into

systems to inform conversations at a local level. Criteria for and response to escalation will continue to the based on the **National Guidance on Quality Risk Response and Escalation in Integrated Care Systems,** which is jointly used by NHSE and ICBs.

4.3 Key quality concerns involving specialised services will also be reported into Midlands Acute Specialised Commissioning Group (MASCG) and the Mental Health Learning Disability & Autism Commissioning Group (MHLDACG) of which all 11 Midlands ICBs are members or have representation.

4.4. To be proactive in identification of areas for quality improvement, a Quality Surveillance and Improvement Framework (QSIF) has been developed for acute specialised services. Similarly, a Quality Assurance Framework (QAF) is in place for specialised MHLDA services. These frameworks aim to identify risks and implement mitigations and remedial actions. The QSIF/QAF involves proactive triangulation of intelligence and data from a range of sources (e.g., CQC reports, specialised services dashboards, national audit etc) to monitor the quality of each service and a workplan of service review will be agreed through the Quality Group which has ICB representation, is jointly chaired by the RMDC and an ICB representative.

5. Financial Governance

5.1 The Financial governance arrangements in Schedule 4 shall apply to the Collaborative Arrangements.

5.2 **Risk Management Arrangements** - In line with their overall role to provide strategic decision-making, leadership, and oversight for the joint services the Joint Committee will establish a monitoring and management in relation to risk and issue management and escalation, and co-ordinating the approach to intervention with providers where there are quality or contractual issues. This will include feeding back to individual ICBs for consideration of any impact on their own risk management arrangements.

5.3 A formal risk register will be maintained by the Midlands Specialised Commissioning Team and reported monthly through the Midlands Acute Specialised Commissioning Group to ensure ICBs & NHSE are aware of any risks

they may impact their systems.

6. Assurance arrangements

6.1. The Joint Committees will be responsible for ensuring that the ICBs are able to meet their obligations under the NHSE Oversight and Assurance Framework in relation to the delegation of specialised services which, requires that the ICBs must at all times operate in accordance with:

(a) the Oversight and Assurance Framework published by NHS England;

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

(c) any other relevant NHS oversight and assurance guidance;

collectively known as the “Assurance Processes”.

6.2 And that the ICBs must:

(a) Develop and operate in accordance with mutually agreed ways of working in line with the Assurance Processes.

(b) Oversee the provision of Delegated Services and the outcomes being delivered for their patients and Populations in accordance with the Assurance Processes.

(c) Assure Providers are meeting, or have an improvement plan in place to meet, National Standards.

(d) Provide any information and comply with specific actions in relation to the Delegated Specialised Services, as required by NHS England, including metrics and detailed reporting in accordance with the Terms of Reference.

SCHEDULE 3: INDIVIDUAL SCHEMES

PART 1 – EAST MIDLANDS SCHEME

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1 OVERVIEW OF THE EAST MIDLANDS SCHEME FOR DELEGATED SPECIALISED SERVICES

1.1 This scheme sets out the arrangements through which the Partners will work together to commission the specialised services delegated to the East Midlands Integrated Care Boards (ICBs) by NHS England.

1.2 The Partners' aims are:

(a) to maximise the benefits to patients of integrating the Delegated Functions with the ICBs' Commissioning Functions through designing and commissioning the Specialised Services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim.

2 SERVICES AND FUNCTIONS

2.1 NHS England has delegated the statutory function for the commissioning of the specified specialised services to the ICBs. The key powers and duties that the ICBs will be required to carry out in exercise of the delegated functions being, in summary:

(a) decisions in relation to the commissioning and management of the delegated services;

(b) planning delegated services for the population, including carrying out needs assessments;

(c) undertaking reviews of delegated services in respect of the population;

(d) supporting the management of the specialised commissioning budget for delegated services;

(e) co-ordinating a common approach to the commissioning and delivery of delegated services with other health and social care bodies in respect of the population where appropriate; and

(f) such other ancillary activities that are necessary to exercise the specialised commissioning functions.

2.2 A list of the delegated services included within the scheme are detailed within schedule 2 of the Delegation Agreement.

2.3 The services are being provided to the populations within the East Midlands ICBs geographical footprints.

3 PARTNERS

3.1 The partners of this scheme are Lincolnshire ICB, Nottingham & Nottinghamshire ICB, Leicester, Leicestershire & Rutland ICB, Northamptonshire ICB, Derby & Derbyshire ICB.

4 THE ARRANGEMENTS

4.1 The Scheme will be overseen by the East Midlands Joint Committee established via a Joint Working Agreement between the ICBs whose role shall be to carry out the strategic decision-making, leadership and oversight functions relating to the commissioning of specified delegated specialised services as agreed by the partners and outlined in Schedule 2 of the ICB Collaboration Agreement.

4.2 Administrative and management functions will be provided to the East Midlands multi-ICB by the Commissioning Team, which is hosted by Birmingham and Solihull ICB. Details of which are set out in an Commissioning Team Agreement and Standard Operating Framework between all parties.

4.3 Details of the financial arrangements relating to this scheme are contained with Schedule 4 of the ICB Collaboration Agreement.

5 GOVERNANCE ARRANGEMENTS

5.1 The scheme shall be governed by the East Midlands Joint Committee, as set out in Schedule 2 of the ICB Collaboration Agreement.

5.2 The terms of reference of the Joint Committee are set out in the in schedule 2 of the ICB Collaboration Agreement

6 COMMISSIONING, CONTRACTING, ACCESS

6.1 Commissioning Arrangements

Delegated services will be commissioned from providers on behalf of the ICBs by the Commissioning Team in line with legislative requirements, NHS planning guidance and the Delegation Agreement between the ICBs and NHS England.

6.2 Contracting Arrangements

The list of contracts which are in place across the Midlands for delegated specialised services are contained in Appendix 1. This includes details of Lead Commissioning arrangements where this has been determined.

6.2.1 The contracting arrangement for the scheme will be as follows:

- The scheme will encompass all existing contracts.
- The contracts will be agreed in line with the National Contracting SOP, the Delegation agreement and the ICB Collaboration Agreement.
- The contracts will be funded in line with the pooled budget arrangements detailed in Schedule 4 of the ICB Collaboration Agreement.
- The contracts will be managed on behalf of the East multi-ICB, by the Commissioning Team.

6.3 Access

The scheme will apply to all delegated specialised services provided via contracts with providers.

7. HIGH-COST DRUGS

7.1 All identified service lines that are delegated include any activities within these areas including High-Cost drugs and support through the networks. Financial responsibility for HCD and networks remains within NHSE, and responsibility will be managed through collaboration and appropriate decision making.

8. FINANCIAL GOVERNANCE ARRANGEMENTS

8.1. The financial governance arrangements are set out in Schedule 4 of the ICB Collaboration Agreement.

9. NON FINANCIAL RESOURCES

9.1. The non-financial resources required to deliver scheme will be provided by Birmingham and Solihull ICB in accordance with Schedule 6 of the ICB Collaboration Agreement.

10. STAFF

10.1. The commissioning team responsible for the operational delivery of specialised commissioning for delegated services will be hosted by Birmingham and Solihull ICB.

10.2. The arrangement through which the commissioning team will provide this support to the ICBs is set out in Schedule 6 of the ICB Collaboration Agreement.

11. ASSURANCE AND MONITORING

11.1. The arrangements in relation to assurance and monitoring in relation to this scheme are contained Schedule 4 of the ICB Collaboration Agreement.

12. AUTHORISED OFFICERS

12.1. The authorised officers for this scheme are as follows:

Partner	**Name of Authorised Officer – Tier 1**
Lincolnshire ICB	John Turner
Nottingham & Nottinghamshire ICB	Amanda Sullivan
Leicester, Leicestershire & Rutland ICB	Dr Caroline Trevithick
Northamptonshire ICB	Toby Sanders
Derby & Derbyshire ICB	Dr Chris Clayton

13. INTERNAL APPROVALS

13.1. The levels of authority relating to this scheme are described within Schedule 4 of the ICB Collaboration Agreement.

14. REGULATORY REQUIREMENTS

14.1. Details in relation to regulatory requirements in relation to this scheme are contained within the delegation agreement and will be fulfilled on behalf of the ICBs by the Commissioning Team.

15. COMPLAINTS

15.1. Complaints will be managed by the specialised commissioning team hosted by the host ICB in line with the agreed complaints process.

15.2. A report summarising complaints, actions and lessons learnt will be provided to the East Midlands Joint Committee and West Midlands Joint Committee annually.

PART 2 – WEST MIDLANDS SCHEME

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1 OVERVIEW OF THE WEST MIDLANDS SCHEME FOR DELEGATED SPECIALISED SERVICES

1.1 This scheme sets out the arrangements through which the Partners will work together to commission the specialised services delegated to the West Midlands Integrated Care Boards (ICBs) by NHS England.

1.2 The Partners' aims are:

(i) to maximise the benefits to patients of integrating the Delegated Functions with the ICBs' Commissioning Functions through designing and commissioning the Specialised Services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim.

2 SERVICES AND FUNCTIONS

2.1 NHS England has delegated the statutory function for the commissioning of the delegated specialised services. The key powers and duties that the ICBs will be required to carry out in exercise of the delegated functions being, in summary:

(a) decisions in relation to the commissioning and management of the delegated services;

(b) planning delegated services for the population, including carrying out needs assessments;

(c) undertaking reviews of delegated services in respect of the population;

(d) supporting the management of the specialised commissioning budget for delegated services;

(e) co-ordinating a common approach to the commissioning and delivery of delegated services with other health and social care bodies in respect of the population where appropriate; and

(f) such other ancillary activities that are necessary to exercise the specialised commissioning functions.

2.2 A list of the delegated services included within the scheme are detailed within schedule 2 of the Delegation Agreement

2.3 The services are being provided to the populations within the West Midlands ICBs geographical footprints.

3 PARTNERS

3.1 The Partners of this scheme are The Black Country ICB, Staffordshire & Stoke-on-Trent ICB, Shropshire Telford & Wrekin ICB, Coventry and Warwickshire ICB, Herefordshire & Worcestershire ICB and Birmingham & Solihull ICB.

4 THE ARRANGEMENTS

4.1 The Scheme will be overseen by the West Midlands Joint Committee established via a Joint Working Agreement between the ICBs whose role shall be to carry out the strategic decision-making, leadership and oversight functions relating to the commissioning of specified delegated specialised services as agreed by the partners and outlined in Schedule 2 of the ICB Collaboration Agreement.

4.2 Administrative and management functions will be provided to the West Midlands multi-ICB by the Commissioning Team, which is hosted by Birmingham and Solihull ICB. Details of which are set out in a Commissioning Team Agreement and Standard Operating Framework between all parties.

4.3 Details of the financial arrangements relating to this scheme are contained with Schedule 4 of the ICB Collaboration Agreement.

5 GOVERNANCE ARRANGEMENTS

5.1 The scheme shall be governed by the West Midlands Joint Committee as set out in Schedule 2 of the ICB Collaboration Agreement.

5.2 The terms of reference of the Joint Committee are contained within the Joint Working Agreement between the ICBs.

6 COMMISSIONING, CONTRACTING, ACCESS

6.1 Commissioning Arrangements

Delegated services will be commissioned from providers on behalf of the ICBs by the Commissioning Team in line with legislative requirements, NHS planning guidance and the Delegation Agreement between the ICBs and NHS England.

6.2 Contracting Arrangements

The list of contracts which are in place across the Midlands for delegated specialised services are contained in Appendix 1. This includes details of Lead Commissioning arrangements where this has been determined.

The contracting arrangement for the scheme will be as follows:

- The scheme will encompass all existing contracts.
- The contracts will be agreed in line with the National Contracting SOP, the delegation agreement and the ICB Collaboration Agreement.
- The contracts will be funded in line with the pooled budget arrangements detailed in Schedule 4 of the ICB Collaboration Agreement.
- The contracts will be managed on behalf of the West Midlands multi-ICB, by the Commissioning Team.

6.3 Access

The scheme will apply to all delegated specialised services provided via contracts with providers.

7 HIGH-COST DRUGS

7.1 All identified service lines that are delegated include any activities within these areas including High-Cost drugs and support through the networks. Financial responsibility for HCD and networks remains within NHSE, and responsibility will be managed through collaboration and appropriate decision making.

8 FINANCIAL GOVERNANCE ARRANGEMENTS

8.1 The financial governance arrangements are set out in Schedule 4 of the ICB Collaboration Agreement.

9 NON FINANCIAL RESOURCES

9.1 The non-financial resources required to deliver scheme will be provided by Birmingham and Solihull ICB in accordance with Schedule 6 of the ICB Collaboration Agreement.

10 STAFF

10.1 The commissioning team responsible for the operational delivery of specialised commissioning for delegated services will be hosted by Birmingham and Solihull ICB.

10.2 The arrangement through which the commissioning team will provide this support to the ICBs is set out in Schedule 6 of the ICB Collaboration Agreement.

11 ASSURANCE AND MONITORING

11.1 The arrangements in relation to assurance and monitoring in relation to this scheme are contained within Schedule 4

12 AUTHORISED OFFICERS

12.1 The authorised officers for this scheme are as follows:

Partner	**Name of Authorised Officer – Tier 1**
Coventry & Warwickshire ICB	Philip Johns
The Black Country ICB	Mark Axcell
Herefordshire & Worcestershire ICB	Simon Trickett
Birmingham & Solihull ICB	David Melbourne
Staffordshire and Stoke-on-Trent ICB	Peter Axon
Shropshire Telford and Wrekin ICB	Simon Whitehouse

13 INTERNAL APPROVALS

13.1 The levels of authority relating to this scheme are described within Schedule 4 of the ICB Collaboration Agreement.

14 REGULATORY REQUIREMENTS

14.1 Details in relation to regulatory requirements in relation to this scheme are contained within the delegation agreement and will be fulfilled on behalf of the ICBs by the Commissioning Team.

15 COMPLAINTS

15.1 Complaints will be managed by the specialised commissioning team hosted by the host ICB in line with the agreed complaints process.

15.2 A report summarising complaints, actions and lessons learnt will be provided to the East Midlands Joint Committee and West Midlands Joint Committee annually.

Appendix 1 List of CONTRACTS held with Providers

Acute Services Standard Contracts

BIRMINGHAM COMMUNITY HEALTHCARE NHS FOUNDATION TRUST
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST
CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST
DERBYSHIRE COMMUNITY HEALTH SERVICES
GEORGE ELIOT HOSPITAL NHS TRUST
HCRG
KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST
MIDLANDS PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST
NORTHAMPTON GENERAL HOSPITAL NHS TRUST
NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST
SOUTH WARWICKSHIRE NHS FOUNDATION TRUST
THE DUDLEY GROUP NHS FOUNDATION TRUST
THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST
THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST
THE ROYAL WOLVERHAMPTON NHS TRUST
THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST
UNITED LINCOLNSHIRE HOSPITALS NHS TRUST
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST
UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST
WALSALL HEALTHCARE NHS TRUST
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST
WYE VALLEY NHS TRUST

Section 75 Contract

LINCOLNSHIRE COMMUNITY HEALTH SERVICES NHS TRUST

Specialised Mental Health, Learning Disability and Autism Lead Provider Contracts

Lead Provider	Coordinating Commissioner
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST (EM ADULT SECURE)	LLR ICB
NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST (EM CYPMH)	LLR ICB
LEICESTERSHIRE PARTNERSHIP NHS TRUST (EM ADULT EATING DISORDER SERVICES)	LLR ICB
DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST (EM PERINATAL SERVICES)	LLR ICB
BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST (WM ADULT SECURE)	BSOL ICB
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST (WM CYPMH)	BSOL ICB
MIDLANDS UNIVERSITY PARTNERSHIP NHS FOUNDATION TRUST (WM ADULT EATING DISORDER SERVICES)	SSOT ICB
MIDLANDS UNIVERSITY PARTNERSHIP NHS FOUNDATION TRUST (WM PERINATAL SERVICES)	SSOT ICB

SCHEDULE 4: FINANCIAL ARRANGEMENTS

PART A: POOLED FUND MANAGEMENT

1 ESTABLISHMENT OF A RISK SHARE

1.1 The ICBs have agreed to establish and maintain a risk share arrangement for in-year financial management, based on the uncommitted element of allocations for variable services within the specialised commissioning contracts.

1.2 The principles of the risk management agreement are that in year financial risk will be managed collectively across the ICBs in the Midlands. All allocations not required for opening contract payments will be considered collectively as part of a notional pooled fund, managed by the specialised commissioning finance team on behalf of the ICBs. In year variation in contract performance will be monitored collectively and funds will be transferred between ICBs proportionately to fund the financial impact of in year variable activity to opening allocations.

1.3 The monies held in the notional Pooled Fund may only be expended on the following:

- the Contract Price,
- Third Party Costs where these are set out in the relevant Scheme Specification or as otherwise agreed in advance in writing in accordance with the relevant Scheme Specification;
- Approved expenditure as set out in the relevant Scheme Specification or as otherwise agreed in advance in accordance with the relevant Scheme Specification.

(collectively known as "Permitted Expenditure")

1.4 The Pooled Fund is explicitly for the management of in year expenditure against specialised services contractual commitments. This includes all contractual commitments for the population of Midlands ICBs including any out of Region contractual arrangements.

1.5 The Pooled Fund is not intended to be the route for recurrent commissioning decisions for specialised services. Such decisions would be made through the governance structure established in East and West Midlands.

1.6 The Partners may only depart from the definition of Permitted Expenditure or exceed Pooled Fund budget with the express written agreement of each relevant Partner and in line with approved delegations.

1.7 The Specialised Commissioning Finance Team, on behalf of the Midlands ICBs, shall be responsible for:

- Providing the financial administrative systems for the Pooled Fund; and
- The manager of the Pooled Fund ("Pooled Fund Manager") will be the Director of Commissioning of Finance
- Ensuring that the Pooled Fund Manager complies with its obligations under this Agreement.

2. RISK EXPOSURE

2.1. ICB population-based allocations have been developed on the basis of current contractual commitments as demonstrated in the document "ICB Baseline Development".

2.2. All ICB 2025/26 opening baselines have been updated for 2024/25 variable activity levels and precommitments.

2.3. All ICB 2025/26 opening baselines are in recurrent financial balance and there is no risk exposure from opening contract baselines for 2025/26.

2.4. The specialised services contract is operated on a block basis and there is no financial exposure to activity variance through the block contract.

2.5. Elective activity is managed through the Elective Recovery Fund which will be managed on the same basis as 2023/24 with contract values and allocations being adjusted for activity variances. There will be no financial risk associated with the application of ERF.

2.6. There are a small number of variable services within the contract, these being:

- Chemotherapy
- Diagnostic Imaging
- Nuclear Medicine
- PRT-CT
- Molecular Radiotherapy

- Renal Transplant

2.7. These services are paid on a cost per case basis. Opening baselines for variable services will be based on 2025/26 outturn with growth applied based on historic activity.

2.8. 2025/26 NHS Payment Scheme Consultation proposes a financial cap on variable elective activity, including the delegated services within the above list. Any financial cap would be in line with the agreed opening contract and associated ICB budget. The application of this financial cap removes the risk of overspend within individual ICBs.

2.9. As the NHS Payment Scheme is still under consultation, there remains risk at an ICB and regional level of variance against contract and budget for variable services and as such risk management arrangements will remain in place for 2025/26.

2.10. **Any financial cap arrangements within the final NHS 2025/26 Payment Scheme will take precedent over locally agreed risk management arrangements.**

3. POOLED FUND MANAGEMENT

3.1. The Pooled Fund Manager for Pooled Fund shall have the following duties and responsibilities:

- The day-to-day operation and management of the notional Pooled Fund and risk management arrangements,
- Ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this Agreement and the relevant Scheme Specification,
- Maintaining an overview of all joint financial issues affecting the Partners in relation to the Services and the Pooled Fund,
- Ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund,
- Reporting to the relevant governance group as required by this Agreement,
- ensuring action is taken to manage any projected under or overspends relating to the Pooled Fund in accordance with this Agreement, and
- preparing and submitting reports as required by the relevant Scheme Specification.

5. RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPEND

5.1. The Specialised Commissioning Team Pooled Fund manager shall manage expenditure within the notional pooled fund and shall use reasonable endeavours to ensure that the expenditure is limited to Permitted Expenditure.

5.2. The Pooled Funs Manager shall not be in breach of its obligations under this Agreement if an Overspend occurs provided that it has used reasonable endeavours to ensure that the only expenditure from a Pooled Fund has been incurred and it has informed the Partners of any variance.

5.3. In the event that the Pooled Fund Manager identifies an actual or projected Overspend the Pooled Fund Manager must ensure that the Partners are informed as soon as reasonably possible.

5.4. If expenditure from the Pooled Fund in any Financial Year is less than the aggregate value of the Financial Contributions made for that Financial Year, financial resources will be returned to the Partners proportionate to the contributions to the Pooled Fund. Arrangements shall be subject to the Law and the Standing Orders and Standing Financial Instructions of the Partners.

5.5. Any unmitigated net variance will need to be recognised in the Agreement of Balances exercise completed as part of the month 09 financial reporting process.

5.6. Residual variances (under or overspend), after mitigations and application of contingency, will be allocated to ICBs proportionately to contributions to the Pooled Fund.

5.7. An illustration of the application of the risk share using Chemotherapy variable activity performance is included in the table below.

ICB	Contract	Forecast	Variance	% Variance	Apply risk share	Risk Shared Forecast	Risk Shared % variance	Impact of risk share
ICB 1	9,000	10,000	1,000	11.11%	653	9,653	7.25%	347
ICB 2	8,500	9,000	500	5.88%	617	9,117	7.25%	-117
ICB 3	7,500	9,000	1,500	20.00%	544	8,044	7.25%	956
ICB 4	8,500	10,000	1,500	17.65%	617	9,117	7.25%	883
ICB 5	11,000	11,000	0	0.00%	798	11,798	7.25%	-798
ICB 6	9,500	10,500	1,000	10.53%	689	10,189	7.25%	311
ICB 7	10,000	9,000	-1,000	-10.00%	725	10,725	7.25%	-1,725
ICB 8	9,000	9,500	500	5.56%	653	9,653	7.25%	-153
ICB 9	7,500	8,500	1,000	13.33%	544	8,044	7.25%	456
ICB 10	5,000	5,500	500	10.00%	363	5,363	7.25%	137
ICB 11	11,000	11,500	500	4.55%	798	11,798	7.25%	-298
Total	96,500	103,500	7,000	7.25%	7,000	103,500	7.25%	0

6. CAPITAL EXPENDITURE

6.1. Pooled Funds shall not be applied towards any one-off expenditure on goods or services, which will provide continuing benefit and would historically have been funded from the capital budgets of one of the Partners. If a need for capital expenditure is identified this must be agreed by the Partners.

7. POOLED FUND FINANCIAL GOVERNANCE

7.1. The Birmingham and Solihull ICB hosted Specialised Services finance team will advise partner ICBs of the opening delegated specialised services contract values at the commencement of the financial year.

7.2. The partners in the Pooled Fund shall be notified of the resources available within the notional Pooled Fund.

7.3. The Specialised Commissioning Team will manage specialised services through the ICB ledgers.

7.4. All contractual payments including variable adjustments will be calculated by the Specialised Commissioning Team.

7.5. Payments to provider Trusts will be made through the payment mandate process through each individual ICB under the single joint Specialised Commissioning contract in line with the Contracting Standard Operating Procedure.

7.6. In year financial management will be undertaken at a multi ICB level across eleven ICBs in the Midlands region, mitigating the risk of variation between systems.

7.7. Regional financial variances (under or overspend) would be mitigated through the application of local financial management and the use of the contingency held by the Host, as agreed by partners, to minimise exposure to financial fluctuation.

7.8. Contract adjustments for variable activity will be advised to partner ICBs quarterly based on actual activity and transacted through amendments to the monthly contractual payments.

7.9. Residual variances (under or overspend), after mitigations and application of contingency, will

be allocated to ICBs proportionately to contributions to the Pooled Fund through transfer of financial allocation between ICBs.

8. POOLED FUND FINANCIAL REPORTING AND ASSURANCE

8.1. The finance subgroup of the Joint Committees will have responsibility to oversee the management of the pooled fund on behalf of the Joint Committees.

8.2. ICB level in year financial reporting will show contract payments in line with notified mandate schedules. In year reporting for ICBs will be based on actual notified variable activity. When forecasts are agreed they will represent the proportional share of variance under the risk share agreement.

8.3. Year-end reporting will be prepared in line with nationally produced annual accounts timetables recognising any locally agreed requirements.

PART B: OTHER FINANCIAL ARRANGEMENTS

9. BUDGETARY DELEGATION

9.1. Commissioning decisions will be made in line with the Arrangements agreed by the East/West Midlands Joint Commissioning Committee which has Delegated Authority to set approval limits in line with those arrangements.

9.2. ICBs have agreed to delegate budgetary responsibility via the joint committees to the specialised commissioning team for the processing and delivery of specialised services transactions. These delegations are to facilitate the delivery of contract signature, purchase orders and non-purchase order invoices and budgetary virement.

9.3. From April 2025 to June 2025, the specialised commissioning team will be employed by NHS England on behalf of the partner ICBs. From July 2025 the specialised commissioning team will be employed by the Host ICB.

10. AUDIT ARRANGEMENTS

10.1. Transactions through ICB ledgers will be subject to audit through existing internal audit arrangements. It will be the responsibility of ICBs to ensure that this appropriately referenced in the audit plan.

10.2. The Specialised Commissioning Team responsible for the management of specialised commissioning resources will be employed by NHS Birmingham and Solihull ICB but will access all ICB ledgers to process transactions for specialised services.

11. FINANCIAL MANAGEMENT

11.1. Financial transactions for the 70 delegated specialised services will be processed through the Oracle ISFE ledger system of the eleven Midlands ICBs. Specialised Commissioning team will have appropriate access to ICB ledgers enabled.

11.2. Financial monitoring reports will be produced by the NHS Birmingham and Solihull ICB hosted Specialised Commissioning Team on behalf of the ICBs.

11.3. Financial reports will be prepared monthly within ten working days of the end of the month. Forecast outturn positions will be included in the monitoring reports from quarter 2.

11.4. Monthly budget reporting with variance analysis and forecasting will be provided to Joint Committee Finance Subgroup, Host ICB, and Partner ICBs including:

- ICB reporting based on pool contribution,
- Overall pool financial performance report to be shared with all ICBs,
- Management and review of reserves and investments.

Annex 1 to Schedule 4

Budgetary Delegation Schedule

Contract award, signature and variation		
Description of delegation: Approval of contract award reports, providing requirements for competitive tendering have been met. Signature of contracts and contract variations, within the approved budget.		
Delegated Limit Limits are annual values	Up to £2m	Unlimited
Approvers and/or restrictions No variation can be granted to a contract awarded under the PCR threshold where the value of the variation results in the contract value exceeding the PCR threshold.	Commissioning Lead – Acute Specialised Commissioning (Contracting)	Director of Specialised Commissioning Director of Commissioning Finance (specialised commissioning).

Purchase Requisitions, invoices and non POs			
Description of delegation: Approval of purchase requisitions, purchase credit notes, invoices and non-purchase order invoices. Approval of contract payments to NHS providers.			
Delegated Limit	Up to £50k	Up to £2m or 1/12 of contract value for NHS Providers	Over £2m
Approvers and/or restrictions Expenditure must be covered by a relevant budget. Purchase orders should be raised for all nonhealthcare	Specialised commissioning: Contract Managers or Budget Holders	Director of Specialised Commissioning Director of Commissioning Finance (specialised)	Director of Specialised Commissioning **or** Director of Commissioning Finance (Specialised) **And**

goods and services and the non-purchase order route should only be used in exceptional circumstances.			Pooled Fund Host CFO

Budget Virements			
Description of delegation: Approval of budget virements/movements within approved revenue and capital budgets.			
Delegated Limit	Up to £50k	Up to £2m	Over £2m
Approvers and/or restrictions Expenditure must be covered by a relevant budget. Purchase orders should be raised for all nonhealthcare goods and services and the non-purchase order route should only be used in exceptional circumstances.	Specialised commissioning Contract Managers or Budget Holders	Director of Specialised Commissioning Director of Commissioning Finance (specialised)	MASCG

SCHEDULE 5: FURTHER INFORMATION GOVERNANCE AND SHARING PROVISIONS

PART 1

1. Introduction

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

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

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

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

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

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

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

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

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

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

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

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

2. Purpose

2.1. The Specified Purpose of the data sharing is to facilitate the exercise of the Joint Working Arrangements.

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

3. Benefits of information sharing

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

4. Lawful basis for sharing

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

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

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

5. Restrictions on use of the Shared Information

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

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

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

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

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

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

6. Ensuring fairness to the Data Subject

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

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

6.1.2. amendment of respective privacy notices and policies to reflect the processing of data carried out further to this Agreement, including covering the requirements of articles 13 and 14 UK GDPR and providing these (or making them available to) Data Subjects;

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

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

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

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

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

7. Governance: Staff

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

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

7.3. The Partners shall ensure that all Staff required to access Personal Data (including Special Category Personal Data are informed of the confidential nature of the Personal Data. The

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

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

7.5. The Partners shall ensure that:

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

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

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

8. Governance: Protection of Personal Data

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

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

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

8.4. If any Partner becomes aware of:

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

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

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

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

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

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

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

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

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

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

8.7. Each Partner shall:

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

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

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

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

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

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

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

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

9. Governance: Transmission of Information between the Partners

9.1. This paragraph supplements paragraph 8 of this Schedule.

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

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

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

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

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

10. Governance: Quality of Information

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

11. Governance: Retention and Disposal of Shared Information

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

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

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

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

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

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

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

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

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

12. Governance: Complaints and Access to Personal Data

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

12.2. Complaints about information sharing shall be reported to each Partner. Complaints about information sharing shall be routed through each Partner's own complaints procedure unless otherwise provided for in the Joint Working.

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

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

13. Governance: Single Points of Contact

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

14. Monitoring and review

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

SCHEDULE 6: MIDLANDS SPECIALISED COMMISSIONING TEAM (DELEGATED FUNCTIONS)

The Partners have agreed to establish a Midlands wide Commissioning Team (Delegated Functions) which will be hosted by BSOL ICB under a separate Hosting Agreement between the ICBs and detailed in Schedule 10 of the delegation agreement. The provisions of that agreement are hereby incorporated by reference and made a part of this agreement as if fully set out herein.

Dated 2025

(1) **NHS ENGLAND**

- and -

(2) **NHS SHROPSHIRE, TELFORD AND WREKIN INTEGRATED CARE BOARD**

Delegation Agreement between NHS England and NHS Shropshire, Telford and Wrekin ICB in relation to Specialised Commissioning Functions

Table of contents

Clause heading and number Page number:

Contents

DELEGATION AGREEMENT FOR SPECIFIED FUNCTIONS

1. PARTICULARS

1.1 This Agreement records the particulars of the agreement made between NHS England and the Integrated Care Board (ICB) named below.

Integrated Care Board	NHS Shropshire, Telford and Wrekin Integrated Care Board
Area	The area covered by the ICB is aligned with the two unitary authorities: County of Shropshire and Borough of Telford and Wrekin
Date of Agreement	[Date]
ICB Representative	Simon Whitehouse, Chief Executive
ICB Email Address for Notices	simon.whitehouse@nhs.net
NHS England Representative	Dale Bywater, Regional Director (Midlands)
NHS England Email Address for Notices	england.midlandscorporate@nhs.net

1.2 This Agreement comprises:

1.2.1 the Particulars (Clause 1);

1.2.2 the Terms and Conditions (Clauses 2 to 32);

1.2.3 the Schedules; and

1.2.4 the Mandated Guidance

Signed by **NHS England**

Dale Bywater

Regional Director – Midlands

(for and on behalf of NHS England)

Signed by **NHS Shropshire, Telford and Wrekin Integrated Care Board**

[Insert name of Authorised Signatory]

[Insert title of Authorised Signatory]

[for and on behalf of] NHS Shropshire, Telford and Wrekin Integrated Care Board

TERMS AND CONDITIONS

2. INTERPRETATION

2.1 This Agreement is to be interpreted in accordance with SCHEDULE 1 *(Definitions and Interpretation)*.

2.2 If there is any conflict or inconsistency between the provisions of this Agreement, that conflict or inconsistency must be resolved according to the following order of priority:

2.2.1 the Developmental Arrangements;

2.2.2 the Particulars and Terms and Conditions (Clauses 1 to 32);

2.2.3 Mandated Guidance;

2.2.4 all Schedules excluding Developmental Arrangements and Local Terms; and

2.2.5 Local Terms.

2.3 This Agreement constitutes the entire agreement and understanding between the Parties relating to the Delegation and supersedes all previous agreements, promises and understandings between them, whether written or oral, relating to its subject matter.

2.4 Where it is indicated that a provision in this Agreement is not used, that provision is not relevant and has no application in this Agreement.

2.5 Where a particular clause is included in this Agreement but is not relevant to the ICB because that clause relates to matters which do not apply the ICB (for example, if the clause only relates to functions that are not Delegated Functions in respect of the ICB), that clause is not relevant and has no application to this Agreement.

3. BACKGROUND

3.1 NHS England has statutory functions (duties and powers) conferred on it by legislation to make arrangements for the provision of prescribed services known as Specialised Services. These services support people with a range of rare and complex conditions. They are currently set out in the Prescribed Specialised Services Manual. The legislative basis for identifying these Specialised Services is Regulation 11 and Schedule 4 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996.

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

3.3 Pursuant to section 65Z5 of the NHS Act, NHS England is able to delegate responsibility for carrying out its Commissioning Functions to an ICB. NHS England will remain accountable to Parliament for ensuring that statutory requirements to commission all Specialised Services, and duties set out in the mandate, are being met.

3.4 By this Agreement, NHS England delegates the functions of commissioning certain Specialised Services (the “Delegated Functions”) to the ICB under section 65Z5 of the NHS Act.

3.5 This Agreement also sets out the elements of commissioning those Specialised Services for which NHS England will continue to have responsibility (the “Reserved Functions”).

3.6 Arrangements made under section 65Z5 may be made on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the ICB.

3.7 This Agreement sets out the terms that apply to the exercise of the Delegated Functions by the ICB. It also sets out each Party's responsibilities and the measures required to ensure the effective and efficient exercise of the Delegated Functions and Reserved Functions.

4. TERM

4.1 This Agreement has effect from the Date of Agreement set out in the Particulars and will remain in force unless terminated in accordance with Clause 27 *(Termination)* below.

5. PRINCIPLES

5.1 In complying with the terms of this Agreement, NHS England and the ICB must:

5.1.1 at all times have regard to the Triple Aim;

5.1.2 at all times act in good faith and with integrity towards each other;

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

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

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

5.1.6 act in a timely manner;

5.1.7 share information and Best Practice, and work collaboratively to identify solutions and enhance the evidence base for the commissioning and provision of health services, eliminate duplication of effort, mitigate risk and reduce cost; and

5.1.8 have regard to the needs and views of the other Party and as far as is lawful and reasonably practicable, take such needs and views into account.

6. DELEGATION

6.1 In accordance with its statutory powers under section 65Z5 of the NHS Act, NHS England hereby delegates the exercise of the Delegated Functions to the ICB to empower it to commission a range of services for its Population, as further described in this Agreement ("Delegation").

6.2 The Delegated Functions are the functions described as being delegated to the ICB as have been identified and included within Schedule 3 to this Agreement but excluding the Reserved Functions set out within Schedule 4.

6.3 The Delegation in respect of each Delegated Function has effect from the Effective Date of Delegation.

6.4 Decisions of the ICB in respect of the Delegated Functions and made in accordance with the terms of this Agreement shall be binding on NHS England and the ICB.

6.5 To the extent that this Agreement applies:

6.5.1 The ICB must ensure that its officers or employees do not make statutory or financial decisions that allocate NHS England resources.

6.5.2 NHS England must ensure that its officers or employees do not make statutory or financial decisions that allocate ICB resources, except as provided for in this Agreement.

6.6 Unless expressly provided for in this Agreement, the ICB is not authorised to take any step or make any decision in respect of Reserved Functions. Any such purported decision of the ICB is invalid and not binding on NHS England unless ratified in writing by NHS England in accordance with the NHS England Scheme of Delegation and Standing Financial Instructions.

6.7 NHS England may, acting reasonably and solely to the extent that the decision relates to the Delegated Functions, substitute its own decision for any decision which the ICB purports to make where NHS England reasonably considers that the impact of the ICB decision could cause the ICB to be acting unlawfully, in breach of this Agreement including Mandated Guidance, or in breach of any Contract. The ICB must provide any information, assistance and support as NHS England requires to enable it to determine whether to make any such decision.

6.8 The terms of Clauses 6.5, 6.6 and 6.7 are without prejudice to the ability of NHS England to enforce the terms of this Agreement or otherwise take action in respect of any failure by the ICB to comply with this Agreement.

7. EXERCISE OF DELEGATED FUNCTIONS

7.1 The ICB must establish effective, safe, efficient and economic arrangements for the discharge of the Delegated Functions.

7.2 The ICB agrees that it will exercise the Delegated Functions in accordance with:

7.2.1 the terms of this Agreement;

7.2.2 Mandated Guidance;

7.2.3 any Contractual Notices;

7.2.4 the Local Terms;

7.2.5 any Developmental Arrangements;

7.2.6 all applicable Law and Guidance;

7.2.7 the ICB's constitution;

7.2.8 the requirements of any assurance arrangements made by NHS England; and

7.2.9 Good Practice.

7.3 The ICB must perform the Delegated Functions in such a manner:

7.3.1 so as to ensure NHS England's compliance with NHS England's statutory duties in respect of the Reserved Functions and to enable NHS England to fulfil its Reserved Functions; and

7.3.2 having regard to NHS England's accountability to the Secretary of State and Parliament in respect of both the Delegated Functions and Reserved Functions; and

7.3.3 so as to ensure that the ICB complies with its statutory duties and requirements including those duties set out in Section 14Z32 to Section 14Z44 of the NHS Act and the NICE Regulations.

7.4 In exercising the Delegated Functions, the ICB must comply with all Mandated Guidance as set out in this Agreement or as otherwise may be issued by NHS England from time to time including, but not limited to, ensuring compliance with National Standards and following National Specifications.

7.5 Where Developmental Arrangements conflict with any other term of this Agreement, the Developmental Arrangements shall take precedence until such time as NHS England agrees to the removal or amendment of the relevant Developmental Arrangements in accordance with Clause 26 (*Variations*).

7.6 The ICB must develop an operational scheme(s) of delegation defining those individuals or groups of individuals, including committees, who may discharge aspects of the Delegated Functions. For the purposes of this clause, the ICB may include the operational scheme(s) of delegation within its general organisational scheme of delegation.

7.7 NHS England may by Contractual Notice allocate Contracts to the ICB such that they are included as part of the Delegation. The Delegated Functions must be exercised both in respect of the relevant Contract and any related matters concerning any Specialised Service Provider that is a party to a Contract. NHS England may add or remove Contracts where this is associated with an extension or reduction of the scope of the Delegated Functions.

7.8 Subsequent to the Effective Date of Delegation and for the duration of this Agreement, unless otherwise agreed any new Contract entered into in respect of the Delegated Functions shall be managed by the ICB in accordance with the provisions of this Agreement.

7.9 Subject to the provisions of this Agreement, the ICB may determine the arrangements for the exercise of the Delegated Functions.

8. REQUIREMENT FOR ICB COLLABORATION ARRANGEMENT

8.1 Subject to the provisions of Clause 12 *(Further Arrangements)*, the ICB must establish appropriate ICB Collaboration Arrangements with other ICBs in order to ensure that the commissioning of the Delegated Services can take place across an appropriate geographical footprint for the nature of each particular Delegated Service with consideration of population size, provider landscape and patient flow. Such ICB arrangements in respect of the Delegated Functions must be approved in advance by NHS England.

8.2 The ICB must establish, as part of or separate to the arrangements set out in Clause 8.1, an agreement that sets out the arrangements in respect of the Commissioning Team as required by Clause 13.

8.3 The ICB must participate in discussions, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view with the other ICBs within the ICB Collaboration Arrangement. The members of the ICB Collaboration Arrangement shall have a collective responsibility for the operation of the ICB Collaboration Arrangement.

8.4 The ICB shall ensure that any ICB Collaboration Arrangement is documented and such documentation must include (but is not limited to) the following:

8.4.1 membership which is limited solely to ICBs unless otherwise approved by NHS England;

8.4.2 clear governance arrangements including reporting lines to the ICBs' Boards;

8.4.3 provisions for independent scrutiny of decision making;

8.4.4 the Delegated Functions or elements thereof which are the subject of the arrangements;

8.4.5 the Delegated Services which are subject to the arrangements;

8.4.6 financial arrangements and any pooled fund arrangements;

8.4.7 data sharing arrangements including evidence of a Data Protection Impact Assessment;

8.4.8 terms of reference for decision making; and

8.4.9 limits on onward delegation.

8.5 The ICB must not terminate an ICB Collaboration Arrangement in respect of the Delegated Functions without the prior written approval of NHS England.

9. PERFORMANCE OF THE RESERVED FUNCTIONS AND COMMISSIONING SUPPORT ARRANGEMENTS

9.1 NHS England will remain responsible for the performance of the Reserved Functions.

9.2 For the avoidance of doubt, the Parties acknowledge that the Delegation may be amended, and additional functions may be delegated to the ICB, in which event consequential changes to this Agreement shall be agreed with the ICB pursuant to Clause 26 (*Variations*) of this Agreement.

9.3 Where it considers appropriate NHS England will work collaboratively with the ICB when exercising the Reserved Functions.

9.4 If there is any conflict or inconsistency between functions that are named as Delegated Functions and functions that are named as Reserved Functions, then such functions shall be interpreted as Reserved Functions unless and until NHS England confirms otherwise. If an ICB identifies such a conflict or inconsistency, it will inform NHS England as soon as is reasonably practicable.

9.5 The Parties acknowledge that they may agree for the ICB to provide Administrative and Management Services to NHS England in relation to certain Reserved Functions and Retained Services in order to assist in the efficient and effective exercise of such functions. Any such Commissioning Team Arrangements shall be set out in writing.

9.6 Notwithstanding any arrangement for or provision of Administrative and Management Services in respect of the Retained Services and Reserved Functions, NHS England shall retain statutory responsibility for, and be accountable for, the commissioning of the Retained Services.

9.7 The Parties acknowledge that they may agree for NHS England to provide Administrative and Management Services to ICBs in relation to certain Delegated Functions and Delegated Services in order to assist in the efficient and effective exercise of such Delegated Functions. Any such Administrative and Management Services shall be set out in writing.

9.8 Notwithstanding any arrangement for or provision of Administrative and Management Services in respect of the Delegated Services, the ICB shall retain delegated responsibility for the commissioning of the Delegated Services.

9.9 Any arrangement made between the ICB and NHS England under Clauses 9.5 or 9.7 must be made in accordance with: Clause 6.5, Clause 10.14 and Paragraph 4.2 of Schedule 4.

10. FINANCE

10.1 Without prejudice to any other provision in this Agreement, the ICB must comply with the Finance Guidance and any such financial processes as required by NHS England for the management, reporting and accounting of funds used for the purposes of the Delegated Functions.

10.2 The ICB acknowledges that it will receive funds from NHS England in respect of the Delegated Functions (the "Delegated Funds") and that these are in addition to the funds allocated to it within its Annual Allocation.

10.3 Subject to Clause 10.4 and any provisions in the Schedules or Mandated Guidance, the ICB may use:

10.3.1 its Annual Allocation and the Delegated Funds in the exercise of the Delegated Functions; and

10.3.2 the Delegated Funds and its Annual Allocation in the exercise of the ICB's Functions other than the Delegated Functions.

