Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

# STW Integrated Care Board - appendices

MEETING
24 April 2024 14:00 BST

PUBLISHED
19 April 2024

# Agenda

| Location | Date | Time |
| --- | --- | --- |
| The Reynolds Suite Holiday Inn Telford International Centre, St. Quentin Gate, Telford TF3 4EH | 24 Apr 2024 | 14:00 BST |

# Contents

Agenda Item

ICB 24-04-036a

NHS STW Operating Model

# Engagement Log

| Sharing | Response |
|---|---|
| Values and Behaviours developed with All Staff 23 November and through subsequent newsletter<br>Goals, Assets and Capabilities and Leadership model shared at All Staff session 23 November and through subsequent newsletter | Draft value descriptors developed into value statements and behaviours from staff contributions |
| Values and Behaviours shared with Non-Executive Directors | Value descriptors shortened to give a memorable tagline to go with the statements and metrics proposed |
| Chapters 1-3 All Staff 19 December<br>1. The document is too long<br>2. There is too much management speak<br>3. There should be more emphasis on health inequalities<br>4. We need a more obvious link between the values and behaviours<br>5. We need to understand what the design principles mean for the organisation<br>6. We want more on ways of working to bring it to life<br>7. There should be less emphasis on the CCGs and how things were, focus on how things are and will be<br>8. Include where procurement links in | 1. Chapters 1 and 2 have been shortened<br>2. More explanations of terminology have been included<br>3. A new section on life course experiences added to the case for change<br>4. Each behaviour has been linked to the value it aligns to – identified through colour coding on the behaviours slides<br>5. New section on how the design principles shape our teams<br>6. New section on ways of working added, new sections on Place and Provider Collaborative working added, draft Chapter 4 added showing the board, ICS portfolios and executive<br>7. References to CCGs removed, the only reference to previous arrangements is confirming where responsibilities for other organisations have not changed<br>8. Links to procurement added |
| Chapters 1-3 stakeholder engagement sessions offered to all board members | Stakeholder feedback informed appetite and ambition for sharing back-office functions, development of provider collaboratives and desire for new relationships to support new ways of working<br><br>Chair – greater emphasis on ways of working and direction of travel for shared services |
| First full draft shared 5 January, Updated Draft shared after closure of staff engagement and associated updates | Chapter 3 place and provider components edited to remove duplication<br>Chapter 6 condensed to highlight how the Team of Teams will work together to deliver the commissioning cycle<br>Appendices added to remove additional detail from the core document |
| First full draft shared 5 January, Updated Draft shared after closure of staff engagement and associated updates | Exec portfolios and responsibilities appendix added<br>Place and Provider components updated on receipt of new materials<br>Commissioning arrangements moved to Appendix 2 |
| Updated Chapters 1-3 shared with Neil McKay | No comments received to date |
| Full draft shared with All Staff 6 February<br>Ways of Working engagement sessions 12 Feb-15 Mar | See changes slide following |
| | |