10.4 The ICB's expenditure on the Delegated Functions must be sufficient to:

10.4.1 ensure that NHS England is able to fulfil its functions, including without limitation the Reserved Functions, effectively and efficiently;

10.4.2 meet all liabilities arising under or in connection with all Contracts in so far as they relate to the exercise of the Delegated Functions;

10.4.3 appropriately commission the Delegated Services in accordance with Mandatory Guidance, National Specifications, National Standards and Guidance; and

10.4.4 meet national commitments from time to time on expenditure on specific Delegated Functions.

10.5 NHS England may increase or reduce the Delegated Funds in any Financial Year, by sending a notice to the ICB of such increase or decrease:

10.5.1 in order to take into account any monthly adjustments or corrections to the Delegated Funds that NHS England considers appropriate, including without limitation, adjustments following any changes to the Delegated Functions, changes in allocations, changes in Contracts, to implement Mandated Guidance or otherwise;

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

10.5.3 to take into account any Losses of NHS England for which the ICB is required to indemnify NHS England under Clause 17 (*Claims and Litigation)*;

10.5.4 to take into account any adjustments that NHS England considers appropriate (including without limitation in order to make corrections or otherwise to reflect notional budgets) to reflect funds transferred (or that should have been transferred) to the ICB in respect of the Delegated Functions or funds transferred (or that should have been transferred) to the ICB in respect of Administrative and Management Services; and

10.5.5 in order to ensure compliance by NHS England with its obligations under the NHS Act (including, Part 11 of the NHS Act) or any action taken or direction made by the Secretary of State in respect of NHS England under the NHS Act.

10.6 NHS England acknowledges that the intention of Clause 10.5 is to reflect genuine corrections and adjustments to the Delegated Funds and may not be used to change the allocation of the Delegated Funds unless there are significant or exceptional circumstances that would require such corrections or adjustments.

10.7 The ICB acknowledges that it must comply with its statutory financial duties, including those under Part 11 of the NHS Act to the extent that these sections apply in relation to the receipt of the Delegated Funds.

10.8 NHS England may in respect of the Delegated Funds:

10.8.1 notify the ICB regarding the required payment of sums by the ICB to NHS England in respect of charges referable to the valuation or disposal of assets and such conditions as to records, certificates or otherwise;

10.8.2 by notice, require the ICB to take such action or step in respect of the Delegated Funds, in order to ensure compliance by NHS England of its duties or functions under the NHS (including Part 11 of the NHS Act) or any action taken or direction made by the Secretary of State under the NHS Act.

10.9 The Schedules to this Agreement may identify further financial provisions in respect of the exercise of the Delegated Functions.

10.10 NHS England may issue Mandated Guidance in respect of the financial arrangements in respect of the Delegated Functions.

10.11 NHS England will pay the Delegated Funds to the ICB using the revenue transfer process as used for the Annual Allocation or such other process as notified to the ICB from time to time.

10.12 Without prejudice to any other obligation upon the ICB, for the purposes of the Delegated Functions the ICB agrees that it must use its resources in accordance with:

10.12.1 the terms and conditions of this Agreement including any Mandated Guidance issued by NHS England from time to time in relation to the use of resources for the purposes of the Delegated Functions (including in relation to the form or contents of any accounts);

10.12.2 any NHS payment scheme published by NHS England;

10.12.3 the business rules as set out in NHS England's planning guidance or such other documents issued by NHS England from time to time;

10.12.4 any Capital Investment Guidance;

10.12.5 the HM Treasury Guidance *Managing Public Money* (dated September 2022) as replaced or updated from time to time; and

10.12.6 any other Guidance published by NHS England with respect to the financial management of Delegated Functions.

10.13 Without prejudice to any other obligation upon the ICB, the ICB agrees that it must provide:

10.13.1 all information, assistance and support to NHS England in relation to the audit and/or investigation (whether internal or external and whether under Law or otherwise) in relation to the use of or payment of resources for the purposes of the Delegated Functions and the discharge of those functions;

10.13.2 such reports in relation to the expenditure on the Delegated Functions as set out in Mandated Guidance, the Schedules to this Agreement or as otherwise required by NHS England.

Ledger access and use of financial data

10.14 NHS England and the ICB agree that they shall not access a financial ledger or other finance system that is operated by another organisation, or use data directly obtained from such a financial ledger or other finance system.

10.15 Clause 10.14 applies unless that access or use has been approved in advance by the organisation that operates that financial ledger or other finance system, or as is otherwise expressly provided for in this Agreement.

Pooled Funds

10.16 Subject to the provisions of this Agreement, the ICB may, for the purposes of exercising the Delegated Functions under this Agreement, establish and maintain a pooled fund(s) in respect of any part of the Delegated Funds with:

10.16.1 NHS England in accordance with sections 13V or 65Z6 of the NHS Act;

10.16.2 one or more ICBs in accordance with section 65Z6 of the NHS Act as part of a Further Arrangement; or

10.16.3 NHS England and one or more ICBs in accordance with section 13V of the NHS Act; and

10.16.4 NHS England and one or more ICBs in accordance with section 65Z6 of the NHS Act.

10.17 Where the ICB has decided to enter into arrangements under Clause 10.16 the agreement must be in writing and must specify:

10.17.1 the agreed aims and outcomes of the arrangements;

10.17.2 the payments to be made by each partner and how those payments may be varied;

10.17.3 the specific Delegated Functions which are the subject of the arrangements;

10.17.4 the Delegated Services which are subject to the arrangements;

10.17.5 the duration of the arrangements and provision for the review or variation or termination of the arrangements;

10.17.6 the arrangements in place for governance of the pooled fund; and

10.17.7 the arrangements in place for assuring, oversight and monitoring of the ICB's exercise of the functions referred to in 10.17.3.

10.18 At the date of this Agreement, details of the pooled funds (including any terms as to the governance and payments out of such pooled fund) of NHS England and the ICB are set out in the Local Terms.

11. INFORMATION, PLANNING AND REPORTING

11.1 The ICB must provide to NHS England:

11.1.1 such information or explanations in relation to the exercise of the Delegated Functions as required by NHS England from time to time; and

11.1.2 all such information (and in such form), that may be relevant to NHS England in relation to the exercise by NHS England of its other duties or functions including, without limitation, the Reserved Functions.

11.2 The provisions of this Clause 11 are without prejudice to the ability of NHS England to exercise its other powers and duties in obtaining information from and assessing the performance of the ICB.

Forward Plan and Annual Report

11.3 Before the start of each Financial Year, the ICB must describe in its joint forward plan prepared in accordance with section 14Z52 of the NHS Act how it intends to exercise the Delegated Functions.

11.4 The ICB must report on its exercise of the Delegated Functions in its annual report prepared in accordance with section 14Z58 of the NHS Act.

Risk Register

11.5 The ICB must maintain a risk register in respect of its exercise of the Delegated Functions and periodically review its content. The risk register must follow such format as may be notified by NHS England to the ICB from time to time.

12. FURTHER ARRANGEMENTS

12.1 In addition to any ICB Collaboration Arrangement agreed in accordance with Clause 8 (*ICB Collaboration Arrangements*) the ICB must give due consideration to whether any of the Delegated Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under section 65Z5 and section 75 of the NHS Act ("Further Arrangements").

12.2 The ICB may only make Further Arrangements with another person (a "Sub-Delegate") with the prior written approval of NHS England.

12.3 The approval of any Further Arrangements may:

12.3.1 include approval of the terms of the proposed Further Arrangements; and

12.3.2 require conditions to be met by the ICB and the Sub-Delegate in respect of that arrangement.

12.4 All Further Arrangements must be made in writing.

12.5 The ICB must not terminate Further Arrangements without the prior written approval of NHS England.

12.6 If the ICB enters into a Further Arrangement it must ensure that the Sub-Delegate does not make onward arrangements for the exercise of any or all of the Delegated Functions without the prior written approval of NHS England.

12.7 The terms of this Clause 12 do not prevent the ICB from making arrangements for assistance and support in the exercise of the Delegated Functions with any person,

where such arrangements reserve the consideration and making of any decision in respect of a Delegated Function to the ICB.

12.8 Where Further Arrangements are made, and unless NHS England has otherwise given specific prior written agreement, any obligations or duties on the part of the ICB under this Agreement that are relevant to those Further Arrangements shall also require the ICB to ensure that all Sub-Delegates comply with such obligations or duties and support the ICB in doing so.

13. STAFFING, WORKFORCE AND COMMISSIONING TEAMS

13.1 Where there is an arrangement for NHS England to provide Administrative and Management Services to the ICB, the ICB shall provide full co-operation with NHS England and enter into any necessary arrangements with NHS England and, where appropriate, other ICBs in respect of the Specialised Services Staff.

13.2 The ICB shall, if and where required by NHS England, enter into appropriate arrangements with NHS England in respect of the transfer of Specialised Services Staff.

13.3 The ICB shall, where appropriate, enter into an agreement with other ICBs, in order to establish arrangements in respect of the Commissioning Team. Where appropriate, this agreement may be included as part of the ICB Collaboration Arrangement entered into in accordance with Clause 8.

14. BREACH

14.1 If the ICB does not comply with the terms of this Agreement, then NHS England may:

14.1.1 exercise its rights under this Agreement; and

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

14.2 Without prejudice to Clause 14.1, if the ICB does not comply with the terms of this Agreement (including if the ICB exceeds its delegated authority under the Delegation), NHS England may (at its sole discretion):

14.2.1 waive its rights in relation to such non-compliance in accordance with Clause 14.3;

14.2.2 ratify any decision in accordance with Clause 6.6;

14.2.3 substitute a decision in accordance with Clause 6.7;

14.2.4 amend Developmental Arrangements or impose new Developmental Arrangements;

14.2.5 revoke the whole or part of the Delegation and terminate this Agreement in accordance with Clause 27 *(Termination)* below;

14.2.6 exercise the Escalation Rights in accordance with Clause 155 *(Escalation Rights)*; and/or

14.2.7 exercise its rights under common law.

14.3 NHS England may waive any non-compliance by the ICB with the terms of this Agreement provided that the ICB provides a written report to NHS England as required by Clause 14.4 and, after considering the ICB's written report, NHS England is satisfied that the waiver is justified.

14.4 If:

14.4.1 the ICB does not comply with this Agreement;

14.4.2 the ICB considers that it may not be able to comply with this Agreement;

14.4.3 NHS England notifies the ICB that it considers the ICB has not complied with this Agreement; or

14.4.4 NHS England notifies the ICB that it considers that the ICB may not be able to comply with this Agreement,

then the ICB must provide a written report to NHS England within ten (10) Operational Days of the non-compliance (or the date on which the ICB identifies that it may not be able to comply with this Agreement) setting out:

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

14.4.6 a plan for how the ICB proposes to remedy the non-compliance.

15. ESCALATION RIGHTS

15.1 If the ICB does not comply with this Agreement, NHS England may exercise the following Escalation Rights:

15.1.1 NHS England may require a suitably senior representative of the ICB to attend a review meeting within ten (10) Operational Days of NHS England becoming aware of the non-compliance; and

15.1.2 NHS England may require the ICB to prepare an action plan and report within twenty (20) Operational Days of the review meeting (to include details of the non-compliance and a plan for how the ICB proposes to remedy the non-compliance).

15.2 If NHS England does not comply with this Agreement, the ICB may require a suitably senior representative of NHS England to attend a review meeting within ten (10) Operational Days of the ICB making NHS England aware of the non-compliance.

15.3 Nothing in Clause 15 *(Escalation Rights)* will affect NHS England's right to substitute a decision in accordance with Clause 6.87, revoke the Delegation or terminate this Agreement in accordance with Clause 27 *(Termination)* below.

16. LIABILITY AND INDEMNITY

16.1 NHS England is liable in respect of any Losses arising in respect of NHS England's negligence, fraud, recklessness or deliberate breach in respect of the Delegated Functions and occurring after the Effective Date of Delegation and, if the ICB suffers any Losses in respect of such actions by NHS England, NHS England shall make such adjustments to the Annual Allocation (or other amounts payable to the ICB) in order to reflect any Losses suffered by the ICB (except to the extent that the ICB is liable for such Losses pursuant to Clause 16.3).

16.2 For the avoidance of doubt, NHS England remains liable for a Claim relating to facts, events or circumstances concerning the Delegated Functions before the Effective Date of Delegation.

16.3 The ICB is liable to (and shall pay) NHS England for any Losses suffered by NHS England that result from or arise out of the ICB's negligence, fraud, recklessness or breach of the Delegation (including any actions that are taken that exceed the authority

conferred by the Delegation) or this Agreement. In respect of such Losses, NHS England may, at its discretion and without prejudice to any other rights, either require payment from the ICB or make such adjustments to the Delegated Funds pursuant to Clause 10.5. The ICB shall not be liable to the extent that the Losses arose prior to the Effective Date of Delegation.

16.4 Each Party acknowledges and agrees that any rights acquired, or liabilities (including liabilities in tort) incurred, in respect of the exercise by the ICB of any Delegated Function are enforceable by or against the ICB only, in accordance with section 65Z5(6) of the NHS Act.

16.5 Each Party will at all times take all reasonable steps to minimise and mitigate any Losses or other matters for which one Party is entitled to be indemnified by or to bring a claim against the other under this Agreement.

17. CLAIMS AND LITIGATION

17.1 Nothing in this Clause 17 *(Claims and Litigation)* shall be interpreted as affecting the reservation to NHS England of the Reserved Functions.

17.2 Except in the circumstances set out in Clause **Error! Reference source not found.**17.5 and subject always to compliance with this Clause 17 *(Claims and Litigation)*, the ICB shall be responsible for and shall retain the conduct of any Claim.

17.3 The ICB must:

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

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

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

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

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

17.4 Subject to Clauses 17.3 and 17.5 the ICB is entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit.

NHS England Stepping into Claims

17.5 NHS England may, at any time following discussion with the ICB, send a notice to the ICB stating that NHS England will take over the conduct of the Claim and the ICB must immediately take all steps necessary to transfer the conduct of such Claim to NHS England unless and until NHS England transfers conduct back to the ICB. In such cases:

17.5.1 NHS England shall be entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit, provided that if NHS England wishes to invoke Clause 17.5.3 it agrees to seek the ICB's views on any proposal to pay or settle that Claim prior to finalising such payment or settlement; and

17.5.2 the Delegation shall be treated as being revoked to the extent that and for so long as NHS England has assumed responsibility for exercising those of the Delegated Functions that are necessary for the purposes of having conduct of the Claim; and

17.5.3 NHS England may, at its discretion and without prejudice to any other rights, either require payment from the ICB for such Claim Losses or make an adjustment to the Delegated Funds pursuant to Clause 10.5.3 for the purposes of meeting any Claim Losses associated with that Claim.

Claim Losses

17.6 The ICB and NHS England shall notify each other as soon as reasonably practicable of becoming aware of any Claim Losses.

17.7 The ICB acknowledges that NHS England will pay to the ICB the funds that are attributable to the Delegated Functions. Accordingly, the ICB acknowledges that it must pay any Claim Losses out of either the Delegated Funds or its Annual Allocation. NHS England may, in respect of any Claim Losses, at its discretion and without prejudice to any other rights, either require payment from the ICB for such Claim Losses or pursuant to Clause 10.5.3 make such adjustments to the Delegated Funds to take into account the amount of any Claim Losses (other than any Claim Losses in respect of which NHS England has retained any funds, provisions or other resources to discharge such Claim Losses). For the avoidance of doubt, in circumstances where NHS England suffers any Claim Losses, then NHS England shall be entitled to recoup such Claim Losses pursuant to Clause 10.5.3. If and to the extent that NHS England has retained any funds, provisions or other resources to discharge such Claim Losses, then NHS England may either use such funds to discharge the Claim Loss or make an upward adjustment to the amounts paid to the ICB pursuant to Clause 10.5.3.

18. DATA PROTECTION, FREEDOM OF INFORMATION AND TRANSPARENCY

18.1 The Parties must ensure that all Personal Data processed by or on behalf of them while carrying out the Delegated Functions and Reserved Functions is processed in accordance with the relevant Party's obligations under Data Protection Legislation and Data Guidance and the Parties must assist each other as necessary to enable each other to comply with these obligations.

18.2 The ICB must respond to any information governance breach in accordance with Information Governance Guidance for Serious Incidents. If the ICB is required under Data Protection Legislation to notify the Information Commissioner's Office or a Data Subject of an information governance breach then as soon as reasonably practical and in any event on or before the first such notification is made the ICB must fully inform NHS England of the information governance breach. This clause does not require the ICB to provide NHS England with information which identifies any individual affected by the information governance breach where doing so would breach Data Protection Legislation.

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

18.4 NHS England may, from time to time, issue a data sharing protocol or update a protocol previously issued relating to the data sharing in relation to the Delegated Functions and/or Reserved Functions. The ICB shall comply with such data sharing protocols.

18.5 Each Party acknowledges that the other is a public authority for the purposes of the Freedom of Information Act 2000 ("FOIA") and the Environmental Information Regulations 2004 ("EIR").

18.6 Each Party may be required by statute to disclose further information about the Agreement and the Relevant Information in response to a specific request under FOIA or EIR, in which case:

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

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

18.6.3 subject only to Clause 17 *(Claims and Litigation)*, each Party acknowledges that the final decision as to the form or content of the response to any request is a matter for the Party to whom the request is addressed.

18.7 NHS England may, from time to time, issue a FOIA or EIR protocol or update a protocol previously issued relating to the handling and responding to of FOIA or EIR requests in relation to the Delegated Functions. The ICB shall comply with such FOIA or EIR protocols.

18.8 Delegated **Services**

NHS England delegates to the ICB the statutory function for commissioning the Specialised Services set out in this Schedule 2 (*Delegated Services*) subject to the reservations set out in Schedule 4 (*Reserved Functions*) and the provisions of any Developmental Arrangements set out in Schedule 9.

The list of Delegated Services set out in Schedule 2 of this Agreement contains two categories of service: the first is drawn from the Prescribed Specialised Services (PSS) Manual and aligns to Schedule 4 of the 2012 Standing Rules Regulations; the second is the sub-service line codes that NHS England has introduced over time to assist in the commissioning of Specialised Services. From time-to-time, NHS England will amend the list of sub-service line codes, either to repurpose, remove or add a code.

This is done to support in the management of finances, activity or for other administrative reasons; or to support transformational work that may be ongoing in the service area that requires a sub-service line code to track and manage funding and activity. The intention is that any changes will be supportive of ICBs' commissioning responsibilities, and that there will be a small number of changes in the Delegated Services sub-service line codes in any one year.

All future changes to sub-service line codes relating to Delegated Services will be developed with ICBs. ICBs will be engaged and have the opportunity to provide comment on the proposed change before it is made. Changes to the sub-service line codes will be discussed at and agreed by the Delegated Commissioning Group, hosted by NHS England and attended by ICB representatives. If changes are agreed, the latest lists will be made available on the NHS England website here [NHS England » NHS England service codes by year 2024/25] and a more detailed version on the Future NHS site here [Service Portfolio Analysis - Integrating specialised services within Integrated Care Systems - FutureNHS Collaboration Platform].

The PSS Manual Lines in Schedule 2 of the Agreement, which derive from the 2012 Standing Rules Regulations, will not be altered unless there is a decision of the NHS England Board, which will necessitate wider engagement with ICBs and stakeholders.

The following Specialised Services through this agreement will be delegated to the ICB:

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
2	Adult congenital heart disease services	13X	Adult congenital heart disease services (non-surgical)
		13Y	Adult congenital heart disease services (surgical)
3	Adult specialist pain management services	31Z	Adult specialist pain management services
4	Adult specialist respiratory services	29M	Interstitial lung disease (adults)
		29S	Severe asthma (adults)
		29L	Lung volume reduction (adults)
		29V	Complex home ventilation (adults)
5	Adult specialist rheumatology services	26Z	Adult specialist rheumatology services
6	Adult secure mental health services	22S(a)	Secure and specialised mental health services (adult) (medium and low) – excluding LD/ASD/WEMS/ABI/DEAF
		22S(c)	Secure and specialised mental health services (adult) (Medium and low) – ASD MHLDA PC
		22S(d)	Secure and specialised mental health services (adult) (Medium and low) – LD MHLDA PC
7	Adult Specialist Cardiac Services	13A	Complex device therapy
		13B	Cardiac electrophysiology & ablation
		13C	Inherited cardiac conditions
		13E	Cardiac surgery (inpatient)
		13F	PPCI for ST- elevation myocardial infarction
		13H	Cardiac magnetic resonance imaging
		13T	Complex interventional cardiology
		13Z	Cardiac surgery (outpatient)
8	Adult specialist eating disorder services	22E	Adult specialist eating disorder services MHLDA PC
9	Adult specialist endocrinology services	27E	Adrenal Cancer (adults)
		27Z	Adult specialist endocrinology services
11	Adult specialist neurosciences services	08O	Neurology (adults)
		08P	Neurophysiology (adults)
		08R	Neuroradiology (adults)
		08S	Neurosurgery (adults)
		08T	Mechanical Thrombectomy
		58A	Neurosurgery LVHC national: surgical removal of clival chordoma and chondrosarcoma
		58B	Neurosurgery LVHC national: EC-IC bypass (complex/high flow)
		58C	Neurosurgery LVHC national: transoral excision of dens
		58D	Neurosurgery LVHC regional: anterior skull based tumours
		58E	Neurosurgery LVHC regional: lateral skull based tumours
		58F	Neurosurgery LVHC regional: surgical removal of brainstem lesions
		58G	Neurosurgery LVHC regional: deep brain stimulation
		58H	Neurosurgery LVHC regional: pineal tumour surgeries - resection
		58I	Neurosurgery LVHC regional: removal of arteriovenous malformations of the nervous system
		58J	Neurosurgery LVHC regional: epilepsy
		58K	Neurosurgery LVHC regional: insula glioma's/complex low grade glioma's

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
	Adult specialist neurosciences services (continued)	58L	Neurosurgery LVHC local: anterior lumbar fusion
		58M	Neurosurgery LVHC local: removal of intramedullary spinal tumours
		58N	Neurosurgery LVHC local: intraventricular tumours resection
		58O	Neurosurgery LVHC local: surgical repair of aneurysms (surgical clipping)
		58P	Neurosurgery LVHC local: thoracic discectomy
		58Q	Neurosurgery LVHC local: microvascular decompression for trigeminal neuralgia
		58R	Neurosurgery LVHC local: awake surgery for removal of brain tumours
		58S	Neurosurgery LVHC local: removal of pituitary tumours including for Cushing's and acromegaly
12	Adult specialist ophthalmology services	37C	Artificial Eye Service
		37Z	Adult specialist ophthalmology services
13	Adult specialist orthopaedic services	34A	Orthopaedic surgery (adults)
		34R	Orthopaedic revision (adults)
15	Adult specialist renal services	11B	Renal dialysis
		11C	Access for renal dialysis
		11T	Renal Transplantation
16	Adult specialist services for people living with HIV	14A	Adult specialised services for people living with HIV
17	Adult specialist vascular services	30Z	Adult specialist vascular services
18	Adult thoracic surgery services	29B	Complex thoracic surgery (adults)
		29Z	Adult thoracic surgery services: outpatients
29	Haematopoietic stem cell transplantation services (adults and children)	02Z	Haematopoietic stem cell transplantation services (adults and children)
		ECP	Extracorporeal photopheresis service (adults and children)
30	Bone conduction hearing implant services (adults and children)	32B	Bone anchored hearing aids service
		32D	Middle ear implantable hearing aids service
32	Children and young people's inpatient mental health service	23K	Tier 4 CAMHS (general adolescent inc eating disorders) MHLDA PC
		23L	Tier 4 CAMHS (low secure) MHLDA PC
		23O	Tier 4 CAMHS (PICU) MHLDA PC
		23U	Tier 4 CAMHS (LD) MHLDA PC
		23V	Tier 4 CAMHS (ASD) MHLDA PC
35	Cleft lip and palate services (adults and children)	15Z	Cleft lip and palate services (adults and children)
36	Cochlear implantation services (adults and children)	32A	Cochlear implantation services (adults and children)
40	Complex spinal surgery services (adults and children)	06Z	Complex spinal surgery services (adults and children)
		08Z	Complex neuro-spinal surgery services (adults and children)
45	Cystic fibrosis services (adults and children)	10Z	Cystic fibrosis services (adults and children)
54	Fetal medicine services (adults and adolescents)	04C	Fetal medicine services (adults and adolescents)
58	Specialist adult gynaecological surgery and urinary surgery services for females	04A	Severe Endometriosis
		04D	Complex urinary incontinence and genital prolapse

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
58A	Specialist adult urological surgery services for men	41P	Penile implants
		41S	Surgical sperm removal
		41U	Urethral reconstruction
59	Specialist allergy services (adults and children)	17Z	Specialist allergy services (adults and children)
61	Specialist dermatology services (adults and children)	24Z	Specialist dermatology services (adults and children)
62	Specialist metabolic disorder services (adults and children)	36Z	Specialist metabolic disorder services (adults and children)
63	Specialist pain management services for children	23Y	Specialist pain management services for children
64	Specialist palliative care services for children and young adults	E23	Specialist palliative care services for children and young adults
65	Specialist services for adults with infectious diseases	18A	Specialist services for adults with infectious diseases
		18E	Specialist Bone and Joint Infection (adults)
72	Major trauma services (adults and children)	34T	Major trauma services (adults and children)
78	Neuropsychiatry services (adults and children)	08Y	Neuropsychiatry services (adults and children)
83	Paediatric cardiac services	23B	Paediatric cardiac services
94	Radiotherapy services (adults and children)	01R	Radiotherapy services (Adults)
		51R	Radiotherapy services (Children)
		01S	Stereotactic Radiosurgery / radiotherapy
98	Specialist secure forensic mental health services for young people	24C	FCAMHS MHLDA PC
103A	Specialist adult haematology services	03C	Castleman disease
105	Specialist cancer services (adults)	01C	Chemotherapy
		01J	Anal cancer (adults)
		01K	Malignant mesothelioma (adults)
		01M	Head and neck cancer (adults)
		01N	Kidney, bladder and prostate cancer (adults)
		01Q	Rare brain and CNS cancer (adults)
		01U	Oesophageal and gastric cancer (adults)
		01V	Biliary tract cancer (adults)
		01W	Liver cancer (adults)
		01X	Penile cancer (adults)
		01Y	Cancer Outpatients (adults)
		01Z	Testicular cancer (adults)
		04F	Gynaecological cancer (adults)
		19V	Pancreatic cancer (adults)
		19C	Biliary tract cancer surgery (adults)
		19M	Liver cancer surgery (adults)
		19Q	Pancreatic cancer surgery (adults)
		24Y	Skin cancer (adults)
		29E	Management of central airway obstruction (adults)
		51A	Interventional oncology (adults)
		51B	Brachytherapy (adults)
		51C	Molecular oncology (adults)
		61M	Head and neck cancer surgery (adults)
		61Q	Ophthalmic cancer surgery (adults)
		61U	Oesophageal and gastric cancer surgery (adults)

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
		61Z	Testicular cancer surgery (adults)
		33C	Transanal endoscopic microsurgery (adults)
		33D	Distal sacrectomy for advanced and recurrent rectal cancer (adults)
106	Specialist cancer services for children and young adults	01T	Teenage and young adult cancer
		23A	Children's cancer
106A	Specialist colorectal surgery services (adults)	33A	Complex surgery for faecal incontinence (adults)
		33B	Complex inflammatory bowel disease (adults)
107	Specialist dentistry services for children	23P	Specialist dentistry services for children
108	Specialist ear, nose and throat services for children	23D	Specialist ear, nose and throat services for children
109	Specialist endocrinology services for children	23E	Specialist endocrinology and diabetes services for children
110	Specialist gastroenterology, hepatology and nutritional support services for children	23F	Specialist gastroenterology, hepatology and nutritional support services for children
112	Specialist gynaecology services for children	73X	Specialist paediatric surgery services - gynaecology
113	Specialist haematology services for children	23H	Specialist haematology services for children
114	Specialist haemoglobinopathy services (adults and children)	38S	Sickle cell anaemia (adults and children)
		38T	Thalassemia (adults and children)
115	Specialist immunology services for adults with deficient immune systems	16X	Specialist immunology services for adults with deficient immune systems
115A	Specialist immunology services for children with deficient immune systems	16Y	Specialist immunology services for children with deficient immune systems
115B	Specialist maternity care for adults diagnosed with abnormally invasive placenta	04G	Specialist maternity care for women diagnosed with abnormally invasive placenta
118	Neonatal critical care services	NIC	Specialist neonatal care services
119	Specialist neuroscience services for children	23M	Specialist neuroscience services for children
		07Y	Paediatric neurorehabilitation
		08J	Selective dorsal rhizotomy
120	Specialist ophthalmology services for children	23N	Specialist ophthalmology services for children
121	Specialist orthopaedic services for children	23Q	Specialist orthopaedic services for children
122	Paediatric critical care services	PIC	Specialist paediatric intensive care services
124	Specialist perinatal mental health services (adults and adolescents)	22P	Specialist perinatal mental health services (adults and adolescents) MHLDA PC
125	Specialist plastic surgery services for children	23R	Specialist plastic surgery services for children
126	Specialist rehabilitation services for patients with highly complex needs (adults and children)	07Z	Specialist rehabilitation services for patients with highly complex needs (adults and children)
127	Specialist renal services for children	23S	Specialist renal services for children
128	Specialist respiratory services for children	23T	Specialist respiratory services for children
129	Specialist rheumatology services for children	23W	Specialist rheumatology services for children
130	Specialist services for children with infectious diseases	18C	Specialist services for children with infectious diseases

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
131	Specialist services for complex liver, biliary and pancreatic diseases in adults	19L	Specialist services for complex liver diseases in adults
		19P	Specialist services for complex pancreatic diseases in adults
		19Z	Specialist services for complex liver, biliary and pancreatic diseases in adults
		19B	Specialist services for complex biliary diseases in adults
132	Specialist services for haemophilia and other related bleeding disorders (adults and children)	03X	Specialist services for haemophilia and other related bleeding disorders (Adults)
		03Y	Specialist services for haemophilia and other related bleeding disorders (Children)
134	Specialist services to support patients with complex physical disabilities (excluding wheelchair services) (adults and children)	05C	Specialist augmentative and alternative communication aids (adults and children)
		05E	Specialist environmental controls (adults and children)
		05P	Prosthetics (adults and children)
135	Specialist paediatric surgery services	23X	Specialist paediatric surgery services - general surgery
136	Specialist paediatric urology services	23Z	Specialist paediatric urology services
139A	Specialist morbid obesity services for children	35Z	Specialist morbid obesity services for children
139AA	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital	04P	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital
ACC	Adult Critical Care	ACC	Adult critical care

SCHEDULE 3: Delegated Functions

1 Introduction

1.1 Subject to the reservations set out in Schedule 4 (*Reserved Functions*) and the provisions of any Developmental Arrangements, NHS England delegates to the ICB the statutory function for commissioning the Delegated Services. This Schedule 3 sets out the key powers and duties that the ICB will be required to carry out in exercise of the Delegated Functions being, in summary:

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

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

1.1.3 undertaking reviews of Delegated Services in respect of the Population;

1.1.4 supporting the management of the Specialised Commissioning Budget;

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

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

1.2 When exercising the Delegated Functions, ICBs are not acting on behalf of NHS England but acquire rights and incur any liabilities in exercising the functions.

2 General Obligations

2.1 The ICB is responsible for planning the commissioning of the Delegated Services in accordance with this Agreement. This includes ensuring at all times that the Delegated Services are commissioned in accordance with the National Standards.

2.2 The ICB shall put in place arrangements for collaborative working with other ICBs in accordance with Clause 8 (*Requirement for ICB Collaboration Arrangement*).

2.3 The Developmental Arrangements set out in Schedule 9 shall apply.

Specific Obligations

3 Assurance and Oversight

3.1 The ICB must at all times operate in accordance with:

3.1.1 the Oversight Framework published by NHS England;

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

3.1.3 any other relevant NHS oversight and assurance guidance;

collectively known as the “Assurance Processes”.

3.2 The ICB must:

3.2.1 develop and operate in accordance with mutually agreed ways of working in line with the Assurance Processes;

3.2.2 oversee the provision of Delegated Services and the outcomes being delivered for its Population in accordance with the Assurance Processes;

3.2.3 assure that Specialised Service Providers are meeting, or have an improvement plan in place to meet, National Standards;

3.2.4 provide any information and comply with specific actions in relation to the Delegated Services, as required by NHS England, including metrics and detailed reporting.

4 Attendance at governance meetings

4.1 The ICB must ensure that there is appropriate representation at forums established through the ICB Collaboration Arrangement.

4.2 The ICB must ensure that an individual(s) has been nominated to represent the ICB at the Delegated Commissioning Group (DCG) and regularly attends that group. This could be a single representative on behalf of the members of an ICB Collaboration Arrangement. Where that representative is not an employee of the ICB, the ICB must have in place appropriate arrangements to enable the representative to feedback to the ICB.

4.3 The ICB should also ensure that they have a nominated representative with appropriate subject matter expertise to attend National Standards development forums as requested by NHS England. This could be a single representative on behalf of the members of an ICB Collaboration Arrangement. Where that representative is not an employee of the ICB, the ICB must have in place appropriate arrangements to enable the representative to feedback to the ICB.

5 Clinical Leadership and Clinical Reference Groups

5.1 The ICB shall support the development of clinical leadership and expertise at a local level in respect of Specialised Services.

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

6 Clinical Networks

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

6.2 The ICB will be involved in the development and agreement of a single annual plan for the Relevant Clinical Network.

6.3 The ICB shall monitor the implementation of the annual plan and receive an annual report from the Relevant Clinical Network that considers delivery against the annual plan.

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

6.5 The ICB shall support NHS England in the management of Relevant Clinical Networks.

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

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

6.8 The ICB shall ensure that network reports are considered where relevant as part of exercising the Delegated Functions.

7 Complaints

7.1 This part (*Complaints*) applies from the Effective Date of Delegation or the date on which the Commissioning Team is transferred to the relevant Host ICB (whichever is the later) ("the Applicable Date").

7.2 The ICB will be responsible for all complaints in respect of the Delegated Services that are received from the Applicable Date, regardless of whether the circumstances to which the complaint relates occurred prior to the Applicable Date.

7.3 For the avoidance of doubt, NHS England will retain responsibility for all complaints in respect of the Delegated Services that were received prior to the Applicable Date.

7.4 At all times the ICB shall operate in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and shall co-operate with other ICBs to ensure that complaints are managed effectively.

7.5 Where NHS England has provided the ICB with a protocol for sharing complaints in respect of any or all Specialised Services then those provisions shall apply and are deemed to be part of this Agreement (the "Complaints Sharing Protocol").

7.6 The ICB shall:

7.6.1 work with local organisations, including other ICBs that are party to the ICB Collaboration Arrangement or Commissioning Team, to ensure that arrangements are in place for the management of complaints in respect of the Delegated Services.

7.6.2 consider, in the context of the ICB Collaboration Arrangement for the commissioning of the Delegated Services and employment arrangements for the Commissioning Team, whether it is best placed to manage the complaint, or whether it should be transferred to another ICB that is better placed to affect change.

7.6.3 provide the relevant individuals at NHS England with appropriate access to complaints data held by the ICB that is necessary to carry out the complaints function as set out in the Complaints Sharing Protocol.

7.6.4 Provide such information relating to key performance indicators ("KPIs") as is requested by NHS England.

7.6.5 co-operate with NHS England in respect of the review of complaints related to the Delegated Services and shall, on request, share any learning identified in carrying out the complaints function.

7.6.6 take part in any peer review process put in place in respect of the complaints function.

8 Commissioning and optimisation of High Cost Drugs

8.1 The ICB must support the effective and efficient commissioning of High Cost Drugs for Delegated Services.

8.2 The ICB must support NHS England in its responsibility for the financial management and reimbursement of High Cost Drugs for Specialised Services. The ICB and NHS England must agree the support to be provided. The support must be set out in writing and may include staffing, processes, reporting, prescribing analysis and oversight arrangements, but is not limited to these matters.

8.3 The ICB must ensure equitable access to High Cost Drugs used within the Delegated Services that may be impacted by health inequalities and develop a strategy for delivering equitable access.

8.4 The ICB must develop and implement Shared Care Arrangements across the Area of the ICB.

8.5 The ICB must provide clinical and commissioning leadership in the commissioning and management of High Cost Drugs.

8.6 The ICB must ensure:

8.6.1 safe and effective use of High Cost Drugs in line with national Clinical Commissioning Policies, NICE technology appraisal or highly specialised technologies guidance;

8.6.2 effective introduction of new medicines;

8.6.3 compliance with all NHS England commercial processes and frameworks for High Cost Drugs;

8.6.4 Specialised Services Providers adhere to all NHS England commercial processes and frameworks for High Cost Drugs;

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

8.6.6 consistency of prescribing and unwarranted prescribing variation are addressed.

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

8.8 Where the relevant pharmacy teams have transferred to the ICB or Host ICB, the ICB must provide:

8.8.1 support to prescribing networks and forums, including but not limited to, Immunoglobulin Assessment panels, prescribing networks and medicines optimisation networks;

8.8.2 expert medicines advice and input into the Individual Funding Request process for Delegated Services;

8.8.3 advice and input to national procurement and other commercial processes relating to medicines and High Cost Drugs (for example, arrangements for Homecare);

8.8.4 advice and input to NHS England policy development relating to medicines and High Cost Drugs.

9 Contracting

9.1 The ICB shall be responsible for ensuring appropriate arrangements are in place for the commissioning of the Delegated Services which for the avoidance of doubt includes:

9.1.1 co-ordinating or collaborating in the award of appropriate Specialised Service Contracts;

9.1.2 drafting of the contract schedules so that it reflects Mandatory Guidance, National Specifications and any specific instructions from NHS England; and

9.1.3 management of Specialised Services Contracts.

9.2 The ICB must comply with the Contracting Standard Operating Procedure issued by NHS England.

9.3 In relation to the contracting for NHS England Retained Services where the ICB has agreed to act as the co-ordinating commissioner, to implement NHS England's instructions in relation to those Retained Services and, where appropriate, put in place a Collaborative Commissioning Agreement with NHS England as a party.

10 Data Management and Analytics

10.1 The ICB shall:

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

10.1.2 lead on the provision of data and analytical services to support commissioning of Delegated Services;

10.1.3 ensure collaborative working across partners on agreed programmes of work focusing on provision of pathway analytics;

10.1.4 share expertise and existing reporting tools with partner ICBs in the ICB Collaboration Arrangement;

10.1.5 ensure interpretation of data is made available to NHS England and other ICBs within the ICB Collaboration Arrangement;

10.1.6 ensure data and analytics teams within ICBs and NHS England work collaboratively on jointly agreed programmes of work focusing on provision of pathway analytics;

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

11 Finance

11.1 The provisions of Clause 10 (*Finance*) of this Agreement set out the financial requirements in respect of the Delegated Functions.

12 Freedom of Information and Parliamentary Requests

12.1 The ICB shall lead on the handling, management and response to all Freedom of Information and parliamentary correspondence relating to Delegated Services.

13 Incident Response and Management

13.1 The ICB shall:

13.1.1 lead on local incident management for Delegated Services as appropriate to the stated incident level;

13.1.2 support national and regional incident management relating to Specialised Services; and

13.1.3 ensure surge events and actions relating to Specialised Services are included in ICB escalation plans.

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

14 Individual Funding Requests

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

15 Innovation and New Treatments

15.1 The ICB shall support local implementation of innovative treatments for Delegated Services.

16 Mental Health, Learning Disability and Autism Specialised Services

16.1 The ICB will oversee the lead provider contract(s) relating to mental health, learning disability and autism (MHLDA) Provider Collaboratives that are transferred to the ICB on 1 April 2025 by NHS England. This includes complying with all terms and conditions of the contract(s), including in respect of notice periods and extensions.

16.2 If the ICB proposes to terminate a MHLDA lead provider contract before the end of its term, it must seek written approval from NHS England in advance.

16.3 In the performance of its commissioning responsibilities for MHLDA Specialised Services, the ICB shall:

16.3.1 Have regard to any commissioning guidance relating to MHLDA Specialised Services issued by NHS England;

16.3.2 Comply with the requirements of the Mental Health Investment Standard and related guidance issued by NHS England;

16.3.3 Generally have regard to the need to commission MHLDA Specialised Services for the ICB's Population in such a manner as to ensure safe, efficient and effective services, across appropriate geographies, and which may require partnership working across other ICB or other organisational boundaries.

16.3.4 Ensure that its case management function will work collaboratively across Delegated Services and Retained Services to support the oversight and progression of individual patient care, including the movement across elements of the care pathway.

17 Provider Selection and Procurement

17.1 The ICB shall:

17.1.1 run appropriate local provider selection and procurement processes for Delegated Services;

17.1.2 align all procurement processes with any changes to national procurement policy (for example new legislation) for Delegated Services;

17.1.3 support NHS England with national procurements where required with subject matter expertise on provider engagement and provider landscape; and

17.1.4 monitor and provide advice, guidance and expertise to NHS England on the overall provider market and provider landscape.

17.2 In discharging these responsibilities, the ICB must comply at all times with Law and any relevant Guidance including but not limited to Mandated Guidance; any applicable procurement law and Guidance on the selection of, and award of contracts to, providers of healthcare services.

17.3 When the ICB makes decisions in connection with the awarding of Specialised Services Contracts, it should ensure that it can demonstrate compliance with requirements for the award of such Contracts, including that the decision was:

17.3.1 made in the best interest of patients, taxpayers and the Population;

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

17.3.3 made transparently; and

17.3.4 compliant with relevant Guidance and legislation.

18 Quality

18.1 The ICB must ensure that appropriate arrangements for quality oversight are in place. This must include:

18.1.1 clearly defined roles and responsibilities for ensuring governance and oversight of Delegated Services;

18.1.2 defined roles and responsibilities for ensuring robust communication and appropriate feedback, particularly where Delegated Services are commissioned through an arrangement with one or more other ICBs;

18.1.3 working with providers and partner organisations to address any issues relating to Delegated Services and escalate appropriately if such issues cannot be resolved;

18.1.4 developing and standardising processes that align with regional systems to ensure oversight of the quality of Delegated Services, and participating in local System Quality Groups and Regional Quality Groups, or their equivalent;

18.1.5 ensuring processes are robust and concerns are identified, mitigated and escalated as necessary;

18.1.6 ensuring providers are held to account for delivery of safe, patient-focused and quality care for Delegated Services, including mechanisms for monitoring patient complaints, concerns and feedback; and

18.1.7 the implementation of the Patient Safety Incident Response Framework for the management of incidents and serious events, appropriate reporting of any incidents, undertaking any appropriate patient safety incident investigation and obtaining support as required.

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

18.3 The ICB must ensure that the oversight of the quality of the Delegated Services is integrated with wider quality governance in the local system and aligns with the NHS England National Quality Board's recommended quality escalation processes.

18.4 The ICB must ensure that there is a System Quality Group (or equivalent) to identify and manage concerns across the local system.

18.5 The ICB must ensure that there is appropriate representation at any Regional Quality Groups or their equivalent.

18.6 The ICB must have in place all appropriate arrangements in respect of child and adult safeguarding and comply with all relevant Guidance.

19 Service Planning and Strategic Priorities

19.1 The ICB is responsible for setting local commissioning strategy, policy and priorities and planning for and carrying out needs assessments for the Delegated Services.

19.2 In planning, commissioning and managing the Delegated Services, the ICB must have processes in place to assess and monitor equitable patient access, in accordance with

the access criteria set out in Clinical Commissioning Policies and National Specifications, taking action to address any apparent anomalies.

19.3 The ICB must ensure that it works with Specialised Service Providers and Provider Collaboratives to translate local strategic priorities into operational outputs for Delegated Services.

19.4 The ICB shall provide input into any consideration by NHS England as to whether the commissioning responsibility in respect of any of the Retained Services should be delegated.

20 National Standards, National Specifications and Clinical Commissioning Policies

20.1 The ICB shall provide input into national decisions on National Standards and national transformation regarding Delegated Services through attendance at governance meetings.