# Changes further to staff engagement

| Feedback | Change made |
|---|---|
| Feedback by email during engagement period – part 1<br>Additional detail provided around the people portfolio by People team | Additional responsibilities for the ICB added, referencing to hosting of the team on behalf of the system and the associated responsibilities included in the exec structure, chapter 6 and appendix 5 – revisions agreed with Execs 20 Feb and implemented in this version |
| Ways of Working sessions:<br>1. Matrix Working – needs a definition<br>2. Could we add to chapter 6 to help us understand how the matrix works? Maybe a flow chart?<br>3. Can we map the full governance to show where things like cardiovascular programme boards sit?<br>4. How do we find the named leads for topics? | 1. Definition added to the opening of chapter 6 – revision agreed with Execs 20 Feb<br>2. In development to follow (awaiting confirmation of delivery team/commissioning piece which has been advised will be delayed)<br>3. There is a separate piece of work on governance under the Shaping the ICB programme which will address this query. Suggest that teams work through scenarios to bring the operating model to life for their work<br>4. Feedback referred to the structure consultation process for consideration – the executive portfolios in Appendix 5 give a high-level direction as a starting point if anyone is not sure where to start looking for a named lead for a topic |
| Feedback by email/survey during engagement period – part 2<br>1. Add health inequalities information at place level/core 20 plus level<br>2. Add LTC, healthy life expectancy and mortality information<br>3. Add reference to differently investment to slide 15<br>4. Greater emphasis on health inequalities duties and action<br>5. Could we include a section in our Operating Model which talks to the moral identify of our organisation which evidences our commitment to our specific communities e.g. our commitment to be Greener, inclusivity, allies, the Smoke Free Pledge? Are there other moral initiatives/pledges we can take as an organisation?<br>6. Add our role as an anchor institution – slide 22<br>7. Our new legal duty to collect, analyse and publish information on health inequalities must be included<br>8. Add safeguarding to CEO responsibilities and refer to Working Together 2023 in CEO/CNO<br>9. Health inequalities infographic – wrong structure<br>10. More focused needed on Prevention<br>11. Could the values be presented in a more visual way?<br>12. Could we add contact details for teams to Ch4?<br>13. Where are the Chief Business Officers responsibilities in Appendix 3 (now 5)?<br>14. Can we have the next layer down and flow charts for governance, along with development of frameworks?<br>15. More detail on public health response<br>16. Add vaccination and immunization reporting responsibilities<br>17. Move vaccs and imms responsibility from Chief Pharmacy Officer to Chief Medical Officer<br>18. Change references to Insights to Business Intelligence<br>19. Update to Place slides wanted | 1. Information requested and awaited<br>2. Information requested and awaited<br>3. Reference added<br>4. Added to Chief Strategy Officer slide, chapter 6, exec structure<br>5. Exec team to advise – new appendix added on anchor organisation status and draft statement included (appendix 4)<br>6. Added<br>7. Added to Chief Strategy Officer slide<br>8. Added to CEO/CNO slides<br>9. New slide 10 added plus new appendix 1, narrative added to infographic and set in support of detailed local information from Core20Plus5 now rather than stand alone<br>10. Addition to Our Purpose and Team of Teams: Strategic Planning<br>11. Visual representation options for presentation/colours (to be refined upon selection) slide 26-9<br>12. Exec to take a view and add if required<br>13. The Chief Business Officer supports the CEO in the discharge of their responsibilities and is not a board level post holding their own set of responsibilities<br>14. There is a separate piece of work on governance under the Shaping the ICB programme which will address this query. The Governance Handbook will be updated and will address some of these queries.<br>15. Detail added to appendix 2 as provided and CMO responsibilities in appendix 5<br>16. Added to CFO responsibilities in Appendix 5<br>17. Moved<br>18. Done<br>19. Updated content requested, not yet received |

Integrated Care System
Shropshire, Telford and Wrekin

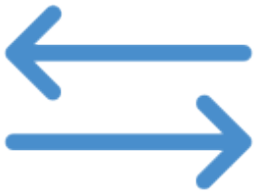
NHS
Shropshire, Telford and Wrekin

# NHS Shropshire, Telford & Wrekin (STW) Integrated Care Board (ICB) Operating Model

Version 3.00

7 March 2024

# Our Operating Model – What does it include?

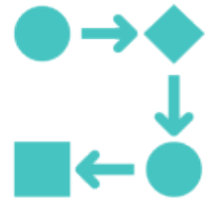


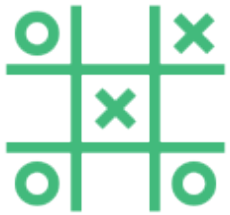
Our Case for Change

Our Structures

Our Statutory Duties

Our Governance





Our Organisational Strategy

Our Practice

Appendices for Further Information

# Chapter 1:
# Our Case for Change

# Our Case for change

The introduction of statutory Integrated Care Systems (ICSs), and transition from Clinical Commissioning Groups (CCGs) to Integrated Care Boards (ICBs), was intended to be part of a fundamental shift in approach for the NHS.

However, this ambition can only be fully realised if ICBs play a new role within the Integrated Care System.

In addition, on 3 March 2023, NHS England announced that the running cost* allowance for ICBs will be reduced by 30% by April 2026.

*The money which is spent on doing the work of the organisation is known as running cost.
The money spent on buying services for the people of Shropshire, Telford and Wrekin is known as programme and service cost.

# The Health and Care Act 2022

The statutory roles of the Local Authorities, Trusts and Foundation Trusts have remained largely unchanged.

- ✓ The purpose of the Local Authorities is to arrange for core services in each Place - including housing, social care, education, planning, licensing, waste collection etc.
- ✓ The purpose of NHS Trusts and Foundation Trusts (FT) continues to focus on the delivery of health services to their population.
- ✓ The purpose of Provider Collaboratives is to support the collaboration between these organisations along with Voluntary, Community and Social Enterprise (VCSE) Providers and coordinate the route for health and care organisations to reach a wide range of provider organisations.
- ✓ The purpose of the Health and Wellbeing Boards is to set the strategic direction to improve the health and wellbeing of the local population at Place.

The Health and Care Act 2022 required some changes to the health and care landscape and:

- ❑ Created Integrated Care Boards and Integrated Care Partnerships (ICPs) – along with the legal requirement to create an Integrated Care System strategy and an NHS Joint Forward Plan.
- ❑ NHS Trusts and Foundation Trusts now have a legal duty to collaborate, be partner members of ICB boards, and are expected to join Provider Collaboratives and Place-based partnerships.
- ❑ No new responsibilities were placed on local government, but they are expected to join and play an active role in Place-based partnerships and ICPs.