20.2 The ICB shall facilitate engagement with local communities on National Specification development.

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

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

20.5 The ICB must have appropriate mechanisms in place to ensure National Standards and National Specifications are being adhered to.

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

21 Transformation

21.1 The ICB shall:

21.1.1 prioritise pathways and services for transformation according to the needs of its Population and opportunities for improvement in ICB commissioned services and for Delegated Services;

21.1.2 lead ICB and ICB Collaboration Arrangement driven transformation programmes across pathways for Delegated Services;

21.1.3 lead the delivery locally of transformation in areas of national priority (such as Cancer, Mental Health and Learning Disability and Autism), including supporting delivery of commitments in the NHS Long Term Plan;

21.1.4 support NHS England with agreed transformational programmes for Retained Services;

21.1.5 support NHS England with agreed transformational programmes and identify future transformation programmes for consideration and prioritisation for Delegated Services where national co-ordination and enablement may support transformation;

21.1.6 work collaboratively with NHS England on the co-production and co-design of transformation and improvement interventions and solutions in those areas prioritised; and

21.1.7 ensure Relevant Clinical Networks and other clinical networks use levers to facilitate and embed transformation at a local level for Delegated Services.

SCHEDULE 4: Reserved Functions

Introduction

1. Reserved Functions in Relation to the Delegated Services

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

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

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

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

2. Retained Services

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

3. Reserved Specialised Service Functions

3.1. NHS England shall carry out the functions set out in this Schedule 4 in respect of the Delegated Services.

Reserved Functions

4. Assurance and Oversight

4.1. NHS England shall:

4.1.1. have oversight of what ICBs are delivering (inclusive of Delegated Services) for their Populations and all patients;

4.1.2. design and implement appropriate assurance of ICBs' exercise of Delegated Functions including the Assurance Processes;

4.1.3. help the ICB to coordinate and escalate improvement and resolution interventions where challenges are identified (as appropriate);

4.1.4. ensure that the NHS England Board is assured that Delegated Functions are being discharged appropriately;

4.1.5. ensure specialised commissioning considerations are appropriately included in NHS England frameworks that guide oversight and assurance of service delivery; and

4.1.6. host a Delegated Commissioning Group ("DCG") that will undertake an assurance role in line with the Assurance Processes. This assurance role shall include assessing and monitoring the overall coherence, stability and sustainability of the commissioning model of Specialised Services at a

national level, including identification, review and management of appropriate cross-ICB risks.

4.2. Where an officer or employee of NHS England is performing its Reserved Functions in respect of assurance and oversight, NHS England must ensure that those officers or employees do not hold responsibility for, or undertake any, decision making in respect of the ICB's Delegated Functions.

5. Attendance at governance meetings

5.1. NHS England shall ensure that there is appropriate representation in respect of Reserved Functions and Retained Services at local governance forums (for example, the Regional Leadership Team) and at the National Commissioning Group ("NCG").

5.2. NHS England shall:

5.2.1. ensure that there is appropriate representation by NHS England subject matter expert(s) at National Standards development forums;

5.2.2. ensure there is appropriate attendance by NHS England representatives at nationally led clinical governance meetings; and

5.2.3. co-ordinate, and support key national governance groups.

6. Clinical Leadership and Clinical Reference Groups

6.1. NHS England shall be responsible for the following:

6.1.1. developing local leadership and support for the ICB relating to Specialised Services;

6.1.2. providing clinical leadership, advice and guidance to the ICB in relation to the Delegated Services;

6.1.3. providing point-of-contact and ongoing engagement with key external bodies, such as interest groups, charities, NICE, DHSC, and Royal Colleges; and enabling access to clinical trials for new treatments and medicines.

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

6.2.1. Clinical Commissioning Policies;

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

7. Clinical Networks

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

7.2. NHS England shall ensure development of multi-ICB, and multi-region (where necessary) governance and oversight arrangements for Relevant Clinical Networks that give line of sight between all clinical networks and all ICBs whose Population they serve.

7.3. NHS England shall be responsible for:

7.3.1. developing national policy for the Relevant Clinical Networks;

7.3.2. developing and approving the specifications for the Relevant Clinical Networks;

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

7.3.4. convening or supporting national networks of the Relevant Clinical Networks;

7.3.5. agreeing the annual plan for each Relevant Clinical Network with the involvement of the ICB and Relevant Clinical Network, ensuring these reflect national and regional priorities;

7.3.6. managing Relevant Clinical Networks jointly with the ICB; and

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

8. Complaints

8.1. NHS England shall manage all complaints in respect of the Delegated Services that are received prior to the Effective Date of Delegation or the date on which the Commissioning Team is transferred to the Host ICB (whichever is the later).

8.2. NHS England shall provide the relevant individuals at the ICB with appropriate access to complaints data held by NHS England that is necessary to carry out the complaints function as set out in the Complaints Sharing Protocol.

8.3. NHS England shall manage all complaints in respect of the Retained Services.

8.4. NHS England shall set out what information the ICB is required to provide when reporting on the key performance indicators. NHS England should notify the ICB in advance and provide sufficient time to allow compliance.

9. Commissioning and optimisation of High Cost Drugs

9.1. Unless otherwise agreed with the ICB, NHS England shall manage a central process for reimbursement of High Costs Drugs for Specialised Services. This may include making reimbursements directly to Specialised Services Providers.

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

9.2.1. where appropriate, ensure that only validated drugs spend is reimbursed, there is timely drugs data and drugs data quality meets the standards set nationally;

9.2.2. support the ICB on strategy for access to medicines used within Delegated Services, minimising barriers to health inequalities;

9.2.3. provide support, as reasonably required, to the ICB to assist it in the commissioning of High Cost Drugs for Delegated Services including shared care agreements;

9.2.4. seek to address consistency of prescribing in line with national commissioning policies, introduction of new medicines, and addressing unwarranted prescribing variation;

9.2.5. develop medicines commissioning policies and criteria for access to medicines within Specialised Services;

9.2.6. develop support tools, including prior approval criteria, and frameworks to support the delivery of cost-effective and high quality commissioning of High Cost Drugs;

9.2.7. co-ordinate the development, implementation and monitoring of initiatives that enable the use of better value medicines;

9.2.8. where appropriate, co-ordinate national procurement or other commercial processes to secure medicines or High Cost Drugs for Specialised Services.

10. Contracting

10.1. NHS England shall retain the following obligations in relation to contracting for Delegated Services:

10.1.1. ensure Specialised Services are included in national NHS England contracting and payment strategy (for example, Aligned Payment Incentives);

10.1.2. provide advice for ICBs on schedules to support the Delegated Services;

10.1.3. set, publish or make otherwise available the Contracting Standard Operating Procedure and Mandated Guidance detailing contracting strategy and policy for Specialised Services; and

10.1.4. provide and distribute contracting support tools and templates to the ICB.

10.2. In respect of the Retained Services, NHS England shall:

10.2.1. where appropriate, ensure a Collaborative Commissioning Agreement is in place between NHS England and the ICB(s); and

10.2.2. where appropriate, construct model template schedules for Retained Services and issue to ICBs.

11. Data Management and Analytics

11.1. NHS England shall:

11.1.1. support the ICB by collaborating with the wider data and analytics network (nationally) to support development and local deployment or utilisation of support tools;

11.1.2. support the ICB to address data quality and coverage needs, accuracy of reporting Specialised Services activity and spend on a Population basis to support commissioning of Specialised Services;

11.1.3. ensure inclusion of Specialised Services data strategy in broader NHS England, DHSC and government data strategies;

11.1.4. lead on defining relevant contractual content of the information schedule (Schedule 6) of the NHS Standard Contract for Clinical Services;

11.1.5. work collaboratively with the ICB to drive continual improvement of the quality and coverage of data used to support commissioning of Specialised Services;

11.1.6. provide a national analytical service to support oversight and assurance of Specialised Services, and support (where required) the national Specialised

Commissioning team, Programmes of Care and Clinical Reference Groups; and

11.1.7. provide access to data and analytic subject matter expertise to support the ICB when considering local service planning, needs assessment and transformation.

12. Finance

12.1. The provisions of Clause 10 shall apply in respect of the financial arrangements in respect of the Delegated Functions.

12.2. NHS England shall:

12.2.1. hold the budgets for prescribed specialised services top-up payments for specialist centres;

12.2.2. administer the top-up payments schemes; and

12.2.3. make top-up payments to the Specialised Services Providers.

12.3. For the avoidance of doubt, the functions set out in 12.2 include top-up payments for the Delegated Services and Retained Services.

13. Freedom of Information and Parliamentary Requests

13.1. NHS England shall:

13.1.1. lead on handling, managing and responding to all national FOIA and parliamentary correspondence relating to Retained Services; and

13.1.2. co-ordinate a response when a single national response is required in respect of Delegated Services.

14. Incident Response and Management

14.1. NHS England shall:

14.1.1. provide guidance and support to the ICB in the event of a complex incident;

14.1.2. lead on national incident management for Specialised Services as appropriate to stated incident level and where nationally commissioned services are impacted;

14.1.3. lead on monitoring, planning and support for service and operational resilience at a national level and provide support to the ICB; and

14.1.4. respond to specific service interruptions where appropriate; for example, supplier and workforce challenges and provide support to the ICB in any response to interruptions.

15. Individual Funding Requests

15.1. NHS England shall be responsible for:

15.1.1. leading on Individual Funding Requests (IFR) policy, IFR governance and managing the IFR process for Delegated Services and Retained Services;

15.1.2. taking decisions in respect of IFRs at IFR Panels for both Delegated Services and Retained Services; and

15.1.3. providing expertise for IFR decisions, including but not limited to pharmacy, public health, nursing and medical and quality.

16. Innovation and New Treatments

16.1. NHS England shall support the local implementation of innovative treatments for Delegated Services.

16.2. NHS England shall ensure services are in place for innovative treatments such as advanced medicinal therapy products recommended by NICE technology appraisals within statutory requirements.

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

17. Mental Health, Learning Disability and Autism Specialised Services

17.1. NHS England shall issue commissioning guidance for MHLDA Specialised Services in relation to the Delegated Services and Retained Services.

17.2. NHS England shall prepare and issue National Specifications and Clinical Commissioning Policies for MHLDA Specialised Services.

17.3. NHS England will monitor the ICB's compliance with the Mental Health Investment Standard in respect of MHLDA Delegated Services.

17.4. NHS England shall ensure that its case management function will work collaboratively across Delegated Services and Retained Services to support the oversight and progression of individual patient care, including the movement across elements of the care pathway.

18. Provider Selection and Procurement

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

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

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

18.1.3. where appropriate, running provider selection and procurement processes for Specialised Services.

19. Quality

19.1. In respect of quality, NHS England shall:

19.1.1. work with the ICB to ensure oversight of Specialised Services through quality surveillance and risk management and escalate as required;

19.1.2. work with the ICB to seek to ensure that quality and safety issues and risks are managed effectively and escalated to the National Specialised Commissioning Quality and Governance Group (QGG), or other appropriate forums, as necessary;

19.1.3. work with the ICB to seek to ensure that the quality governance and processes for Delegated Services are aligned and integrated with broader clinical quality governance and processes in accordance with National Quality Board Guidance;

19.1.4. facilitate improvement when quality issues impact nationally and regionally, through programme support, and mobilising intensive support when required on specific quality issues;

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

19.1.6. support the ICB to identify key themes and trends and utilise data and intelligence to respond and monitor as necessary;

19.1.7. report on quality to both NCG and DCG as well as QGG and Executive Quality Group as required;

19.1.8. facilitate and support the national quality governance infrastructure (for example, the QGG); and

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

20. National Standards, National Specifications and Clinical Commissioning Policies

20.1. NHS England shall carry out:

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

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

20.1.3. maintenance and publication of the Prescribed Specialised Services Manual and engagement with the DHSC on policy matters; and

20.1.4. determination of content for national clinical registries.

21. Transformation

21.1. NHS England shall be responsible for:

21.1.1. co-ordinating and enabling ICB-led specialised service transformation programmes for Delegated Services where necessary;

21.1.2. supporting the ICB to implement national policy and guidance across its Populations for Retained Services;

21.1.3. supporting the ICB with agreed transformational programmes where national transformation support has been agreed for Delegated Services;

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

21.1.5. co-production and co-design of transformation programmes with the ICB and wider stakeholders; and

21.1.6. providing access to subject matter expertise including Clinical Reference Groups, national clinical directors, Programme of Care leads for the ICB where it needs support, including in relation to local priority transformation.

SCHEDULE 5: Retained Services

NHS England shall retain the function of commissioning the Specialised Services that are not Delegated Services and as more particularly set out by NHS England and made available from time to time.

18.9 6 (*Further Information Governance, Sharing and Processing Provisions*) makes further provision about information sharing, information governance and the Data Sharing Agreement.

19. IT INTER-OPERABILITY

19.1 The Parties will work together to ensure that all relevant IT systems they operate in respect of the Delegated Functions and Reserved Functions are inter-operable and that data may be transferred between systems securely, easily and efficiently.

19.2 The Parties will use their respective reasonable endeavours to help develop initiatives to further this aim.

20. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY

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

20.2 Without prejudice to the general obligations set out in Clause 20.1, the ICB must maintain a register of interests in respect of all persons making decisions concerning the Delegated Functions. This register must be publicly available. For the purposes of this clause, the ICB may rely on an existing register of interests rather than creating a further register.

21. PROHIBITED ACTS AND COUNTER-FRAUD

21.1 The ICB must not commit any Prohibited Act.

21.2 If the ICB or its Staff commits any Prohibited Act in relation to this Agreement with or without the knowledge of NHS England, NHS England will be entitled:

21.2.1 to revoke the Delegation;

21.2.2 to recover from the ICB the amount or value of any gift, consideration or commission concerned; and

21.2.3 to recover from the ICB any loss or expense sustained in consequence of the carrying out of the Prohibited Act.

21.3 The ICB must put in place and maintain appropriate arrangements, including without limitation, Staff training, to address counter-fraud issues, having regard to any relevant Guidance, including from the NHS Counter Fraud Authority.

21.4 If requested by NHS England or the NHS Counter Fraud Authority, the ICB must allow a person duly authorised to act on behalf of the NHS Counter Fraud Authority or on behalf of NHS England to review, in line with the appropriate standards, any counter-fraud arrangements put in place by the ICB.

21.5 The ICB must implement any reasonable modifications to its counter-fraud arrangements required by a person referred to in Clause 21.4 in order to meet the appropriate standards within whatever time periods as that person may reasonably require.

21.6 The ICB must, on becoming aware of:

21.6.1 any suspected or actual bribery, corruption or fraud involving public funds; or

21.6.2 any suspected or actual security incident or security breach involving Staff or involving NHS resources;

promptly report the matter to NHS England and to the NHS Counter Fraud Authority.

21.7 On the request of NHS England or NHS Counter Fraud Authority, the ICB must allow the NHS Counter Fraud Authority or any person appointed by NHS England, as soon as it is reasonably practicable and in any event not later than five (5) Operational Days following the date of the request, access to:

21.7.1 all property, premises, information (including records and data) owned or controlled by the ICB; and

21.7.2 all Staff who may have information to provide.

relevant to the detection and investigation of cases of bribery, fraud or corruption, or security incidents or security breaches directly or indirectly in connection with this Agreement.

22. CONFIDENTIAL INFORMATION OF THE PARTIES

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

22.2 Subject to Clauses 22.3 to 22.5, the receiving Party agrees:

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

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

22.2.3 to maintain the confidentiality of the disclosing Party's Confidential Information.

22.3 The receiving Party may disclose the disclosing Party's Confidential Information:

22.3.1 in connection with any dispute resolution procedure under Clause 25;

22.3.2 in connection with any litigation between the Parties;

22.3.3 to comply with the Law;

22.3.4 to any appropriate Regulatory or Supervisory Body;

22.3.5 to its Staff, who in respect of that Confidential Information will be under a duty no less onerous than the receiving Party's duty under Clause 22.2;

22.3.6 to NHS bodies for the purposes of carrying out their functions;

22.3.7 as permitted under or as may be required to give effect to Clause 21 (*Prohibited Acts and Counter-Fraud*); and

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

22.4 The obligations in Clauses 22.1 and 22.2 will not apply to any Confidential Information which:

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

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

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

22.5 This Clause 22 does not prevent NHS England making use of or disclosing any Confidential Information disclosed by the ICB where necessary for the purposes of exercising its functions in relation to the ICB.

22.6 The Parties acknowledge that damages would not be an adequate remedy for any breach of this Clause 22 by the receiving Party, and in addition to any right to damages the disclosing Party will be entitled to the remedies of injunction, specific performance and other equitable relief for any threatened or actual breach of this Clause 22.

22.7 This Clause 222 will survive the termination of this Agreement for any reason for a period of five (5) years.

22.8 This Clause 22 will not limit the application of the Public Interest Disclosure Act 1998 in any way whatsoever.

23. INTELLECTUAL PROPERTY

23.1 The ICB grants to NHS England a fully paid-up, non-exclusive, perpetual licence to use the ICB Deliverables for the purposes of the exercise of its statutory and contractual functions.

23.2 NHS England grants the ICB a fully paid-up, non-exclusive licence to use the NHS England Deliverables for the purpose of performing this Agreement and the Delegated Functions.

23.3 The ICB must co-operate with NHS England to enable it to understand and adopt Best Practice (including the dissemination of Best Practice to other commissioners or providers of NHS services), and must supply such materials and information in relation to Best Practice as NHS England may reasonably request, and (to the extent that any Intellectual Property Rights ("IPR") attaches to Best Practice) grants NHS England a fully paid-up, non-exclusive, perpetual licence for NHS England to use Best Practice IPR for the commissioning and provision of NHS services and to share any Best Practice IPR with other commissioners of NHS services (and other providers of NHS services) to enable those parties to adopt such Best Practice.

24. NOTICES

24.1 Any notices given under this Agreement must be sent by e-mail to the other Party's address set out in the Particulars or as otherwise notified by one Party to another as the appropriate address for this Clause 24.1.

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

25. DISPUTES

25.1 This clause does not affect NHS England's right to exercise its functions for the purposes of assessing and addressing the performance of the ICB.

25.2 If a Dispute arises out of, or in connection with, this Agreement then the Parties must follow the procedure set out in this clause:

25.2.1 either Party must give to the other written notice of the Dispute, setting out its nature and full particulars ("Dispute Notice"), together with relevant supporting documents. On service of the Dispute Notice, the Agreement Representatives must attempt in good faith to resolve the Dispute;

25.2.2 if the Agreement Representatives are, for any reason, unable to resolve the Dispute within twenty (20) Operational Days of service of the Dispute Notice, the Dispute must be referred to the Chief Executive Officer (or equivalent person) of the ICB and a director of or other person nominated by NHS England (and who has authority from NHS England to settle the Dispute) who must attempt in good faith to resolve it; and

25.2.3 if the people referred to in Clause 25.2.2 are for any reason unable to resolve the Dispute within twenty (20) Operational Days of it being referred to them, the Parties may attempt to settle it by mediation in accordance with the CEDR model mediation procedure. Unless otherwise agreed between the Parties, the mediator must be nominated by CEDR. To initiate the mediation, a Party must serve notice in writing ('Alternative Dispute Resolution' ("ADR) notice") to the other Party to the Dispute, requesting a mediation. A copy of the ADR notice should be sent to CEDR. The mediation will start no later than ten (10) Operational Days after the date of the ADR notice.

25.3 If the Dispute is not resolved within thirty (30) Operational Days after service of the ADR notice, or either Party fails to participate or to continue to participate in the mediation before the expiration of the period of thirty (30) Operational Dys, or the mediation terminates before the expiration of the period of thirty (30) Operational Days, the Dispute must be referred to the NHS England Board, who shall resolve the matter and whose decision shall be binding upon the Parties.

26. VARIATIONS

26.1 The Parties acknowledge that the scope of the Delegated Functions may be reviewed and amended from time to time including by revoking this Agreement and making alternative arrangements.

26.2 NHS England may vary this Agreement without the ICB's consent where:

26.2.1 it is reasonably satisfied that the variation is necessary in order to comply with legislation, NHS England's statutory duties, or any requirements or direction given by the Secretary of State;

26.2.2 where variation is as a result of amendment to or additional Mandated Guidance;

26.2.3 it is satisfied that any Developmental Arrangements are no longer required;

26.2.4 it reasonably considers that Developmental Arrangements are required under Clause 14 (*Breach*); or

26.2.5 it is satisfied that such amendment or Developmental Arrangement is required in order to ensure the effective commissioning of the Delegated Services or other Specialised Services.

26.3 Where NHS England wishes to vary the Agreement in accordance with Clause 26.2 it must notice in writing to the ICB of the wording of the proposed variation and the date on which that variation is to take effect which must, unless it is not reasonably

practicable, be a date which falls at least thirty (30) Operational Days after the date on which the notice under that clause is given to the ICB.

26.4 For the avoidance of doubt, NHS England may issue or update Mandated Guidance at any point during the term of the Agreement.

26.5 Either Party ("the Proposing Party") may notify the other Party (the "Receiving Party") of a Variation Proposal in respect of this Agreement including, but not limited to the following:

26.5.1 a request by the ICB to add, vary or remove any Developmental Arrangement; or

26.5.2 a request by NHS England to include additional Specialised Services or NHS England Functions within the Delegation; and

the Proposing Party will identify whether the proposed variation may have the impact of changing the scope of the Delegated Functions or Reserved Functions so that NHS England can establish the requisite level of approval required.

26.6 The Variation Proposal will set out the variation proposed and the date on which the Proposing Party requests the variation to take effect.

26.7 When a Variation Proposal is issued in accordance with 26.6, the Receiving Party must respond within thirty (30) Operational Days following the date that it is issued by serving notice confirming either:

26.7.1 that it accepts the Variation Proposal; or

26.7.2 that it refuses to accept the Variation Proposal and setting out reasonable grounds for that refusal.

26.8 If the Receiving Party accepts the Variation Proposal issued in accordance with Clause 26.5, the Receiving Party agrees to take all necessary steps (including executing a variation agreement) in order to give effect to any variation by the date on which the proposed variation will take effect as set out in the Variation Proposal.

26.9 If the Receiving Party refuses to accept a Variation Proposal submitted in accordance with 26.5 to 26.7, or to take such steps as are required to give effect to the variation, then the provisions of Clause 15 (*Escalation Rights*) shall apply.

26.10 When varying the Agreement in accordance with Clause 26, the Parties must consider the impact of the proposed variation on any ICB Collaboration Arrangements and any Further Arrangements.

27. TERMINATION

27.1 The ICB may:

27.1.1 notify NHS England that it requires NHS England to revoke the Delegation; and

27.1.2 terminate this Agreement;

with effect from the end of 31 March in any calendar year, provided that:

27.1.3 on or before 30 September of the previous calendar year, the ICB sends written notice to NHS England of its requirement that NHS England revoke the Delegation and its intention to terminate this Agreement; and

27.1.4 the ICB meets with NHS England within ten (10) Operational Days of NHS England receiving the notice set out at Clause 27.1.3 above to discuss arrangements for termination and transition of the Delegated Functions to a successor commissioner in accordance with Clause 28.2; and

27.1.5 the ICB confirms satisfactory arrangements for terminating any ICB Collaboration Arrangements or Further Agreements in whole or part as required including agreed succession arrangements for Commissioning Teams,

in which case NHS England shall revoke the Delegation and this Agreement shall terminate with effect from the end of 31 March in the next calendar year.

27.2 NHS England may revoke the Delegation in whole or in part with effect from 23.59 hours on 31 March in any year, provided that it gives notice to the ICB of its intention to terminate the Delegation on or before 30 September in the year prior to the year in which the Delegation will terminate, and in which case Clause 27.4 will apply.

27.3 The Delegation may be revoked in whole or in part, and this Agreement may be terminated by NHS England at any time, including in (but not limited to) the following circumstances:

27.3.1 the ICB acts outside of the scope of its delegated authority;

27.3.2 the ICB fails to perform any material obligation of the ICB owed to NHS England under this Agreement;

27.3.3 the ICB persistently commits non-material breaches of this Agreement;

27.3.4 NHS England is satisfied that its intervention powers under section 14Z61 of the NHS Act apply;

27.3.5 to give effect to legislative changes, including conferral of any of the Delegated or Reserved Functions on the ICB;

27.3.6 failure to agree to a variation in accordance with Clause 26 *(Variations)*;

27.3.7 NHS England and the ICB agree in writing that the Delegation shall be revoked and this Agreement shall terminate on such date as is agreed; and/or

27.3.8 the ICB merges with another ICB or other body.

27.4 This Agreement will terminate upon revocation or termination of the full Delegation (including revocation and termination in accordance with this Clause 277 *(Termination)*) except that the provisions referred to in Clause 299 (*Provisions Surviving Termination*) will continue in full force and effect.

27.5 Without prejudice to Clause 14.3 and to avoid doubt, NHS England may waive any right to terminate this Agreement under this Clause 27 *(Termination)*. Any such waiver is only effective if given in writing and shall not be deemed a waiver of any subsequent right or remedy.

27.6 As an alternative to termination of the Agreement in respect of all the Delegated Functions, NHS England may terminate the Agreement in respect of specified Delegated Functions (or aspects of such Delegated Functions) only, in which case this Agreement shall otherwise remain in effect.

28. CONSEQUENCE OF TERMINATION

28.1 Termination of this Agreement, or termination of the ICB's exercise of any of the Delegated Functions, will not affect any rights or liabilities of the Parties that have accrued before the date of that termination or which later accrue in respect of the term of this Agreement. For the avoidance of doubt, the ICB shall be responsible for any Claims or other costs or liabilities incurred in the exercise of the Delegated Functions during the period of this Agreement unless expressly agreed otherwise by NHS England.

28.2 Subject to Clause 28.4, on or pending termination of this Agreement or termination of the ICB's exercise of any of the Delegated Functions, NHS England, the ICB and, if appropriate, any successor delegate will:

28.2.1 agree a plan for the transition of the Delegated Functions from the ICB to the successor delegate, including details of the transition, the Parties' responsibilities in relation to the transition, the Parties' arrangements in respect of the Staff engaged in the Delegated Functions and the date on which the successor delegate will take responsibility for the Delegated Functions;

28.2.2 implement and comply with their respective obligations under the plan for transition agreed in accordance with Clause 28.2.1; and

28.2.3 act with a view to minimising any inconvenience or disruption to the commissioning of healthcare in the Area.

28.3 For a reasonable period before and after termination of this Agreement or termination of the ICB's exercise of any of the Delegated Functions, the ICB must:

28.3.1 co-operate with NHS England and any successor delegate to ensure continuity and a smooth transfer of the Delegated Functions; and

28.3.2 at the reasonable request of NHS England:

28.3.2.1 promptly provide all reasonable assistance and information to the extent necessary for an efficient assumption of the Delegated Functions by a successor delegate;

28.3.2.2 deliver to NHS England all materials and documents used by the ICB in the exercise of any of the Delegated Functions; and

28.3.2.3 use all reasonable efforts to obtain the consent of third parties to the assignment, novation or termination of existing contracts between the ICB and any third party which relate to or are associated with the Delegated Functions.

28.4 Where any or all of the Delegated Functions or Reserved Functions are to be directly conferred on the ICB, the Parties will co-operate with a view to ensuring continuity and a smooth transfer to the ICB.

29. PROVISIONS SURVIVING TERMINATION

29.1 Any rights, duties or obligations of any of the Parties which are expressed to survive, including those referred to in Clause 29.2, or which otherwise by necessary implication survive the termination for any reason of this Agreement, together with all indemnities, will continue after termination, subject to any limitations of time expressed in this Agreement.

29.2 The surviving provisions include the following clauses together with such other provisions as are required to interpret and give effect to them:

29.2.1 Clause 10 (*Finance*);

29.2.2 Clause 13 (*Staffing, Workforce and Commissioning Teams*);

29.2.3 Clause 16 *(Liability and Indemnity*);

29.2.4 Clause 17 (*Claims and Litigation*);

29.2.5 Clause 18 (*Data Protection, Freedom of Information and Transparency*);

29.2.6 Clause 25 (*Disputes*);

29.2.7 Clause 27 (*Termination*);

29.2.8 Schedule 6 (*Further Information Governance, Sharing and Processing Provisions*).

30. COSTS

30.1 Each Party is responsible for paying its own costs and expenses incurred in connection with the negotiation, preparation and execution of this Agreement.

31. SEVERABILITY

31.1 If any provision or part of any provision of this Agreement is declared invalid or otherwise unenforceable, that provision or part of the provision as applicable will be severed from this Agreement. This will not affect the validity and/or enforceability of the remaining part of that provision or of other provisions.

32. GENERAL

32.1 Nothing in this Agreement will create a partnership or joint venture or relationship of principal and agent between NHS England and the ICB.

32.2 A delay or failure to exercise any right or remedy in whole or in part shall not waive that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy.

32.3 This Agreement does not give rise to any rights under the Contracts (Rights of Third Parties) Act 1999 to enforce any term of this Agreement.

SCHEDULE 1: Definitions and Interpretation

1. The headings in this Agreement will not affect its interpretation.

2. Reference to any statute or statutory provision, Law, Guidance, Mandated Guidance or Data Guidance, includes a reference to that statute or statutory provision, Law, Guidance, Mandated Guidance or Data Guidance as from time to time updated, amended, extended, supplemented, re-enacted or replaced in whole or in part.

3. Reference to a statutory provision includes any subordinate legislation made from time to time under that provision.

4. References to clauses and schedules are to the clauses and schedules of this Agreement, unless expressly stated otherwise.

5. References to any body, organisation or office include reference to its applicable successor from time to time.

6. Any references to this Agreement or any other documents or resources includes reference to this Agreement or those other documents or resources as varied, amended, supplemented, extended, restated and/or replaced from time to time and any reference to a website address for a resource includes reference to any replacement website address for that resource.

7. Use of the singular includes the plural and vice versa.

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

9. Use of the term “including” or “includes” will be interpreted as being without limitation.

10. The following words and phrases have the following meanings:

“Administrative and Management Services”	means administrative and management support provided in accordance with Clause 9.5 or 9.7;
“Agreement”	means this agreement between NHS England and the ICB comprising the Particulars, the Terms and Conditions, the Schedules and the Mandated Guidance;
“Agreement Representatives”	means the ICB Representative and the NHS England Representative as set out in the Particulars or such person identified to the other Party from time to time as the relevant representative;
“Annual Allocation”	means the funds allocated to the ICB annually under section 223G of the NHS Act;
“Area”	means the geographical area covered by the ICB;
“Assurance Processes”	has the definition given in paragraph 3.1 of Schedule 3;
“Best Practice”	means any methodologies, pathway designs and processes relating to this Agreement or the Delegated Functions developed by the ICB or its Staff for the purposes of delivering the Delegated Functions and which are capable of wider use in the delivery of healthcare services for the purposes of the NHS, but not including inventions that are capable of patent protection

	and for which patent protection is being sought or has been obtained, registered designs, or copyright in software;
"Capital Investment Guidance"	means any Mandated Guidance issued by NHS England from time to time in relation to the development, assurance and approvals process for proposals in relation to: - the expenditure of Capital, or investment in property, infrastructure or information and technology; and - the revenue consequences for commissioners or third parties making such investment;
"CEDR"	means the Centre for Effective Dispute Resolution;
"Claims"	means, for or in relation to the Delegated Functions (i) 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 (ii) any dispute with, or any investigation, inquiry or enforcement proceedings by, any governmental, regulatory or similar body or agency;
"Claim Losses"	means all Losses arising in relation to any Claim;
"Clinical Commissioning Policies"	means a nationally determined clinical policy setting out the commissioning position on a particular clinical treatment issue and defines accessibility (including a not for routine commissioning position) of a medicine, medical device, diagnostic technique, surgical procedure or intervention for patients with a condition requiring a specialised service;
"Clinical Reference Groups"	means a group consisting of clinicians, commissioners, public health experts, patient and public voice representatives and professional associations, which offers specific knowledge and expertise on the best ways that Specialised Services should be provided;
"Collaborative Commissioning Agreement"	means an agreement under which NHS Commissioners set out collaboration arrangements in respect of commissioning Specialised Services Contracts;
"Commissioning Functions"	means the respective statutory functions of the Parties in arranging for the provision of services as part of the health service;
"Commissioning Team"	means those Specialised Services Staff that support the commissioning of Delegated Services immediately prior to this Agreement and, at the point that Staff transfer from NHS England to an identified ICB, it shall mean those NHS England Staff and such other Staff appointed by that ICB to carry out a role in respect of commissioning the Delegated Services;
"Commissioning Team Arrangements"	means the arrangements through which the services of a Commissioning Team are made available to another NHS body for the purposes of commissioning the Delegated Services;

"Complaints Sharing Protocol"	has the definition given in paragraph 7.5 of Schedule 3;
"Confidential Information"	means any information or data in whatever form disclosed, which by its nature is confidential or which the disclosing Party acting reasonably states in writing to the receiving Party is to be regarded as confidential, or which the disclosing Party acting reasonably has marked 'confidential' (including, financial information, strategy documents, tenders, employee confidential information, development or workforce plans and information, and information relating to services) but which is not information which is disclosed in response to an FOIA request, or information which is published as a result of NHS England or government policy in relation to transparency;
"Contracts"	means any contract or arrangement in respect of the commissioning of any of the Delegated Services;
"Contracting Standard Operating Procedure"	means the Contracting Standard Operating Procedure produced by NHS England in respect of the Delegated Services;
"Contractual Notice"	means a contractual notice issued by NHS England to the ICB, from time to time and relating to allocation of contracts for the purposes of the Delegated Functions;
"CQC"	means the Care Quality Commission;
"Data Controller"	shall have the same meaning as set out in the UK GDPR;
"Data Guidance"	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement regarding information governance, confidentiality, privacy or compliance with Data Protection Legislation to the extent published and publicly available or their existence or contents have been notified to the ICB by NHS England and/or any relevant Regulatory or Supervisory Body. This includes but is not limited to guidance issued by NHS Digital, the National Data Guardian for Health & Care, the Department of Health and Social Care, NHS England, the Health Research Authority, the UK Health Security Agency and the Information Commissioner;
"Data Protection Impact Assessment"	means an assessment to identify and minimise the data protection risks in relation to any data sharing proposals;
"Data Protection Officer"	shall have the same meaning as set out in the Data Protection Legislation;
"Data Processing Agreement"	means a data processing agreement which should be in substantially the same form as a Data Processing Agreement template approved by NHS England;
"Data Processor"	shall have the same meaning as set out in the UK GDPR;
"Data Protection Legislation"	means the UK GDPR, the Data Protection Act 2018 and all applicable Law concerning privacy, confidentiality or the processing of personal data including but not limited to the

	Human Rights Act 1998, the Health and Social Care (Safety and Quality) Act 2015, the common law duty of confidentiality and the Privacy and Electronic Communications (EC Directive) Regulations 2003;
"Data Sharing Agreement"	means a data sharing agreement which should be in substantially the same form as a Data Sharing Agreement template approved by NHS England;
"Data Subject"	shall have the same meaning as set out in the UK GDPR;
"Delegated Commissioning Group (DCG)"	means the advisory forum in respect of Delegated Services set up by NHS England currently known as the Delegated Commissioning Group for Specialised Services;
"Delegated Functions"	means the statutory functions delegated by NHS England to the ICB under the Delegation and as set out in detail in this Agreement;
"Delegated Funds"	means the funds defined in Clause 10.2;
"Delegated Services"	means the services set out in Schedule 2 of this Agreement and which may be updated from time to time by NHS England;
"Delegation"	means the delegation of the Delegated Functions from NHS England to the ICB as described at Clause 6.1;
"Developmental Arrangements"	means the arrangements set out in Schedule 9 as amended or replaced;
"Dispute"	a dispute, conflict or other disagreement between the Parties arising out of or in connection with this Agreement;
"Effective Date of Delegation"	means for the Specialised Services set out in Schedule 2, the date set out in Schedule 2 as the date delegation will take effect in respect of that particular Specialised Service and for any future delegations means the date agreed by the parties as the date that the delegation will take effect;
"EIR"	means the Environmental Information Regulations 2004;
"Escalation Rights"	means the escalation rights as defined in Clause 15 *(Escalation Rights)*;
"Finance Guidance"	means the guidance, rules and operating procedures produced by NHS England that relate to these delegated arrangements, including but not limited to the following: - Commissioning Change Management Business Rules; - Contracting Standard Operating Procedure; - Cashflow Standard Operating Procedure; - Finance and Accounting Standard Operating Procedure;

- Service Level Framework Guidance;

"Financial Year"	shall bear the same meaning as in section 275 of the NHS Act;
"FOIA"	means the Freedom of Information Act 2000;
"Further Arrangements"	means arrangements for the exercise of Delegated Functions as defined at Clause 12;
"Good Practice"	means using standards, practices, methods and procedures conforming to the law, reflecting up-to-date published evidence and exercising that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced commissioner;
"Guidance"	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the ICB has a duty to have regard (and whether specifically mentioned in this Agreement or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified to the ICB by any relevant Regulatory or Supervisory Body but excluding Mandated Guidance;
"High Cost Drugs"	means medicines not reimbursed though national prices and identified on the NHS England high cost drugs list;
"Host ICB"	means the ICB that employs the Commissioning Team as part of the Commissioning Team Arrangements;
"ICB"	means an Integrated Care Board established pursuant to section 14Z25 of the NHS Act and named in the Particulars;
"ICB Collaboration Arrangement"	means an arrangement entered into by the ICB and at least one other ICB under which the parties agree joint working arrangements in respect of the exercise of the Delegated Functions;
"ICB Deliverables"	all documents, products and materials developed by the ICB or its Staff in relation to this Agreement and the Delegated Functions in any form and required to be submitted to NHS England under this Agreement, including data, reports, policies, plans and specifications;
"ICB Functions"	the Commissioning Functions of the ICB;
"Information Governance Guidance for Serious Incidents"	means the checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incidents Requiring Investigation' (2015) as may be amended or replaced;
"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);

"IPR"	means intellectual property rights and includes inventions, copyright, patents, database right, trademarks, designs and confidential know-how and any similar rights anywhere in the world whether registered or not, including applications and the right to apply for any such rights;
"Law"	means any applicable law, statute, rule, bye-law, regulation, direction, order, regulatory policy, guidance or code, rule of court or directives or requirements of any regulatory body, delegated or subordinate legislation or notice of any regulatory body (including any Regulatory or Supervisory Body);
"Local Terms"	means the terms set out in Schedule 8 *(Local Terms)* and/or such other Schedule or part thereof as designated as Local Terms;
"Losses"	means all damages, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services) proceedings, demands and charges whether arising under statute, contract or common law;
"Managing Conflicts of Interest in the NHS"	the NHS publication by that name available at: https://www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-guidance-for-staff-and-organisations/ ;
"Mandated Guidance"	means any protocol, policy, guidance, guidelines, framework or manual relating to the exercise of the Delegated Functions and issued by NHS England to the ICB as Mandated Guidance from time to time, in accordance with Clause 7.34 which at the Effective Date of Delegation shall include the Mandated Guidance set out in Schedule 7;
"National Commissioning Group (NCG)"	means the advisory forum in respect of the Retained Services currently known as the National Commissioning Group for Specialised, Health and Justice and Armed Forces Services;
"National Standards"	means the service standards for each Specialised Service, as set by NHS England and included in Clinical Commissioning Policies or National Specifications;
"National Specifications"	the service specifications published by NHS England in respect of Specialised Services;
"Need to Know"	has the meaning set out in paragraph 1.2 of Schedule 6 (*Further Information Governance, Sharing and Processing Provisions)*;
"NICE Regulations"	means the National Institute for Health and Care Excellence (Constitution and Functions) and the Health and Social Care Information Centre (Functions) Regulations 2013 as amended or replaced;
"NHS Act"	means the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022 and other legislation from time to time);

"NHS Counter Fraud Authority"	means the Special Health Authority established by and in accordance with the NHS Counter Fraud Authority (Establishment, Constitution, and Staff and Other Transfer Provisions) Order 2017/958;
"NHS Digital Data Security and Protection Toolkit"	means the toolkit published by NHS Digital and available on the NHS Digital website at: https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/data-security-and-protection-toolkit ;
"NHS England"	means the body established by section 1H of the NHS Act;
"NHS England Deliverables"	means all documents, products and materials NHS England in which NHS England holds IPRs which are relevant to this Agreement, the Delegated Functions or the Reserved Functions in any form and made available by NHS England to the ICB under this Agreement, including data, reports, policies, plans and specifications;
"NHS England Functions"	means all functions of NHS England as set out in legislation excluding any functions that have been expressly delegated;
"Non-Personal Data"	means data which is not Personal Data;
"Operational Days"	a day other than a Saturday, Sunday, Christmas Day, Good Friday or a bank holiday in England;
"**Oversight Framework**"	means the NHS Oversight Framework, as may be amended or replaced from time to time, and any relevant associated Guidance published by NHS England;
"Party/Parties"	means a party or both parties to this Agreement;
"Patient Safety Incident Response Framework"	means the framework published by NHS England and made available on the NHS England website at: https://www.england.nhs.uk/patient-safety/incident-response-framework/ ;
"Personal Data"	shall have the same meaning as set out in the UK GDPR and shall include references to Special Category Personal Data where appropriate;
"Population"	means, in relation to any particular delegated service, the group of people for which the ICB would have the duty to arrange for the provision of that service under section 3 of the NHS Act (hospital and other services), if it was not a service which NHS England had a duty to arrange under its Specialised Commissioning Functions; For guidance on the persons for whom an ICB is responsible for arranging services see *Who Pays? Determining which NHS commissioner is responsible for commissioning healthcare services and making payments to providers*;

"Prescribed Specialised Services Manual"	means the document which may be amended or replaced from time to time which is currently known as the prescribed specialised services manual which describes how NHS England and ICBs commission specialised services and sets out the identification rules which describe how NHS England and ICBs identify Specialised Services activity within data flows;
"Provider Collaborative"	means a group of Specialised Service Providers who have agreed to work together to improve the care pathway for one or more Specialised Services;
"Provider Collaborative Guidance"	means the guidance published by NHS England in respect of Provider Collaboratives;
"Prohibited Act"	means the ICB: (i) offering, giving, or agreeing to give NHS England (or an of their officers, employees or agents) any gift or consideration of any kind as an inducement or reward for doing or not doing or for having done or not having done any act in relation to the obtaining of performance of this Agreement, the Reserved Functions, the Delegation or any other arrangement with the ICB, or for showing or not showing favour or disfavour to any person in relation to this Agreement or any other arrangement with the ICB; and (ii) in connection with this Agreement, paying or agreeing to pay any commission, other than a payment, particulars of which (including the terms and conditions of the agreement for its payment) have been disclosed in writing to NHS England; or (iii) committing an offence under the Bribery Act 2010;
"Regional Quality Group"	means a group set up to act as a strategic forum at which regional partners from across health and social care can share, identify and mitigate wider regional quality risks and concerns as well as share learning so that quality improvement and best practice can be replicated;
"Regulatory or Supervisory Body"	means any statutory or other body having authority to issue guidance, standards or recommendations with which the relevant Party and/or Staff must comply or to which it or they must have regard, including: (i) CQC; (ii) NHS England; (iii) the Department of Health and Social Care; (iv) the National Institute for Health and Care Excellence; (v) Healthwatch England and Local Healthwatch; (vi) the General Medical Council;

(vii) the General Dental Council;

(viii) the General Optical Council;

(ix) the General Pharmaceutical Council;

(x) the Healthcare Safety Investigation Branch; and

(xi) the Information Commissioner;

"**Relevant Clinical Networks"**	means those clinical networks identified by NHS England as required to support the commissioning of Specialised Services for the Population;
"Relevant Information"	means the Personal Data and Non-Personal Data processed under the Delegation and this Agreement, and includes, where appropriate, "confidential patient information" (as defined under section 251 of the NHS Act), and "patient confidential information" as defined in the 2013 Report, The Information Governance Review – "*To Share or Not to Share?"*);
"Reserved Functions"	means statutory functions of NHS England that it has not delegated to the ICB including but not limited to those set out in the Schedules to this Agreement;
"Retained Services"	means those Specialised Services for which NHS England shall retain commissioning responsibility, as set out in Schedule 5;
"Secretary of State"	means the Secretary of State for Health and Social Care;
"Shared Care Arrangements"	means arrangements put in place to support patients receiving elements of their care closer to home, whilst still ensuring that they have access to the expertise of a specialised centre and that care is delivered in line with the expectation of the relevant National Specification;
"Single Point of Contact"	means the member of Staff appointed by each relevant Party in accordance with Paragraph 9.6 of Schedule 6;
"Special Category Personal Data"	shall have the same meaning as in UK GDPR;
"Specialised Commissioning Budget"	means the budget identified by NHS England for the purpose of exercising the Delegated Functions;
"Specialised Commissioning Functions"	means the statutory functions conferred on NHS England under Section 3B of the NHS Act and Regulation 11 and Schedule 4 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996 (as amended or replaced);
"Specialised Services"	means the services commissioned in exercise of the Specialised Commissioning Functions;

"Specialised Services Contract"	means a contract for the provision of Specialised Services entered into in the exercise of the Specialised Commissioning Functions;
"Specialised Services Provider"	means a provider party to a Specialised Services Contract;
"Specialised Services Staff"	means the Staff or roles identified as carrying out the Delegated Functions immediately prior to the date of this Agreement;
"Specified Purpose"	means the purpose for which the Relevant Information is shared and processed, being to facilitate the exercise of the ICB's Delegated Functions and NHS England's Reserved Functions as specified in paragraph **Error! Reference source not found.** of Schedule 6 *(Further Information Governance, Sharing and Processing Provisions)* to this Agreement;
"Staff or Staffing"	means the Parties' employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of either Party (whether or not the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors' and their sub-contractors' personnel;
"Sub-Delegate"	shall have the meaning in Clause 12.2;
"System Quality Group"	means a group set up to identify and manage concerns across the local system. The system quality group shall act as a strategic forum at which partners from across the local health and social care footprint can share issues and risk information to inform response and management, identify and mitigate quality risks and concerns as well as share learning and best practice;
"Triple Aim"	means the duty to have regard to wider effect of decisions, which is placed on each of the Parties under section 13NA (as regards NHS England) and section 14Z43 (as regards the ICB) of the NHS Act;
"UK GDPR"	means Regulation (EU) 2016/679 of the European Parliament and of the Council of 27th April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018;
"Variation Proposal"	means a written proposal for a variation to the Agreement, which complies with the requirements of Clause 26.5.

SCHEDULE 2: Delegated Services

Delegated Services

NHS England delegates to the ICB the statutory function for commissioning the Specialised Services set out in this Schedule 2 (*Delegated Services*) subject to the reservations set out in Schedule 4 (*Reserved Functions*) and the provisions of any Developmental Arrangements set out in Schedule 9.

The list of Delegated Services set out in Schedule 2 of this Agreement contains two categories of service: the first is drawn from the Prescribed Specialised Services (PSS) Manual and aligns to Schedule 4 of the 2012 Standing Rules Regulations; the second is the sub-service line codes that NHS England has introduced over time to assist in the commissioning of Specialised Services. From time-to-time, NHS England will amend the list of sub-service line codes, either to repurpose, remove or add a code.

This is done to support in the management of finances, activity or for other administrative reasons; or to support transformational work that may be ongoing in the service area that requires a sub-service line code to track and manage funding and activity. The intention is that any changes will be supportive of ICBs' commissioning responsibilities, and that there will be a small number of changes in the Delegated Services sub-service line codes in any one year.

All future changes to sub-service line codes relating to Delegated Services will be developed with ICBs. ICBs will be engaged and have the opportunity to provide comment on the proposed change before it is made. Changes to the sub-service line codes will be discussed at and agreed by the Delegated Commissioning Group, hosted by NHS England and attended by ICB representatives. If changes are agreed, the latest lists will be made available on the NHS England website here [NHS England » NHS England service codes by year 2024/25] and a more detailed version on the Future NHS site here [Service Portfolio Analysis - Integrating specialised services within Integrated Care Systems - FutureNHS Collaboration Platform].

The PSS Manual Lines in Schedule 2 of the Agreement, which derive from the 2012 Standing Rules Regulations, will not be altered unless there is a decision of the NHS England Board, which will necessitate wider engagement with ICBs and stakeholders.

The following Specialised Services through this agreement will be delegated to the ICB:

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
2	Adult congenital heart disease services	13X	Adult congenital heart disease services (non-surgical)
		13Y	Adult congenital heart disease services (surgical)
3	Adult specialist pain management services	31Z	Adult specialist pain management services
4	Adult specialist respiratory services	29M	Interstitial lung disease (adults)
		29S	Severe asthma (adults)
		29L	Lung volume reduction (adults)
		29V	Complex home ventilation (adults)
5	Adult specialist rheumatology services	26Z	Adult specialist rheumatology services

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
6	Adult secure mental health services	22S(a)	Secure and specialised mental health services (adult) (medium and low) – excluding LD/ASD/WEMS/ABI/DEAF
		22S(c)	Secure and specialised mental health services (adult) (Medium and low) – ASD MHLDA PC
		22S(d)	Secure and specialised mental health services (adult) (Medium and low) – LD MHLDA PC
7	Adult Specialist Cardiac Services	13A	Complex device therapy
		13B	Cardiac electrophysiology & ablation
		13C	Inherited cardiac conditions
		13E	Cardiac surgery (inpatient)
		13F	PPCI for ST- elevation myocardial infarction
		13H	Cardiac magnetic resonance imaging
		13T	Complex interventional cardiology
		13Z	Cardiac surgery (outpatient)
8	Adult specialist eating disorder services	22E	Adult specialist eating disorder services MHLDA PC
9	Adult specialist endocrinology services	27E	Adrenal Cancer (adults)
		27Z	Adult specialist endocrinology services
11	Adult specialist neurosciences services	08O	Neurology (adults)
		08P	Neurophysiology (adults)
		08R	Neuroradiology (adults)
		08S	Neurosurgery (adults)
		08T	Mechanical Thrombectomy
		58A	Neurosurgery LVHC national: surgical removal of clival chordoma and chondrosarcoma
		58B	Neurosurgery LVHC national: EC-IC bypass (complex/high flow)
		58C	Neurosurgery LVHC national: transoral excision of dens
		58D	Neurosurgery LVHC regional: anterior skull based tumours
		58E	Neurosurgery LVHC regional: lateral skull based tumours
		58F	Neurosurgery LVHC regional: surgical removal of brainstem lesions
		58G	Neurosurgery LVHC regional: deep brain stimulation
		58H	Neurosurgery LVHC regional: pineal tumour surgeries - resection
		58I	Neurosurgery LVHC regional: removal of arteriovenous malformations of the nervous system
		58J	Neurosurgery LVHC regional: epilepsy
		58K	Neurosurgery LVHC regional: insula glioma's/complex low grade glioma's
		58L	Neurosurgery LVHC local: anterior lumbar fusion
	Adult specialist neurosciences services (continued)	58M	Neurosurgery LVHC local: removal of intramedullary spinal tumours
		58N	Neurosurgery LVHC local: intraventricular tumours resection
		58O	Neurosurgery LVHC local: surgical repair of aneurysms (surgical clipping)
		58P	Neurosurgery LVHC local: thoracic discectomy
		58Q	Neurosurgery LVHC local: microvascular decompression for trigeminal neuralgia
		58R	Neurosurgery LVHC local: awake surgery for removal of brain tumours
		58S	Neurosurgery LVHC local: removal of pituitary tumours including for Cushing's and acromegaly
12	Adult specialist ophthalmology services	37C	Artificial Eye Service
		37Z	Adult specialist ophthalmology services
13	Adult specialist orthopaedic services	34A	Orthopaedic surgery (adults)

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
		34R	Orthopaedic revision (adults)
15	Adult specialist renal services	11B	Renal dialysis
		11C	Access for renal dialysis
		11T	Renal Transplantation
16	Adult specialist services for people living with HIV	14A	Adult specialised services for people living with HIV
17	Adult specialist vascular services	30Z	Adult specialist vascular services
18	Adult thoracic surgery services	29B	Complex thoracic surgery (adults)
		29Z	Adult thoracic surgery services: outpatients
29	Haematopoietic stem cell transplantation services (adults and children)	02Z	Haematopoietic stem cell transplantation services (adults and children)
		ECP	Extracorporeal photopheresis service (adults and children)
30	Bone conduction hearing implant services (adults and children)	32B	Bone anchored hearing aids service
		32D	Middle ear implantable hearing aids service
32	Children and young people's inpatient mental health service	23K	Tier 4 CAMHS (general adolescent inc eating disorders) MHLDA PC
		23L	Tier 4 CAMHS (low secure) MHLDA PC
		23O	Tier 4 CAMHS (PICU) MHLDA PC
		23U	Tier 4 CAMHS (LD) MHLDA PC
		23V	Tier 4 CAMHS (ASD) MHLDA PC
35	Cleft lip and palate services (adults and children)	15Z	Cleft lip and palate services (adults and children)
36	Cochlear implantation services (adults and children)	32A	Cochlear implantation services (adults and children)
40	Complex spinal surgery services (adults and children)	06Z	Complex spinal surgery services (adults and children)
		08Z	Complex neuro-spinal surgery services (adults and children)
45	Cystic fibrosis services (adults and children)	10Z	Cystic fibrosis services (adults and children)
54	Fetal medicine services (adults and adolescents)	04C	Fetal medicine services (adults and adolescents)
58	Specialist adult gynaecological surgery and urinary surgery services for females	04A	Severe Endometriosis
		04D	Complex urinary incontinence and genital prolapse
58A	Specialist adult urological surgery services for men	41P	Penile implants
		41S	Surgical sperm removal
		41U	Urethral reconstruction
59	Specialist allergy services (adults and children)	17Z	Specialist allergy services (adults and children)
61	Specialist dermatology services (adults and children)	24Z	Specialist dermatology services (adults and children)
62	Specialist metabolic disorder services (adults and children)	36Z	Specialist metabolic disorder services (adults and children)
63	Specialist pain management services for children	23Y	Specialist pain management services for children
64	Specialist palliative care services for children and young adults	E23	Specialist palliative care services for children and young adults
65	Specialist services for adults with infectious diseases	18A	Specialist services for adults with infectious diseases

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
		18E	Specialist Bone and Joint Infection (adults)
72	Major trauma services (adults and children)	34T	Major trauma services (adults and children)
78	Neuropsychiatry services (adults and children)	08Y	Neuropsychiatry services (adults and children)
83	Paediatric cardiac services	23B	Paediatric cardiac services
94	Radiotherapy services (adults and children)	01R	Radiotherapy services (Adults)
		51R	Radiotherapy services (Children)
		01S	Stereotactic Radiosurgery / radiotherapy
98	Specialist secure forensic mental health services for young people	24C	FCAMHS MHLDA PC
103A	Specialist adult haematology services	03C	Castleman disease
105	Specialist cancer services (adults)	01C	Chemotherapy
		01J	Anal cancer (adults)
		01K	Malignant mesothelioma (adults)
		01M	Head and neck cancer (adults)
		01N	Kidney, bladder and prostate cancer (adults)
		01Q	Rare brain and CNS cancer (adults)
		01U	Oesophageal and gastric cancer (adults)
		01V	Biliary tract cancer (adults)
		01W	Liver cancer (adults)
		01X	Penile cancer (adults)
		01Y	Cancer Outpatients (adults)
		01Z	Testicular cancer (adults)
		04F	Gynaecological cancer (adults)
		19V	Pancreatic cancer (adults)
		19C	Biliary tract cancer surgery (adults)
		19M	Liver cancer surgery (adults)
		19Q	Pancreatic cancer surgery (adults)
		24Y	Skin cancer (adults)
		29E	Management of central airway obstruction (adults)
		51A	Interventional oncology (adults)
		51B	Brachytherapy (adults)
		51C	Molecular oncology (adults)
		61M	Head and neck cancer surgery (adults)
		61Q	Ophthalmic cancer surgery (adults)
		61U	Oesophageal and gastric cancer surgery (adults)
		61Z	Testicular cancer surgery (adults)
		33C	Transanal endoscopic microsurgery (adults)
		33D	Distal sacrectomy for advanced and recurrent rectal cancer (adults)
106	Specialist cancer services for children and young adults	01T	Teenage and young adult cancer
		23A	Children's cancer
106A	Specialist colorectal surgery services (adults)	33A	Complex surgery for faecal incontinence (adults)
		33B	Complex inflammatory bowel disease (adults)
107	Specialist dentistry services for children	23P	Specialist dentistry services for children
108	Specialist ear, nose and throat services for children	23D	Specialist ear, nose and throat services for children
109	Specialist endocrinology services for children	23E	Specialist endocrinology and diabetes services for children

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
110	Specialist gastroenterology, hepatology and nutritional support services for children	23F	Specialist gastroenterology, hepatology and nutritional support services for children
112	Specialist gynaecology services for children	73X	Specialist paediatric surgery services - gynaecology
113	Specialist haematology services for children	23H	Specialist haematology services for children
114	Specialist haemoglobinopathy services (adults and children)	38S	Sickle cell anaemia (adults and children)
		38T	Thalassemia (adults and children)
115	Specialist immunology services for adults with deficient immune systems	16X	Specialist immunology services for adults with deficient immune systems
115A	Specialist immunology services for children with deficient immune systems	16Y	Specialist immunology services for children with deficient immune systems
115B	Specialist maternity care for adults diagnosed with abnormally invasive placenta	04G	Specialist maternity care for women diagnosed with abnormally invasive placenta
118	Neonatal critical care services	NIC	Specialist neonatal care services
119	Specialist neuroscience services for children	23M	Specialist neuroscience services for children
		07Y	Paediatric neurorehabilitation
		08J	Selective dorsal rhizotomy
120	Specialist ophthalmology services for children	23N	Specialist ophthalmology services for children
121	Specialist orthopaedic services for children	23Q	Specialist orthopaedic services for children
122	Paediatric critical care services	PIC	Specialist paediatric intensive care services
124	Specialist perinatal mental health services (adults and adolescents)	22P	Specialist perinatal mental health services (adults and adolescents) MHLDA PC
125	Specialist plastic surgery services for children	23R	Specialist plastic surgery services for children
126	Specialist rehabilitation services for patients with highly complex needs (adults and children)	07Z	Specialist rehabilitation services for patients with highly complex needs (adults and children)
127	Specialist renal services for children	23S	Specialist renal services for children
128	Specialist respiratory services for children	23T	Specialist respiratory services for children
129	Specialist rheumatology services for children	23W	Specialist rheumatology services for children
130	Specialist services for children with infectious diseases	18C	Specialist services for children with infectious diseases
131	Specialist services for complex liver, biliary and pancreatic diseases in adults	19L	Specialist services for complex liver diseases in adults
		19P	Specialist services for complex pancreatic diseases in adults
		19Z	Specialist services for complex liver, biliary and pancreatic diseases in adults
		19B	Specialist services for complex biliary diseases in adults
132	Specialist services for haemophilia and other related bleeding disorders (adults and children)	03X	Specialist services for haemophilia and other related bleeding disorders (Adults)
		03Y	Specialist services for haemophilia and other related bleeding disorders (Children)
134	Specialist services to support patients with complex physical disabilities (excluding wheelchair services) (adults and children)	05C	Specialist augmentative and alternative communication aids (adults and children)
		05E	Specialist environmental controls (adults and children)

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
		05P	Prosthetics (adults and children)
135	Specialist paediatric surgery services	23X	Specialist paediatric surgery services - general surgery
136	Specialist paediatric urology services	23Z	Specialist paediatric urology services
139A	Specialist morbid obesity services for children	35Z	Specialist morbid obesity services for children
139AA	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital	04P	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital
ACC	Adult Critical Care	ACC	Adult critical care

SCHEDULE 3: Delegated Functions

22 Introduction

22.1 Subject to the reservations set out in Schedule 4 (*Reserved Functions*) and the provisions of any Developmental Arrangements, NHS England delegates to the ICB the statutory function for commissioning the Delegated Services. This Schedule 3 sets out the key powers and duties that the ICB will be required to carry out in exercise of the Delegated Functions being, in summary:

22.1.1 decisions in relation to the commissioning and management of Delegated Services;

22.1.2 planning Delegated Services for the Population, including carrying out needs assessments;

22.1.3 undertaking reviews of Delegated Services in respect of the Population;

22.1.4 supporting the management of the Specialised Commissioning Budget;

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

22.1.6 such other ancillary activities that are necessary to exercise the Specialised Commissioning Functions.

22.2 When exercising the Delegated Functions, ICBs are not acting on behalf of NHS England but acquire rights and incur any liabilities in exercising the functions.

23 General Obligations

23.1 The ICB is responsible for planning the commissioning of the Delegated Services in accordance with this Agreement. This includes ensuring at all times that the Delegated Services are commissioned in accordance with the National Standards.

23.2 The ICB shall put in place arrangements for collaborative working with other ICBs in accordance with Clause 8 (*Requirement for ICB Collaboration Arrangement*).

23.3 The Developmental Arrangements set out in Schedule 9 shall apply.

Specific Obligations

24 Assurance and Oversight

24.1 The ICB must at all times operate in accordance with:

24.1.1 the Oversight Framework published by NHS England;

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

24.1.3 any other relevant NHS oversight and assurance guidance;

collectively known as the “Assurance Processes”.

24.2 The ICB must:

24.2.1 develop and operate in accordance with mutually agreed ways of working in line with the Assurance Processes;

24.2.2 oversee the provision of Delegated Services and the outcomes being delivered for its Population in accordance with the Assurance Processes;

24.2.3 assure that Specialised Service Providers are meeting, or have an improvement plan in place to meet, National Standards;

24.2.4 provide any information and comply with specific actions in relation to the Delegated Services, as required by NHS England, including metrics and detailed reporting.

25 Attendance at governance meetings

25.1 The ICB must ensure that there is appropriate representation at forums established through the ICB Collaboration Arrangement.

25.2 The ICB must ensure that an individual(s) has been nominated to represent the ICB at the Delegated Commissioning Group (DCG) and regularly attends that group. This could be a single representative on behalf of the members of an ICB Collaboration Arrangement. Where that representative is not an employee of the ICB, the ICB must have in place appropriate arrangements to enable the representative to feedback to the ICB.

25.3 The ICB should also ensure that they have a nominated representative with appropriate subject matter expertise to attend National Standards development forums as requested by NHS England. This could be a single representative on behalf of the members of an ICB Collaboration Arrangement. Where that representative is not an employee of the ICB, the ICB must have in place appropriate arrangements to enable the representative to feedback to the ICB.

26 Clinical Leadership and Clinical Reference Groups

26.1 The ICB shall support the development of clinical leadership and expertise at a local level in respect of Specialised Services.

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

27 Clinical Networks

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

27.2 The ICB will be involved in the development and agreement of a single annual plan for the Relevant Clinical Network.

27.3 The ICB shall monitor the implementation of the annual plan and receive an annual report from the Relevant Clinical Network that considers delivery against the annual plan.

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

27.5 The ICB shall support NHS England in the management of Relevant Clinical Networks.

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

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

27.8 The ICB shall ensure that network reports are considered where relevant as part of exercising the Delegated Functions.

28 Complaints

28.1 This part (*Complaints*) applies from the Effective Date of Delegation or the date on which the Commissioning Team is transferred to the relevant Host ICB (whichever is the later) ("the Applicable Date").

28.2 The ICB will be responsible for all complaints in respect of the Delegated Services that are received from the Applicable Date, regardless of whether the circumstances to which the complaint relates occurred prior to the Applicable Date.

28.3 For the avoidance of doubt, NHS England will retain responsibility for all complaints in respect of the Delegated Services that were received prior to the Applicable Date.

28.4 At all times the ICB shall operate in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and shall co-operate with other ICBs to ensure that complaints are managed effectively.

28.5 Where NHS England has provided the ICB with a protocol for sharing complaints in respect of any or all Specialised Services then those provisions shall apply and are deemed to be part of this Agreement (the "Complaints Sharing Protocol").

28.6 The ICB shall:

28.6.1 work with local organisations, including other ICBs that are party to the ICB Collaboration Arrangement or Commissioning Team, to ensure that arrangements are in place for the management of complaints in respect of the Delegated Services.

28.6.2 consider, in the context of the ICB Collaboration Arrangement for the commissioning of the Delegated Services and employment arrangements for the Commissioning Team, whether it is best placed to manage the complaint, or whether it should be transferred to another ICB that is better placed to affect change.

28.6.3 provide the relevant individuals at NHS England with appropriate access to complaints data held by the ICB that is necessary to carry out the complaints function as set out in the Complaints Sharing Protocol.

28.6.4 Provide such information relating to key performance indicators ("KPIs") as is requested by NHS England.

28.6.5 co-operate with NHS England in respect of the review of complaints related to the Delegated Services and shall, on request, share any learning identified in carrying out the complaints function.

28.6.6 take part in any peer review process put in place in respect of the complaints function.

29 Commissioning and optimisation of High Cost Drugs

29.1 The ICB must support the effective and efficient commissioning of High Cost Drugs for Delegated Services.

29.2 The ICB must support NHS England in its responsibility for the financial management and reimbursement of High Cost Drugs for Specialised Services. The ICB and NHS England must agree the support to be provided. The support must be set out in writing and may include staffing, processes, reporting, prescribing analysis and oversight arrangements, but is not limited to these matters.

29.3 The ICB must ensure equitable access to High Cost Drugs used within the Delegated Services that may be impacted by health inequalities and develop a strategy for delivering equitable access.

29.4 The ICB must develop and implement Shared Care Arrangements across the Area of the ICB.

29.5 The ICB must provide clinical and commissioning leadership in the commissioning and management of High Cost Drugs.

29.6 The ICB must ensure:

29.6.1 safe and effective use of High Cost Drugs in line with national Clinical Commissioning Policies, NICE technology appraisal or highly specialised technologies guidance;

29.6.2 effective introduction of new medicines;

29.6.3 compliance with all NHS England commercial processes and frameworks for High Cost Drugs;

29.6.4 Specialised Services Providers adhere to all NHS England commercial processes and frameworks for High Cost Drugs;

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

29.6.6 consistency of prescribing and unwarranted prescribing variation are addressed.

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

29.8 Where the relevant pharmacy teams have transferred to the ICB or Host ICB, the ICB must provide:

29.8.1 support to prescribing networks and forums, including but not limited to, Immunoglobulin Assessment panels, prescribing networks and medicines optimisation networks;

29.8.2 expert medicines advice and input into the Individual Funding Request process for Delegated Services;

29.8.3 advice and input to national procurement and other commercial processes relating to medicines and High Cost Drugs (for example, arrangements for Homecare);

29.8.4 advice and input to NHS England policy development relating to medicines and High Cost Drugs.

30 Contracting

30.1 The ICB shall be responsible for ensuring appropriate arrangements are in place for the commissioning of the Delegated Services which for the avoidance of doubt includes:

30.1.1 co-ordinating or collaborating in the award of appropriate Specialised Service Contracts;

30.1.2 drafting of the contract schedules so that it reflects Mandatory Guidance, National Specifications and any specific instructions from NHS England; and

30.1.3 management of Specialised Services Contracts.

30.2 The ICB must comply with the Contracting Standard Operating Procedure issued by NHS England.

30.3 In relation to the contracting for NHS England Retained Services where the ICB has agreed to act as the co-ordinating commissioner, to implement NHS England's instructions in relation to those Retained Services and, where appropriate, put in place a Collaborative Commissioning Agreement with NHS England as a party.

31 Data Management and Analytics

31.1 The ICB shall:

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

31.1.2 lead on the provision of data and analytical services to support commissioning of Delegated Services;

31.1.3 ensure collaborative working across partners on agreed programmes of work focusing on provision of pathway analytics;

31.1.4 share expertise and existing reporting tools with partner ICBs in the ICB Collaboration Arrangement;

31.1.5 ensure interpretation of data is made available to NHS England and other ICBs within the ICB Collaboration Arrangement;

31.1.6 ensure data and analytics teams within ICBs and NHS England work collaboratively on jointly agreed programmes of work focusing on provision of pathway analytics;

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

32 Finance

32.1 The provisions of Clause 10 (*Finance*) of this Agreement set out the financial requirements in respect of the Delegated Functions.

33 Freedom of Information and Parliamentary Requests

33.1 The ICB shall lead on the handling, management and response to all Freedom of Information and parliamentary correspondence relating to Delegated Services.

34 Incident Response and Management

34.1 The ICB shall:

34.1.1 lead on local incident management for Delegated Services as appropriate to the stated incident level;

34.1.2 support national and regional incident management relating to Specialised Services; and

34.1.3 ensure surge events and actions relating to Specialised Services are included in ICB escalation plans.

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

35 Individual Funding Requests

35.1 The ICB shall provide any support required by NHS England in respect of determining an Individual Funding Request and shall implement the decision of the Individual Funding Request panel.

36 Innovation and New Treatments

36.1 The ICB shall support local implementation of innovative treatments for Delegated Services.

37 Mental Health, Learning Disability and Autism Specialised Services

37.1 The ICB will oversee the lead provider contract(s) relating to mental health, learning disability and autism (MHLDA) Provider Collaboratives that are transferred to the ICB on 1 April 2025 by NHS England. This includes complying with all terms and conditions of the contract(s), including in respect of notice periods and extensions.

37.2 If the ICB proposes to terminate a MHLDA lead provider contract before the end of its term, it must seek written approval from NHS England in advance.

37.3 In the performance of its commissioning responsibilities for MHLDA Specialised Services, the ICB shall:

37.3.1 Have regard to any commissioning guidance relating to MHLDA Specialised Services issued by NHS England;

37.3.2 Comply with the requirements of the Mental Health Investment Standard and related guidance issued by NHS England;

37.3.3 Generally have regard to the need to commission MHLDA Specialised Services for the ICB's Population in such a manner as to ensure safe, efficient and effective services, across appropriate geographies, and which may require partnership working across other ICB or other organisational boundaries.

37.3.4 Ensure that its case management function will work collaboratively across Delegated Services and Retained Services to support the oversight and progression of individual patient care, including the movement across elements of the care pathway.

38 Provider Selection and Procurement

38.1 The ICB shall:

38.1.1 run appropriate local provider selection and procurement processes for Delegated Services;

38.1.2 align all procurement processes with any changes to national procurement policy (for example new legislation) for Delegated Services;

38.1.3 support NHS England with national procurements where required with subject matter expertise on provider engagement and provider landscape; and

38.1.4 monitor and provide advice, guidance and expertise to NHS England on the overall provider market and provider landscape.

38.2 In discharging these responsibilities, the ICB must comply at all times with Law and any relevant Guidance including but not limited to Mandated Guidance; any applicable procurement law and Guidance on the selection of, and award of contracts to, providers of healthcare services.

38.3 When the ICB makes decisions in connection with the awarding of Specialised Services Contracts, it should ensure that it can demonstrate compliance with requirements for the award of such Contracts, including that the decision was:

38.3.1 made in the best interest of patients, taxpayers and the Population;

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

38.3.3 made transparently; and

38.3.4 compliant with relevant Guidance and legislation.

39 Quality

39.1 The ICB must ensure that appropriate arrangements for quality oversight are in place. This must include:

39.1.1 clearly defined roles and responsibilities for ensuring governance and oversight of Delegated Services;

39.1.2 defined roles and responsibilities for ensuring robust communication and appropriate feedback, particularly where Delegated Services are commissioned through an arrangement with one or more other ICBs;

39.1.3 working with providers and partner organisations to address any issues relating to Delegated Services and escalate appropriately if such issues cannot be resolved;

39.1.4 developing and standardising processes that align with regional systems to ensure oversight of the quality of Delegated Services, and participating in local System Quality Groups and Regional Quality Groups, or their equivalent;

39.1.5 ensuring processes are robust and concerns are identified, mitigated and escalated as necessary;

39.1.6 ensuring providers are held to account for delivery of safe, patient-focused and quality care for Delegated Services, including mechanisms for monitoring patient complaints, concerns and feedback; and

39.1.7 the implementation of the Patient Safety Incident Response Framework for the management of incidents and serious events, appropriate reporting of any incidents, undertaking any appropriate patient safety incident investigation and obtaining support as required.

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

39.3 The ICB must ensure that the oversight of the quality of the Delegated Services is integrated with wider quality governance in the local system and aligns with the NHS England National Quality Board's recommended quality escalation processes.

39.4 The ICB must ensure that there is a System Quality Group (or equivalent) to identify and manage concerns across the local system.

39.5 The ICB must ensure that there is appropriate representation at any Regional Quality Groups or their equivalent.

39.6 The ICB must have in place all appropriate arrangements in respect of child and adult safeguarding and comply with all relevant Guidance.

40 Service Planning and Strategic Priorities

40.1 The ICB is responsible for setting local commissioning strategy, policy and priorities and planning for and carrying out needs assessments for the Delegated Services.

40.2 In planning, commissioning and managing the Delegated Services, the ICB must have processes in place to assess and monitor equitable patient access, in accordance with

the access criteria set out in Clinical Commissioning Policies and National Specifications, taking action to address any apparent anomalies.

40.3 The ICB must ensure that it works with Specialised Service Providers and Provider Collaboratives to translate local strategic priorities into operational outputs for Delegated Services.

40.4 The ICB shall provide input into any consideration by NHS England as to whether the commissioning responsibility in respect of any of the Retained Services should be delegated.

41 National Standards, National Specifications and Clinical Commissioning Policies

41.1 The ICB shall provide input into national decisions on National Standards and national transformation regarding Delegated Services through attendance at governance meetings.

41.2 The ICB shall facilitate engagement with local communities on National Specification development.

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

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

41.5 The ICB must have appropriate mechanisms in place to ensure National Standards and National Specifications are being adhered to.

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

42 Transformation

42.1 The ICB shall:

42.1.1 prioritise pathways and services for transformation according to the needs of its Population and opportunities for improvement in ICB commissioned services and for Delegated Services;

42.1.2 lead ICB and ICB Collaboration Arrangement driven transformation programmes across pathways for Delegated Services;

42.1.3 lead the delivery locally of transformation in areas of national priority (such as Cancer, Mental Health and Learning Disability and Autism), including supporting delivery of commitments in the NHS Long Term Plan;

42.1.4 support NHS England with agreed transformational programmes for Retained Services;

42.1.5 support NHS England with agreed transformational programmes and identify future transformation programmes for consideration and prioritisation for Delegated Services where national co-ordination and enablement may support transformation;

42.1.6 work collaboratively with NHS England on the co-production and co-design of transformation and improvement interventions and solutions in those areas prioritised; and

42.1.7 ensure Relevant Clinical Networks and other clinical networks use levers to facilitate and embed transformation at a local level for Delegated Services.

SCHEDULE 4: Reserved Functions

Introduction

22. Reserved Functions in Relation to the Delegated Services

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

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

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

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

23. Retained Services

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

24. Reserved Specialised Service Functions

24.1. NHS England shall carry out the functions set out in this Schedule 4 in respect of the Delegated Services.

Reserved Functions

25. Assurance and Oversight

25.1. NHS England shall:

25.1.1. have oversight of what ICBs are delivering (inclusive of Delegated Services) for their Populations and all patients;

25.1.2. design and implement appropriate assurance of ICBs' exercise of Delegated Functions including the Assurance Processes;

25.1.3. help the ICB to coordinate and escalate improvement and resolution interventions where challenges are identified (as appropriate);

25.1.4. ensure that the NHS England Board is assured that Delegated Functions are being discharged appropriately;

25.1.5. ensure specialised commissioning considerations are appropriately included in NHS England frameworks that guide oversight and assurance of service delivery; and

25.1.6. host a Delegated Commissioning Group ("DCG") that will undertake an assurance role in line with the Assurance Processes. This assurance role shall include assessing and monitoring the overall coherence, stability and sustainability of the commissioning model of Specialised Services at a

national level, including identification, review and management of appropriate cross-ICB risks.

25.2. Where an officer or employee of NHS England is performing its Reserved Functions in respect of assurance and oversight, NHS England must ensure that those officers or employees do not hold responsibility for, or undertake any, decision making in respect of the ICB's Delegated Functions.

26. Attendance at governance meetings

26.1. NHS England shall ensure that there is appropriate representation in respect of Reserved Functions and Retained Services at local governance forums (for example, the Regional Leadership Team) and at the National Commissioning Group ("NCG").

26.2. NHS England shall:

26.2.1. ensure that there is appropriate representation by NHS England subject matter expert(s) at National Standards development forums;

26.2.2. ensure there is appropriate attendance by NHS England representatives at nationally led clinical governance meetings; and

26.2.3. co-ordinate, and support key national governance groups.

27. Clinical Leadership and Clinical Reference Groups

27.1. NHS England shall be responsible for the following:

27.1.1. developing local leadership and support for the ICB relating to Specialised Services;

27.1.2. providing clinical leadership, advice and guidance to the ICB in relation to the Delegated Services;

27.1.3. providing point-of-contact and ongoing engagement with key external bodies, such as interest groups, charities, NICE, DHSC, and Royal Colleges; and enabling access to clinical trials for new treatments and medicines.

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

27.2.1. Clinical Commissioning Policies;

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

28. Clinical Networks

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

28.2. NHS England shall ensure development of multi-ICB, and multi-region (where necessary) governance and oversight arrangements for Relevant Clinical Networks that give line of sight between all clinical networks and all ICBs whose Population they serve.

28.3. NHS England shall be responsible for:

28.3.1. developing national policy for the Relevant Clinical Networks;

28.3.2. developing and approving the specifications for the Relevant Clinical Networks;

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

28.3.4. convening or supporting national networks of the Relevant Clinical Networks;

28.3.5. agreeing the annual plan for each Relevant Clinical Network with the involvement of the ICB and Relevant Clinical Network, ensuring these reflect national and regional priorities;

28.3.6. managing Relevant Clinical Networks jointly with the ICB; and

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

29. Complaints

29.1. NHS England shall manage all complaints in respect of the Delegated Services that are received prior to the Effective Date of Delegation or the date on which the Commissioning Team is transferred to the Host ICB (whichever is the later).

29.2. NHS England shall provide the relevant individuals at the ICB with appropriate access to complaints data held by NHS England that is necessary to carry out the complaints function as set out in the Complaints Sharing Protocol.

29.3. NHS England shall manage all complaints in respect of the Retained Services.

29.4. NHS England shall set out what information the ICB is required to provide when reporting on the key performance indicators. NHS England should notify the ICB in advance and provide sufficient time to allow compliance.

30. Commissioning and optimisation of High Cost Drugs

30.1. Unless otherwise agreed with the ICB, NHS England shall manage a central process for reimbursement of High Costs Drugs for Specialised Services. This may include making reimbursements directly to Specialised Services Providers.

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

30.2.1. where appropriate, ensure that only validated drugs spend is reimbursed, there is timely drugs data and drugs data quality meets the standards set nationally;

30.2.2. support the ICB on strategy for access to medicines used within Delegated Services, minimising barriers to health inequalities;

30.2.3. provide support, as reasonably required, to the ICB to assist it in the commissioning of High Cost Drugs for Delegated Services including shared care agreements;

30.2.4. seek to address consistency of prescribing in line with national commissioning policies, introduction of new medicines, and addressing unwarranted prescribing variation;

30.2.5. develop medicines commissioning policies and criteria for access to medicines within Specialised Services;

30.2.6. develop support tools, including prior approval criteria, and frameworks to support the delivery of cost-effective and high quality commissioning of High Cost Drugs;

30.2.7. co-ordinate the development, implementation and monitoring of initiatives that enable the use of better value medicines;

30.2.8. where appropriate, co-ordinate national procurement or other commercial processes to secure medicines or High Cost Drugs for Specialised Services.

31. Contracting

31.1. NHS England shall retain the following obligations in relation to contracting for Delegated Services:

31.1.1. ensure Specialised Services are included in national NHS England contracting and payment strategy (for example, Aligned Payment Incentives);

31.1.2. provide advice for ICBs on schedules to support the Delegated Services;

31.1.3. set, publish or make otherwise available the Contracting Standard Operating Procedure and Mandated Guidance detailing contracting strategy and policy for Specialised Services; and

31.1.4. provide and distribute contracting support tools and templates to the ICB.

31.2. In respect of the Retained Services, NHS England shall:

31.2.1. where appropriate, ensure a Collaborative Commissioning Agreement is in place between NHS England and the ICB(s); and

31.2.2. where appropriate, construct model template schedules for Retained Services and issue to ICBs.

32. Data Management and Analytics

32.1. NHS England shall:

32.1.1. support the ICB by collaborating with the wider data and analytics network (nationally) to support development and local deployment or utilisation of support tools;

32.1.2. support the ICB to address data quality and coverage needs, accuracy of reporting Specialised Services activity and spend on a Population basis to support commissioning of Specialised Services;

32.1.3. ensure inclusion of Specialised Services data strategy in broader NHS England, DHSC and government data strategies;

32.1.4. lead on defining relevant contractual content of the information schedule (Schedule 6) of the NHS Standard Contract for Clinical Services;

32.1.5. work collaboratively with the ICB to drive continual improvement of the quality and coverage of data used to support commissioning of Specialised Services;

32.1.6. provide a national analytical service to support oversight and assurance of Specialised Services, and support (where required) the national Specialised

Commissioning team, Programmes of Care and Clinical Reference Groups; and

32.1.7. provide access to data and analytic subject matter expertise to support the ICB when considering local service planning, needs assessment and transformation.

33. Finance

33.1. The provisions of Clause 10 shall apply in respect of the financial arrangements in respect of the Delegated Functions.

33.2. NHS England shall:

33.2.1. hold the budgets for prescribed specialised services top-up payments for specialist centres;

33.2.2. administer the top-up payments schemes; and

33.2.3. make top-up payments to the Specialised Services Providers.

33.3. For the avoidance of doubt, the functions set out in 12.2 include top-up payments for the Delegated Services and Retained Services.

34. Freedom of Information and Parliamentary Requests

34.1. NHS England shall:

34.1.1. lead on handling, managing and responding to all national FOIA and parliamentary correspondence relating to Retained Services; and

34.1.2. co-ordinate a response when a single national response is required in respect of Delegated Services.

35. Incident Response and Management

35.1. NHS England shall:

35.1.1. provide guidance and support to the ICB in the event of a complex incident;

35.1.2. lead on national incident management for Specialised Services as appropriate to stated incident level and where nationally commissioned services are impacted;

35.1.3. lead on monitoring, planning and support for service and operational resilience at a national level and provide support to the ICB; and

35.1.4. respond to specific service interruptions where appropriate; for example, supplier and workforce challenges and provide support to the ICB in any response to interruptions.

36. Individual Funding Requests

36.1. NHS England shall be responsible for:

36.1.1. leading on Individual Funding Requests (IFR) policy, IFR governance and managing the IFR process for Delegated Services and Retained Services;

36.1.2. taking decisions in respect of IFRs at IFR Panels for both Delegated Services and Retained Services; and

36.1.3. providing expertise for IFR decisions, including but not limited to pharmacy, public health, nursing and medical and quality.

37. Innovation and New Treatments

37.1. NHS England shall support the local implementation of innovative treatments for Delegated Services.

37.2. NHS England shall ensure services are in place for innovative treatments such as advanced medicinal therapy products recommended by NICE technology appraisals within statutory requirements.

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

38. Mental Health, Learning Disability and Autism Specialised Services

38.1. NHS England shall issue commissioning guidance for MHLDA Specialised Services in relation to the Delegated Services and Retained Services.

38.2. NHS England shall prepare and issue National Specifications and Clinical Commissioning Policies for MHLDA Specialised Services.

38.3. NHS England will monitor the ICB's compliance with the Mental Health Investment Standard in respect of MHLDA Delegated Services.

38.4. NHS England shall ensure that its case management function will work collaboratively across Delegated Services and Retained Services to support the oversight and progression of individual patient care, including the movement across elements of the care pathway.

39. Provider Selection and Procurement

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

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

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

39.1.3. where appropriate, running provider selection and procurement processes for Specialised Services.

40. Quality

40.1. In respect of quality, NHS England shall:

40.1.1. work with the ICB to ensure oversight of Specialised Services through quality surveillance and risk management and escalate as required;

40.1.2. work with the ICB to seek to ensure that quality and safety issues and risks are managed effectively and escalated to the National Specialised Commissioning Quality and Governance Group (QGG), or other appropriate forums, as necessary;

40.1.3. work with the ICB to seek to ensure that the quality governance and processes for Delegated Services are aligned and integrated with broader clinical quality governance and processes in accordance with National Quality Board Guidance;

40.1.4. facilitate improvement when quality issues impact nationally and regionally, through programme support, and mobilising intensive support when required on specific quality issues;

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

40.1.6. support the ICB to identify key themes and trends and utilise data and intelligence to respond and monitor as necessary;

40.1.7. report on quality to both NCG and DCG as well as QGG and Executive Quality Group as required;

40.1.8. facilitate and support the national quality governance infrastructure (for example, the QGG); and

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

41. National Standards, National Specifications and Clinical Commissioning Policies

41.1. NHS England shall carry out:

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

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

41.1.3. maintenance and publication of the Prescribed Specialised Services Manual and engagement with the DHSC on policy matters; and

41.1.4. determination of content for national clinical registries.

42. Transformation

42.1. NHS England shall be responsible for:

42.1.1. co-ordinating and enabling ICB-led specialised service transformation programmes for Delegated Services where necessary;

42.1.2. supporting the ICB to implement national policy and guidance across its Populations for Retained Services;

42.1.3. supporting the ICB with agreed transformational programmes where national transformation support has been agreed for Delegated Services;

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

42.1.5. co-production and co-design of transformation programmes with the ICB and wider stakeholders; and

42.1.6. providing access to subject matter expertise including Clinical Reference Groups, national clinical directors, Programme of Care leads for the ICB where it needs support, including in relation to local priority transformation.

SCHEDULE 5: Retained Services

NHS England shall retain the function of commissioning the Specialised Services that are not Delegated Services and as more particularly set out by NHS England and made available from time to time.

SCHEDULE 6: Further Information Governance, Sharing and Processing Provisions

PART 1

1. Introduction

1.1. This Schedule sets out the scope for the secure and confidential sharing of information between the Parties on a Need To Know basis, or where a Party acts as a Data Processor on behalf of the other Party in order to enable the Parties to exercise their functions in pursuance of this Agreement.

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

1.3. This Schedule (including the details at Part 2 and 3 of this Schedule) and any Data Sharing Agreement and/or Data Processing Agreements entered into under this Schedule are designed to:

1.3.1. provide information about the reasons why Relevant Information may need to be shared and/or processed on behalf of another Party and how this will be managed and controlled by the Parties;

1.3.2. describe the purposes for which the Parties have agreed to share and/or the basis on which a Party is instructed to act as a Data Processor in relation to the Relevant Information;

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

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

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

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

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

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

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

2. Purpose

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

2.2. Each Party must ensure that they have in place appropriate data sharing or data processing arrangements to enable data to be received from any third party organisations from which the Parties must obtain data in order to achieve the Specified Purpose.

2.3. Where necessary specific and detailed purposes must be set out in a Data Sharing Agreement or Data Processing Agreement that complies with all relevant legislation and Guidance.

3. Benefits of information sharing

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

4. Lawful basis for sharing

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

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


DPIA

4.3. Further details regarding the Relevant Information to be shared shall be set out in a Data Sharing Agreement and/or Data Processing Agreement.

5. Restrictions on use of the Shared Information

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

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

5.3. Neither the provisions of this Schedule nor any associated Data Sharing Agreement and/or Data Processing Agreement should be taken to permit unrestricted access to data held by any of the Parties.

5.4. Neither Party shall subcontract any processing of the Relevant Information without the prior consent of the other Party. Where a Party subcontracts its obligations, it shall do so only by way of a written agreement with the sub-contractor which imposes the same

obligations as are imposed on that Party under this Agreement, and shall remain liable for the performance of the subcontractor's obligations.