# Our Integrated Care System (ICS)

Around 500,000 people living in Shropshire, Telford & Wrekin

Shrewsbury and Telford Hospital NHS Trust, Shropshire Community Health NHS Trust, Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust, Midlands Partnership University NHS Foundation trust, and West Midlands Ambulance Service University NHS Foundation Trust

51 GP Practices working through 8 Primary Care Networks,
Community Pharmacies, Dentists and Optometrists

Shropshire Council, Telford & Wrekin Council and Shropshire, Telford and Wrekin Integrated Care Board

Many Independent and VCSE organisations supporting people and delivering services in our communities

# Our ICS Challenges

Continuing industrial action and an ongoing cost of living crisis

Delays in the flow through our emergency pathways

Financial and performance challenges across the system

Challenges in the demand for and access to primary care, mental health and children's services

Elective and cancer care recovery since the pandemic

Long-term conditions which are on the rise and our significant health inequality challenge

# Health Inequalities within our ICS

According to the 2021 Census, **12% (60,100) of people in Shropshire, Telford & Wrekin live in geographical areas considered to be in the 20% most deprived areas across England.**

**45,400** of those people currently reside in in Telford & Wrekin (approximately 24% of the population) and **14,700** live in Shropshire (approximately 5% of the population).

In Shropshire, Telford & Wrekin, life expectancy is lowest in areas considered to be in the 20% most deprived areas across England. This difference can be as much as 8.1 years for men and 7.8 years for women in Telford and Wrekin and 7.2 years for men and 5.0 years for women in Shropshire.

This inequality has been increasing over the last decade, however, during 2016-18, inequality in life expectancy in Telford & Wrekin started to decrease.

**CORE20**

The 20% most deprived areas across the UK.

**PLUS**

Population groups who experience poorer than average health access, experience and outcomes.

**5**

5 key clinical areas where we can make a difference.

The Core20Plus5 approach identifies the key areas of focus for reducing healthcare inequalities for both children and young people and the wider population. This sets out our priorities for prevention and early intervention with cardiovascular disease being the most significant cause driving inequality in life expectancy in Shropshire, Telford and Wrekin.

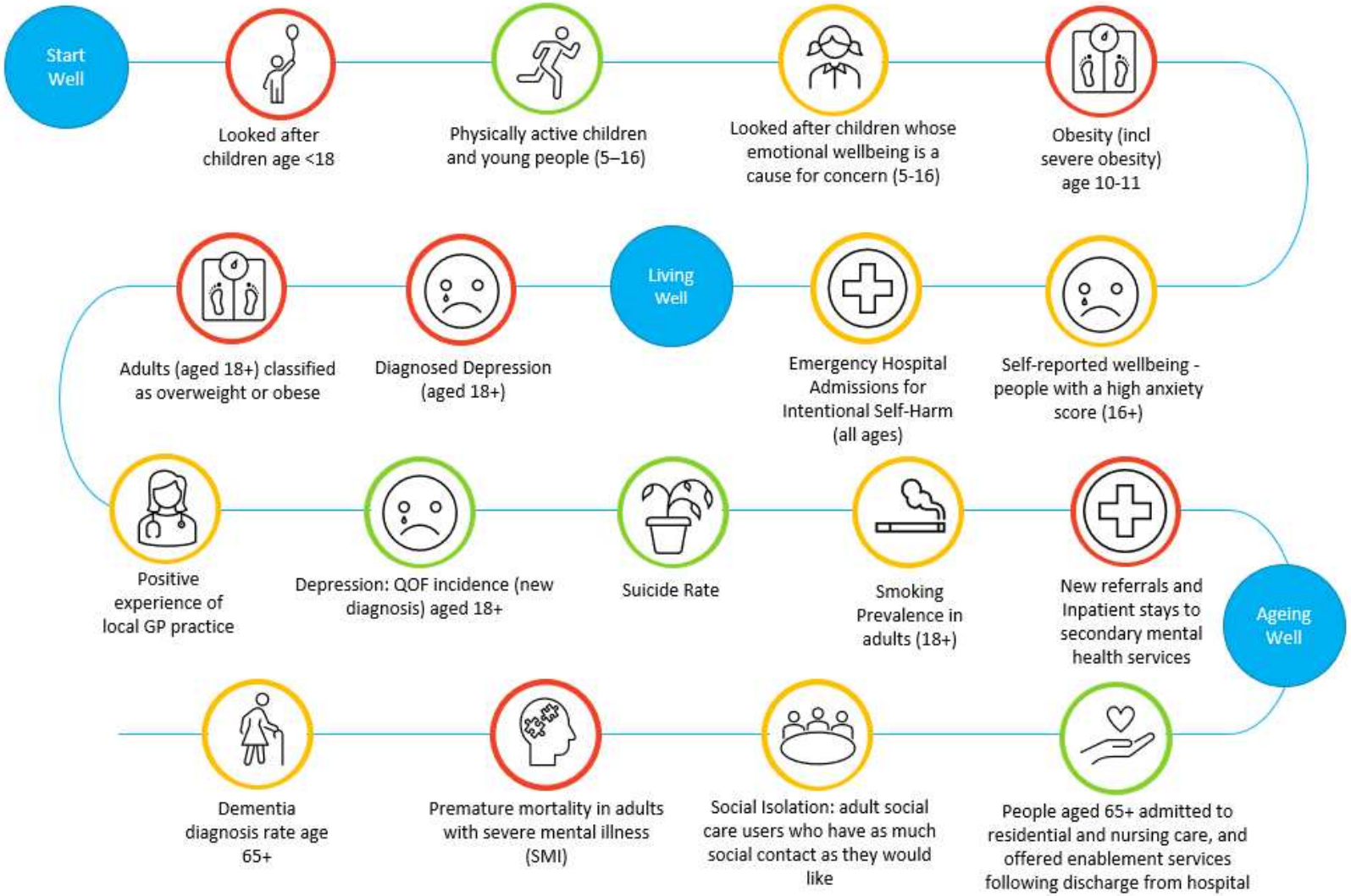
For more detail see Appendix 1.