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

5.6. Any particular restrictions on use of certain Relevant Information should be included in a Data Sharing Agreement and/or Data Processing Agreement.

6. Ensuring fairness to the Data Subject

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

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

6.1.2. amendment of respective privacy notices and policies to reflect the processing of data carried out further to this Agreement, including covering the requirements of articles 13 and 14 UK GDPR and providing these (or making them available to) Data Subjects;

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

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

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

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

6.4. Further provision in relation to specific data flows may be included in a Data Sharing Agreement and/or Data Processing Agreement between the Parties.

7. Governance: Staff

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

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

7.3. The Parties shall ensure that all Staff required to access Personal Data (including Special Category Personal Data) are informed of the confidential nature of the Personal

Data. The Parties shall include appropriate confidentiality clauses in employment/service contracts of all Staff that have any access whatsoever to the Relevant Information, including details of sanctions for acting in a deliberate or reckless manner that may breach the confidentiality or the non-disclosure provisions of Data Protection Legislation requirements, or cause damage to or loss of the Relevant Information.

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

7.5. The Parties shall ensure that:

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

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

7.5.3. specific limitations on the Staff who may have access to the Relevant Information are set out in any Data Sharing Agreement and/or Data Processing Agreement entered into in accordance with this Schedule.

8. Governance: Protection of Personal Data

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

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

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

8.4. If any Party becomes aware of:

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

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

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

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

8.5.1. in accordance with the terms of this Agreement and otherwise (to the extent that it acts as a Data Processor for the purposes of Article 27-28 GDPR) only in accordance with written instructions from the originating Data Controller in respect of its Relevant Information including any instructions set out in a Data Processing Agreement entered into under this Schedule, unless required by law (in which case, the processor shall inform the relevant Data Controller of that legal requirement before processing, unless that law prohibits such information on important grounds of public interest);

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

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

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

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

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

8.7. In particular, each Party shall:

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

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

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

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

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

8.8. The Parties shall adhere to the specific requirements as to information security set out in any Data Sharing Agreement and/or Data Processing Agreement entered into in accordance with this Schedule.

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

8.10. The Parties' Single Points of Contact set out in paragraph **Error! Reference source not found.** will be the persons who, in the first instance, will have oversight of third party security measures.

9. Governance: Transmission of Information between the Parties

9.1. This paragraph supplements paragraph 8 of this Schedule.

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

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

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

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

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

10. Governance: Quality of Information

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

11. Governance: Retention and Disposal of Shared Information

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

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

11.3. If a Party is required by any law, regulation, or government or regulatory body to retain any documents or materials that it would otherwise be required to return or destroy in

accordance with this Schedule, it shall notify the other Parties in writing of that retention, giving details of the documents or materials that it must retain.

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

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

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

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

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

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

12. Governance: Complaints and Access to Personal Data

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

12.2. Complaints about processing shall be reported to the Single Points of Contact and the ICB. Complaints about information sharing shall be routed through each Parties' own complaints procedure unless otherwise provided for in the Agreement or determined by the ICB. Where the complaint relates to processing undertaken by a Party acting as a Data Processor on behalf of the other Party, complaints shall be routed through the relevant Data Controller's own complaints procedure unless otherwise provided for in the Agreement.

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

12.4. Basic details of the Agreement shall be included in the appropriate log under each Party's publication scheme.

13. Governance: Single Points of Contact

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

14. Monitoring and review

14.1. The Parties shall monitor and review on an ongoing basis the sharing and wider processing of Relevant Information to ensure compliance with Data Protection

Legislation and Best Practice. Specific monitoring requirements must be set out in the relevant Data Sharing Agreement and/or Data Processing Agreement.

SCHEDULE 6: Further Information Governance~~,~~ Sharing and Processing Provisions

PART 2

Data Sharing Agreement

Description	**Details**
Subject matter of the processing	Due to the complexities of Specialised Services and the distinctions between Delegated Functions and Reserved Functions, both the ICB Commissioning Teams (employed by the Host ICB) delivering Delegated Functions and the NHS England teams delivering Reserved Functions will need access to Relevant Information, which contains Personal Data. As set out in Schedule 6, Part 1, Paragraph 2.1, the Specified Purpose for sharing data is: *'…to facilitate the exercise of the Delegated Functions and NHS England's Reserved Functions.'* In order to achieve this purpose in the most effective, efficient and cost effective manner, the data will be hosted by NHS England in a collaborative working space which ICBs will have access to. NHS England will be responsible for ensuring that Commissioning Team staff have sufficient and appropriate access to Relevant Information to enable those staff to fulfil their commissioning functions in respect of the Delegated Services, including those described in Schedule 3 (Delegated Functions) to this agreement. In addition, NHS England may process the data for the following purposes: • development, oversight, and the quality improvement of Specialised Commissioning Functions; • undertaking work to evaluate the effectiveness of innovation and changes in delivery models and advising other bodies and organisations about these functions; • arranging the provision of services to support commissioning activities, to enable reporting and evaluations; • undertaking analysis, audits, and inspections to assess and assure the quality of Specialised Commissioning Functions; • supporting healthcare organisations to interpret population health data and evidence, and to undertake reviews of the likely effectiveness and cost-effectiveness of a range of interventions; • development a of strategies on population health outcomes and to identify gaps or deficiencies in current care and to produce recommendations for improvements, including in relation to specific pathways of care; • using and supporting health organisations to use health economic tools to support decision-making and interpreting data about the surveillance or assessment of a population's health to improve health outcomes and reduce health inequalities; • the development of population health policies and strategies, and their implementation
Duration of the processing	Unless otherwise specified in this Data Sharing Agreement, the processing shall commence on the Effective Date of Delegation and, as per paragraph

	11.1 of this Schedule, shall continue until the need to use it has passed or, if later, upon the termination of this Agreement.
Nature and purpose of the processing	Personal Data is shared between the in relation to the delivery of the Delegated Functions. Such processing should ensure continued: • Provision of live services and associated reporting; • Quality improvement and assurance of services; • Dissemination of data for health and research purposes.
Type of Personal Data being Processed	Name / address / date of birth / NI number / telephone number / pay / NHS number / GP and clinical information e.g. patient escalations / complaints / FOIs / subject matter requests / bespoke patient planning.
Categories of Data Subject	Contracting data Finance data Supplier data Patient & public engagement data BI & analytical data Performance data Service provision & planning data Patient identifiable data HR and recruitment data Staff personal data

SCHEDULE 6: Further Information Governance~~,~~ Sharing and Processing Provisions

PART 3

Data Processing Agreement

Description	**Details**
Identity of the Controller and Processor	The ICB is the Data Controller and NHS England is the Data Processor.
Subject matter of the processing	Both the ICB Commissioning Teams (employed by the Host ICB) delivering Delegated Functions and the NHS England teams delivering Reserved Functions will need access to Relevant Information. In order to achieve this purpose in the most effective, efficient and cost effective manner, the data will be hosted by NHS England in a collaborative working space which ICBs will have access to. Consequently, NHS England will act as a Data Processor on behalf of the ICB in relation to the Relevant Information required to commission the Delegated Services and fulfil the Delegated Functions.
Duration of the processing	Unless otherwise specified in this Data Processing Agreement the processing shall commence on the Effective Date of Delegation and, as per paragraph 11.1 of this Schedule, shall continue until the need to use it has passed or, if later, upon the termination of this Agreement.
Plan for return and destruction of the data once the processing is complete	As set out in paragraph 11.1 of this Schedule
Nature and purpose of the processing	This Data Processing Agreement considers processing of any data by NHS England on behalf of the ICB Commissioning Teams in relation to the delivery of the Delegated Functions. Such processing should ensure continued: • Provision of live services and associated reporting; • Quality improvement and assurance of services; • Dissemination of data for health and research purposes.
Type of Personal Data being Processed	Name / address / date of birth / NI number / telephone number / pay / NHS number / GP and clinical information e.g. patient escalations / complaints / FOIs / subject matter requests / bespoke patient planning.
Categories of Data Subject	Contracting data Finance data Supplier data Patient & public engagement data BI & analytical data Performance data Service provision & planning data Patient identifiable data HR and recruitment data Staff personal data

SCHEDULE 7: Mandated Guidance

Generally applicable Mandated Guidance

- National Guidance on System Quality Groups.
- Managing Conflicts of Interest in the NHS.
- Arrangements for Delegation and Joint Exercise of Statutory Functions.
- Guidance relating to procurement and provider selection.
- Information Governance Guidance relating to serious incidents.
- All other applicable IG and Data Protection Guidance.
- Any applicable Freedom of Information protocols.
- Any applicable Guidance on Counter Fraud, including from The NHS Counter Fraud Authority.
- Any applicable Guidance relating to the use of data and data sets for reporting.
- Guidance relating to the processes for making and handling individual funding requests, including:
    - Commissioning policy: Individual funding requests;
    - Standard operating procedures: Individual funding requests.

Workforce

- Guidance on the Employment Commitment.

Finance

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

Specialised Services Mandated Guidance

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

SCHEDULE 8: Local Terms

General

Where there is a Dispute as to the content of this Schedule, the Parties should follow the Disputes procedure set out at Clause 25.

Following signature of the Agreement, this Schedule can be amended by the Parties using the Variations procedure at Clause 26.

NHS England can amend this Schedule without the ICB's consent by using the variation procedure set out in Clause 26.2 but the expectation is that variations should be by consent.

Part 1 – the services to be planned or commissioned at an ICB level

There are no specialised services that are planned at an individual ICB level.

Part 2 – the services to be planned or commissioned by an ICB Collaboration Arrangement

All delegated specialised services included in Schedule 2 will be planned on across the 11 ICBs working through the ICB Collaboration Agreement delivered by the integrated commissioning team detailed in Schedule 10.

Part 3 – Workforce and Commissioning Team Arrangements

The workforce delivering the commissioning responsibilities for the safe and effective commissioning of Specialised Acute and Mental Health Learning Disability and Autism for Retained NHSE services and Delegated ICB services will work together as one integrated commissioning team working across all 12 NHS commissioning bodies in the midlands. The details of what services will be delivered employees of the host ICB and employees of NHSE are described in schedule 10 of this agreement.

Part 4 – ICB Collaboration Arrangements

The 11 ICBs in the Midlands region will establish a Collaboration Agreement and will include all the requirements set out in clause 8.4, the Collaboration Agreement is a separate document.

Part 5 – Pooled Funds and Non-Pooled Funds

Clause 10.16 permits the ICB to establish pooled fund arrangements under Section 65Z5 or section 75 of the NHS Act. These should be with the prior approval of NHS England.

Pooling arrangements will be detailed in the collaboration agreement

Part 6 – MHLDA Provider Collaboratives

East Midlands
A single ICB will host the following four lead provider contracts on behalf of the five ICBs in the East Midlands:

Leicester, Leicestershire & Rutland ICB

- Adult Low & Medium Secure – Nottinghamshire Healthcare NHS Trust
- CYPMHS – Northamptonshire Healthcare NHS Trust
- Adult Eating Disorder – Leicestershire Partnership NHS Trust
- Perinatal Inpatient Services – Derbyshire Healthcare NHS Trust

West Midlands

Two ICB's will host the following four lead provider contracts on behalf of the six ICBs in the West Midlands:

Birmingham & Solihull ICB

- Adult Low & Medium Secure – Birmingham & Solihull Mental Health NHS Trust
- CYPMHS – Birmingham Women's & Children's NHS Trust

Staffordshire & Stoke on Trent ICB

- Adult Eating Disorder – Midlands University Partnership NHS Trust
- Perinatal Inpatient Services – Midlands University Partnership NHS Trust

Process to transfer commissioning responsibilities

The draft national commissioning guidance that is in development, which is aligned to national policy advice for 2025/26 recommends that as the existing Lead Provider contracts are 2-year contracts, expiring on 31 March 2026, the NHSE regional team should complete a notice under General Condition 12 (GC12)[1] to assign commissioning responsibilities under the existing contracts to the relevant ICBs.

At the point NHSE completes a notice under GC12, NHSE will no longer have any commissioning responsibilities under these contracts and therefore the named ICB will become the coordinating commissioner.

Roles and responsibilities for the coordinating ICB and associate ICBs, will need to be outlined in the collaborative commissioning agreement between the relevant ICB's with responsibilities listed in Schedule 5C of the contract.

Part 7 – Further Governance Arrangements

Governance arrangements are in place operating through two formal joint committees which has delegated decision making from each of their member ICB for the commissioning of defined services which include specialised Acute and MHLDA services outlined in this delegation agreement. The two joint committees are

The East Midlands Joint Committee made up of:
Lincolnshire ICB, Nottingham & Nottinghamshire ICB, Leicester, Leicestershire & Rutland ICB, Northamptonshire ICB, Derby & Derbyshire ICB.

and

The West Midlands Joint Committee made up of
Birmingham & Solihull ICB, Black Country ICB, Herefordshire & Worcestershire ICB, Coventry & Warwickshire ICB, Shropshire, Telford & Wrekin ICB and Staffordshire & Stoke-on-Trent ICB

There are four formal sub groups of the joint committees which cover all 11 ICBs and NHSE, these sub groups have delegated decision making responsibilities as outlined in both Joint Committee terms of reference.

[1] https://www.england.nhs.uk/wp-content/uploads/2024/02/04-NHS-Standard-Contract-2024-to-2025-General-Conditions-full-length-version-1-February-2024.pdf

These sub committees are:

- Finance and Contracting
- Clinical & Quality
- Midlands Specialised Commissioning Group
- Midlands MHLDA Commissioning Group

There may be additional advisory non-decision-making groups which will be detailed in the terms of reference of either of the Joint Committees for either of the sub-committees.

SCHEDULE 9: Developmental Arrangements

These Development Arrangements take precedence over the terms of this Agreement including other Schedules, and the Agreement shall be read as varied by these Developmental Arrangements. Save as varied by these Developmental Arrangements the Agreement remains in full force and effect.

The Developmental Arrangements

The following Developmental Arrangements apply to this Agreement:

For all ICBS in NOF3 or NOF4, any decision that impacts on the overall spend of the specialised service allocation must have NHSE Regional approval before the commissioning change is made or any change process is begun.

NHSE guidance on the review application and governance of developmental arrangements will be applied and updated as appropriate.

Quality

Where ICBs are in NOF 4, NHSE commit to offer additional/supplementary clinical and quality support and will work jointly with ICB colleagues to fulfil their responsibilities in line with the NQB Shared Commitment to Quality and Risk Response and Escalation Guidance. This will include where delegated Services are deemed as requiring enhanced or intensive level support.
NHSE will arrange access to identified key contacts from both a clinical and quality perspective to provide professional, clinical advice and support including with:

- Regional Medical Director for Specialised Services
- Deputy Director of Nursing & Quality Direct Commissioning

NHSE will support options for potential buddying arrangements with other ICB Clinical and Quality leads and provide support with the joint development of Improvement/Action Plans and the supporting of Quality Improvement Groups and/or Rapid Quality Review meetings as required.

Review

Review and removal of the delegation arrangement is the responsibility of the Regional Director of Nursing and Regional Director of Commissioning Integration. This will be carried out based on the regional and the ICB position and following and agreed assurance process.

SCHEDULE 10: Administrative and Management Services

The purpose of this schedule is to set out the functions that will operate to support the overall delivery of specialised services within the Midlands, improving outcomes for our local populations, and working on behalf of patients accessing care in providers outside the region.

The Midlands have developed a clear commitment to maintaining an integrated approach to the commissioning of the nationally prescribed specialised services across delegated and retained provision. This will require a collaborative approach to working as represented through the integrated governance structures set out. In some cases, individual functions will be conducted by teams hosted by the ICBs or managed by NHSE. These arrangements will be set out in this schedule.

1. Specialised Commissioning functions: Delegated and Retained

Listed below are the key functions and roles that have been split between the ICB commissioning team and the NHSE retained team (including any roles/functions that have a wider responsibilities)

Functions/Areas	Midlands Specialised Commissioning Team (Delegated Function) ICB Hosted	Midlands Specialised Commissioning Team (Retained Function) NHSE Employed	Shared/joint roles /functions/issues
Commissioning	Team function (contracting, finance, quality and corporate) responsible and working on behalf of 11 ICBs through the Joint Committees (East and West Midlands) Hosted (employed by BSOL ICB) from July 2025	Team function (contracting, finance, quality and corporate) responsible and working on retained services. Employed by NHSE	Programme of care advice and guidance across the team structure
Executive Leadership	**MSCT (delegated) Senior Leadership Team:** • Director of specialised /collaborative commissioning • Director of Commissioning finance • Director of Nursing & Quality • Medical Director Line management reporting to BSOL ICB (details to be refined across the first six months as the team settles into the new hosting).	**MSCT (retained) Senior Leadership Team:** • Deputy Director of retained specialised commissioning • Assistant Director of commissioning Finance • Deputy Director of Nursing • Assistant Director of Specialised Pharmacy • Medical Director (0.4 WTE) Reporting to Regional Director of Commissiong & Integration	Medical Director will be seconded back to NHSE to complete 0.4 WTE equivalent activity agreed to a clear specification It is expected both sets of leaders will work towards promoting and leading areas of integration. A coordinated single operational plan will be developed and agreed ensuring a coordinated approach to specialised provision and maximising

	Supported through the Executive Leadership Group (ELG) for East and West Midlands.		opportunity with all systems.
Finance	National red line related to access to NHSE Ledger	National Red line related to access to ICB ledgers	Finance teams will work to support the single operational plan with a focus on enabling value in system delivery. There will remain a separate governance for financial decision making.
Communications & media	No posts/function transferred.	Communications & media function	NHSE hosted communications team to provide coordination through to national team and in the management of approach for specialised services (delegated and retained) working with ICB leads as needed.
Clinical networks	The staff team for commissioning and overseeing the clinical Networks will be transferred Coordination of work programme delivery including delegated and retained service areas working with the retained teams. The Programme of Care team provide the Business-as-Usual point of contact for all networks, and this will be coordinated by the transferred teams.	No posts /function Resources for Networks retained by NHSE.	Decisions related to the funding and model for Clinical Networks will be jointly developed and commissioned and financially governed through NHSE.
Contracting	Contracting lead and function for Acute and MHLDA for delegated functions. Provider relationship management and coordination including with	Contracting Lead and function for Acute and MHLDA retained services Resource to enable development of contract schedules including role for Midlands and East of	Contracting model and SOP

	ICB teams on behalf of all services.	England (Geographical Unit)	
BI & Analytics function	CSU analytics support for ICB delegated services through NHSE contract Deputy Director of Planning & BI will work closely with the retained commission development support team and embedded CSU team to ensure data quality	CSU analytical support for 25/26 remains commissioned by NHSE with the contract being centrally managed and overseen by the retained Commissiong development function.	Further work during 25/26 to finalise April 2026 end state for core Commissioning Support Unit (CSU) provided BI services agreed position through joint governance.
High-Cost Drugs	No posts/function	Dedicated pharmacy team	Clinical & pharmaceutical support and expertise provided to ICBs and in partnership with Midlands Specialised Commissioning Team (delegated) from NHSE retained function. Leadership of the delivery for specialised commissioning.
Estates	BSOL ICB as host providing option of estate. ICBs to confirm general access as needed to sites. National agreed position for team access to NHSE estate	NHSE based offices Consideration of practical access to wider sites.	Agreed approach to maintaining team connectivity to be set out by the integrated leadership.
Targeted Clinical responsibilities	Case Management function for Neurorehabilitation pathway hosted on behalf of delegated and retained services, including direct employment. Peer Review capacity to operate across all specialised services	MHLDA Clinical Advice aligned to mental act and quality networks Death in Custody reviews completed for all specialised service lines	
Other advice /support	Continued commitment and opportunity to engage with NHSE Medical and commissioning Integration Senior Leadership Team.	NHSE Commissioning leadership attends Joint Committees in line with agreed ToR.	
Public Health	No transferring function	The healthcare public health team (Public Health directorate) will continue to provide public health advice and work in relation to all retained and	Links with system Publica Health teams will be made where beneficial.

		delegated prescribed specialised services	
Geographical Unit	N/A	The team will work as part of the NHSE Operating Model in a geographical unit with East of England	

** If at any time in the future any roles/functions that support both teams change then this must be mutually agreed and approved regarding any resource implications or risks.*
** Complaints function is defined in the Collaboration agreement. The MSCT will support complaint responses for specialised services meeting statutory requirements*

2. Integrated Commissioning approach – Our team of teams

One of the key principles that has been agreed is that we should not lose the opportunities for teams to work jointly together across the entire specialised services and commissioning portfolio. The benefits would ensure:

- Integrated approach and ways of working maintained
- Consistency of delivery across pathways
- Common strategic approach to problem solving
- Reduction in duplication and bureaucracy
- Simplifying policy and decision making
- Transparency for providers across the whole commissioning portfolio
- Opportunity to share joint objectives where it adds value.

This will be achieved through consideration of a set of 'team of teams' principles that will guide our ways of working and enable opportunities to work together more consistently and effectively. Our committed behaviours are:

- Assumptions that doing once and well together will achieve better outcomes for our population
- Our differences in approaches and responsibilities create opportunities for exploring new ways of working, rather than barriers to working together

We articulate and act with common purpose to improve care, reduce waste and improve efficiency
The areas where it is felt the combined teams would integrate and work together include:

Area /work programme	Description of work
Planning across whole pathways at scale Development of a single integrated operational plan for specialised services across delegated and retained service lines.	This would be reflective of ICB and NHSE priorities which form part of each teams' individual plans. Further work is required to work through how /which teams would liaise and co-ordinate the production. The benefit of having a single integrated plan would be to be visible /transparent to stakeholders and providers.
Strategy Development Development, delivery and reporting of a prioritised list of specialised services strategies which reflect both ICB and NHSE priorities and link to the strategic intent of improving health equity, improving efficiency and reducing unwarranted variation	Each year ICBs and NHSE would agree a programme of work for strategy development work that would benefit from a single consistent approach across all services /populations. An agreed resource plan to support the work would also be agreed
Mutual support and aid	Strengthen opportunities to meet and ensure the teams can benefit and learn from each other

Regular joint meetings across delegated, retained and ICB leadership teams to ensure an integrated and joined up approach enabling sharing of risks and benefits	

The concept of Integrated working between the teams will need to be further refined and developed over the next year to allow clear roles and responsibilities and best use of resources. This will be agreed jointly through integrated governance across the three parts of specialised commissioning (retained, delegated and Midlands ICBs).
The opportunities and available resources to support an integrated commissioning approach will recognise the size and complexity of the portfolio and workload of all the teams.

3. Hosting of the ICB commissioning Team

BSOL ICB has been agreed to be the host ICB employer for the ICB specialised commissioning team (on behalf of all 11 ICBs) Any changes to the host ICB will be agreed with NHSE. Full details of the hosting agreement will be covered in a separate hosting agreement to be in place before 1st July 25.
In summary the host ICB will provide:

Function	Description
Employment of staff	HR /training /payroll
Corporate support functions for staff including office space and IT requirements	Legal/IG etc
Senior leadership: - Agreed joint objectives on behalf of 11 ICBs - Line management	

The hosted function will develop an appropriate identity as a team working on behalf of the 11 ICBs through the joint Committees.
The agreed OD programme will ensure that the hosted function, NHSE employed team and ICBs develop a coordinated approach to delivering improved access, outcomes, productivity and value in specialised services.

DATA PROTECTION IMPACT ASSESSMENT

Delegation of the identified Specialised Commissioning Services in the Midlands region of NHSE to their respective ICBs (no staff transfers)

IG Reference: Delegation: Spec comm April 2025

1. Document contributors

The Data Protection Impact Assessment (DPIA) is owned by the team undertaking the processing and will be completed with the support of data protection and records management specialists from the Corporate IG team.

1.1 Document owners

To be completed by the business lead.

The individuals named below will be responsible for implementing all compliance activities required as a result of the assessment process.

Business owner

This should be the project or team lead responsible for completing this DPIA.

Names	Key contacts: Stacey Brittain, Development Manager – stacey.brittain@nhs.net

Senior Responsible Owner (SRO)

This should be a relevant Band 9 or above accountable for the project or programme.

Name	RDC contact: Jo Melling, Deputy Director Commissioning Integration – jomelling@nhs.net

1.2 Corporate IG specialist

To be completed by Corporate IG.

Corporate IG – the IG Officer, Manager or Lead supporting this DPIA.

Name	Rebecca Bray & Lindsay Ince
Job title	Snr IG Manager, RM Manager
Corporate IG work stream	PTT, Digital & Corporate Operations & Records management
Email address	rebecca.bray11@nhs.net Lindsay.ince@nhs.net england.ig-delegationsupport@nhs.net

2. Data Protection Impact Assessment (Level 1)

To be completed by the business owner and emailed to Corporate IG.

2.1. Previous reviews

Has this project, programme or initiative been subject to a previous Data Protection Impact Assessment?

No	If yes, provide IG reference of previous DPIA	

2.2. Purpose of the processing

Describe your project or initiative and the outcomes and benefits it hopes to achieve.

On the 1st April 2025 the final phase of the delegation of specialised services to ICBs will be complete.

NHS commissioning » How commissioning is changing

workspace homepage – *this holds the detail of the services being delegated, including other relevant material to both delegated and retained specialised commissioning functions.*

The specialised commissioning team will transfer from NHS England to the host ICB on the 1st July 2025 and will form part of an integrated commissioning team working alongside staff employed by NHSE in the retained geographical Unit.

There will be little change to the data being collected and shared as there is already the commitment to work with ICBs, there are joint working arrangements and operating models (see appendix 4) already in place and these are continuously being updated by the regional Commissioning Integration team and respective ICBs.

The further identified services to be delegated will be added to the revised Delegation Agreement (DA) for April 2025. The current Joint Data controller agreement (JDCA) (see Appendix 3) will be updated to include the further 3 months between April and July 25. This change covers the interim period during which staff will remain with NHS England until 1 July 2025.

The Operating model for the Specialised Integrated Commissioning team made up of the ICB employed team for delegated specialised services and the NHSE employed team for retained specialised services will be appended to the document for reference when they are finalised. These will help us understand what changes or additional sharing and governance mechanisms we need to have in place at the point of staff transfer, on the 1st July 2025.

What is the anticipated timeframe for your project or initiative?

On 1st April 2025 the midlands ICBs will take responsibility for the delegated functions (detailed within the DA), however the regional NHSE Commissioning Integration team, will continue to process this data on behalf of the ICBs as staff will not transfer from NHSE to the relevant ICB host, until 1st July 2025 – the detail around this is in both the DA and JDC

IG Reference: Delegation: Spec comm April 2025

Agreement
The Joint controller agreement currently in place with the NHSE regional commissioning teams and their relevant ICBs will need to be extended to cover the additional three months between 1st April 2025, when the further services are added to the DA agreement and 30th June 2025 when the staff will transfer to their respective ICBs.

2.3. Description of personal data to be processed

Who will the data you intend to use be about (e.g. cancer patients, NHSE staff)?

See list of functions in Appendix 1. This detail all functions/services which will be delegated to the ICBs.

Please select all relevant options below to describe the data you will receive and use.

Types of people

Patients	Yes
NHSE staff	Yes
Wider health and care staff	Yes
Other	Yes

Number of people

Less than 100	No
Between 100 and 999	No
Between 1,000 and 99,999	No
Between 100,000 and 10m	Yes
Over 10m	No

Types of data

Data concerning health	Yes
Racial or ethnic origin	Yes
Political opinions	No
Religious or philosophical beliefs	No
Trade union membership information	No
Genetic data	No
Biometric data	No
Sex life or sexual orientation	No
Criminal convictions	No

Sensitivity of data

Contains identifiers (e.g. name, address, NHS number)	Yes
Data about individual people with identifiers removed	Yes
Summary or aggregated data that does not describe individual people	Yes

2.4. How the personal data will be collected and used

Will **all** personal data to be processed for your project be received via the National Commissioning Data Repository (NCDR) or Strategic Information Platform (SIP)?

No, some but not ALL

If any personal data will be collected from sources other than the NCDR or SIP, describe where you will collect the personal data from.

Directly from providers and between commissioners. Directly from patients (case workers only)

Describe how you intend to use this information and how you will ensure it is securely stored and managed.

For the delivery of the delegated commissioning specialised function which are delegated to the ICBs.

Will your use of the data result in automated decisions or actions being made about people in ways that could have a significant impact on them?

Yes	If yes, how will this impact people	Used to plan service provision and financial planning for these related services.

Do you have a Records and Information Management Co-ordinator (RIMC) in your team?

Yes	If yes, confirm their name	Lindsay Ince
	Summarise their advice in relation to the storage, management and retention of any corporate records this processing may generate	Specific records management guidance and support materials, supported by Q&A sessions, with each region, will be provided.

If you do not have an RIMC, you may continue with the assessment. However, all teams should have a nominated co-ordinator, you must contact england.ig-corporate@nhs.net to arrange for a member of your team to be trained and registered.

Will NHS England colleagues be using a new IT platform that requires users to log in (i.e. with a username and password or other authentication process) or one that has substantially changed following a previous DPIA to process the personal data?

No

If yes, you will need to produce or update a System-Level Security Policy (SLSP) before this review can be assured – please contact england.itsecurity@nhs.net. You must submit a copy of the approved SLSP with this DPIA to Corporate IG before your project can be signed off.

List any other organisations who will be given access to this data (for example, suppliers, data processors, contractors, consultancies, research agencies).

Organisation	Country of operation	Data to be shared
NHS Black Country ICB As per the appended Joint Data Controller agreement	United Kingdon	Contracting data / Performance data / Service provision & planning data / employment data and personal files / patient identifiable data
NHS Birmingham and Solihull ICB As per the appended Joint Data Controller agreement	United Kingdon	Contracting data / Performance data / Service provision & planning data / employment data and personal files / patient identifiable data
NHS Coventry & Warwickshire ICB As per the appended Joint Data Controller agreement	United Kingdon	Contracting data / Performance data / Service provision & planning data / employment data and personal files / patient identifiable data
NHS Derby and Derbyshire ICB As per the appended Joint Data Controller agreement	United Kingdon	Contracting data / Performance data / Service provision & planning data / employment data and personal files / patient identifiable data
NHS Herefordshire & Worcestershire ICB As per the appended Joint Data Controller agreement	United Kingdon	Contracting data / Performance data / Service provision & planning data / employment data and personal files / patient identifiable data
NHS Leicester, Leicestershire, and Rutland ICB As per the appended Joint Data Controller agreement	United Kingdon	Contracting data / Performance data / Service provision & planning data / employment data and personal files / patient identifiable data
NHS Lincoln and Lincolnshire ICB	United Kingdon	Contracting data / Performance data /

As per the appended Joint Data Controller agreement		Service provision & planning data / employment data and personal files / patient identifiable data
NHS Northamptonshire ICB As per the appended Joint Data Controller agreement	United Kingdon	Contracting data / Performance data / Service provision & planning data / employment data and personal files / patient identifiable data
NHS Nottingham and Nottinghamshire ICB As per the appended Joint Data Controller agreement	United Kingdon	Contracting data / Performance data / Service provision & planning data / employment data and personal files / patient identifiable data
NHS Shropshire, Telford and Wrekin ICB As per the appended Joint Data Controller agreement	United Kingdon	Contracting data / Performance data / Service provision & planning data / employment data and personal files / patient identifiable data
NHS Staffordshire and Stoke on Trent ICB As per the appended Joint Data Controller agreement	United Kingdon	Contracting data / Performance data / Service provision & planning data / employment data and personal files / patient identifiable data

2.5. Lawful basis for processing the personal data

What is it in statute or common law that enables and/or entitles NHSE, TDA or Monitor to use information about people in the proposed way? (For example, this might be a specific clause(s) within the NHS Act 2006 or the Health and Social Care Act 2012, a set of Regulations, Ministerial Directions, or a clear common law task. A list of NHS England statutory duties can be found here.)

NHS England has statutory functions to arrange for the provision of prescribed services for the purposes of the NHS, including the **'Specialised Services'**. Pursuant to section 65Z5 of the NHS Act 2006 NHS England intends to delegate to ICBs (via the **'Delegation Agreement'**) the statutory functions for commissioning certain of those Specialised Services (**'the Delegated Specialised Services'**) to take effect from the beginning of the 2025/26 financial year.

However, staff to support the delivery of delegated commissioning functions won't transfer to the relevant ICBs until 1st July 2025, there will be supporting arrangements to cover this transitional period (Joint Data Controller Agreements 1 April – 30 June 2025). For this interim period NHS England will also continue to deliver supporting functions such as FOI, SRR and complaints as they will retain the data and staff required to fully answer these types of queries.

NHS England will continue to hold the statutory function for a number of Specialised Services who are not, at present, to be delegated to the ICBs (**'the Retained Specialised Services'**).

- NHS Act 2006, Schedule 1, paragraph 13(3) to obtain and analyse data.
- NHS Act 2006, Section 2 gives NHS England the power to do anything calculated to facilitate, or that is conducive or incidental to the discharge of any of the tasks given to it by the NHS 2006 Act. This includes sharing data when this is done for a proper purpose

Do any of the following statements apply?

We need the information to enact a contract between us and the person to whom the data relates	No
We will be seeking explicit and unconditional consent from each person to which the data relates	No
We are responding to a legally binding request from a court or other statutory agency to provide this information	No
We need the information to protect the life of an immediately endangered individual or persons	No

2.6. Risk assessment

This risk log should be updated throughout the DPIA process and may be contributed to by the business owner, IG Specialist, IG Management, the Data Protection Officer (DPO) or the SIRO.

Please record below any information risks associated with this programme, project or initiative. Several general information risks have been pre-populated and must be considered in all cases. Please also add any additional, project-specific information risks. All risks identified in this DPIA should be transferred to the project, programme or initiative's local risk log for operational management by the business owner.

Risk scores should be calculated assuming any proposed mitigating actions have been successfully implemented, using the scoring matrix in the DPIA guidance.

	Risk title	**Description of how the risk impacts this activity or a justification of why it is not applicable**	**Risk score** (Prior to mitigations)			**Proposed solution(s) or mitigating action(s)**	**Action owner(s)**	**Action Due Date(s)**	**Risk score** (After mitigations are implemented)			**Status**
			Likelihood	Impact	RAG status				Likelihood	Impact	RAG status	
1	There is a risk that personal data may be misused by those with access	New ways of working may invoke challenges and over sharing of data	2	3	A	There will be minimal data shared between NHSE and the ICBs further than what is already available already and that which is required to deliver the delegated functions. Shared work space minimises the risk as access controls will be mapped out and implemented prior to staff transfer.	NHSE and ICBs	31/03/2024	1	3	A	Closed
2	There is a risk that insufficient organisational measures are in place to ensure appropriate security of the personal data (e.g. policies, procedures, disciplinary controls)	minimal personal data being processed as part of this work.	1	2	G	Case managers have been identified as part of the data flow mapping appended to this DPIA, they will have access to relevant PID however their working folders will continue to be locked down only to those staff required to have access.	NHSE	31/03/2025	1	1	G	Closed
3	There is a risk that insufficient technical measures are in place to ensure appropriate security of the personal data (e.g. encryption, access controls)	minimal personal data being processed as part of this work.	1	2	G	As above. Similarly in terms of the contractually sensitive information, this data in managed so only those staff members who need access will have access, this is mapped out	NSHE	31/03/2025	1	1	G	Closed

Risk title		Description of how the risk impacts this activity or a justification of why it is not applicable	Risk score (Prior to mitigations)			Proposed solution(s) or mitigating action(s)	Action owner(s)	Action Due Date(s)	Risk score (After mitigations are implemented)			Status
			Likelihood	Impact	RAG status				Likelihood	Impact	RAG status	
						within the data flow mapping document appended to this DPIA.						
4	There is a risk that insufficient testing has taken place to assess and improve the effectiveness of technical and organisational measures	New ways of working, delegation is new to these teams.	2	3	A	NHSE regional commissioning teams have already been working in a collaborative way and this year's arrangement should not bring any new risk as no new data will be made available that what is already in place/available to either party. In addition to this the access controls which have been mapped out will be tested and in place prior to staff transferring to the ICBs host hub.	NHSE and ICBs	31/03/2025	1	3	A	Closed
5	There is a risk that data that has had identifiers removed could be manipulated in some way to re-identify individual people	This would always be a risk due to the nature of the nature available to either organisation, however this is not the intention and data is always treated as confidential and care is always take to ensure only the minimum amount necessary is available to only those who require it.	3	3	AG	This is not the intention and data is always treated as confidential and care is always take to ensure only the minimum amount necessary is available to only those who require it.	NHSE and ICBs	31/03/2024	2	2	A	Closed
6	There is a risk that…		Select	Select	Select				Select	Select	Select	Select

Thank you for completing the Level 1 Data Protection Impact Assessment. Please submit it to Corporate IG, where it will be assigned to a member of Corporate IG who will contact you to appraise the processing and complete the review. We aim to respond to you within ten working days.

IG Reference: Delegation: Spec comm April 2025

3. DPIA (Level 1) Risk Screening

To be completed by the allocated Corporate IG specialist.

3.1. Type(s) of personal data

Fully identifiable	Yes
Pseudonymised	Yes
Anonymised in context	Yes
Fully anonymised	Yes

Will the processing involve fully identifiable data about patients?

Yes

3.2. Risk thresholds

There is no processing of personal data involved in this activity	No	**If the answer to any of these statements is "Yes", there is no need to progress further with the DPIA**
Data has been fully aggregated with small-number suppression applied prior to processing	Yes (some, not all)	
NHS England is **not** a data controller or processor for this processing	No	

Any element of automated processing in which decisions are made about a person in the absence of human intervention (including profiling)	No	**If all these statements are answered "No", progress as Level 1 DPIA** Complete Section 5 and seek local IG Manager approval **If the answer to any of these statements is "Yes", progress as Level 2 DPIA** Complete Section 4 and Section 5 and seek DPO and SIRO approval
Processing of individual-level data that includes special categories or criminal convictions/offences (this does not apply to data from the SIP/NCDR or fully anonymised data)	Yes DSCRO CSUs only	
Processing of fully anonymised data about more than 10,000,000 people that includes special categories or criminal convictions/offences	No	
Systematic monitoring of a publicly accessible area involving more than 1,000 people	No	
Transfer, storage or access of personal data outside of the UK	No	
Any other risks to peoples' rights and freedoms that cannot be mitigated below amber-red	No	

4 Data Protection Impact Assessment (Level 2)

To be completed by the business owner in discussion with the allocated IG Specialist if Corporate IG assess the processing as being high-risk.

4.1. Justification for personal data to be processed

Describe why it would not be possible to undertake your project or initiative without the personal data described in 2.3. Explain why this is the minimum amount of data necessary for the task and, if applicable, why you could not use de-identified data.

In order for NHSE to delegate the identified commissioning functions (listed in Appendix 1) to be updated for April 25, to include the additional services which have been added to the delegation agreement, ready for the staff transfer in July 2025. Identifiable data is only used in a small percentage of services in Specialised commissioning, full details are within the associated Data flow mapping document. Operating models will be jointly developed. To promote an open and collaborative approach to deliver specialised commissioning functions a shared repository workspace will be developed (on NHSE .net tenancy), for each region, accessible via SharePoint or Teams. Records management guidance and support will be provided to support this work within the regional teams.

Is the provision of personal data obligatory?

Yes	If yes, describe why this is the case	Some data is classed a pseudonymised level data, provided from the CSUs DSCROs. Both organisations already have access to this level of data. The only addition to this will be in relation to the case managers as detailed earlier in this document and in the data flow mapping document appended.

What are the possible consequences for a data subject if there is a failure to provide the requested personal data?

The possible consequences are: • The ICB could not fulfil their obligations to deliver the delegated functions. • NHSE could not discharge these functions on behalf of the ICBs for this interim period until staff are transferred. • NHSE would carry the risk associated with these functions as it remains overall accountable for all delegated services. It is in the interest of all organisations involved

to ensure the risks are addressed prior to delegation and for the staff transfer.

If the processing will result in a decision being made about an individual without any human intervention, describe the logic by which any decisions will be reached?

n/a

Will any personal data be used for direct marketing to data subjects?

No	If yes, provide further details	

4.2. Additional information about personal data to be processed

Describe the dataset(s) that you intend to collect and process, who will have access to it and how it will be securely stored. Please either submit a comprehensive data flow diagram or complete the section below.

Dataset	Personal data items	To be accessed by	Secure storage
See Appendix 2			

List any flows of personal data into NHS England.

Sender	Content	Secure transfer mechanism	Recipient
N/A			

List any flows of personal data out of NHS England.

Sender	Content	Secure transfer mechanism	Recipient
See Appendix 2			

Will the personal data be recoverable in the event of a physical or technical incident?

No	If yes, explain how or refer to SLSP	

If you are using a data processor, are arrangements in place to securely return or destroy the personal data at the end of the contract?

No	If yes, explain how or refer to SLSP	

Will it be possible to provide an individual, or another organisation, a copy of their personal data in a structured, commonly used and machine-readable format? Note this only applies in limited circumstances – your IG Specialist will support you with this.

NA	If yes, explain how	

5 IG Assessment

To be completed by a Corporate IG specialist in discussion with the business owner and records management colleagues.

5.1. Controllers, processors and third parties

Confirm the controller(s) for this processing.

NHS England - all Spec comm retained services	Yes
ICBs - for all delegated services	Yes

List additional joint controller(s)/processors for this processing and upload evidence of the compliant joint data controller arrangements (e.g. Joint Controller Agreement/processing agreement).

Organisation	Evidence of arrangements
Regional teams within NHSE together with ICBs for the delegation specialised functions for the interim period between Delegation and staff transfer.	**Joint Controller Agreement** In support of the package of arrangements detailed in **appendix 3**
NHSE as host of the data related to all spec comm services , full details within the schedule detailed in the Delegation Agreement.	**Delegation Agreement, Data Processing & Sharing schedule 6**
ICB hub arrangements between all associated ICBs	**Processing arrangements. Tbd between ICBs**

List any Commissioning Support Units or Hosted Bodies that will undertake processing of personal data for this purpose and provide a copy of the relevant SLA or MoU that commissions the work.

CSU	MoU or SLA
ALL CSUs nationally via DSCROs	Under current arrangements, no new data flows.

5.2. International Transfers

If any of the organisations listed in Section 2.4 will process personal data outside of the UK, describe the arrangements in place. Ensure copies of any contractual agreements (e.g. standard contractual clauses, binding corporate rules) are attached in Section 5.1 above.

Organisation	Location	Control
n/a		Choose an item.

5.3. Lawful basis

Confirm the UK GDPR Article 6 condition for the processing.

Not made available to either party as identifiable data. Processed via the DSCROs in the CSUs.

Art 6.1a Consent	No
If yes, explain how consent will be sought and how data subjects can revoke it if required	

Art 6.1b Contract	No
If yes, describe the contract between NHSE/I and the data subject	

Art 6.1c Legal obligation	Yes
If yes, describe the legal obligation to which NHSE/I needs to adhere	Processing is necessary to comply with NHS England's statutory duties under the NHS Act 2006. DPA 2018 schedule 1, paragraph 2, (health or social care purposes).

Additional considerations:

- Statutory Function Justification: NHS England and ICBs have statutory duties under the Act 2006 to commission healthcare services.
- Data Protection Safeguards: Processing must comply with schedule 1, part 4 of DPA 2018, which requires appropriate policies and documentation (DPIA, JCA & Delegation Agreement and supporting information including Records Management documentation).

Art 6.1d Vital interests	No
If yes, describe why processing the data is necessary to protect someone's vital interests	

Art 6.1e Public authority	Yes
If yes, detail the clause(s) from an Act or Regulation that describes the legal duty	

Art 6.1f Legitimate interests	No
If yes, describe NHSE/I's legitimate interests to process this data	

Will the processing involve special categories of personal data?

Yes

Not made available to either party as identifiable data. Processed via the DSCROs in the CSUs.

If yes, confirm the UK GDPR Article 9 condition for the processing.

Art.9.2a Explicit consent	No
Art.9.2b Employment, social security, social protection law	No
Art.9.2c Vital interests	No
Art.9.2d Political, philosophical, religious or trade union not-for-profit body	No
Art.9.2e Data manifestly made public by the data subject	No
Art.9.2f Legal claims	No
Art.9.2g Public interest	No
Art.9.2h Health or social care system	Yes
Art.9.2i Public health	No
Art.9.2j Archiving, scientific or historical research	No

Will the processing involve disclosing data that is subject to a duty of confidentiality for a purpose other than direct care?

No

If yes, confirm the lawful basis for processing.

Consent	Yes/No
Safeguarding	Yes/No
Covered by Section 251 decision	Yes/No
Required by law (e.g. COPI regulations)	Yes/No
Overriding public interest	Yes/No

5.4. Information asset management

Does an information asset already exist in relation to this processing?

Yes

If yes, provide the asset number	
If no, confirm the new IAO	Jo Melling
If no, confirm the new IAA(s)	Stacey Brittain

5.1. Records and information management

Will any records be created or managed as part of this processing?

Yes	If yes, identify the types of record	Specialised Commissioning delegated and retained services working papers and digital records
	If yes, confirm where the records will be stored	Within the NHSE SharePoint environment, hosted on the NHS Mail tenancy. Most areas will be open to retained and delegated staff, with some exceptions (e.g. PID/historic contracts/ledgers) locked down to specified access permissions groups, specified on the Data Mapping spreadsheet. ICB staff will be given access to the SharePoint space via their email accounts, and folders can be managed down to different staff
	If yes, provide the retention period for the personal data and the basis for this retention period (e.g. corporate retention schedule, applicable guidance or rationale)	In line with NHSE Retention Schedules (applicable to legacy records pre-April 2025) and thereafter the retention schedule of the ICB for data April 2025 onwards.
	If yes, and where records are processed outside of NHSE premises or systems, how will they be securely returned for the remainder of the retention period(s) as and when this becomes necessary (e.g. following the closure of the project)?	Only nonidentifiable data that is already available to the ICBs via DSCROs; rest of data will be retained within NHSE environment.
	If yes, name of Corporate Records Management specialist who has reviewed the processing	Lindsay Ince IG Manager – Records Management

5.2. Fair processing

Is NHS England exempt from providing fair processing information under provisions specified in the UK GDPR?

No	If yes, describe exemption	Choose an item.

If no, is the processing sufficiently described in NHS England's central privacy notice?

Yes- already updated

6 Approval

All Level 1 and Level 2 DPIAs must be assessed and assured by a Corporate IG Manager, Senior Manager or SMT Lead via section 6.1.

Processing activities subject to a Level 2 DPIA must also be submitted to the national Senior Information Risk Owner (SIRO) and Data Protection Officer (DPO) for approval – complete section 6.2.

6.1. Actions required

Select all mandatory actions that apply to this processing from the list below.

Action	Applies	Due date or pre-go-live	Complete
RIMC trained	Yes		Yes/No/NA
Asset registered or updated on IAMS	Yes		Yes/No/NA
Local privacy information provided	Yes		Yes/No/NA
Data processing and sharing agreements signed	Yes		Yes/No/NA
Mitigation of outstanding risks	Yes		Yes/No/NA

List any additional actions specific to this project or initiative below.

Action	Due date	Status
Joint Controller Agreement agreed and completed as part of the suit of documents jointly drafted by NHSE regional teams and the ICBs moving toward delegation. To be extended to include the interim period between April and July 2025	Prior to sign off	
Operating models appended to the DPIA to provide further detail not able to be articulated in this DPIA.	Prior to sign off	

6.2. DPIA Assurance (Level 1 and Level 2)

Outcome of IG Management assurance	Assurance pending
Date of IG Management assurance	

Corporate IG Manager, Senior Manager or SMT Lead

Name	Rebecca Bray
Job title	Senior Information Governance Manager
Corporate IG work stream	PTT, Digital and Operations
Email address	Rebecca.bray11@nhs.net

Submit Level 2 DPIAs to england.dpo@nhs.net for consideration by the Data Protection Officer and Senior Information Risk Owner

6.3. DPIA Approval (Level 2 only)

Outcome of SIRO assessment	Choose an item.
Date of SIRO assessment	

Does the Data Protection Officer have any concerns regarding this processing that they feel have not been sufficiently mitigated?

Yes/No	If yes, provide details	

Data Protection Officer or deputy

Name	
Job title	
Email address	

Senior Information Risk Owner or deputy

Name	
Signature	
Job title	
Email address	

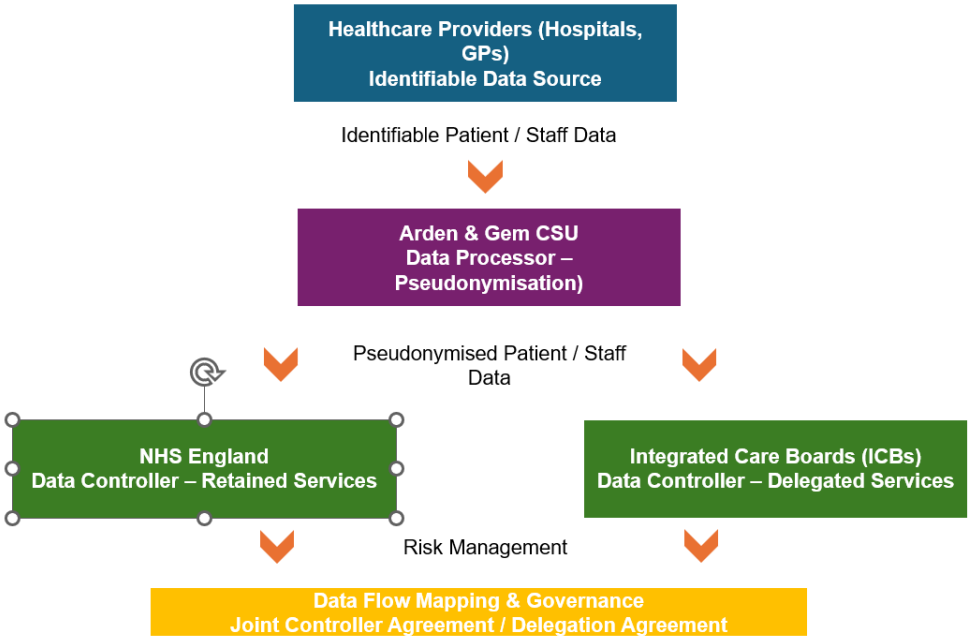
Ensure that this DPIA and its status is logged on the IG Advice Register and a copy saved in the relevant SharePoint folder.

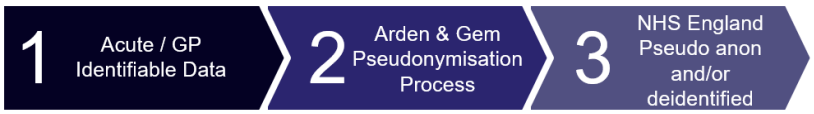
Appendix 1: Delegated Commissioning Services

20241201%20SPA%20List%20Mapping%2

Appendix 2: Data Sets and Flow

Data%20Flow%20Mapping%20for%20Midl





Appendix Three

The following documents referenced within this DPIA can be found on **NHS Futures**

- List of functions, to be delegated and those retained by NHSE
- Delegation Agreement for Specialised Services
- MOU and Collaboration Agreement for the Delegation of Specialised Services 2024/25
- Commissioning Team Agreement and Standard Operating Framework for 2024/25
- IG considerations for Delegation Phase 3
- Joint Controller Agreement

Joint Controller Agreement

Contracting SOP **NHS Futures**

Finance SOP **NHS Futures**

Future resource pages **Tools**

Appendix Four

Operating models for delegated Hubs and Retained Units

Consultation Close Briefing _FINAL.docx

IG Reference: Delegation: Spec comm April 2025

Agenda Item

ICB 26-03.141

Quality and Performance Committee Chair's Report

Appendix A - Enclosure 1 final Draft Minutes 28th November 2024

Appendix B - Enclosure 1 Draft Minutes of QPc Meeting held on 30th January 2025

Appendix C - QPC TOR updated Feb 25

NHS Shropshire Telford and Wrekin
ICS Quality & Performance Committee Meeting

Thursday, 28th November 2024

Via Microsoft Teams

Committee Members Present:

Meredith Vivian	Chair & Non-Executive Director, NHS STW
Vanessa Whatley	CNO NHS STW
Julie Garside	Director of Planning & Performance NHS STW
Dr Lorna Clarson	Chief Medical Officer, NHS STW
Dr Mahadeva Ganesh	Medical Director SCHT
Anne Maclachlan	Clinical and Care Director, Shropshire Care Group, MPFT (Part only)
Tracey Slater	Head of Quality. NHS STW
Rosi Edwards	Non-Executive Director, SaTH
Lisa Rowley	PA to CNO and minute taker

Attendees Representing Committee Members:

Jaz Dhillon	Interface and governance pharmacist NHS STW
Sara Bailey	Deputy Director of Nursing- SaTH (representing Hayley Flavell)
Sara Ellis-Anderson	Deputy Director of Nursing & Quality Shropcom (representing Clair Hobbs)
Sara Reeve	Deputy Director of Quality, MPFT (representing Liz Lockett)
Kirsty Foskett	Assistant Chief Nurse and Patient Safety Officer (representing Paul Kavanagh Fields)
Emma Pyrah	Head of System Development, NHS STW (Representing Claire Parker)

Presenters in Attendance:

Emma Pyrah	Head of System Development, Strategy & Development NHS STW
Vickie Jones	Senior Lead for Delivery and Assurance NHS STW

1.0 Minute No. QPC-24-11.145 - Welcome/Apologies - Meredith Vivian (Chair)

1.1 The Chair of the Committee welcomed members and attendees to the meeting and introductions were made.

2.0 Minute No. QPC-24.11.146 Apologies:

Apologies were received from:

Angie Parkes	Deputy Director Planning & Performance NHS STW
Jill Barker	Non-Executive Director, Shropcom
Lynn Cawley	Chief Executive, Healthwatch Shropshire
Clair Hobbs	director of Nursing & Clinical Delivery Shropcom
Paul Kavanagh-Fields	Chief Nursing Officer RJAH
Claire Parker	Director of Strategy and Development NHS STW
Helen Onions	Interim Director of Public Health, Telford & Wrekin Council.
Sharon Fletcher	Head of Quality & Safety Improvement & Patient Safety Specialist NHS STW
Laura Tyler	Shropshire Council

3.0 QPC-24-11.147 - Members' Declarations of Interests

3.1 No new declarations of interest were noted.

4.0 Minute No. QPC-24-11.148 - Minutes of Meeting held on 31st October 2024

4.1 The minutes of the meeting held on 31st October were reviewed and accepted as an accurate record of the meeting subject to the following:

4.2 Rosi Edwards via email requested some amendments to be made:

5.0 Minute No. QPC-24-11.149- Matters Arising and Action Log

5.1.1 Actions have been updated and are outlined on the action log.

6.0 Minute No QPC-24-11.150 - BAF – System Strategic Risk Register, System Quality Risk Register Covering Report, System Quality Risk Register

6.1 The Committee agreed to receive the SORR & BAF on a quarterly basis at QPC rather than monthly.

6.2 Risk SQG14 Oral Maxillofacial – extended cancer waiting times have been seen across a number of specialities. The senior quality lead within the ICB's Quality Team is working with the acute provider looking how to streamline the reporting and governance processes for harm reviews for cancer waiting times.

6.3 Risk SQG10 IPC – The system is currently over trajectory for C diff; there is significant work being undertaken in the system with action plans which are being monitored by IPC system groups.

Action: Vanessa Whatley to speak with Alison Smith about the frequency the BAF needs to be presented to QPC so that it is aligned with presentation at other Committees.

6.2 Julie Garside said that in terms of risks, she expressed concern that diagnostic reporting times and risks of delayed diagnostics and deterioriating outcome for patients are not on the register although a recovery plan is in place.

Action: VW to liaise with Sharon Fletcher to ensure Delayed diagnostics is included within the Risk Register.

6.3 Vanessa Whatley commented that a risk owner needs to be identified for Delayed Diagnostics and that she would cross check what is on the plan and Care groups risk register. Julie Garside advised that Maureen Wain would be the risk owner.

6.4 Meredith Vivian highlighted that the process of risks is that they go through the System Quality Group process prior to being presented to QPC.

6.5 Vanessa Whatley added that the quality risks should be presented and discussed for mitigation at System Quality Group, however if there is a performance risk, these will go via another group into QPC, the quality element of a risk is combined with performance; once the risk has been drafted, this will go to SQG for discussion around mitigation.

6.6 Julie Garside commented that there is a planned Care Delivery Group meeting scheduled for 9th December and will ask if this risk can be added to the agenda and she will work with Maureen to draft a risk to be taken through this forum and then passed onto SQG for discussion.

Action: Vanessa Whatley to work with Sharon Feltcher in Identifying risk owners and ensure that any updates go through SQG and then QPC .

7.0 <u>Minute No QPC-24.11.151 – Quality & Performance Exception Report – Julie Garside for Performance & Tracey Slater for Quality</u>

The report was taken as read and the following key points were highlighted

7.1 Performance – Julie Garside

.

7.1.1 Concerns remain around the volume of patients waiting over 4 and 12 hours in ED from a quality and a risk perspective. Daily position statements are received from NHSE on UEC where it shows that the region is consistently exceeding the percentage target of patients over 12 hours; across East and West Midlands.

7.1.2 Elective Care – since the report was written there has been a change in the number of long waits. The over 65 week position at the end of November shows a deterioration of the 286 quoted in the report which has increased to 3234 for SaTH, however there has been some improvement in some specialties, but the main areas are in ENT and oral surgery.

7.1.3 Diagnostics – Since the report was written recovery trajectories from SaTH have been received; there has been a significant amount of work carried out, however, further work is required in terms of eliminating the over 13 weeks by the end of March 2025 and achieving the 85% of diagnostics seen within six weeks.

7.1.4 Further work will be carried out on the performance section of the report to include the level of waiting list for ADHD and autism assessments, this information will be included from January 2025; the report will also include more detail around community long waits. The ICB are working closely with the Community Trust in relation to community services with long waits that are non RTT measures.

Action: Julie Garside to work with Sharon Fletcher and Vanessa Whatley to put together the schedule of risk spotlights for 2025/26, to be presented to QPC in January 2025. This schedule to be forwarded to Committee members in advance of the next QPC meeting.

7.1.5 The chair requested that the Spotlight schedule is circulated to the Committee for their views/comments so that it can be presented at the January QPC meeting as an informed paper as there may be other areas that need investigating.

7.1.6 Rosie Edwards commented that the Trust held a seminar on winter pressures looking at their readiness in urgent and emergency care with Saskia Jones-Perrott reporting on what has been happening in A&E and frailty work.

7.1.7 Rosie referred to Page 45 of the performance report regarding insufficient hysteroscopes to support the achievement of the 62 day performance.

Rosie advised that she wrote to Ned Hobbs asking why the Trust did not have enough hysteroscopes and was informed these are on order.

7.1.8 Vanessa Whatley commented that frailty strategy should be ready for comment in February, 2025.A Service Specification is also being negotiated around community nursing.

7.2 **Quality – Tracey Slater**

7.2.1 UEC – patient services team feedback shows that those waiting times and ambulance waiting times are a particular challenge from a quality point of view. Weekly meetings with SaTH colleagues are held looking at harm reviews; six-hour ambulance harm review offloads and 12-hour breaches. This highlighted several people waiting over 12 hours in hospital are over the age of 90 during July and August some of which had dementia.

7.2.2 There is an improved triage compliance at 97.5% in ED and harms are low for ambulance offloads.

7.2.3 Regular insight visits are taking place at both ED sites across SaTH and findings to be reported to SQG.

7.2.4 The learning disability annual health checks – There is high confidence that the 75% target will be achieved.

7.2.5 Continuing healthcare's key statutory target is 80% of referrals processed within 28 days, this has been exceeded, during quarter two it reached 93%.

7.2.6 Sara Ellis referred to harm reviews and the themes being picked out in terms of alternative admissions to ED and asked if these were being fed into the ED UEC workstream?

7.2.7 Tracey Slater said she would need to check and commented that this would be the ideal route in which to do this for harm reviews that are worked through with SaTH.

7.2.8 Sara Bailey explained a range of actions taken by saTH to address the flow and reduce harm in the EDs.

7.2.9 Sara Bailey referred to virtual wards and commented that the offer of this route should be part of business as usual and not an add-on.

Following discussion, the Committee:

- Noted the continued collaborative content of the performance and quality integrated report regarding performance of key metrics and quality against national standards and local targets where performance/quality falls short of national standards and locally agreed targets,
- Noted the actions being taken and risks are being appropriately mitigated and provide the necessary assurance.

- Noted that this report continues to evolve to improve the way data and actions are presented to provide assurance to the Committee.
- Provided feedback on the new integrated report to ensure the report meets the needs of the Committee as part of continuous improvement.

8.0 Minute No QPC-24-11.152 – Spotlight Report Diabetes Update – Emma Pyrah and Dr Lorna Clarson

The paper was taken as read and the following points were highlighted:-

8.1 Dr Clarson said the aim is to underpin principles with the diabetes transformation so that there is a consistent offer for every patient with or at risk of diabetes across STW based on scientific evidence. Best practice will be aimed to empower patients to take control of their health that is easy to navigate and provide support to those who might struggle with diabetes as care can be fragmented and may need to be provided in a number of different places. The aim is to provide a digital diabetes service and to offer alternatives for those patients who are at risk of digital exclusion with an offer of access technology to enable patients to self-manage their condition accessing their own data with the ability to upload their own outcomes into a record that clinicians and professionals have sight of.

8.2 A priority area of good practice is to look at prevention and identify patients at risk and to offer a care pathway in terms of reducing the risk of developing diabetes. Telford & Wrekin and Shropshire Councils have recently published a well aligned healthy weight strategy as approximately 70% of the population in Shropshire are obese, with focus on helping people to make healthy choices around physical activity nutrition; these will be built into the pathway.

8.3 Medicines used to manage diabetes need to be looked at and support provided for patients in understanding their medication and how to use them in a safe and effective way. But also offer up to date treatments.

8.4 Another area of focus is the reduction of complications of diabetes such as neurovascular; Shropshire are an outlier for amputations, complications for mothers and babies ensuring good prenatal and anti-Natal reducing complications such as cardiovascular disease, chronic kidney disease and sight loss.

8.5 Collaboration with providers will be required in terms of digital delivery so that Care records can be linked together so that the patient journey can be understood from beginning to end and to recognise those patients who are diagnosed as being pre diabetic and are obese, the path to remission that supports patients to lose weight and is successful in providing remission for

diabetes relies on a patient to consultant and then to provide a referral into that service. Collaboration is also important around care navigation.

8.6 The approach that needs to be taken will be driven by population health management that starts with identifying as a system where the poorest outcomes are. A set of metrics and measures have been developed showing targets to be reached an to develop population segments and identify priority cohorts e.g., Who are most at risk; who are those with the poorest outcomes; where inequalities lie and how different groups of people can be reached in a way to improve their outcomes.

8.7 A set of interventions will be established for patients who would benefit from particular medications and those who should be offered access to the path to remission and those who would be eligible for injectable weight loss medications; metrics and measures being proposed require further consultation.

8.8 Risk factors have been looked at with the aim to reduce the proportion of adults classified as obese or overweight and reduce the incidence of type 2 diabetes with early identification and treatment and increasing the number of newly diagnosed who achieve remission and the number of newly diagnosed people who achieve optimal glucose control and those who have a care plan.

8.9 Consistent care – this is the achievement of treatment targets for HBA1C, blood pressure and cholesterol levels. As these conditions are impactful on cardiovascular and renal vascular health. Completion of all the care processes will show a reduction in length of stay in hospital for patients, thus alleviating complications and end organ damage, such as limb amputations; a reduction in maternal and perinatal morbidity whether gestational or otherwise; a reduction in visual loss, an improvement in kidney care. The aim of the diabetes pathway is to reduce complications and improve outcomes; with focus on prevention, secondary prevention and tertiary prevention with an improved offer through general practice and PCNs, ensuring consistent delivery of care and treatment targets across the system.

8.10 Ann Maclachlan commented she has concerns about people with a serious mental illness who are at an increased risk of developing diabetes and not knowing they have the condition and asked if routine screening for anxiety , depression, eating disorders and cognitive impairment would be part of the pathway development.

8.11 Lorna Clarson responded that the mental health element will be incorporated into the pathway as it is known that people with long term conditions are more likely to develop anxiety and depression. A request for a mental health representative will be made to join the Group.

8.12 Dr Ganesh suggested that a clinical psychologist is part of the strategy and operational group for difficult patients who do not comply with treatment.

8.13 Kirsty Foskett requested that when appropriate RJAH are engaged as they have seen a significant impact onto their orthotic service with the demand of diabetic patients; RJAH have seen a 70% increase in referrals since 2020 which has had an impact on the prevention and management within the Community.

8.14 Sara Ellis commented that Shropcom' diabetes specialist nurses deliver the expert patient program and suggested that some of their patients could form part of the network and would be happy to share outcomes and data from that program.

Following Discussion, the Committee:

- Agreed to receive a further update on progress in May 2025
- Noted the next steps within the report.

9.0 Minute No QPC-24-11.153 – Spotlight Report CDiff – Vanessa Whatley

The report was taken as read and the following key points were highlighted: -

9.1 A system task and finish group has been established to make recommendations for further action in relation to the control of *C diff.*

9.2 The antimicrobial stewardship work progress in primary care is showing reduced use of antimicrobials.

9.3 SaTH cases are variable, September data was under trajectory, October is above trajectory.

9.4 SaTH have had a further workshop recently where further actions were identified for the Trust.

9.5 Sara Bailey commented that SaTH have focussed workstreams around all key areas such as hand hygiene, walk processes and antimicrobial stewardship. Their antimicrobial stewardship group has been re-established; a meeting has been held to review their terms of business with a further meeting planned which will galvanise their work around their reviews of prescribing. The Trust are looking at a new programme of auditing cleaning working closely with facilities to identify a more robust method of cleaning equipment and mattresses including a dedicated cleaning service. The actions are being closely monitored through the Trust's internal Quality and Safety Committees.

9.6 Kirsty Foskett added that RJAH have revised their IPC Policy and the Trust has been carrying out targeted education with their spinal injuries' unit staff although the number of cases at the Trust are currently below trajectory.

9.7 Dr Ganesh said the best prevention for any infection is proper hand hygiene. And asked if SaTH had regular audits of hand washing. Sara Bailey confirmed they were as wells as further additional checks by the IPC team

9.8 The chair asked if there was any information for patients in a healthcare setting to adopt a leadership role in requesting that healthcare staff have washed their hands?

9.9 Sara Bailey explained that SaTH have a reminder to wash hands in their admission booklet and patients are reminded daily to wash their hands before mealtimes and after using the toilet with soap and water.

9.10 Sara Ellis commented that Shropcom ask for this information on their IPC quality assurance audit.

Following discussion, the Committee:

- Discussed report for assurance against current guidance.
- Considered additional actions required.

10.0 Minute No. QPC-24-11.154- Spotlight Report Children & Young People- Vickie Jones

The report was taken as read, and the following key points were highlighted:-

10.1 The risks around CYP currently in the system are around electives and communities getting to the 52 week wait or less by March 2025. CAMHS is around the access target and end the assessment times.

10.2 Mental Health waits for children are down to 9 weeks, from 12 months.

10.3 The multi agency case file audit has come out supporting CYP with the appropriate mental health and emotional well-being.

10.4 There has been an increase in the number of children in the system which is putting pressure on demand and capacity; the demand is increasing around initial health assessments, the volume of annual health checks and the number of inter-area placements continue to rise. There is a high number of children placed in Shropshire, Telford and Wrekin which is not their normal place of residence.

10.5 All of these risks are owned by several different boards across the system. For assurance purposes, these risks have been owned and are being looked at.

10.6 The expectation is that CYP mental health waits should be no more than 4 weeks, and currently there is a 9 week wait for Mental health services There is a delivery plan, this is monitored as part of the contract, there is assurance that the 4-week waiting target will be met before the end of 2024/2025. The assurance for the waiting time is sought by the LD&A Operational Delivery board and SEND Partnerships.

Following discussion, the Committee:-

- The committee received and accepted the report.
- The committee has assurance that risks for CYP are managed across the system

11.0 Minute No. QPC-24-11.155 – Update on Quality Governance Report – Tracey Slater

The paper was taken as read and the following points were highlighted:

11.1 The chair recommended that an update is provided to QPC on 30th January following the Governance review meeting on 31st December.

11.2 Tracey Slater referred to QPC Terms of reference advising that she has forwarded this to Committee members for comments/amendments to be made by 6th December 2024

Action: Tracey to meet with Meredith Vivian outside of the meeting to go through QPC terms of reference.

11.3 Tracey Slater advised that the actions are due for completion by 31st March 2025 which she is confident will be achieved.

Following discussion, the Committee:

- Noted the content of the Governance review and action plan and recognise the issues and actions required at pace to make tangible and sustainable change.

12.0 Minute NO QPC-24-11-156 – Exception Report System Quality Group Chairs Update – Vanessa Whatley

The report was taken as read and the following points were highlighted:-

12.1 The chair asked what the position was in relation to paediatric audiology.

12.2 Vanessa Whatley commented that a risk is being looked at, previously there was full assurance that paediatric audiology, however, it has now been highlighted there is a risk across the broader pathway, particularly in ENT.

12.3 Dr Ganesh added that he was responsible for a long time as the lead clinician for paediatric aetiology, there was a succession plan in place for the specialist aspect of this service, but this did not work out while children with hearing issues are being looked after well, identifying the cause of hearing loss remains a gap.

Following discussion, the Committee:-

- Considered the lack of assurance around the issues related to paediatric hearing.
- Considered the other alerts for further action
- Noted the shred learning.

13.0 Minute No QPC-25-11.157 – Health Protection Assurance Report – Vanessa Whatley

The report was taken as read and the following key points were highlighted

13.1 The TB service specification has now been written and agreed with SaTH, It is based on the National Service specification. It has details of what staffing might look like with using the College of Nursing Guidance who have a specialist TB nursing forum.

13.2 A business case is needed from SaTH for the case management and ongoing care pathway once patients have been diagnosed with TB; this was expected earlier in the year however has not yet been received. Several attempts have been made to chase this via John Jones, the last information received from the Trust was that the staffing model was not affordable however, the business case supports the staffing model. From the ICB's perspective they are ready to support this this service as a high commissioning priority and the Commissioning Working Group are ready and awaiting papers.

Action: Sara Bailey to pick up the status of the TB Business Case with John Jones.

13.3 Julie Garside highlighted that the deadline for the papers for the Commissioning Working Group on 18th December, Is 12th December.

Action: Julie Garside to ensure TB Business Case is on the December Agenda of the Commissioning Working Group meeting.

14.0 Minute No QPC-25-11-158 – Healthwatch Shropshire Update- Lynn Cawley

14.1 There was no representative from Healthwatch Shropshire present to provide an update.

15.0 Minute No QPC-25-11-159 – Healthwatch Telford & Wrekin – Simon Fogell

15.1 There was no representative from Healthwatch Telford & Wrekin present to provide an update.

16.0 Minute No QPC-25-11-160 - Evaluation of meeting

16.1 The chair highlighted that if any Committee member has any comments, observations, improvements to make that you'd like from the meeting, just e-mail himself or the meeting Administrator.

17.0 Minute No QPC-25-11-161 - Items for Escalation/Referral to Other Board Committees

17.1 The chair to escalate to the ICB Chair Roger Dunshea and Simon Whitehouse the fact that QPC are extremely encouraged by the work underway for the diabetes transformation.

18.0 Minute No. QPC-25-11.161 Any Other Business (AOB)

18.1 No Other Business was raised.

Date and Time of Next Meeting

The Next meeting is scheduled to be held on 30th January 2025 starting at 2.00pm to 4.00pm via Microsoft Teams.

SIGNED …… DATE ……

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

NHS Shropshire, Telford and Wrekin
Quality & Performance Committee Meeting

Thursday 30th January, 2025 at 2.00pm
Via Microsoft Teams

Present:

Meredith Vivian	**Non-Executive Director (Chair)**	**NHS STW**
Vanessa Whatley	**Chief Nursing Officer**	**NHS STW**
Tracey Slater	**Head of Quality**	**NHS STW**
Julie Garside	**Director of Planning, BI & analytics**	**NHS STW**
Ann Maclachlan	**Clinical & Care Director**	**MPFT**
Jill Barker	**Non-Executive Director**	**SCHT**
Rosie Edwards	**Non-Executive Director**	**SaTH**
Sharon Fletcher	**Head of Safety & Quality Improvement & Patient Safety Specialist**	**NHS STW**
Dr Ganesh Mahadeva	**Medical director,**	**SCHT**
Clair Hobbs	**Director of Nursing,**	**SCHT**
Tracey Slater	**Head of Quality**	**NHS STW**
Lynn Cawley	**Chief Officer - Healthwatch Shropshire**	
Simon Fogell	**Chief Executive, Healthwatch T&W**	
Lisa Rowley	**Meeting Administrator & EA to CNO**	**NHS STW**

In attendance:

Name	title	Organisation
Jaz Dhillon	**Pharmacist Governance & Interface**	NHS STW
Kirsty Foskett	**Assistant Chief Nurse & Patient safety Specialist Specialist**	RJAH Representing Paul Kavanagh-Fields
Sara Reeve	**Deputy Director of quality**	MPFT Representing Liz Locket

Ambition Compassion Optimism Focus

Kara Blackwell	**Deputy director of Nursing**	SaTH

Apologies:
Helen Onions – Director of Public Health, Telford & Wrekin Council
Paul Kavanagh-Fields, CNO RJAH
Paula Gardner – Interim Director of Nursing, SaTH
Laura Tyler – Shropshire Council

1.0 Minute No. QPC-25.01.001 – Welcome & Apologies

1.1 Meredith Vivian welcomed Quality & Performance Committee members to the meeting.

2.0 Minute No. QPC-25.01.002 – Quoracy

2.1.1 The Chair confirmed that the meeting was quorate.

2.2 Apologies were noted as above.

3.0 Minute No. QPC-25.01.003 – Members' Declarations of Interests

3.1 Members had previously declared their interests, which were listed on the ICB's Register of Interests for ICB Staff only and was available to view on the website at: Non ICB Staff have been requested to complete a Declarations of Interest form which is held separately on the attendance/action Log of this Committee.

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. There were no further conflicts of interest declared.

4.0 Minute No. QPC-25.01.004 Minutes of QPC November 2024

4.1 The Committee reviewed the minutes of the meeting from 28th November which were accepted as an accurate record of the meeting.

ACTION: The Meeting Secretary to review the distribution list

5.0 **Minute No. QPC25.01.005 SORR & BAF – Sharon Fletcher**

5.1 The documents were provided to the Committee for information purposes only.

6.0 **Minute No. QPC-25.01.006 System Quality Risk Register – Sharon Fletcher**

6.1 The Risk register was reviewed and discussed at the System Quality Group meeting on 4th December, 2024 further updates will be presented to QPC in February 2025

6.2 There are two keys Risks SQG 4 UEC with focus on quality and insight visits, as well as significant multi agency reviews around discharges and frailty to try and influence and support improvement. This risk has consistent oversight with regular updates into the risk register from the risk owner.

6.3 The diabetes risk remains an extreme risk with challenges within the pathway. A driver diagram involving full system partners has been put together and the Commissioning Team report on this discussion with input from the contracts team, SaTH's Improvement hub and the diabetes transformation team.

6.4 A review of quality improvement maturities is ongoing within the system. A pulse survey across the ICB and potentially the ICS is being looked around maturity of the system and the ability to align continuous quality improvement methodology.

6.5 Emergent risks for discussion at the next System Quality Group on 5th February will be around neonatal services; Stroke pathways and paediatric audiology and diagnostics following which an update will be provided at QPC in February, 2025.

6.6 Rosie Edwards highlighted that a report has been commissioned by the ICB, led by Shropshire Community Trust looking at over 12 hour waits in ED and commented that once the report has been through the Trust's governance process it would be useful to discuss at QPC.

6.7 Vanessa Whatley commented that all risks to QPC should be escalated through SQG or an equivalent performance group, relevant stakeholders need to be asked what their risks are and then look at how these are formulated into a system risk to avoid duplication at system level. This issue has been raised with Alison Smith about getting this process right and ownership, responsibilities and accountabilities being identified.

6.8 Julie Garside pointed out there is going to be a system risk management policy which is part of the system integrated improvement plan and associated accountability and performance framework that needs to be the document that gives shared ownership and responsibility of risks.

6.9 Julie referred to patients over 12 hour report which had recently been presented at the UEC Delivery Group and said that this risk could either be linked to one of the UEC updates scheduled. Julie said she would check on the schedule and link it as there will be an update in the spring in terms of how the system has fared over the winter.

Action: Julie to discuss the 12 hour breach report with Gareth Wright

7.0 **Minute No. QPC-25.01.007 - Quality & Performance Exception Report**

7.1 **Performance – Julie Garside**

7.1.1 Julie highlighted that the report presented has a new format in that it has been shortened to make it easier for colleagues to see what the key issues are and is based on the insightful board guidance, within the report there is slide (slide 6) showing a pictorial summary of the system. Julie welcomed feedback from the Committee asking if they felt it added value to the pack and if so, she would do an equivalent for STW to be included in draft form from February 2025.

7.1.2 Waiting lists for autistic spectrum disorder and ADHD are now in the report; a section on waits in the Community Service has also been added, not necessarily referral to treatment waits but to ensure equal scrutiny.

7.1.3 Urgent and emergency care - there was an increase in demand generated from a combination of flu, Norovirus and COVID19. Performance deteriorated in ambulance handovers which impacted on ambulance category two response times and also patients waiting over 12 hours for admission however, there has been improved levels in patients over 12 hours.

7.1.4 There has been considerable recovery of the 4-hour performance since the December period, this position continues to improve. During the December period discharge processes remained strong and management of the no criteria to reside patients with the support from the two local authorities meant that although it was difficult as a system, STW have coped relatively better than other parts of the West Midlands and improvement has been noted by NHS England.

7.2 **Quality – Tracey Slater**

7.2.1 There have been delayed ambulance offloads over six hours and extended waits post decision to admit. The trust continues to do harm reviews on ambulance offload delays over 8 hours; there is a new directive from NHS England that 8 hour harm reviews will be undertaken using an updated methodology with an aim to have real time reviews of patients. SaTH is having internal discussions about how to operationalise as a process.

7.2.2 There has been some low levels of harm with the delays in administration of IV antibiotics and impact on staff morale, the quality team continue to carry site visits, at both sites to alleviate some of the pressures on the clinical teams, the ICB are facilitating and will be leading on a collaborative review

with staff. The ICB have been involved in made events on both sites in the frailty assessment units.

7.2.3 Clair Hobbs referred to the 8- and 12-hour harm reviews and commented that an increase has been seen in pressure ulcers which link back to patients that have waited on trolleys and asked whether the 12-hour reviews would capture this information.

7.2.4 Tracey Slater responded that the 12-hour reviews do not look at the whole patient journey and said conversations should be happening regarding a system approach to the harm reviews.

Action: TS to meet with CH to a system approach to harm reviews and to look at how this can be facilitated.

7.2.5 Tracey Slater highlighted that C diff rates are above trajectory where there is the potential for harm; IPC is on the System Quality Risk register.

7.2.6 Meredith Vivian referred to talking therapies and said that MPFT colleagues had advised plans were being put in place last year and it looks like there has been improvements.

7.2.7 Ann MacLachlan responded there is still room for further improvement in terms of access. There are still data issues around the six week, but 18 weeks is looking good, some of the outliers are challenges where people are offered appointments and then decline them. These Outliers are being worked through and the list has decreased for these long waiters.

7.2.8 Meredith Vivian then referred to the increase in dementia diagnosis rates and stated that it is not yet at the right level and whether this could be attributed to MPFT work or in the GP community?

7.2.9 Julie Garside commented that this was raised at the Confirm and Challenge meeting the ICB held with MPFT colleagues, MPFT have carried out a lot of work however there was an ask that there are things to do around a data mismatch and work through a more streamlined primary care; a PFT interface. Dr Lorna Clarson, the ICB's Chief Medical officer took the action to meet up with MPFT outside of the confirm and challenge process to see what else could be done to improve the long-standing issues with general practice. It was also acknowledged when people are diagnosed, there is capacity to support them. An action plan around the diagnosis rate is in place and will be tracked through the planning process; Julie said she would provide updates via the Performance & quality Report.

7.2.10 Vanessa Whatley referred to learning disability and autism key indicators and said there has been challenges with getting people with LD&A discharged in a timely way. Fortnightly Task and Finish Group meetings have taken place since September last year to get some of these back on track, there are also quarterly escalation meetings where the most difficult cases are escalated with system partners.

7.2.11 Ann MacLachlan thanked Vanessa Whatley for her focus on this vulnerable group. Ann said she would welcome a meeting with Vanessa following a recent conversation Ann has had with Dale Coleman who has raised a number of concerns about the trajectory of the dynamic support register.

Action: Ann MacLachlan and Vanessa Whatley to meet to discuss LD&A

Following Discussion, The Committee:

- Noted the continued collaborative content of the performance and quality integrated report regarding performance of key metrics and quality against national standards and local targets.
- Noted Where performance/quality falls short of national standards and locally agreed targets, to note the actions being taken and that risks are being appropriately mitigated and provide the necessary assurance.
- Noted the report continues to evolve to improve the way data and actions are presented to provide assurance to the Committee. The Committee is asked to feed back on the new integrated report to ensure the report meets the needs of the Committee as part of continuous improvement.

8.0 **Minute No. QPC-25.01.008- Insight Report – Sharon fletcher**

The report was taken as read and the following discussion ensued; -

8.1 Sharon highlighted the data within this report is not received at any other meetings for scrutiny and there needs to be an improved process which she will take forward.

8.2 Kirsty Foskett said she welcomed this information from a complaints perspective and asked if themes being seen as an ICB are the same as what is being seen as a provider? Kirsty raised a question in relation to the PPFS which had been discussed in a meeting about doing system Quality improvement work around transfers, transitions of care and patient discharges, and asked what the current status of this work was.

8.3 Vanessa Whatley responded that a timescale needed to be committed to as this work halted when Haley Flavell left SaTH and has not been picked up yet with the Director of Nursing's incumbent.

Action: Vanessa to pick up System Quality Improvement work around transfers with Paula Gardner at SaTH and will report back to QPC in February on the plan

8.4 Sharon referred to Kirsty's Comment about transitions of care and commented that a lot of the feedback either in PPFs and feedback from patients will be hidden information in relation to the communication around transitions of care that are affecting patient experience and said promotion of safe transitions of care has been looked at i.e., should there be a commitment that a system civility is put together in terms how people interact with each other to promote safety.

Action:Sharon to forward to Meredith Vivian the link from the Patient safety network of the programme called Civility Saves Lives.

8.5 Lynn Cawley added that many of the themes behind the comments Healthwatch Shropshire receive from the public are about staff attitude and how they have been spoken to which impacts on what people remember from that treatment, and it also impacts on their future access to services.

8.6 Healthwatch Shropshire currently provides the independent health complaints advocacy service for Shropshire and would be happy to share their learning from that and also the challenges people have using the NHS complaints process (link below)

https://www.healthwatchshropshire.co.uk/report/2023-10-18/nhs-and-social-care-complaints-report

Following discussion, the Committee;

- That the Committee receives this report for discussion
- That the report will form part of a wider review of how the data in this report can be triangulated with other data sources to show a holistic view of feedback shared and how this is aligned to quality improvement and strategy.

9.0 Minute No. QPC-25.01.009 LMNS Programme Board & Perinatal Quality – Sue Bull

The report was taken as read and the following discussion ensued:-

9.1 Recommendations have been received following the neonatal review, the Trust has identified 27 actions and progress against these actions are monitored through the Maternity and Neonatal Assurance Committee which is

an internal meeting that the ICB sit on, one action has been evidenced and assured., nine actions have been delivered but not yet evidenced and 17 actions have not yet been delivered. The Trust are using the same methodology as they did with the Ockenden recommendations.

9.2 A peer review took place by the West Midlands Neonatal ODN in December 2024 which was a positive and supportive visit and there were no immediate concerns raised, the final report from this visit is still awaited.

9.3 The LMNS has offered funding to the neonatal unit to support them with their quality improvement projects/initiatives. The neonatal team have been asked to develop a business case for the funding, this will go to Programme Board for discussion and approval.

9.4 Sue referred to the neonatal dashboards where there had been concerns about the quality of data, which has now improved. From the November 2024 data, the Trust reported that the data was reassuring overall

9.5 During November 2024, term admission rates were below the target rate of 6%. The timely admit and administration of antenatal steroids to mother and optimum cord clamping of the PERIprem Care bundle did show a dip in November 24, the Neonatal Workstream have oversight of this.

9.6 Maternity – Of the 210 actions from the original Ockenden report, 183 have now been evidenced and completed. 15 have been delivered but not evidenced. 12 actions have not been delivered. The Trust class has descoped majority of these not within their remit to progress; this is being progressed through the MTAC meeting.

9.7 Delivery suite acuity In December was 90%, which is above the national target of 85% inductions of labour rates for December was 36.1% compared to November which was 48.4%, however this does remain above the range of 29.2%. There is an induction of Labour Qi project being developed by staff and this was presented at the Quality and Safety Workstream for oversight and progress towards term admissions rates; the term admission rate in December was 5% which is below the target term admission rate of 6%.

9.8 Smoking rate increased to 9.2% in December and remains a focus for LMNS.

9.9 The metric for screening before 10 weeks is now on the dashboard, patients being screened before 10 weeks was 48%, which is below the accepted target of 50%, however, since October 2024 there has been an increase. Early bird clinics are being trialled to get women seen before 9 weeks.

9.10 Antenatal education - The funding project to implement antenatal classes is progressing, regular touch point meetings take place and the content for the classes is due to be shared with the Trust's maternity governance on the 21st of February following which it will then be presented at the LMNS board for

approval. It is anticipated that the antenatal classes will commence in SaTH from April 2025.

9.11 Work is progressing on implementing the NSPCC booklet for the region and the contract between NSPCC and the ICB is being developed which will provide a digital licence, the accident prevention tender waiver is currently with the ICB finance team which will to enable the ICB to Commission mini first aid from April 2025, preparation for the contract is taking place which will include Shropshire, previously only for Telford and Wrekin as it was taken from start for life funding.

9.12 Infant feeding - Telford and Wrekin Council delivered a feeding conference. With regard to preconception, a bid is being put together in partnership with balanced fertility, to develop a preconception education package that can be delivered to women and young girls with the aim to prepare them for pregnancy and improve maternal and child health outcomes.

9.13 The Workforce Workstream carried out a deep dive into reasons for absence, one of the reasons that came up within the neonatal team was absence due to menopause. Support for staff workforce is being looked into with the help of the Women's Health hub.

9.14 Rosi Edwards highlighted a study was carried out ago around care in the community and community midwifery and is being reintroduced by Kim Williams SaTH's interim director of Maternity to look at providing good coverage and support to mothers. Rosie then referred to the workforce and the high levels of absence due to menopause and said she would raise this and send Sue's report through to SaTH's Operational Development Committee to discuss and said it would be useful to pursue to see if there is enough support in place for the Trust's workforce.

9.15 Jill Barker asked what is the community's confidence like in the unit and are they aware of the positive experience? Sue responded that the MNVP lead is now in place and there will be focus on the neonatal service users and their experience.

9.16 Julie Garside added that she is aware the dashboard is dealt with by the CSU and there are plans to bring these into the internal BI and dashboard and asked if there was anything the BI team could do to help support consistency and how data is reported in terms of the making data count rules. Julie said she would ask Craig Kynaston to contact Sue to discuss further.

Action: Julie Garside to ask Craig Kynaston to contact Sue Bull to discuss data reporting.