NHS

# Life Experiences in STW Compared to England

## Shropshire, Telford & Wrekin ICB life course statistics

A comparison to England




### Population Overview

- Telford is ranked **among the 30% most deprived populations in England.**
- Telford and Wrekin is home to around 179,900 people with the **fastest growing population being aged 65+.**
- Shropshire covers a large rural population with problems of **physical isolation and low population density** (0.96 people per hectare compared to 4.09 in England) and has a mix of rural and urban aging populations.
- Between 2017 and 2035 **the number of people aged 65+ with dementia is expected to increase by 80%.**

***Source: NHS Shropshire, Telford and Wrekin, 2023***

**KEY**

Statistical significance to England

- **Worse**
- **No different**
- **Better**

Based on an infographic design from Halton Borough Council's Public Health Intelligence Team.

Data is the most up-to-date available at the time of production where open data is available at Local Authority and England. Data source: OHID Public Health profiles. 2023 https://fingertips.phe.org.uk Crown copyright 2023. Accessed 8th Jan 2023

National public health data shows that whilst we have some areas to improve, our population also experience some positive health inequalities in their life experiences in comparison to the rest of England, including in activity levels for our children.

# Our Integrated Care Partnership (ICP)

The STW Integrated Care Partnership (ICP) is responsible for setting the system strategic direction and must ensure the following requirements are met as set out in the Health and Care Act 2022:

*Prepare an integrated care strategy setting out how the assessed needs in relation to its area are met by:*

- *ICB, Place-based Partnerships and Provider Collaboratives*
- *NHS England*
- *Local Authorities*

The purpose of the Integrated Care Partnership in STW:

*The Integrated Care Partnership's primary objective is to formulate an integrated care strategy that guides STW. This will be achieved by actively involving and collaborating with system partners to articulate the approach ICS partners should adopt in addressing the broader health and care requirements of individuals in STW.*

Through the development of the integrated care strategy, the ICP must:

- Ensure the integrated care strategy sets out how the local 'assessed needs' from joint strategic needs assessments are met by the functions of NHS STW, partner local authorities and NHSE.
- Have regard to the NHS mandate in preparation of the integrated care strategy.
- Consider whether the needs could be more effectively met with an arrangement under section 75 of the NHS Act 2006.
- Involve local Healthwatch organisations and people who live and work in the area in preparation of the integrated care strategy.
- Publish the integrated care strategy and give a copy to each partner local authority and integrated care board.
- Consider revising the integrated care strategy whenever they receive a joint strategic needs assessment and may include a statement on better integration of health or social care services with 'health-related' services in the integrated care strategy.

# Our Integrated Care Partnership Strategy

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

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

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

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

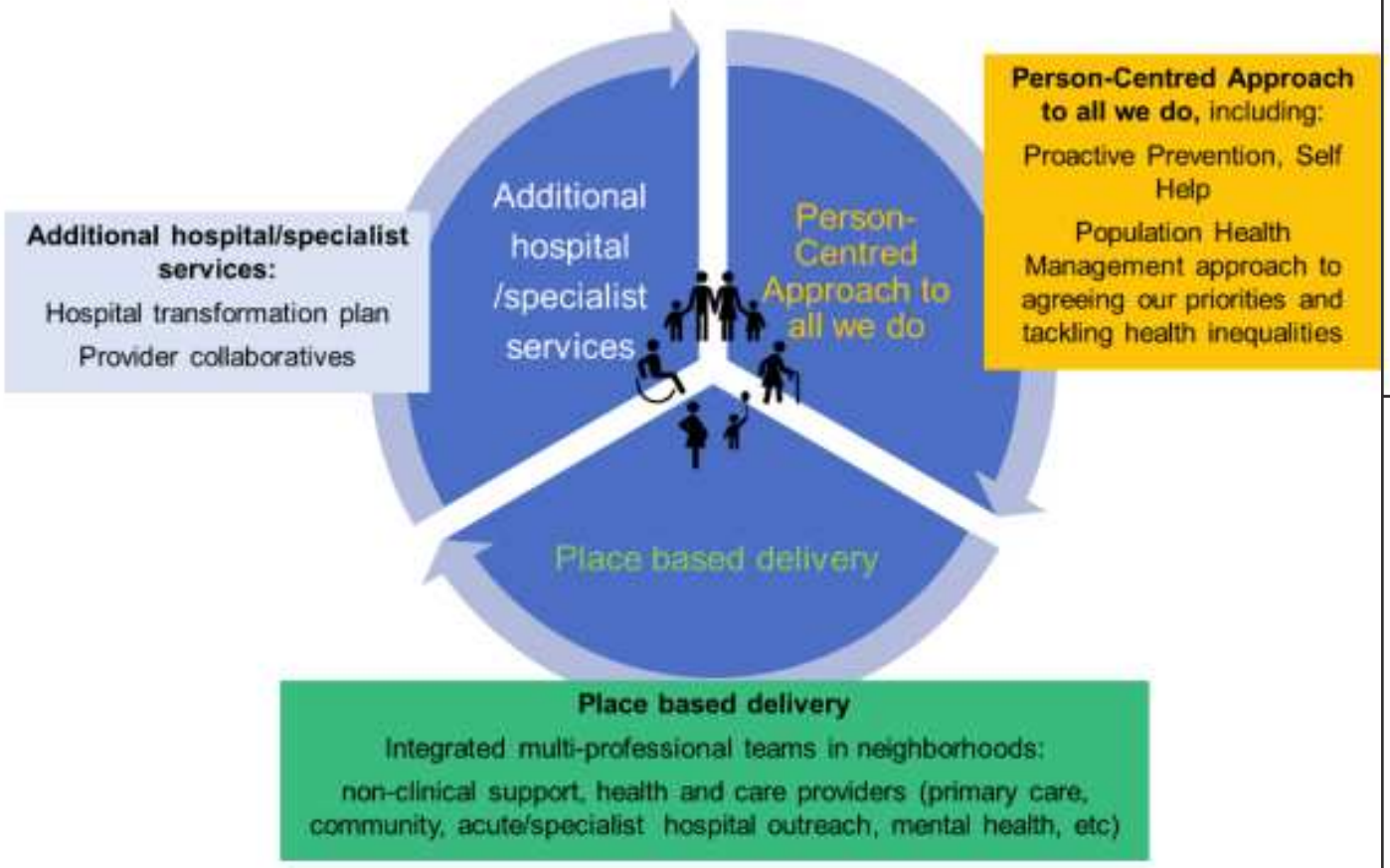
We will focus on our Places and our communities to create truly integrated care including working across our boundaries and borders.

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

# Our Joint Forward Plan

The three key elements of our plan are:

- Taking a person-centred approach (including proactive prevention, self-help and population health to tackle health inequalities and wider inequalities).
- Improving Place-based delivery, having integrated multi-professional teams providing a joined approach in neighbourhoods, supporting our citizens and providing care closer to home, where possible.
- Providing additional and specialist hospital services through our Hospital Transformation Programme (HTP).



# What is the role of the ICB within the ICS?

| |
|---|
| Focus on population health and improving outcomes |
| Strategic commissioning |
| System focus |
| System enabler |
| Developing relationships and partnerships |
| Convenor for collective decisions |
| Low bureaucracy, high trust |
| Monitoring system-wide performance and providing improvement support through involved assurance |
| Developing local solutions |
| Improvement and transformation |