Following Discussion, the Committee:

- Noted the contents of the report.

10.0 **Minute No. QPC-25.01.010 - Exception Report - System Quality Group Chairs Update - Vanessa whatley**

The report was taken as read and the following points were highlighted:-

10.1 Any ambulance with a person on held over 8 hours will have a harm review process. The numbers were high in December, 2024 average of reports 132 patients delayed.

10.2 C diff remains concerning which is now slipping into the very bottom tier of systems. A task and finish group meet to drive forward best practice and follow up of cases.

10.3 The quarter two child death report was presented to SQG. There were 7 child deaths from April to the end of October, a slight increase from the year before.

Following Discussion, the Committee:-

- Accepted the report.
- Considered the other alerts for further action
- Noted the Shared Learning

11.0 **Minute No. QPC-25.01.011 Healthwatch Shropshire Update – Lynn Cawley**

11.1 Healthwatch Shropshire are drafting Their “find our pharmacy”, interim findings have been shared with Rachel Jones from the ICB.

11.2 Health workshops are going to be following the Health watch England share for better Care campaign, which is another attempt to encourage people to share experiences of health and social care; partners will be asked to promote this and there are plans to move around the Shropshire area to reach the market towns and go into different areas rather than relying on social media etc.

11.3 Healthwatch Shropshire have been part of the cancer engagement event in Telford and will be part of the Shropshire event

11.4 Healthwatch Shropshire will begin to look at their forward plan for 2025/26 in terms of what their priority areas of work will be and asked if the ICB could advise what their areas of focus will be in the next 12 months.

11.5 Julie Garside said she is pulling together a work plan for the commissioning working group and once she has this she will share with both Healthwatch’s.

11.6 Vanessa Whatley added that she would be happy to have a conversation with Lynn Cawley outside of QPC to discuss commissioning priorities.

Action:Vanessa Whatley & Lynn Cawley to meet to discuss commissioning priorities.

Following discussion, the Committee:-

- Noted the verbal Update

12.0 Minute No. QPC-25.01.12 Healthwatch Telford & Wrekin Update, Simon Fogell

12.1 Healthwatch Telford & Wrekin have received some complaints about CDC in particular the waiting areas with the chairs being too low and signage within that area.

12.2 There has also been concerns raised over discharge of people where relatives are questioning the person's capacity and being put into unsafe situations.

12.3 Healthwatch Telford & Wrekin will be publishing their accident and emergency report, based on last year's events and following the dispatches programme; this will be put on their website. Another survey will be resumed to hear about how all the improvements have made a difference to people over the last six months that SaTH have been working on, Simon has communicated this to both Paula Gardner and Ned Hobbs at SaTH.

12.4 Healthwatch Telford & Wrekin have shared their pharmacy first report with the pharmacy PNA working group which will be published soon

12.5 Meredith Vivian referred to Simon's comment about the issue of discharge and mental capacity and said that it seems to be a safeguarding matter and asked whether this needed to be picked up by Paul Cooper, the safeguarding Adults Lead at the ICB.

12.6 Vanessa Whatley asked Simon if he had picked this up directly with the Trust.

12.7 Simon responded that one person was signposted and was advised to make a safeguarding referral and go back to the trust with their concerns. There was another raised via a web form which was anonymous.

Action: Vanessa Whatley to pick up Safeguarding concerns with Paul Cooper

13.0 **Minute No. QPC-25.01.13 - QPC terms of Reference Review – Tracey Slater**

13.1 Committee members had been asked to review QPC terms of reference. Tracey advised all comments had been considered and had taken the opportunity to revise standard reporting templates, standard agenda, reporting

template and key risks template to reflect what was asked within the governance review.

13.2 The governance review action plan is progressing and on target for completion of the actions by the 31st of March, 2025.

13.3 Julie Garside stated that she has reviewed the TOR and recommended that Angi Parkes' job title needs correcting and on page 9, where it is quoted that primary care report will go to QPC and said it should be distinguished, primary care reporting relating to general practice will go through the ICB and any reports relating to pharmacy, optometry and dental will come go via the office of the West Midlands.

13.4 Vanessa Whatley highlighted that there is a board report on primary care and showing how they were reporting and it said that primary care reported directly to QPC; which was not agreed, Julie concurred.

Action: Vanessa Whatley to pick up the issue with primary care reporting with Lorna Clarson outside of the meeting.

13.5 Sara Reeve highlighted asked that the "U" is taken out of the Midlands Partnership Foundation Trust's abbreviation.

Following discussion, the Committee:-

- Approved the terms of reference, subject to the minor amendments discussed.
- Approved the revised standard agenda document.
- Approved the meeting template document.

14.0 Minute No 25-02.014 – Escalations

14.1 No Escalations were recommended to any other Committee.

15.0 **Minute No. 25.02.15 – Any Other Business**

System Integrated Improvement Plan (SIIP) assurance report

15.1 The NHS oversight framework describes NHS England's approach to oversight. The ICB and SaTH have been assessed as segment 4 requiring mandated intensive support, RJAH and SCHT have been assessed as segment 3 and MPFT and WMAS have been assessed as segment 2. All organisations at segment 3 and 4 have agreed an action plan across 5 criteria: Finance, Workforce, UEC, Governance and Leadership

15.2 A process has been developed to monitor progress of the actions within the plans and collect evidence to support whilst providing assurance to NHSE that actions required have been completed. A monthly highlight report outlining overall completion of actions will be submitted to QPC, criteria specific highlight reports will be submitted to the System Transformation Group (STG) to provide further detail on progress.

15.3 QPC will be provided with progress updates from February onwards together with an impact dashboard which is currently being developed.

Date and Time of Next Meeting - The next meeting will be held on 27th February 2025, 2.00pm to 4.00pm Via Microsoft Teams.

16.15pm – *Meeting Closed*

Integrated Care Board Quality and Performance Committee

Terms of Reference

1. Constitution

The Quality and Performance Committee (QPC) is established by the Integrated Care Board (ICB) as a Committee of the ICB in accordance with its constitution.

These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities, and reporting arrangements of the Committee and may only be changed with the approval of the ICB.

The Committee is non-executive chaired, and its members, including those who are not members of the Board, are bound by the standing orders and other policies of the ICB.

2. Authority

The Quality and Performance Committee is authorised by the ICB to:

- Investigate any activity within its terms of reference.
- Seek any information it requires within its remit, from health and care partners within the Integrated care System (ICS).
- Create task and finish sub-groups to take forward specific programmes of work as considered necessary by the Committee's members.

Scope

The QPC is concerned with all services:

- Commissioned by the NHS (either the ICB or NHS England).).
- Jointly commissioned by the NHS and local authorities.
- Commissioned by local authorities from NHS and non-NHS providers.

It includes services within its population boundary regardless of whether NHS STW ICB commissions services from that provider, consideration of out of area placements and providers that cross ICS and regional boundaries. Independent providers are also included.

3. Purpose

The aims of the ICB are to:

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

The purpose of the QPC is:

For Quality

- To assure the ICB that regulatory elements of quality are being met as set out in the Health and Care Act 2022 and in line with The National Quality Board (NQB) Shared Commitment to Quality https://www.england.nhs.uk/publication/national-quality-board-shared-commitment-to-quality/.
- To assure the ICB that our services are safe, effective, caring (which aligns with positive experience in NQB definition of quality), well-led, sustainable, and equitable and in line with STW Pledge 1 – Improving Quality.
- To assure the ICB that there is an effective system of quality governance and internal control that supports the development and delivery of sustainable, high-quality care.
- To provide the ICB with assurance that the STW ICB Quality Strategy, (currently being refreshed) with particular emphasis on addressing health inequalities and quality improvement, is being delivered.
- To assure the ICB that quality risks are recognised, controlled, mitigated, and escalated as appropriate.

For Performance

- To assure the ICB that all system providers have oversight of their key performance indicators and / or oversight frameworks and are reporting to the required national standards.
- To assure the ICB that where national standards/local targets are not being met there are effective recovery plans in place with associated trajectories for achievement of those standards/ targets.
- To provide the ICB with assurance that our system providers are utilising performance reporting for the purposes of quality improvement (QI).
- To provide the ICB with assurance that performance risks are recognised, controlled, mitigated, and escalated as appropriate.

4. Membership and attendance

The Committee members will be appointed by the ICB in accordance with the ICB Constitution. The ICB will appoint no fewer than four members of the Committee including one Non-Executive Member of the ICB and one independent lay member. Other members of the Committee need not be members of the ICB.

Chair

The meeting will be chaired by an STW ICB non-executive director. In the event of the Chair being unable to attend, a nominated deputy will chair the meeting.

If a chair has a conflict of interest another member of the Committee will be responsible for deciding the appropriate course of action.

The Chair will ensure full participation during meetings, all relevant matters and agenda items are discussed, and that effective decisions are made and communicated to the partners within the ICS.

Members

Members include:

- ICB Non-Executive Director – Chair
- ICB Chief Nursing Officer (Deputy Chair)
- ICB Chief Medical Officer
- ICB Director of Planning, Performance, BI & Analytics
- ICB Patient safety Specialist
- Shropshire Council Director of Public Health
- Telford and Wrekin Council Director of Public Health
- Shropshire Council senior leadership representative
- Telford and Wrekin Council senior leadership representative
- Primary Care representative
- Shropshire Community Health Trust (SCHT) Executive representative
- Shrewsbury and Telford Hospital NHS Trust (SaTH) Executive representative
- Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) Executive representative
- Midlands Partnership University Foundation Trust (MPFT) Executive representative
- SCHT non-executive representative
- SaTH non-executive representative
- RJAH non-executive representative
- MPFT non-executive representative
- Shropshire Healthwatch
- Telford and Wrekin Healthwatch

Members may nominate suitably informed deputies to have decision-making authority if they are unable to attend the meeting. Where necessary, this should be limited to maintain a trusting group dynamic.

Executive members can commit resources within the boundaries of their own organisations Standing Financial Instructions.

Attendees

Only members of the Committee have the right to attend Quality and Performance Committee meetings, however others may be invited to attend all or part of any meeting, as and when appropriate, to assist with discussions on any particular matter.

5. Meetings Frequency, Quoracy and Decisions

Frequency

The Quality and Performance Committee will meet monthly, 10 times a year, (with the exception of August and December or January). Members are expected to attend a minimum of 8 meetings a year.

Where necessary, apologies should be sent prior to the start of a meeting. The membership of any member who misses 3 consecutive meetings will be re-considered by the Chair.

Quoracy

- Chair or deputy chair
- ICB Chief Nursing Officer
- Director of Planning and Performance
- Shropshire Council representative.
- Telford and Wrekin Council representative
- NHS Provider representative from each NHS provider (either Exec or non-exec)

If the quorum has not been reached, the meeting may proceed if those attending agree, but no decisions may be taken. 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.

Decision making and voting.
The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote for committee members only and in the event of a tie, the Chair will have the casting vote. The outcome will be recorded in the minutes.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis using telephone, email, or other electronic communication.

6. Responsibilities of the Committee

6.1 Quality

The Committee will ensure regulatory requirements of the Health and Care Act 2022, relating to quality are met, that quality is considered in context of NQB Shared Commitment to Quality (2021), and that Pledge 1- Improving Quality, is delivered. This will be achieved through the delivery of the Quality Strategy. Key responsibilities therefore include:

1. Assurance and Regulatory Compliance

- To be assured that there are robust structures and processes in place for the effective management of quality planning, control, and improvement for the system.
- To be assured that system wide safeguarding arrangements for children and adults meet statutory responsibilities.
- To be assured that system wide area prescribing, and medicines safety arrangements are compliant with statutory requirements.
- To be assured that system wide infection prevention and control arrangements are compliant with statutory requirements.
- To be assured that actions align with addressing health inequalities.
- To approve ICS statutory quality reports in line with reporting framework and seek Board approval for publication.
- Oversee and scrutinise the ICB's response to quality directives, regulations, national standards, policies, reports, or reviews from external agencies (including for

- example, CQC and Ockenden) to gain assurance that they are appropriately reviewed and required actions are being taken, embedded, and sustained.
- Maintain an overview of changes in the methodology employed by regulators and changes in legislation / regulation and assure the ICB that these are disseminated and implemented across all sites.

2. Quality Structure and Processes

- Ensure this committee, and groups that feed into it, remain aligned to the wider organisational governance structure presenting information that is timely and reflects the most recent data available.
- Promote alignment of system wide, quality culture and methodology.
- Ensure Integrated Care System (ICS) systems and processes track quality information from patient / client/service user to ICB through a clearly defined Information Governance framework and in line with GDPR.
- Seek assurance that opportunities to pool skill, knowledge, competence, and other resources lead to coordinated actions that drive improvement, whilst respecting statutory responsibilities of member organisations.
- Adopt a culture of operational efficiency and effectiveness by ensuring quality monitoring is fit for purpose, reporting is aligned and all opportunities to share learning are taken (including but not limited to incidents, complaints, mortality reviews, resident engagement).
- Have oversight of and approve the System Quality Group Terms of Reference.
- Consider and, where appropriate invite, additional assurance from independent sources.

3. Quality Strategy

- To recommend updates and revisions and agree the Quality Strategy and seek approval by the STW ICB Board.
- To receive updates on progress against quality priorities and actions outlined in the Quality Strategy.

4. Risk

- To maintain oversight of a system quality risk register for all risks relating to system quality. This does not include provider specific risks managed at source, and in line with provider's risk appetite.
- To consider any provider specific risks that rate high and emerging risks that may threaten wider service delivery. This does not preclude any individual organisation within the system calling a Rapid Quality Review, as set out in National Guidance on Quality Risk Response and Escalation in Integrated Care Systems (National Quality Board, June 2022) and Principles for assessing and managing risks across integrated care systems (National Quality Board, Dec 2024)
-

- To receive, consider and escalate for ICB action, any system quality risks that manifest across organisational boundaries to a Rapid Quality Review where these cannot be resolved locally.
- To acknowledge, mitigate and escalate / de-escalate risks within the Committee's remit and escalate in line with STW ICB Board appetite for risk.
- To ensure risks associated with quality are incorporated in the Board Assurance Framework and the System Oversight Risk Register as appropriate, mitigation and gaps in control remain current.

6. Quality Metrics

- To approve system quality metrics recommended by ICB System Quality Group.
- To seek assurance that the system is meeting the system quality metrics and where this is not happening, escalate with recommendations to the STW ICB Board for a system approach to be agreed.
- To ensure as the system matures, quality metrics remain fit for purpose.

5. Quality Improvement

- To be assured that a system wide process is in place to identify and escalate matters for quality improvement.
- To seek assurance that quality improvement programmes demonstrably reduce health inequalities, improve patient / client safety, outcomes and / or experience in accordance with the NHS IMPACT (**Improving Patient Care Together**) framework.
- Ensure that system barriers to quality improvement are addressed and where possible, removed.
- Implement evidence-based practice, recognised good practice and new and innovative procedures to further increase the skills, knowledge, and competence of staff.
- Empower those who access the services to own their health and wellbeing with clear signposting when and how to access the most appropriate support.
- Allow for deep dives to understand care quality and performance within a directorate, department, team, service and at the point of care.

6.2 Performance

The Performance Directorate aim to turn data into information and then information into insight for the Committee to consider as part of a quality improvement journey.

The Committee will ensure regulatory requirements relating to performance are met and Pledge 1 is delivered. Key performance responsibilities of the Committee are:

1. Performance Assurance Framework (PAF)

- To recommend updates and revisions and agree the PAF and seek approval by the ICB Board.

2. Regulatory compliance

- To approve ICB statutory performance reports for publication.
- To be assured that provider level performance is the best it can be, and on a journey of Quality Improvement (QI).

3. Risk
- To receive, consider and escalate for ICB action, any System Performance risks that manifest across organisational boundaries to a Risk Summit where these cannot be resolved locally.
- To consider any provider specific risks that rate high, and emerging risks that may threaten wider service delivery.

4. Outcome Measures
- The purpose of collecting data is to provide a basis for action, recommendation, and acknowledgement to support a culture of Quality Improvement and delivery of high-quality care for our population.
- Ensure the use of quality and performance intelligence to enable systemwide improvements, including transforming care pathways and reducing unwarranted variation.

6.3 General

Triangulation
- Triangulate quality and performance outcomes to ensure context is understood, the current position is clear and decisions around next steps are both valid and reliable.

The QPC does not have executive powers and will not:
- Directly intervene in performance management, contractual or regulatory functions, though it can advise on necessary changes and improvements.
- Substitute the need for individual organisations to act promptly when pressing concerns become apparent.

Conflicts of Interest
Members are required to declare any interests that may conflict with the QPC's business prior to or at the meeting. The chair is required to ensure that any interest is recorded in the minutes of the meeting and managed accordingly within the meeting in accordance with the following NHS Guidance issue 2017.

Confidentiality
To enable the exchange of information between attendees at this meeting to be carried out in accordance with the Data Protection Act 2018, the Human Rights Act 1998, the Freedom of Information Act 2000 and the Common Law Duty of Confidentiality, all attendees must undertake to:
- Ensure all information shared and exchanged within the confines of this meeting is for the specific purpose of the meeting and members agree to:

- not to reveal any confidential information to any person outside of the meeting.
- store all confidential information securely.
- not to make copies or duplicates of the confidential information except to the extent that it is reasonably necessary to carry out any follow up actions.

- Use information exchanged within this meeting for the purpose of identifying any action that can be taken by any of the agencies or departments in attendance to resolve the problem under discussion.
- Treat a disclosure of information outside the meeting, beyond that agreed at the meeting, as a breach of the subjects' confidentiality and a breach of the confidentiality of the agencies involved.

Unless exempt, all papers should be considered as subject to the Freedom of Information Act (FOI). Information sharing agreements between members will be agreed as a principle of working together. All papers that are exempt from public release under the FOI Act must be clearly marked 'in confidence, not for publication'. These papers may not be copied or distributed outside of the Group membership without the expressed permission of the Chair. FOI exemption 41 (duty of confidence) applies.

8. Behaviours and Conduct

Members will be expected to conduct business in line with the ICB values and objectives ensuring that everyone can be present without harassment, interruption, fear, or intimidation.

Valuing equality, diversity, and inclusion
All delegates attending the meeting, must undertake to:

- treat all people with respect and act in a way which does not unlawfully discriminate against or exclude anyone.
- encourage and enable representation from under-represented groups.
- ensure that the meeting is enabled for people with disabilities, e.g., availability of hearing loops, use of virtual chat functions.
- act in a fair and responsible way to any staff, fellow delegates, or volunteers they encounter.
- communicate in advance to the chair, facilitator or nominated officer any information necessary to help them at the meeting or event.

Collective responsibility
All people coming to the meeting agree they will:

- Always observe the authority of the chair or facilitator if one is present, raising points and matters for discussion only through the chair at formal meetings.
- Listen to and respect the views and experiences of other people contributing.

Equality and diversity
Members must demonstrably consider the equality and diversity implications of decisions they make to ensure health and care is accessible and available.

9. Accountability and reporting

The Committee is accountable to the ICB and provides assurance to the ICB and separately to NHS Midlands via the Regional Quality Group.

The QPC also reports, through local authority representation, into the relevant Shropshire, Telford, and Wrekin Local Authorities Assurance Committees and to the regional NHS England teams on risks and issues.

Individual members and advisory/task and finish group leads are responsible for reporting back on activities.

The QPC will consider reports from national policy work and other sources.

The QPC will receive reports from:

For quality

- ICS Quality Risk Register
- Health Protection Assurance Group
- LMNS Programme Board
- Providers by exception
- Healthwatch
- System Quality Group
- Statutory Quality Reports (e.g., Annual reports)

For performance

- Primary care
- Providers by exception
- Programme leads by exception.

The chair and relevant local authority lead member shall draw to the attention of STW ICB any issues that require its consideration or executive action.

Reporting arrangements may change and will be updated to reflect the changes.

The minutes of the meetings shall be formally recorded, supported with an action log and risk registers.

10. Secretariat and Administration

The meeting will be administered by STW ICB, and this arrangement is to be kept under review. The secretariat function will ensure that:

- The agenda and papers are prepared and distributed in accordance with the timeline below.

- Attendance is monitored and non-attendance flagged to the Chair.
- Good quality minutes are taken, and an action log is maintained.
- The agreed business cycle is maintained and reviewed annually or more frequently if required.
- Meetings are recorded and made accessible via MS Teams if conducted by virtual means.

Agenda and Papers
Requests to add agenda items should be made to the chair no later than 5 working days prior to each meeting.

A business cycle of reporting will be maintained.

A final agenda and relevant papers will be circulated electronically to members in 5 working days in advance of each meeting.

Organisational representatives are responsible for ensuring papers are submitted in correct format and on time. Any papers for the Group should be accompanied with a front sheet outlining the purpose, summary of points and clear recommendations.

Minutes
Draft minutes approved by the chair are to be circulated no later than 10 working days after the meeting date. Minutes will be signed off as a true and accurate record of the meeting at each subsequent meeting as a standing agenda item.

11. Review

The Committee will review its effectiveness at least annually.

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 the ICB for approval. Review of effectiveness of the meeting will take place annually in line with the review of the terms of reference.

Date of approval: January 2025 (draft for QPC 30th January 2025)

Date for review: January 2026

Agenda Item

ICB 26-03.142

Finance Committee Chair's Report

Appendix A. STW SFC Enc 1 Minutes of the Finance Committee Section 1 - 26.11.24

Appendix B. STW SFC Enc 1 Minutes of Finance Committee Meeting Section 2 - 26.11.24

Appendix A - STW SFC Enc 1 minutes of the Finance Committe meeting - Section One on 28.01.25

Appendix B - STW SFC Enc 1 Minutes of Finance Committee meeting Section Two 28.01.25

1	2	3	4	5	6	7	8

NHS Shropshire, Telford, and Wrekin
ICB Finance Committee (Section 1) Meeting
Tuesday 26th November 2024, at 13.00,
Via Microsoft Teams

Present:

Name	**Title**
David Bennett (Interim Chair)	Associate Non-Executive NHS STW
Claire Skidmore	Chief Finance Officer NHS STW
Angela Szabo	Director of Finance NHS STW

Attendees:

Sarah Dixon	Improvement Director NHSE
Cynthia Fearon	Corporate PA NHS STW (Note taker).

Apologies:

Ian Bett	Chief Delivery Officer
Kate Owen	Head of PMO NHS STW

1.0 Minute No. SFC-24-11.001 – Introduction and Apologies

1.1 The Chair, **DB**, welcomed everyone to the meeting. **DB** stated apologies as noted.

2.0 Minute No.SFC-24-11.002 – Declarations of Interests

2.1 No declarations of interest were noted.

3.0 Minute No.SFC-24-11.003 – Minutes from the Previous Meeting held on:
29th October 2024.

3.1 Agreed as a true and accurate record.

4.0 Minute No. SFC-24-11.004 Matters Arising and Action List from Previous Meetings

4.1 **DB** referred to the action list from the previous meeting:

Actions outlined on the action log were reviewed and updated accordingly.

The Finance Committee noted the update on the Medium-Term Financial Plan and Finance Strategy as circulated with the papers for this meeting to give an interim update of the work undertaken to this point and what work is proposed. The full report will be circulated to January 2025 Finance Committee.

5.0 Minute No. SFC-24-11.005 - ICB SBAF and SORR

Report received as read.

5.1 AS highlighted that the only change is to the risk score trend which is amended to 'no change' from the previous review, the BAF risk detail is the same as the October 2024 BAF review.

The BAF was updated in October 2024 to reflect the latest actions and alignment to system partner BAF risk scores as reported.

DB flagged that it would be useful for future reporting, to see an explanation of the risk historically, so there is an understanding of how long this risk has been live, how it has changed over time and the target date/period for the intention of the risk to be completed/resolved.

Action: AS to review the BAF risk narrative in future reporting, to include risk trend changes over time and the target date/period for the risk to be completed resolved.

DB also flagged that there needs to be actions to address risks which may differ from the ICB report to the System report. **DB** added that there seems to be some variations i.e., the narrative around performance in the reports from the ICB risk compared to the system risk.

DB requested that risk mitigations should include key mitigating actions, owners and timelines in the report and not just be a 'plan for a plan'. **DB** added that actions outlined in future reports need to be ones that will move us forward as an ICB and System to achieve improvement in the underlying recurrent deficit.

Action: AS to review key mitigating actions within future reports to ensure that they are measurable deliverables.

The ICB Finance Committee:

- Reviewed and received the current system SBAF and SORR risks that fall within its remit and requested that additional information on key actions to support delivery of mitigating actions be added to the next risk report.

6.0 Minute No. SFC-24-11.006 – Finance Committee - ICB Month 7 Capital Report

Report received as read.

6.1 AS highlighted that following the refresh of the primary care estates strategy, the business cases for the utilisation of ICB Primary Care Grants Capital and GPIT in months 7-12 have been submitted and approved by NHSE and capital projects have commenced. Spend is now expected in months 8-12 (rather than commencing in month 7 as planned) so a favourable variance of £51k is reported in M7 Year-To-Date and expected FOT is breakeven to plan.

The ICB Finance Committee:

- Noted that the ICB is reporting a £156k overspend YTD due to Primary Care Firewalls being delivered ahead of plan. Business cases for the utilisation of the £883k capital budget are all approved, and capital spend is expected to be in line with plan for the year end forecast.

7.0 Minute No. SFC-24-11.007 Finance Committee ICB Month 7 Revenue Finance Report

Report received as read.

7.1 **AS** highlighted that in month 6 an allocation of £89.9m was transacted to fund the System's planned deficit; the System is now therefore forecasting a breakeven position. **AS** added that after distribution, the ICB is now reporting a full year deficit of £4.7m which offsets surpluses being reported by System Providers.

AS reported that at month 7 the ICB has an £18.2m Year-To-Date actual deficit which is a £0.3m favourable position against the updated year-to-date plan. Pay award settlements have also been transacted in Month 7.

DB queried the overspend on Individual Commissioning highlighted within the report. **AS** explained, that CHC (Continuing Healthcare) is underspent due to delivery of efficiencies ahead of plan which offsets an overspend in mental health and transforming care packages.

AS reported that the Individual Commissioning team are already delivering significant efficiencies, and more are planned following the development of a new policy to address spend for after care for Section 117. **AS** added that the team also have processes in place to review High-Cost Packages.

DB queried whether the ERF funding over target was at risk as outlined in the finance report. **AS** stated, that the ICB has been informed verbally that the national payment variation will be supported which will mitigate this risk, a formal letter is expected soon to confirm that.

DB asked for confirmation regarding the mitigations outlined in the report. **AS** explained that a lot of work has now been done on refining the most likely expected forecast outturn in relation to delivery of spend to budget including efficiencies. **AS** summarised for efficiency, that there is one remaining high-risk scheme which is for Individual Commissioning. A business case has been submitted to NHSE for approval to bring in a third party to complete reviews in that area of work. this is expected to support delivery of £1.5m of efficiencies in-year.

AS stated, that as part of the work to close the gap to plan, the ICB has fully distributed system allocations for fixed ERF monies and pay award funding to System providers. **AS** added that finance colleagues within the ICB finance team have reviewed the balance sheet prior year accruals, this has offered up another £0.5m to support closing the gap. The forecast therefore is expected to be an improvement on the original deficit plan for the ICB.

AS explained that the System Chief Executive Officers are currently considering options regarding closing the gap.

DB suggested that in this report a page could be added to illustrate a month-by-month view for 2023/24 and 2024/25 outlining the underlying position with a waterfall diagram which looks at the annual underlying position and the movements required to deliver the current plan.

CS mentioned that a slide pack regarding closing the gap has been shared with the regional/national NHSE teams which also outlines the bridge of actions to deliver the 24/25 financial plan.

Action: CS to share* slide *pack on closing the gap with DB.

The ICB Finance Committee:

- Noted that the ICB is reporting an £18.2m YTD actual deficit which is a £0.3m favourable position against the year-to-date plan. The ICB plans to deliver a £4.7m deficit position which is in line with plan and, at month 7, has fully identified mitigations to offset known risks of £20m.
- Noted that since posting he month 7 position, the ICB has identified an additional £0.5m balance sheet flexibility beyond it's plan to support in closing the gap in the overall System position.

8.0 Minute No. SFC-24-11.008 – Efficiency Delivery Update M7

Report received as read.

8.1 **AS** highlighted that the ICB is reporting a positive efficiency position at Month 7, year-to-date with delivery ahead of plan by £3.5m. **AS** added that this over-delivery is attributed to Individual Commissioning care package reductions and Running costs pay savings.

AS explained that work to review forecasts has been undertaken by efficiency programme leads this month to ascertain an accurate forecast outturn position. Where delivery values have decreased, additional mitigating opportunities have been put forward in their place to ensure full delivery of the original plan commitment.

AS reported that PWC have continued to provide support to programme leads in de-risking high risk schemes through the phase 2 Investigation and Intervention (I&I) work. **AS** added the focus has now moved to de-risking the medium risk schemes where required to support full delivery of the 24/25 efficiency plan.

AS summarised areas where mitigations have been put in place to offset slippage in efficiency schemes i.e. contract review efficiency, which won't be enacted until 2025/26.

AS explained the UEC Black Country efficiency target which was introduced to offset additional costs for UEC patient flow to the Black Country; this had intended to be based on reducing ambulance conveyances. This scheme has now been confirmed as not deliverable and future savings will be addressed through the wider UEC programme.

AS reported that Individual Commissioning efficiencies are significantly ahead of plan.

CS stated that in the next meeting in January 2025, she would expect to see more information on what we have planned in the pipeline for next year and beyond. **AS** mentioned, that pipeline information circulated with papers for this meeting also includes pipeline information for next year 2025/26. **AS** highlighted that the biggest areas of delivery opportunity and risk for the ICB based on value are Prescribing and Individual Commissioning**.**

CS mentioned that **KO** will be chairing a 25/26 efficiency development workshop on Wednesday 4th December 2024.

The ICB Finance Committee:

- Noted the month 7 efficiency progress update.

9.0 Minute No. SFC-24-11.009 Deep Dive: Investigation and Intervention Update and FIP Q2 Review Update

Report received as read.

9.1 **AS** reported that this deep dive report sets out the Q2 ICB Financial Improvement Programme Review process, summary and actions. This formed part of the Phase 2 Investigation & Intervention process supported by PWC. **AS** flagged that the process of holding a quarterly review had been successful and it was planned to adopt this on a forward basis.

DB stated that he would like to clarify the governance of the financial improvement process, seeing Finance Committee as having a key role in providing challenge and assurance. **CS** described how she envisages that the outputs of our internal management governance should feed into the Finance Committee. This should be woven into the existing agenda, through the efficiency reporting, rather than being something stand alone. She noted that we could be more explicit in describing management and executive assurances to the Committee to help with the review of reports.

DB also mentioned that there needs to be a review of the finance and efficiency reports, as he finds some of the chart's presented could be done differently or perhaps even excluded.

Action: CS/AS/KO to review the Finance Committee reports with DB ahead of future reporting (for month 9 reporting).

DB stated that it would be good to get updates on the key system transformation programmes within the Finance Committee, Section One and Section Two. **CS** explained that **KO** along with other ICB colleagues are currently developing the Financial Improvement Programme pipeline and will group key financial improvement programmes on themes such as emergency care and elective care. **CS** added that there is an intent to have a system PMO which, once fully implemented, will assist with this reporting.

Action: KO to include an update on the System Transformation Programmes as part of the January 2025 update. Also, to suggest a rolling forward plan of Finance Committee thematic reviews for these programmes.

The ICB Finance Committee:

- Received and discussed the Q2 FIP Deep Dive Report.
- Noted that the ICB intends to run a continuous Financial Improvement Programme review process using the same format as developed for Q2 2024/25.

10.0 Minute No. SFC-24-11.010 Risk review and escalations to Board

DB commended the team on the continued delivery of the financial plan YTD and expected FOT including efficiency delivery. He noted the ICB's ambition to push beyond plan at year end in order to support with closing the gap on the overall system financial position.

.

11.0 Minute No. SFC-24-11.011 – A.O.B

11.1 There were no items noted for this agenda item.

Meeting closed at 13.49.

Date And Time of Next Meeting

Tuesday 28th January 2025, 14:00 via Teams

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

NHS Shropshire, Telford, and Wrekin
Integrated Care System Finance Committee (Section 2) Meeting
Tuesday 26th November 2024 at 14.15
Via Microsoft Teams

Present:

Name:	**Title:**
David Bennett (chair)	Associate Non-Executive NHS STW
Claire Skidmore	Chief Finance Officer NHS STW
Angela Szabo	Director of Finance NHS STW
Helen Troalen	Director of Finance SATH
Craig MacBeth	Chief Finance Officer RJAH
Jonathan Gould (for SL)	Deputy Director of Finance SCHT
Richard Peach (for MB)	Group Accountant T & W Council
Glenn Head (for MC)	Deputy Chief Finance Officer MPFT
Richard Miner	Non-Executive SATH

Attendees:

Sarah Dixon	Improvement Director NHSE
Cynthia Fearon	Executive PA NHS STW (Note Taker)

Apologies:

Trevor J McMillian OBE	Non-Executive NHS STW
Sarfraz Nawaz	Non-Executive RJAH
Ian Bett	Chief Delivery Officer NHS STW
Sarah Lloyd	Chief Finance Officer SCHT
Michele Brockway	Interim Director Finance & Human Resources T&W LA
Kate Owen	Head of PMO NHS STW
Marianne Cleeve	Interim Chief Finance Officer MPFT
Tina Long	NED SCHT
Ben Jay	Assistant Director of Finance & Technology Shropshire LA

1.0 Minute No. SFC-24-11.001 Introductions and Apologies

1.1 **DB** welcomed everyone to the meeting and apologies were received as noted.

2.0 Minute No. SFC-24-11.002 Members' Declarations of Interests

None were declared.

3.0 Minute No.SFC-24.11.003 Minutes of the Previous Meeting held on:
29th October 2024

3.1 **DB** asked if anyone wished to note any points of accuracy or errors within minutes of the previous meeting. None were raised and these were agreed as an accurate record.

4.0 Minute No. SFC-24.11.1004 Matters Arising and Action List from Previous Meeting

4.1 The action list from the previous meeting was reviewed and updated accordingly.

CS mentioned that the MTFP update is included within the papers for this meeting and added that further feedback from SATH's Finance Committee was received after the papers were circulated for this meeting. The paper will be circulated including these additional comments.

Action: CF to re-circulate the MTFP and Finance Strategy Update which will include further comments from SATH's Finance Committee.

The Committee noted that the full MTFP report is on the agenda for the next meeting in January 2025.

5.0 Minute No SFC-24-11.005 M5 ICS - SBAF and SORR

Report received as read.

5.1 **CS** explained that the SBAF and SORR are a standing agenda item on the System Finance Committee agenda. **CS** added that this month's update is focusing more on the SORR as the BAF was reviewed in detail at the last meeting.

DB made reference to the risk discussion held in Section One Finance Committee**.** He explained that he had requested that key actions, owners and timelines were clearer and that a 'plan for a plan' was avoided where possible. **DB** added that actions outlined in future reports need to be ones that will move us forward as an ICB and a System i.e. actions to improve the underlying position.

The System Finance Committee:

- received and reviewed the current system SBAF and SORR risks that fall within its remit and requested that additional information on key actions to support delivery of mitigating actions be added to the next risk report.

6.0 Minute No. SFC-24-11.006 - Finance Committee - Finance Committee – ICS Month 7 Capital Report

Report received as read.

6.1 **CS** highlighted that year-to-date system operational capital spend is £8.4m behind plan at month 7. **CS** added that the full capital plan is expected to be delivered by the end of the financial year with schemes coming online in later months.

CS explained that there has been no material change to what was reported at month 6.

CS flagged that there is quite a significant year to date underspend. However, there are ongoing discussions with DoFs, and they have a clear route on how resources will be spent, subject to agreement of HTP capital plan reprofiling.

CS reported that there are risks that individual organisations are actively managing. DoFs have discussed options for potential in-System brokerage if required, in order to hit the overall System CDEL.

CS mentioned that the System have received a formal request from NHSE via letter to obtain ICB and Provider Board sign off for our most likely system capital forecast outturn alongside reporting the month 8 position.

The System Finance Committee:

- noted that the ICS is reporting an £8.4m favourable variance to plan for operational BAU capital, namely due to slippage on SaTH modular wards and £27m favourable variance to plan overall, due to slippage on HTP.
- Noted the capital expenditure risks and planned mitigations - SCHT IFRS16 risk of £3.25m to be covered by in-system brokerage, RJAH EPR £1m overspend, to be covered by additional NHSE funding and SCHT frontline digital £0.7m included within 24/25 capital plans with other schemes slipped to 25/26.

7.0 Minute No. SFC-24-11.007 - Finance Committee - ICS Month 7 Revenue Finance Report

Report received as read.

7.1 **CS** highlighted that, for the first time, included with this report is a finance summary for Shropshire Local Authority. working with colleagues from the Local Authorities, the intention is for both Shropshire and Telford and Wrekin LAs is to provide headline information to future System Finance Committee meetings.

CS noted that the ICS is reporting a £27.6m actual year-to-date System deficit which is £11.7m adverse to plan at month 7. **CS** added that NHS STW ICS submitted a 24/25 deficit plan of £89.9m, however in Month 6 the deficit plan was funded therefore the expected end of year position is now reported as breakeven.

CS reported the ICB year-to-date favourable variance of £0.3m which is due to efficiency being delivered ahead of plan for Individual Commissioning and Running Costs offset by additional Mental Health CHC spend.

CS mentioned that she had attended the national RSP meeting in London the previous week. The meeting included Julian Kelly, other national colleagues and CEOs from STW. There was a discussion about the unmitigated risk (£29.2m). **CS** noted that a route to close the gap to around £10–15m had been described and that Julian Kelly had tasked the System with proposing how it would fully close the gap within 10 working days of the meeting.

DB queried what was the governance process for sign off of the response to Julian Kelly. **CS** explained whatever goes to Julian will be heavily caveated, as the proposal may not have fully passed through full governance due to working to a very tight deadline.

DB flagged if we are looking to reduce activity, this may have cost implications on next year's financial plan.

SATH update

HT explained that SATH have been looking at their forecast outturn over the last couple of months. One of the risks/cost pressures is linked to how SaTH are using workforce and unavailability of staff leading to SATH's use of premium rate temporary staffing.

HT flagged that SATH have an unmitigated risk/cost pressure due to unfunded escalation capacity. SATH also have pressures linked to income under delivery driven by the issues with the Data Warehouse. She also reported that SATH have a shortfall in delivery of their overall CIP programme which they are working to address.

HT is currently working with the Task Force and PWC to address the pressures which are estimated to be around £15.5m.

HT mentioned that over recent weeks, the SaTH Task Force have been working through a series of mitigating actions options with the support of PWC, these options are being considered by the SaTH Executive team and these will be discussed at the next SATH Board meeting (28th November 2024). The financial impact of the mitigations will not be confirmed until after the board meeting.

HT gave recognition to **AS** and thanked her for the work she has done on securing agreement to the national payment variation. She noted that in securing the variation, this helps to 'decongest the pitch' with regard to financial risk.

When asked where SATH's forecast was likely to land, **HT** described that overall SATH are currently carrying a risk of £41m which is mitigated to £25.2m after the national payment variation.

DB stated the escalation issues **HT** mentioned at SATH are also a System issue, and that a robust System Transformation programme needs to be in place so we can look at how we can address this as a System.

CS added that the System Transformation Group receives reports and escalation of issues from the Urgent and Emergency Care Programme Board. She referenced recent positive references in a letter from NHSE about the winter plan that noted that escalation issues were recognised and addressed as a System issue.

HT requested when we are planning for 2025/26 can all bear in mind that escalation needs to be resolved with input and actions from all System partners and not just SATH.

RJAH

CM reported that RJAH are forecasting lost income due to reduced activity as a result of the loss of LLP workforce, which is having a detrimental impact on RJAH's financial performance. However, RJAH has still been able to improve their end of year forecast position in month. This has been due to receiving System support for ERF where RJAH has received a fixed allocation via the ICB. **CM** added that RJAH have agreed a resolution to the treatment of a service change to their ERF baseline with the ICB and SCHT, which now takes RJAH closer to their planned position.

CM mentioned that RJAH has now introduced a freeze on non-clinical posts, which is improving RJAH's forecast.

With all the measures RJAH have taken, RJAH have managed to reduce unmitigated risks to within £0.5m of their forecast planned position. **CM** flagged there are still risks that they still need to look at mitigating for quarter four activity. **CS** asked **CM** for clarification that RJAH Board were still committed to delivery of the financial plan, **CM** confirmed that this was the case.

RJAH are currently taking part in the System work with PWC, where they are looking at mitigating remaining risks. It is RJAH's intention to improve in all areas where possible.

SCHT

JG reported that SCHT are on target to deliver SCHT's financial plan. **JG** mentioned that SCHT have benefited by £0.2m from the pay award allocation, which came through this month and is showing as part of the current favourable variance to plan.

JG reported that SCHT's CIP delivery is on track and is expected to deliver FOT. **JG** flagged that SCHT have some high-risk schemes which they are effectively managing, which has reduced the risk significantly to date.

JG stated that SCHT's most recent forecast, which is supported by their finance committee, outlined for them to remain on plan for the full year. However, following the national RSP meeting, SCHT are reviewing their forecast with a view to see if they could do more to support the System position.

ICB

CS reported that the ICB are currently forecasting to meet the financial plan. **CS** added that figures have been reviewed over the past few weeks to ensure the ICB has gone as far as it can to reduce costs where possible.

CS noted that she was preparing for a meeting with CEOs this afternoon to present the System proposed forecast and consider where we might close the gap on the system financial plan delivery, including the implications of doing so.
CS added that the ICB have a sound route to going a little bit further than plan, which will contribute to supporting the System position overall.

The System Finance Committee:

- noted that the ICS is reporting a £27.6m actual YTD System deficit v's £15.9m plan, being a £11.7m adverse variance at M7. Key drivers being SaTH £1.7m lost income due to Industrial Action, agency £3.6m, Endoscopy £0.7m, escalation £1.2m and pay award funding shortfall £2.7m and RJAH impact of the end of the LLP arrangement £0.9m, Spec Comm ERF income £0.4m and inflationary pressures £0.3m.
- Noted that the System is also reporting that it cannot currently fully mitigate its financial risk if it were to all materialise (£29.2m at month 7). System partners are actively working to either reduce the risks logged or seek alternate mitigations.
- Noted actions in all NHS partners to focus on options to 'close the gap' to plan in response to the challenge set by the National NHSE team.

8.0 Minute No. SFC-24-11.008 - STW Efficiency Plan Update Month 7

Report received as read.

8.1 **AS** reported that Month 7 year-to-date efficiency delivery shows a positive variance of £3.57m compared to the plan, though performance varies across organisations. Overall risk has significantly decreased this month following a review of forecasts and the identification of additional mitigation opportunities.

Within the ICB, **AS** flagged there is one high risk scheme which is for Individual Commissioning. A business case has been submitted to NHSE and if agreed, the resource outlined will assist in de-risking the plan.

AS flagged the majority of the value in the remaining high-risk schemes are reported by SATH and are linked to System Escalation, Workforce Unavailability and WTE Reduction plan.

AS reported that RJAH are forecasting to deliver ahead of plan.

AS reported SCHT are forecasting to deliver on plan.

The biggest risk to the overall programme at the moment, is under delivery of escalation CIP, circa £6m.

AS highlighted that high value schemes are being supported by PWC who are actively working with programme leads to de-risk and assist with transition into delivery through the phase 2 investigation and intervention work.

The System Finance Committee:

- noted additional oversight through a fortnightly FIP working Group that has been established and that 1-1 Executive meetings have taken place during November to provide further rigour and support for all of the remaining medium and high-risk schemes.
- Received the month 7 Efficiency Plan report update for information and assurance.

9.0 Minute No. SFC-24-11.009 - Deep Dive – Investigation and Intervention Update and FIP Q2 Review Update

Report received as read.