# Why do we need to work differently as an ICB?

- As an Integrated Care Board, we need to create and foster different relationships with the other health and care organisations within Shropshire, Telford and Wrekin. We need to work through these relationships, drawing on our **unique population health perspective** to focus our shared efforts on the changes needed in our system. This enables us to have the greatest impact on health outcomes and to reduce the difference in outcomes experienced by the people who live here.
- We have access to data in a way that our predecessor organisations did not. We have a strategic view for all the people living here, and links across healthcare and beyond which allows us to make different choices. This means that we can use our **focus, energy and resources to shape the future** for our integrated care system (including our NHS and local authority partners). In doing so, we can facilitate changes in how services are focussed and delivered, to have the greatest possible impact. We will work to maximise this impact through differential investment to address health inequalities. We will engage with local people and our staff across all our work, and this will shape and develop our thinking.
- By focussing our energy and resources in this coordinated way we can deliver the best possible care in a way that demonstrates value for money and contribute to the wider economic and social development of Shropshire, Telford and Wrekin. We will **provide meaningful employment opportunities**, retain good people and attract talent to our integrated care system, and support our population to stay well and in employment.
- We are on this development journey along with other Integrated Care Boards across the country, and they, like us, are learning to work differently to enable this change in how we **bring greater focus to preventative care** and deliver health and care services in a more joined up way than we have previously.
- We need to be **agile, able to work across our system** and be able to 'pivot' ourselves to work alongside colleagues in the many and varied geographies of Shropshire, Telford and Wrekin. We will work as a 'Team of Teams', breaking down traditional organisational silos.

# What does that mean for how we undertake our role?

## GOALS

- Improving outcomes in population health and health care
- Tackling inequalities in outcomes, experience and access
- Enhancing productivity and value for money
- Helping the NHS to support broader social and economic development

## ASSETS

- **DATA**
- **STRATEGIC LENS**
- **POPULATION FOCUS**
- **LINKS ACROSS HEALTHCARE AND BEYOND**

## CAPABILITIES

**CHOICES**

- **SHAPING THE FUTURE**
- **FACILITATE** (Enable and hold to account among equals)

**IMPROVED OUTCOMES FOR OUR POPULATION**

- We will make different choices
- We will have different relationships with partners
- We will take responsibility for system overview
- We will act as system convenor and relationship builder – bringing together organisations to meet the health and care needs of the **entire STW population**

# Chapter 2:
# Our Statutory Duties and Responsibilities

# Our Responsibilities

**As set out in the Health and Care Act 2022, we must:**

- *Arrange for the provision of health services to meet the needs of people living in STW, including the financial duties associated with this.*
- *Arrange for the provision of health and care services in an integrated way when this would benefit those living in STW, including through the reduction of inequalities.*

The ICB has 18 core functions informed by legislation and national guidance which support our ability to discharge these responsibilities. You can read more about these along with the expectations of NHS England in Appendix 2

**Responsibilities of NHS STW:**

- Support development of the integrated care strategy
- Lead system-wide action on data and digital
- Establish population health intelligence and analytical capabilities
- Develop a plan for the system to deliver on the ICS strategy
- Establish governance arrangements and arrangements for managing quality and performance
- Establish and support joint working between partners
- Allocate resources to deliver the plan across the system
- Use joined-up data and digital capabilities to assess performance & track delivery of plans
- Lead on NHS STW financial control and work to secure financial sustainability for the system
- Ensure commissioning of services to meet the population health needs of STW
- Invest in local community organisations and infrastructure
- Support delivery of public health, population health and population health management
- Arrange for the provision of health services within allocated resources
- Plan for, respond to, and lead recovery from incidents
- Lead communications and public engagement
- Lead system implementation of the People Plan
- Drive joint work on estates, procurement, supply chain and commercial strategies
- Fulfil additional legal duties including the NHS constitution, information law, equality, advising on adult and children's safeguarding

# The Health and Care Services We Commission

| | |
|---|---|
| 1 | All diagnostic services including radiology, physiological tests, procedures, blood tests, audiology and screening |
| 2 | All secondary acute physical health care including specialised services, planned care, urgent and emergency care for adults, children and young people as well as maternity and neonatal care |
| 3 | All acute inpatient mental health care and all specialised services, for adults, children and young people including individual placements |
| 4 | Emergency services and patient transport including emergency ambulance services and patient hospital transport |
| 5 | Some public health services including vaccines and immunisation, social prescribing, diabetes prevention |
| 6 | All NHS community mental health, learning difficulty and autism services including adult, CAMHS and IAPT services |
| 7 | All primary care services including General Medical, General Pharmaceutical, General Dental, General Ophthalmic, GP Out of Hours and GP Extended Hours |
| 8 | All NHS community services including community nursing and care, AHPs, paediatrics, hospice care, individual placements – CHC and intermediate care – residential, home care |

The ICB uses the commissioning cycle to establish contracts and arrangements for delivery of these services which are set out in Appendix 3

# Delegated Functions from NHS England

In addition to the statutory functions designated in the Health and Care Act 2022 , the ICB requires the capability and capacity to take responsibility for commissioning several services delegated from NHS England.

| Service(s) | Forecast Delegation Date |
|---|---|
| Pharmacy, Optometry and Dentistry | 1 April 2023 (enacted) |
| Specialised Commissioning | 1 April 2025 |
| Vaccination and Immunisation | 1 April 2025 |

To take on or further develop these delegated responsibilities, we will need to establish the commissioning capability (which in the first instance will be shared between the ICBs across our region using the current regional teams) and reshape their priorities and activities to support a population health management approach.  This will mean that we can shape services and improve quality, aligned to ICB identified priorities. We will also need to incorporate these responsibilities into our governance approaches and plans for integration of services, to support improved flow and outcomes, for the people of Shropshire, Telford and Wrekin.

# Chapter 3: Our Organisational Strategy

# Our Purpose

**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.
- commissioning of healthcare to improve outcomes for local people through prevention and effective intervention

**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 and anchor institution* to support the local economy

*see Appendix 4 for more information about anchor institutions and what this means for us

# Our Operating Principles

Our operating principles set out how we will undertake our roles and responsibilities and our approach to achieving our goals.  Our principles begin with our values.

These values set out how people can expect to be treated, and how they will be expected to behave.  How we live these values will enable the people of Shropshire, Telford and Wrekin and our ICS partners to recognise and trust how we work to deliver our shared purpose and priorities. Where our people are not sure what a policy says, or where details are not set out, these values will guide their choices and actions.

Our values in turn determine our behaviours, and our compassionate leadership model.  This enables and empowers our staff to work in different ways and take action to improve outcomes and address health inequalities.

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 including how we commission and how we support our providers of care to collaborate.

# Our Values

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:

**Our ambition to succeed.** You will also see our people being supported and trusted to do the difficult things with integrity and creativity.

## Ambition

Measured by evidence of behaviours captured through the appraisal process, feedback from ICS partners and staff surveys, along with transparency in decision making and ethical issues in our records

**Our shared purpose.** This will be supported by our empathetic, inclusive approach where the contributions of all are valued as we work together to reduce inequalities.

## Compassion

Measured by evidence of behaviours captured through the appraisal process, feedback from ICS partners and staff surveys, along with demonstration of the impact of lived experience in the development and tracking of plans

**Our optimism.** Where our drive for improvement will be shared with clarity, enthusiasm, and openness.

## Optimism

Measured by evidence of behaviours captured through the appraisal process, feedback from ICS partners and staff surveys, along with feedback from our lived experience groups

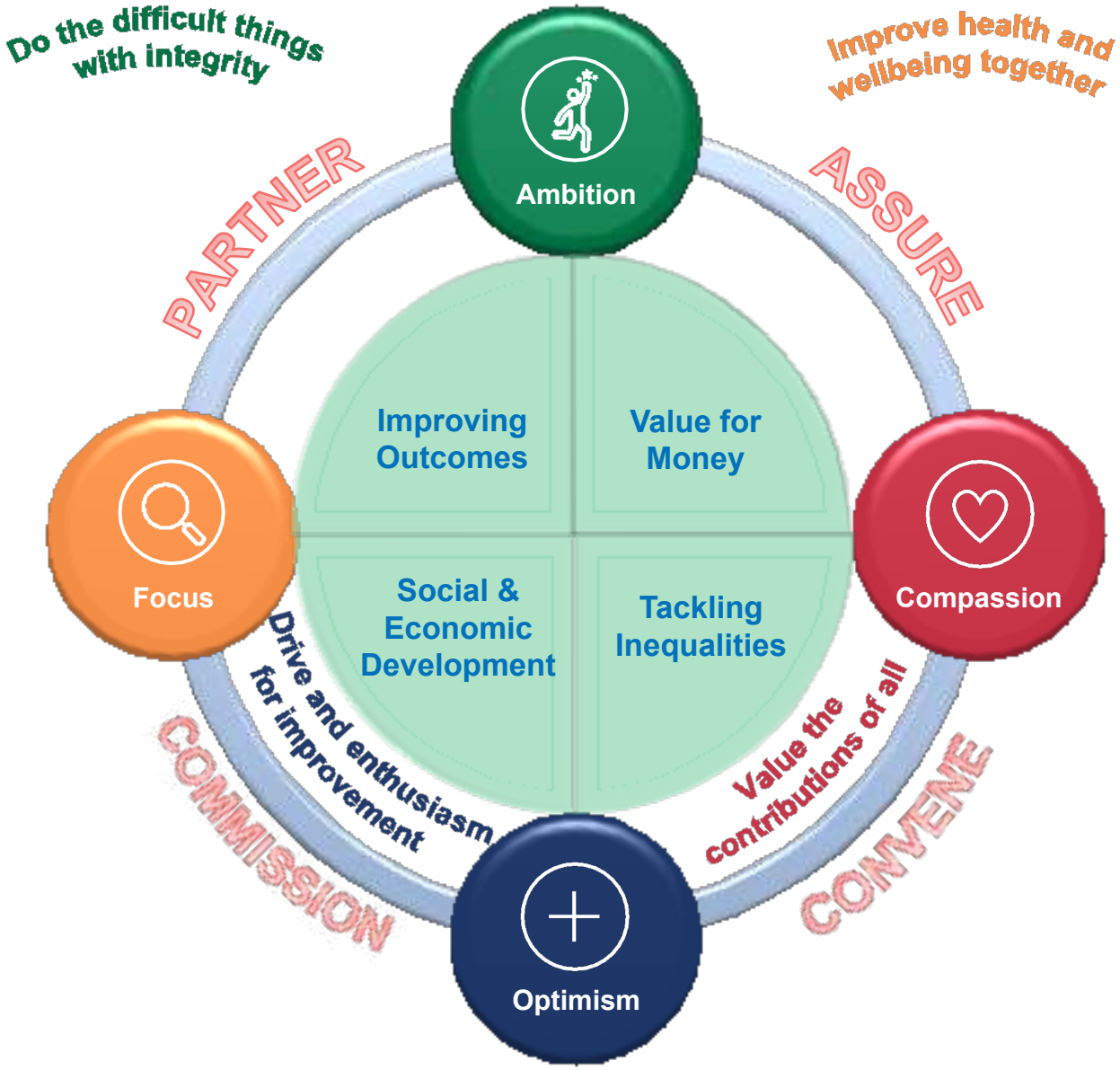
**Our unwavering focus.** Where we concentrate on improving health and wellbeing with the people of Shropshire, Telford and Wrekin.