9.1 **AS** stated that the quarterly review meetings will be an ongoing feature of the management team's work plan and updates from these will be included in the efficiency reports going forward.

AS highlighted that the report sets out the Q2 ICS FIP Review Meeting process, summary and actions as agreed by NHS STW and PWC (Phase 2 Investigation & Intervention support provider). **AS** added that the key lines of enquiry explored as part of the review process are outlined in the main report.

DB stated that the outcomes from the Executive Team and Programme Leads FIP discussion needs to be reported through to the Finance Committee as routine as part of the monthly efficiency report. **HT** stated that she supported what **DB** suggested**.**

DB also mentioned that this committee also needs to receive updates on the transformation work that is going on within the System, e.g. emergency care and elective care. **CS** confirmed that **KO** is currently doing some work on this as part of the pipeline preparation for 25/26 efficiency programme.

Action: KO to include an update on the System Transformation Programmes as part of the January 2025 update. Also, to suggest a rolling forward plan of Finance Committee thematic reviews for these programmes.

HT flagged that NHSE from a national perspective want to discuss what SATH's Medium Term Recovery Plan might look like. So, the more we can articulate the work in clinical category, programmes of work and how that can influence the finances the better.

The System Finance Committee:

- reviewed and noted the Q2 FIP Deep Dive Report.
- Noted that the ICB intend to run a regular Financial Improvement Programme review process using the same format as developed for Q2 2024/25.

10.0 Minute No. SFC-24-10.010 - Risk review and escalations to Board.

DB confirmed that good progress has been made overall in relation to the efficiency programme and highlighted that there has been great improvement compared to where we were last financial year.

The System is reviewing mitigating actions and options for closing the gap (£29.2m) and is required to formally write to Julian Kelly with the outcome by 29th November 2024.

11.0 Minute No. SFC-24-11.011 - Any Other Business

11.1 **CM** mentioned that Sarfraz Nawaz has temporarily stepped into the role of Chair f or RJAH. He suggested that the meeting invite for System Finance Committee is extended to Martin Newsholme, who is temporally chairing the Finance Committee.

Action: CF to extend the invite to this meeting to Martin Newsholme to cover for Safraz Nawaz.

Meeting closed at 15.19.

Date and Time of Next Meeting

Tuesday 28th January 2025, 15:15 via Teams

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

NHS Shropshire, Telford and Wrekin
System Finance Committee Meeting – Section One

Tuesday 28th January 2025 at 14.00
Via Microsoft Teams

Present:

David Bennett (Interim Chair)	Non-Executive NHS STW
Trevor McMillan	Non-Executive NHS STW
Claire Skidmore	Chief Finance Officer NHS STW
Angela Szabo	Director of Finance NHS STW

In Attendance:

Cynthia Fearon	Corporate PA NHS STW (Note taker).
Dan Wright	Deputy Director National Recovery Support Team NHSE

Apologies:

Ian Bett	Chief Delivery Officer
Kate Owen	Head of PMO NHS STW
Sarah Dixon	Improvement Director NHSE

1.0 Minute No. SFC-25-01.001 Welcome & Apologies

1.1 DB welcomed members, attendees to the meeting and noted apologies.

2.0 Minute No. SFC-25.01.002 – Quoracy

2.1 DB confirmed that the meeting was quorate.

3.0 Minute No. SFC-25-01.003 – 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)

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 at this meeting.

4.0 Minute No. SFC-25-01.004 – Minutes from the Previous Meeting held on: 26th November 2024.

4.1 Agreed as a true and accurate record.

5.0 Minute No. SFC-25-01.005 Matters Arising and Action List from Previous Meetings

5.1 DB referred to the action list from the previous meeting. Actions outlined on the action log was reviewed and updated accordingly.

6.0 Minute No. SFC-25-01.006 - ICB SBAF and SORR

Report received as read.

6.1 AS highlighted that this update outlines to the Committee the current System Board Assurance Framework (SBAF) and the System Strategic Operational Risk Register (SORR) entries relevant to the committee, as at January 2025. This is to allow consideration and scrutiny of those risks that have been allotted to the Committee for oversight and assurance.

AS reported that the main changes since the previous report were to the SBAF Risk 2, which has been split into two risks within the full report. These are Risk No.2a: Risk of not achieving underlying financial balance (ICB and System) and Strategic Risk No.2b: Failure to deliver the System and ICB Revenue and Capital Resource Limit Plans for 2024/25.

AS also reported that there were a number of changes made to the SORR, which is outlined in the main report.

DB stated that in the report it does not outline when the target should be achieved on the risk profile to achieve the risks.

Action: AS to outline in future updates, the target date for risk mitigation. She will also confirm a consistent approach to reporting with Governance leads.

DB asked that for future reporting, could the action plan be more action oriented.

Action: AS to ensure for future reporting, the action plan is more action oriented.

DB requested that the System Transformation Plans come to the financial committee.

Action: AS/KO to ensure that System Transformation Plan Reporting is shared with the Finance Committee.

CS explained that the transformation work is picked up within the FIP Meetings and the System Transformation Group (CEO collectives across STW) oversees that. **CS** suggested that it should be a report from the System Transformation Group that comes to the Finance Committee so that we are sighted on what is happening with the Transformation work.

The ICB Finance Committee:

Reviewed the current system SBAF and SORR, noting the amendments made to them and confirmed support of the content presented.

- Asked for further refinement to the description of the actions taken to manage risks for future reports.

7.0 Minute No. Minute No. SFC-25-01.007 - Finance Committee - ICB Month 9 Capital Report

Report received as read.

7.1 AS explained that ICB Capital relates to GP IT and GP Capital Grants.

AS highlighted that following the refresh of the primary care estates strategy, business cases for the utilisation of ICB Primary Care Grants Capital were approved by NHSE and spend was expected in months 8-12 (rather than commencing in month 7 as originally planned).

AS reported that several capital grant schemes have also had PIDs approved, and the associated works are underway. **AS** added that this encompasses the acquisition of DDA-compliant entrance doors at Teldoc (Oakengates), Caxton, Wem & Pres, as well as the extension of South Hermitage and the fitting out of Ironbridge's Lightmoor branch. The expenditure to date for these projects is £154k, with completion anticipated February/March 2025.

AS highlighted that GP Capital Grants year-to-date spend is £154k (on budget) as the schemes have now commenced, with completion anticipated in February/March 2025. If approved, the Linden Hall Muxton's extension would mean that the expected year end forecast is breakeven to plan.

AS mentioned GPIT spend is £207k, which is 19k ahead of plan at M9 due to the primary care firewalls being delivered in full in month 7 ahead of the plan phasing of M8-12, the expected end of year forecast is breakeven to plan.

AS reported that capital spend Year-To-Date is £361k, overall, £14k behind the Year-To-Date plan £375k. **AS** explained that this is due to timing and there are no immediate risks to report.

The ICB Finance Committee:

- Noted that the ICB is reporting a Month 9 £14k underspend Year-To-Date. Business cases for the utilisation of the £883k capital budget are all approved or expected to be approved and therefore capital spend is expected to be in line with plan for the year end forecast.

8.0 Minute No. Minute No. SFC-25-01.008 - Finance Committee – ICB Month 9 Revenue Finance Report

Report received as read.

8.1 AS highlighted that the ICB is reporting a full year forecast deficit of £4.7m which offsets surpluses being reported by System Providers.

AS noted, that at month 9 the ICB is reporting a £12.5m Year-To-Date actual deficit which is a £0.1m favourable position against the updated year-to-date plan.

AS reported that the ICB has plans tofully mitigate risk (£5.8m) at month 9. **AS** explained, if all mitigations are delivered there will be £0.7m favourable variance due to specialised commissioning CAMHS funding which is being returned and the overall reported ICB deficit would therefore be £4m.

The ICB Finance Committee:

- noted that the ICB is reporting a £12.5m Year-To-Date actual deficit which is a £0.1m favourable position against the year-to-date plan.

- noted that the ICB has identified mitigations to offset risk of £5.8m and aims to deliver a £4m deficit position which is £0.7m favourable to plan though this is not reported in the submitted numbers as a final FOT position is not yet agreed with NHSE.

9.0 Minute No. SFC-25-01.009 - Finance Committee Efficiency Delivery Update Month 9

Report received as read.

9.1 AS highlighted that the ICB is reporting a positive efficiency position at Month 9 year-to date with delivery ahead of plan by £1.2m.

AS explained, the main contributors to the positive variance at Month 9 are overperformance in Medicines Management programmes (Apixaban +£508k, Rivaoxaban +£289k), savings from Non-System ECF Funding (+£2.06m), and additional pay-related savings.

AS reported that project leads have assessed each scheme this month to determine the best-case, worst-case, and most likely forecast scenarios. Sheadded that the assessment indicates that the most likely forecast will exceed the current position reported with some savings being stretched beyond target in the coming months.

AS highlighted that the overall confidence in delivery remains high, with no schemes classified as having 'high risk' of delivery. Medium-risk schemes have decreased by £1.6m since last month and now total £552k.

AS explained that the remaining medium risk schemes are being reviewed by leads weekly with progress overseen by the Sustainability Working Group. Any shortfall in the delivery of these schemes will be mitigated through overperformance in other areas.

The ICB Finance Committee:

- confirmed that they are satisfied with the assurance provided in the report, namely that that the ICB will achieve its efficiency plan by March 2025.

10.0 Minute No. SFC-25-01.010 - Risk review and escalations to Board.

10.1 There are no escalations to the Board in relation to the delivery of 2024/25 Revenue, Capital or Efficiency Performance and Delivery at Month 9 or expected Forecast Outturn.

11.0 Minute No. SFC-25-01.011 – Any Other Business

DB explained that there would now be a confidential section to this meeting, to discuss plans for 2025/26. The meeting would commence directly after this meeting is closed.

Meeting closed at 14.37.

Date and Time of Next Meeting

Thursday 27th February 2025, 14.00, via Teams.

NHS Shropshire, Telford, and Wrekin Board 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.)

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

NHS Shropshire, Telford and Wrekin
System Finance Committee Meeting – Section Two

Tuesday 28th January 2025 at 15.15
Via Microsoft Teams

Present:

David Bennett (Interim Chair)	Non-Executive NHS STW
Trevor McMillan	Non-Executive NHS STW
Claire Skidmore	Chief Finance Officer NHS STW
Angela Szabo	Director of Finance NHS STW
Craig MacBeth	Chief Finance Officer RJAH
Jonathan Gould (for SL)	Director of Finance SCHT
Tina Long	NED SCHT
Richard Peach (for MB)	Group Accountant T & W Council
Marianne Cleeve	Interim Chief Finance Officer MPUFT
Martin Newsholme (for SN)	NED RJAH
Adam Winstanley (for HT)	Deputy Director of Finance SATH

In Attendance:

Cynthia Fearon	Corporate PA NHS STW (Note taker).
Dan Wright	Deputy Director National Recovery Support Team NHSE
Julie Garside	Director of Planning, Performance, BI

Apologies:

Ian Bett	Chief Delivery Officer
Kate Owen	Head of PMO NHS STW
Sarah Dixon	Improvement Director NHSE
Sarfraz Nawaz	Non-Executive RJAH
Sarah Lloyd	Chief Finance Officer SCHT
Glenn Head	Deputy Chief Finance Officer MPFT
Richard Miner	Non-Executive SATH
Helen Troalen	Director of Finance SATH

1.0 Minute No. SFC-25-01.001 Welcome & Apologies

1.1 DB welcomed members, attendees to the meeting and noted apologies.

2.0 Minute No. SFC-25.01.002 – Quoracy

2.1 Meeting was quorate.

3.0 Minute No. SFC-25-01.003 – 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)

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 at this meeting.

4.0 Minute No.SFC-25-01.004 – Minutes from the Previous Meeting held on 26th November 2024.

4.1 Minutes were agreed as a true and accurate record.

5.0 Minute No. SFC-25-01.005 Matters Arising and Action List from Previous Meetings

5.1 DB referred to the action list from the previous meeting. Actions outlined on the action log was reviewed and updated accordingly.

6.0 Minute No. SFC-25-01.006 - ICB SBAF and SORR

Report received as read.

6.1 CS highlighted that the report seeks to update the Committee on the current System Board Assurance Framework (SBAF) and the System Strategic Operational Risk Register (SORR) as at January 2025 to allow consideration and scrutiny of those risks that have been allotted to the Committee for oversight and assurance.

CS explained that as per a previous Committee discussion, the SBAF Risk 2 has now been split in two - Strategic Risk No.2a: Risk of not achieving underlying financial balance (ICB and System) and Strategic Risk No.2b: Failure to deliver the System and ICB Revenue and Capital Resource Limit Plans for 2024/25.

CS mentioned that there had also been some updates made to the SORR and reported that the SBAF had also been reviewed by ICB Executives on 7th January 2025.

The ICS Finance Committee:

- Reviewed the current system SBAF and SORR, noting the amendments made to them and confirmed support of the content presented

7.0 Minute No. SFC-25-01.007 - Finance Committee - ICS Month 9 Capital Report

Report received as read.

7.1 AS reported that year to date system operational capital spend is £8.3m behind plan at month 9, although the full capital plan is expected to be delivered by the end of the financial year with schemes coming online in the final months of the year. Slippage is predominantly within SaTH due to the slippage on the modular ward capital programme. **DB** queried whether staff were confident to deliver by the end of the financial year. **AW** responded that SaTH are confident as capital planning leads have confirmed what they need to deliver by the end of the financial year.

AS flagged that RJAH are showing an overcommitment of £3m due to the additional cost of the national EPR programme; this will be covered by Public Dividend Capital (PDC).

AS highlighted that SCHT are forecasting an under commitment compared to plan of £1.1m due to a reduction in the IFRS16 operational lease terms although IFRS16 overall is still £2.1m in excess of the System allocated IFRS16 uplift.

AS reported the total system capital plan including IFRS16, HTP and CRL is £33.5m behind plan at month 9, predominantly due to the phasing of the HTP plan as there was a delay in signing the contract, NHSE are aware of this slippage and discussions about reprofiling the funding across years are ongoing, this is expected to be supported.

The ICS Finance Committee:

- Noted that the ICS is reporting an £8.3m underspend against plan for operational BAU capital, namely due to slippage on SaTH modular wards and £33.5m underspend against plan overall, namely due to slippage on HTP.
- Noted that in Month 8 all providers and the ICB confirmed FOT forecasts to plan (assuming the agreement of NHSE to the SaTH HTP capital budget reprofiling request) with the exception of SCHT who reported an underspend of £1.1m against plan.
- Noted the capital expenditure risks and planned mitigations - IFRS16 risk of £2.1m under discussion with NHSE, if there is no resolution nationally in 2024/25 then this could be removed from the capital envelope in 2025/26.

8.0 Minute No. SFC-25-01.008 - Finance Committee - ICS Month 9 Revenue Finance Report

Report received as read.

8.1 **CS** highlighted that the ICS is reporting a £26.4m actual Year-To-Date System deficit, £15.9m adverse to plan at Month 9. NHS STW ICS submitted a 24/25 deficit plan of £89.9m, however in Month 6 the deficit plan was funded therefore the expected end of year position is now breakeven.

CS reported that the ICB has a year-to-date favourable variance of £0.1m which is due to efficiency being delivered ahead of plan offset by additional MH CHC spend, NCA performance in Acute, Community and Mental Health services**.**

SATH reported the highest year-to-date adverse variance of £16.2m, driven by £2.8m endoscopy, £6.3m agency and £2.5m additional escalation (costs) and £3.3m pay award and resident doctor (external income shortfall) and £0.9m car parking income being less than planned.

RJAH reported a year-to-date adverse variance of £0.7m, £3.2m impact of reduced theatres following the end of LLP arrangements, £0.6m inflationary non-pay pressures, offset by £3.1m favourable net impact of mitigations, I&I actions and interventions. **CM** stated that RJAH are still committed to achieving their plan for their forecast out turn position and continue to manage risks between now and the end of the financial year.

SCHT reported a year-to-date favourable variance of £1m. Favourable efficiency delivery and pay underspends are partially offset by pressures across non-pay including support to community hospitals, sub-acute wards and within the Prison healthcare service.

CS explained that if the System cannot currently fully mitigate the financial risks that are flagged, the risk adjusted System deficit FOT would be £21.3m adverse to plan as at month 9.

CS stated that she will be attending an RSP meeting in London on the 12th February 2025, where she expects the System to be challenged about the exit position for the end of the financial year.

CS mentioned that PWC are still working within the STW System to assist within the investigation and intervention programme.

DB queried SATH's agency spend which is high and what mechanisms are in place to reduce the cost. **AW** explained that SATH have reduced agency spend considerably as it was double the amount this time last year but have acknowledged that there is still a lot more to do.

DB queried SATH's CIP. **AW** explained the £8.4m that was taken out of the forecast, which relates to escalation, slippage and income backed schemes. That has been taken out of CIP and was already accounted for in the forecast out turn as reported in the unmitigated position at Month 9.

DB stated that there needs to be more of a System approach to addressing escalation and on the management of NCTR. **CS** mentioned that the Urgent Emergency Care Group is responsible for this.

DB stated that he would like to start looking at the System Transformation programmes and the implications of them within this meeting.

Action: IB/KO to ensure System Transformation Plans/updates come to the Finance Committee, this will be through a report from the System Transformation Group.

The ICS Finance Committee:

- noted that the ICS is reporting a £26.4m actual YTD System deficit v's £10.5m plan, giving a £15.9m adverse variance at M9.
- Noted that whilst System partners have identified mitigations for significant amounts of risk, it is reported that financial risk cannot be fully mitigated if all risks were to materialise. The value of this risk is assessed as £21.3m adverse variance to plan FOT if it were to all materialise. This has not been included in the submitted forecast position as a final FOT position is not yet agreed with NHSE.

9.0 Minute No. SFC-25-01.009 - Finance Committee - STW Efficiency Plan Update Month 9 Report

Report received as read.

9.1 AS highlighted that at month 9 year-to-date efficiency delivery shows a positive variance of +£336k compared to the plan, with performance differing across organisations.

AS flagged that although overall savings remain ahead of plan, the positive variance has decreased compared to last month, primarily due to SaTH's year-to-date adverse variance of -£2.598m. **AS** added that SaTH have adjusted forecasts this month in line with expected delivery and have removed all remaining high-risk schemes from the total, this has significantly impacted on the overall forecast savings position for the system by -£6.4m.

AS noted, that the high-risk schemes removed from SaTH's position relate to System Escalation (£6.8m), Elective Day cases (£800k) and Divisional Schemes (£819k) total £8.4m.

The ICS Finance Committee:

- Reviewed the report, noting the removal of escalation and income backed efficiency in the SaTH forecast.

10.0 Minute No. SFC-25-01.010 - Finance Committee - Deep Dive: Productivity Report

Report received as read.

10.1 JG highlighted that the ICB has been working with providers to develop bridges of productivity levels from 19/20 to 24/25. These have identified 4 key areas of change that future productivity plans need to take account of:

- Coding and counting changes – e.g., MSST
- Investment in safer staffing levels e.g., Maternity
- Investment in quality improvement e.g. IPC
- NHSE technical adjustments e.g. impact of industrial action

JG added that in addition, we have been informed that the national productivity methodology has been changed and key staff within the ICB & providers will be attending a national webinar on the 5th February where the changes will be explained.

JG explained that since writing her paper, she has now received a national productivity pack which was shared on screen with the committee. This will now help to test our view of productivity opportunities to support the headline plan submission to NHSE on the 27th February 2025. Currently, JG is working with COOs, workforce groups, provider organisations and other colleagues to pull the information together for the submission.

JG noted work on the workforce aspects of productivity and explained that she intended to draw on cost per WTE information to help to tell the story of improvement. At the moment, some of this is lost as expensive insourced capacity features in non-pay rather than pay costs so reductions are masked in the data produced. She also flagged that she is encouraging more clinical leadership and 'buy in' to the productivity agenda.

- Noted the progress made with productivity bridging analyses that show where our underlying productivity opportunities lie.
- Noted the productivity headlines received from the providers for 25/26
- Confirmed that provider colleagues will review the estimated impact of productivity, in their draft plans for review at this committee in February.

Noted that further assurance that the system is planning to improve its productivity in line with national expectations will be provided in future meetings (following the publication of further productivity pack details).

11.0 Minute No. SFC-25-01.011 - Finance Committee - NOF4 System Integrated Improvement Plan (SIIP) Report

Report received as read.

11.1 AS reported that the ICB, along with Shrewsbury and Telford Hospitals NHS Trust, were placed into segment 4 of the Recovery Support Programme (RSP) in August 2021.: This is nationally Mandated Support and while both have made progress against agreed exit criteria in 2023/24, there remains significant work still to be done.

AS explained that a System Integrated Improvement Plan (SIIP) was agreed to enable the ICB and System to move out of NOF segment 4 to NOF segment 3 by March 2026. The SIIP was presented to the ICB Board and signed off on the 27/11/2024.

The ICS Finance Committee:

- noted the SIIP deliverables for finance as agreed by the ICB, System Providers and NHSE to support exit from NOF4 to NOF3 and the SIIP progress made to date and current risks.

12.0 Minute No. SFC-25-01.012 - Finance Committee - Risk review and escalations to Board

DB confirmed that the following risks should be escalated to the board as per the SORR and SBAF:

- Delivery of the 2024/25 Revenue Financial Plan – there is currently £21.3m unmitigated risk reported at Month 9, in spite of SaTH FRG mitigations and Investigation and Intervention support.
- Risk to 2025/26 capital limits of £2.1m if 2024/25 IFRS16 costs are not covered nationally by NHSE.

13.0 Minute No. SFC-25-01.013 - Finance Committee – Any other Business

13.1 DB explained that there would now be a confidential section to this meeting, to discuss plans for 2025/26. The meeting would commence directly after this meeting is closed.

Meeting closed at 16.15.

Date and Time of Next Meeting

Thursday 27th February 2025, 15.15, via Teams.

NHS Shropshire, Telford and Wrekin Board RESOLVED that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (section 1(2) Public Bodies (Admission to Meetings) Act 1960.)

Agenda Item

ICB 26-03.145

People Culture and Inclusion Committee Chair's Report, including revised Terms of Reference

Appendix A - NHS STW PCI Committee ToR for Approval

Appendix B - STW ICS People Culture and Inclusion Committee Minutes - 22.01.2025

NHS Shropshire, Telford and Wrekin Integrated Care Board
System People, Culture & Inclusion Committee

Terms of Reference

1. Constitution

1.1 The System People, Culture & Inclusion Committee (the Committee) is established by the Board of NHS Shropshire, Telford and Wrekin (the Board of NHS STW) as a Committee of the Board in accordance with its Constitution.

1.2 These terms of reference, which must be published on NHS STW website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

1.3 The Committee is an executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of NHS STW.

2. Authority

2.1 The System People, Culture & Inclusion Committee is authorised by the Board to:

- Investigate any activity within its terms of reference.
- Seek any information it requires within its remit, from any employee or member of NHS STW (who are directed to co-operate with any request made by the committee) within its remit as outlined in these terms of reference.
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the committee must follow any procedures put in place by NHS STW for obtaining legal or professional advice.
- Create sub-Committees and 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.

2.2 For the avoidance of doubt, in the event of any conflict, NHS STW Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference.

2.3 The Committee has no executive powers, other than those delegated in the SoRD and specified in these terms of reference.

3. Purpose

3.1 The purpose of the committee is to provide oversight and assurance to the ICB Board on:

- Development of the ICB / ICS People Strategy, in the context of the System and national picture (including the National People Plan);
- Development of the ICB / ICS Equality, Diversity and Inclusion (EDI) Strategy, in the context of the System and national picture;
- Progress against the delivery of those strategies (and supporting strategies), via appropriate Delivery Plans; and
- Risks to delivery of those strategies (and supporting strategies).

4. Membership and attendance

4.1 Membership

4.1.1 The Committee members shall be appointed by the Board in accordance with NHS STW Constitution.

4.1.2 The Board will appoint no fewer than four members of the Committee including one independent non-Executive member of the Board. Other members of the Committee need not be members of the Board, but they may be.

4.1.3 Members will possess between them knowledge, skills and experience in:

- Human Resource Management
- Succession Planning and Talent Management
- Organisational Development
- Equality, Diversity & Inclusion
- Education and training
- Strategic Workforce Planning
- Risk management
- And technical and specialist issues pertinent to NHS STW's business

4.1.4 When determining the membership of the Committee, active consideration will be made to diversity and equality.

4.1.5 Members are expected to attend 75% of meetings held each calendar year. Where this is not possible a nominated deputy of sufficient seniority (as named above) may attend with delegated authority to make decisions on behalf of their organisation or role on the Committee.

4.1.6 The core membership of the People Committee will be:

- Chair of an NHS Trust Partner ICB Member (Chair)
- Non-Executive Director of NHS STW
- 4 Non-Executive Directors, one from each partner provider
- ICS Chief Executive SRO for People
- ICS Chief People Officer (or agreed senior workforce deputy whilst the post is vacant)
- ICS Chief Nurse
- ICS senior medical and/or clinical lead
- A workforce representative from Shropshire Council
- A workforce representative from Telford and Wrekin Council
- A representative from the Voluntary Community and Social Enterprise (VCSE) sector
- System People Collaborative SRO's for the People Strategy priorities.

4.2 Chair and Vice Chair

4.2.1 The Committee will be chaired by a Non-Executive Director of the ICB or the Chair of a Partner Provider NHS Trust of the Board appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee.

4.2.2 In the event of the Chair being unable to attend, the System Chief People Officer or the ICS Chief Executive SRO for People (who are joint Vice Chairs) will chair the meeting.

4.2.3 In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number to Chair the meeting.

4.2.4 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference.

4.3 Attendees

4.3.1 Only members of the Committee have the right to attend Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Committee.

4.3.2 Meetings of the Committee may also be attended by the following individuals who are not members of the Committee for all or part of a meeting as and when appropriate. Such attendees will not be eligible to vote:

- Directors of Nursing from each provider organisation
- Director of Strategy & Delivery NHS STW
- Associate Director of Primary Care NHS STW, representing PCNs
- Chair of ICS AHP Council
- Representatives from local further education institutions
- Representatives from local higher education institutions
- Representative from Social Care
- Representative from out of hours provider
- Representative from NHS England Workforce, Training and Education Directorate
- At least one representative from any working groups created by or reporting to the Committee.

4.3.3 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

5. Meetings Quoracy and Decisions

5.1 Meetings

5.1.1 The Committee will meet at least twice a year, but with the expectation that the meetings take place bimonthly and arrangements and notice for calling meetings are set out in the Standing Orders 4.1. Additional meetings may take place as required.

5.2.1 The Board, Chair or Chief Executive(s) may ask the People Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

5.3.1 In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

5.2 Quorum

5.2.1 For a meeting to be quorate the following core members are required including the Chair or Vice Chair (or their deputy), and two additional NED's (NHS STW or provider), one member of the ICB Executive Team and one Local Authority Representative.

5.2.2 If any member of the Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

5.2.3 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

5.2.4 Where the meeting is unable to maintain the quoracy stipulated for the meeting due to the number of members required to withdraw from a meeting or part of it, owing to the arrangements agreed for the management of conflicts of interests or potential conflicts of interests, the chair (or deputy) will determine whether or not the discussion can proceed.

5.2.5 In making this decision the chair will consider whether the meeting is quorate, in accordance with the number and balance of membership set out in the ICBs standing orders/terms of reference. Where the meeting is not quorate, owing to the absence of certain members, the discussion will be deferred until such time as a quorum can be convened. Where a quorum cannot be convened from the membership of the meeting, owing to the arrangements for managing conflicts of interest or potential conflicts of interests, the chair of the meeting shall consult with the Chief Executive Officer and Chief Business Officer of the ICB on the action to be taken.

5.2.6 In these circumstances the ICB may adopt one of the following actions:

- requiring another of the ICB's committees/group or sub-committees/sub-groups which can be quorate to progress the item of business,

- where the initial responsibility for the decision does not rest with the Board, refer the decision to the Board and exclude any Board members with an interest from the decision making process,

- Subject to the provisions of clause 5.2.7, inviting on a temporary basis one or more of the following individuals who are not conflicted shall act as members for the duration of the relevant meeting, in order to make up the quorum so that the ICB can progress the item of business:

  I. a voting member of the Board;
  II. a voting member of a committee/group, sub committee or sub-group of the ICB;
  III. voting member of the Shropshire, Telford and Wrekin Integrated Care Partnership;
  IV. a voting member of an NHS Trust/ Foundation Trust Board of those organisations listed in section 3.5.1 of the Constitution.

These arrangements must be recorded in the minutes.

5.2.7 In choosing which of the four categories of individual to invite as outlined in 5.2.6(c) above, the Chair and Chief Executive Officer will consider the need for the relevant individual to have either clinical knowledge, patient experience knowledge, and/or locality knowledge and the independence that the proposed individual may bring, in the circumstances and in relation to the item which is to be subject to discussion and decision making at the meeting.

5.2.8 Decisions deemed by the Chair to be 'urgent' can be taken outside of the meeting via email communication, and with the agreement of a quorate number of members.

5.3 Decision Making and Voting

5.3.1 Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

5.3.2 Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

5.3.3 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

6. Reporting Procedures

6.1 The Chair of the People, Culture and Inclusion Committee attends the ICB Board, and is the conduit for reporting to and receiving updates and requests from this Board.

6.2 The Chair of the Committee will report to the Board following each Committee meeting. The Chair's Report shall:

1. Alert the Board to any issues that:

- Represent non-compliance with required standards or pose a significant risk to the ICB's ability to deliver its responsibilities or objectives and therefore require action to address; OR
- Require the approval of the Board for work to progress.

2. Advise the Board of any areas for ongoing monitoring, a potentially worsening position, or an emerging risk to the ICB's ability to deliver its responsibilities or objectives.
3. Assure the Board on other items considered where the Committee did not identify any issues that required escalation to the Board.

6.3 Committee members are responsible for ensuring their respective organisations' Boards and Committees are sighted on the programmes of work and strategic plans from the ICB People, Culture and Inclusion Committee. Representatives will be required to provide assurance that this has taken place by sharing the Chair's Assurance Report with the relevant forum within their own organisation.

7. Responsibilities of the Committee

7.1 The overarching aim of the People Committee is to:

- Provide assurance that appropriate plans and arrangements are in place to deliver workforce, OD, culture and EDI strategic priorities and System ambitions supporting sustainable, safe, high quality, patient-centred care across Shropshire, Telford and Wrekin. To support this overarching aim, the Committee will:
  - Align partners across the ICS, to co-create and support a shared approach to the people agenda.
  - Develop strategic relationships with key stakeholders at a system, regional and national level.
  - Actively seek to reduce inequalities in the staff experience and to promote equality, diversity and inclusion in a systematic and effective way.
  - Provide senior leadership, strategic advice and guidance back to the system and to the leadership board on people, culture and inclusion issues.
  - Develop and deliver a coherent approach to measuring people, culture and inclusion outcomes and strategic objectives to support delivery of ICS ambitions & deliverables.
  - Promote creativity in the design, delivery and evaluation of workforce solutions across all partners in the ICS.
  - Provide a platform for Organisations and ICS workstreams to escalate strategic people, culture and inclusion risks, debate control and mitigation and provide assurance to the Board that such risks are being effectively controlled and managed.
  - Set the strategic direction for delivery groups ensuring that clear outcomes for each group are agreed, monitored and delivered, including impact on outcomes, performance, activity, quality and finance.

7.2 The Committee will deliver these objectives by:

- Overseeing the development and delivery of workforce, OD and cultural change strategies that support the ICB's strategic priorities, in the context of System and national picture (including the National People Plan).
- Overseeing the development and delivery of education, training and learning strategies to upskill and reskill the workforce of the future.
- Overseeing achievement of the ICS Workforce Plan and the NHS Long Term Workforce Plan, to ensure alignment to ICS strategies and provide assurance that the System has adequate staff with the necessary skills and competencies to meet the future health and care needs of patients and service users.
- Providing assurance to the ICB Board on the delivery of the People, Culture and Inclusion strategic objectives.

- Providing oversight and insight to the use of Workforce Development Funding entering the system, ensuring appropriate governance.
- Receiving assurance reports from agreed workstreams or programmes aligned to delivery of the key people priorities, covering the following:
  - the governance arrangements in place to oversee delivery;
  - the operational arrangements in place to deliver the relevant workstream objectives;
  - risks to delivery of the relevant workstream objectives and overall strategy;
  - identification and tracking against success measures.
- Overseeing the work of identified sub-committees and groups via assurance reports covering:
  - the governance arrangements in place to oversee delivery;
  - the operational arrangements in place to deliver the relevant workstream objectives;
  - risks to delivery of the relevant workstream objectives and overall strategy;
  - identification and tracking against success measures.
- Receive annual reports on workforce specific FTSU themes across the system.
- Reviewing those elements of the Board Assurance Framework delegated to the People Committee, seeking further action/ assurance where necessary and reporting to the ICB accordingly.

8. Conflicts of Interest

8.1 In discharging duties transparently, conflicts of interest must be considered, recorded and managed.

8.2 Members should have regard to both the ICB's policies and national guidance on managing conflicts of interest.

8.3 All potential conflicts of interest must be declared and recorded at the start of each meeting. A register of interests must be maintained by the Chair and submitted to the Board. If the Chair considers a conflict of interest exists then the relevant person must not take part in that item, and the Chair may require the affected member to withdraw at the relevant point.

9. Secretariat

9.1 The Committee will be serviced by NHS STW ICB and will operate using the following principles:

- Agenda items will be sought from the members of the Committee 14 days prior to the meeting.
- The Chair will agree the final agenda.
- Papers will be circulated 5 working days before each meeting.
- Additional items for the agenda will be taken by exception with the knowledge and agreement of the Chair in advance of the meeting commencing.
- The minutes of each meeting will be circulated within 10 working days of the meeting being held and will be ratified at the following meeting.

9.2 Ratified minutes of the meeting will be circulated to sub-groups for dissemination to their members as required.

Approved - March 2023, Refreshed January 2025

Minutes
STW ICS People, Culture & Inclusion Committee
Wednesday 22nd January 2025 at 15.00 – 16.30
Via Microsoft Teams

Attendees:	**Title:**
Martin Evans (acting Chair)	Non-Executive Director RJAH
Stacey-Lea Keegan	SRO for People and Workforce
Ellen Shaw	Head of People Solutions Programmes and Consultancy MLSCU (acting as STW ICB Strategic Workforce Lead)
Sarah Allen	Deputy Workforce Operations Director, SCHT
Alex Brett	Chief People Officer MPFT, SRO TRANSFORM
Vanessa Whatley	Chief Nursing Officer STW ICB
Emma Wilkins	People Interim Director SaTH
Teresa Boughey	Non-Executive Director SaTH
Sarah Davies	Director Health and Science Telford College
Jan Heath	STW ICB Workforce Transformation Lead
Andrew Morgan	Chair in Common Shropshire Community Health Trust / SaTH
David Crosby	Chief Executive Partners in Care
Simon Balderstone	Deputy Director of People SCHT and SRO REFORM
Denise Harnin	Chief People Officer and Culture Officer RJAH SRO RETAIN
Nicky Ulloa	Head of Quality Assurance Landau
Shane Baldwin	Workforce Transformation Manager, NHSE
Phil Taylor	NHSE
Amanda Battey	Workforce Transformation Senior Programme Manager, NHSE

Apologies:	
Harry Turner (Chair)	Chair RJAH
Meredith Vivian	Non-Executive Director STW ICB
Rhia Boyode	Chief People Officer SaTH
Alison Trumper	STW ICB Head of People Programmes
Tanya Miles	Executive Director of People Shropshire Council
Matthew Laws	Vice Principal Shrewsbury Colleges Group
Lawrence Wood	CEO Telford College
Paul Cavanagh-Fields	Director of Nursing RJAH
Ian Turner	Director of Nursing MPFT
Alison Sargent	Non-Executive Director SCHT
Claire Hobbs	Director of Nursing SaTH
Carol Bagnall	People Transformation Lead STW ICB

Minute Taker:	
Sally-Anne Smith	STW ICB

1 WELCOME, INTRODUCTIONS AND APOLOGIES

Martin Evans reminded those committee members present that he was acting as temporary Chair in the absence of Harry Turner, who was recovering post-surgery.

Introductions: Ellen Shaw introduced herself to the committee in her temporary position providing strategic workforce leadership to the System People Team.

Apologies: Rhia Boyode, Meredith Vivian, Alison Trumper, Tanya Miles, Alison Sargent, Matt Laws, Lawrence Wood, Paul Cavanagh-Fields, Ian Turner, Claire Hobbs. No other apologies noted.

2 QUORACY, ATTENDANCE REGISTER, CONFLICTS OF INTEREST DECLARATIONS

Quoracy and attendance was noted for the meeting. Following the action from the October meeting Martin Evans asked that the list of members required to make the meeting quorate was noted at the top of the agenda.

No Conflicts of Interest were registered at this meeting.

3 MINUTES AND ACTIONS FROM THE PREVIOUS MEETING

Martin Evans combined the minutes of the meeting held on 14th October 2024 and 3rd January 2025, items 3 and 6.2.
Martin Evans noted the following:

- titles of some committee members were not recorded correctly, and asked this be picked up outside the meeting.
- Sustainability strategy – funding for that role profile, this was discussed through the Collaborative meeting with work ongoing, Alex Brett to cross reference the job description and work with Carol Bagnall. ACTION to stay open

ACTION - Vanessa Whatley asked that the 3rd of January meeting title was changed from ICS People, Culture and Inclusion meeting to Terms of Reference Review, due to the meeting not having full attendance. Martin Evans agreed that the meeting held on 3rd January was an extra-ordinary meeting to look at the Terms of Reference.

EDI – Vanessa Whatley felt that the EDI needs to come to this meeting, it currently goes to the Board every two meetings, and to the ICB Board every four months, she felt this committee need to be cited on any risks.

The combined minutes of the meetings of 14th October 2024 and 3rd January 2025 were approved as an accurate record and the Chair signed them off.

The actions of the combined meetings of 14th October 2024 and 3rd January 2025 were updated, and approved as an accurate record and the Chair signed them off.

4 RISK REGISTER – Progress Update

Ellen Shaw felt that a full review of all risk registers was required in relation to People, looking at the owners, the scores, and mitigations, starting with the Local Risk Register, and feeding in to inform the BAF and SORR. She said the aim was to streamline this and obtain continuity throughout the three levels of risk reporting. Committee agreed Risk should come to this meeting as a standing item.

Martin Evans asked what the timescale for this to be completed, Ellen Shaw aimed to present something at the next committee meeting.

ACTION: The local risk register to be reviewed and brought back to the next committee meeting for review.

5 ICB PEOPLE REVIEW

Stacey-Lea Keegan explained that as part of the system being in RSP (Recovery Support Programme), there was some funding available which was used to commission a review around people services. The review picks up three key areas, a strategic system, people model including consideration of senior role within the ICS and the ICB internal HR service, and potential delivery models for people services across the whole of the system. The review has been completed but is currently a draft report, which has been shared with Simon Whitehouse and CPOs across the system to ensure their views have been incorporated, with a view to take it to System Chief Execs, with HR & DS input to decide on next steps. She hoped that they would be able to provide the outcome at the next meeting.

6 **DRAFT TOR FOR PEOPLE, INCLUSION AND CULTURE COMMITTEE for agreement subject to ICB sign off.**

Matin Evans explained the colour coding within the current draft TOR. Martin Evans, Harry Turner and Stacey-Lee Keegan had carried out the initial work on the draft TOR with the support of the RJAH Trust Secretary. TORs from other systems had been considered and the initial draft was discussed at the extraordinary meeting in January. Martin Evans said he would like to arrive at a stage where the committee had a TOR that could be approved today. He wished to agree on the frequency of the meetings and proposed bimonthly meetings in line with ICBs which were bimonthly, to ensure that assurance reports going in are UpToDate and time appropriate.

Martin Evans noted Vanessa Whatley's point it was important that the committee need to be clear regarding what the roles of ICB members are.

Amanda Battey felt that the list of members was unevenly balanced, there were a lot of People members but in her experience of other systems they have an input from all areas, Chief Medical Officer, Chief Nurse etc, which allowed for a different input and view.

Vanessa Whatley felt there was a gap in representation, agreed that the meetings should be bi-monthly rather quarterly, with a suggestion for named individuals for quoracy rather 50% quoracy.

Martin Evans asked Ellen Shaw to identify the right people to bring a wider perspective to the meeting in line with the comments made by Amanda Battey.

ACTION: Ellen Shaw to link in with Vanessa Whatley regarding the ICB contacts, in particular Exec representation, and to also reach across the membership to identify other people who would be willing to join this committee.

The Committee discussed FTSu and it was felt that this needed to be included within the TOR. Stacey-Lea Keegan and Ellen Shaw to discuss how they pull together Freedom of Speak Up leads and guardians to see what they can help the committee with around themes etc. Potential for NED ICB lead for FTSU to be the link to this committee on themes. Martin referenced health and safety and where this sits, general agreement proposed was not for this committee but do need to be clear where it does feature.

ACTION – Ellen to confirm sustainable secretariate support and finalise TOR incorporating feedback.

7 CYCLE OF BUSINESS AND WORK PLAN

Ellen Shaw shared the Cycle of Business and Work Plan with the committee, which included standing items that linked back to the committee's purpose in the Terms of Reference namely Risk, updates from the People Collaborative around the four work streams, updates around the strategies that are identified within the purpose – People Strategy and ED&I Strategy, delivery in relation to NOF4, annual items. She noted there would also be a need for action plan ratification and oversight, to include operational workforce plan, staff survey results, ED&I reporting, levy utilisation and system oversight framework and workforce metrics. There was also a need to consider other key reporting from non-NHS system partners including social care and local authority partners.

8 PEOPLE COLLABORATIVE CHAIRS REPORT

23rd October and 29th November Meetings

Stacey-Lea Keegan noted in relation to areas that have been identified there was work in progress to reduce risks within the collaborative. Nigel Lee and Claire Parker attended a meeting from a strategy perspective, discussing a refresh of the People Strategy, the refreshed workforce strategy is also part of the System Integrated Improvement plan. Both herself and Ellen Shaw had noted the number of priority areas from a people perspective currently in the system.

9 REVIEW OF PEOPLE COLLABORATIVE TOR

Stacey-Lea Keegan expected to see the transformation part happening within the collaborative TOR, she had been in discussion with Ellen Shaw regarding programme management and oversight as a key part of the collaborative. She hoped to avoid duplication of some of the areas, ensuring that the right people are at the right committees and meetings.

ACTION – Any comments on the TOR to be presented to Stacey-Lea Keegan and brought back to the next meeting.

10 PEOPLE COLLABORATIVE UPDATE ON WORKSTREAMS

TRAIN

Emma Wilkins noted that the papers covered a recap of achievements under the TRAIN portfolio, which sets out and references some ambitions for the year ahead in respect of their system wide website and education strategy and learning management, platform availability, system partners and ongoing work with third education partners and Keele University. It also identifies the risks to the Oliver McGowan training delivery model and T-Level coordinator placement.

RETAIN

Denise Harnin noted funding for the RETAIN agenda had now been provided until March 2025. They had carried out a mini survey across all partners including local authorities, to include menopause training, menopause support and flexible working. They will be working on these across the system, and training programmes for Line Managers on flexible working, which is accessible online.

REFORM

Simon Balderstone noted that the objective of the REFORM was around delivery of the operational plan.

TRANSFORM

Alex Brett gave a quick update on the TRANSFORM plan, the CEO development program has started to mature and they had been successful through NHS England in hosting a national rollout of their high potential scheme. The committee agreed that this was a really good programme of work that has been carried out and rightly recognised nationally for a wider roll out.

ANY OTHER BUSINESS

Ellen Shaw noted the next People, Culture and Inclusion meeting was scheduled for 11th February, which would be three weeks' time, with the one following taking place on 11th March.

The Committee agree that 11th February would be too soon, that the meeting should be bi-monthly and it was agreed that the next meeting would be on 11th March.