## Focus

Measured by evidence of behaviours captured through the appraisal process, feedback from ICS partners and staff surveys, along with evidence that our investment of resources is aligned to our priorities for improvement in health outcomes and reduction in health inequalities

These values form one of the pillars of our recruitment and retention processes and shape our behaviours
Our baseline data from which to measure progress will be collected in 2024/25

# At a Glance




Our values and behaviours align to our four purposes and support our approach to delivery of our four aims.

Each quadrant enhances and supports the others and underpins how we make decisions and focus our energy to work with the population of Shropshire, Telford and Wrekin to reduce health inequalities and improve health outcomes.

# Our Behaviours: All Colleagues

## Expected of all colleagues:


Ambition


Compassion


Optimism


Focus

- Honest and open communication characterised by the free sharing of information, knowledge and expertise.
- Openness to the thoughts and contributions of others characterised by a desire to learn and being open to new ideas.
- Compassion, empathy and consideration characterised by understanding the feelings of others, caring for the wellbeing of colleagues, holding in mind the experience of the individual, and acting to improve the situation.
- Mutual respect for the contributions of others characterised by giving credit for contributions and keeping to commitments made.
- Maintaining a positive mindset, and sense of humour, characterised by seeking the positive even in difficult situations.
- Seeking and valuing collaboration and feedback characterised by valuing the diverse experience and insights offered by all which underpin better decision making.
- Consistency characterised by equitable application of processes and reliability in following through on agreed actions.
- Encouraging others characterised by coaching and supporting colleagues to contribute to the purpose and priorities of the ICB and to develop their skills.
- Bringing your best effort to your role characterised by a sense of pride, attention to detail and persistence to reach the agreed outcome of any task.
- Holding the expectation and experience of the people of Shropshire, Telford and Wrekin at the heart of decision making, characterised by always considering insight and evidence informed clinical outcome, quality and experience when determining the best course of action.
- Being slow to judge characterised by considering all perspectives and challenging ourselves to identify bias, maintain equitable treatment and value diverse perspectives.

These behaviours form one of the pillars of our personal development planning and appraisal process

# Our Behaviours: Additional Expectations

 Ambition  Compassion  Optimism  Focus

## Expected in addition when managing:

- Support characterised by considering the development needs of the team and how this might be supported ranging from day-to-day feedback through to formal development, including those development needs related to their career aspirations.
- Listening characterised by actively seeking the input of colleagues and recognising the impact of their contributions.
- Taking responsibility for delivery characterised by seeing things through and drawing on support to ensure priorities can be delivered.
- Empowering and enabling the team through effective delegation of the actions needed to achieve a goal, and considering the insight offered by others which might further inform and shape the proposed approach.

## Expected in addition when leading:

- Provide clear direction characterised by setting a shared vision, ambition and a sense of the journey.
- Empowering and enabling the team through effective delegation to design how a goal is to be achieved and what approaches offer the greatest opportunities for success
- Considering the insight offered by others which might further inform and shape the direction to be taken to achieve a goal.
- Resilience and reliability characterised by the ability to maintain drive and focus on what matters most.
- Courage characterised by making and communicating decisions even when the message may not be popular, or when the journey might be challenging.
- Flexibility characterised by the ability to maintain an adaptable mindset and learn and adapt to new information and changing circumstances.

These behaviours form one of the pillars of our personal development planning and appraisal process

NHS

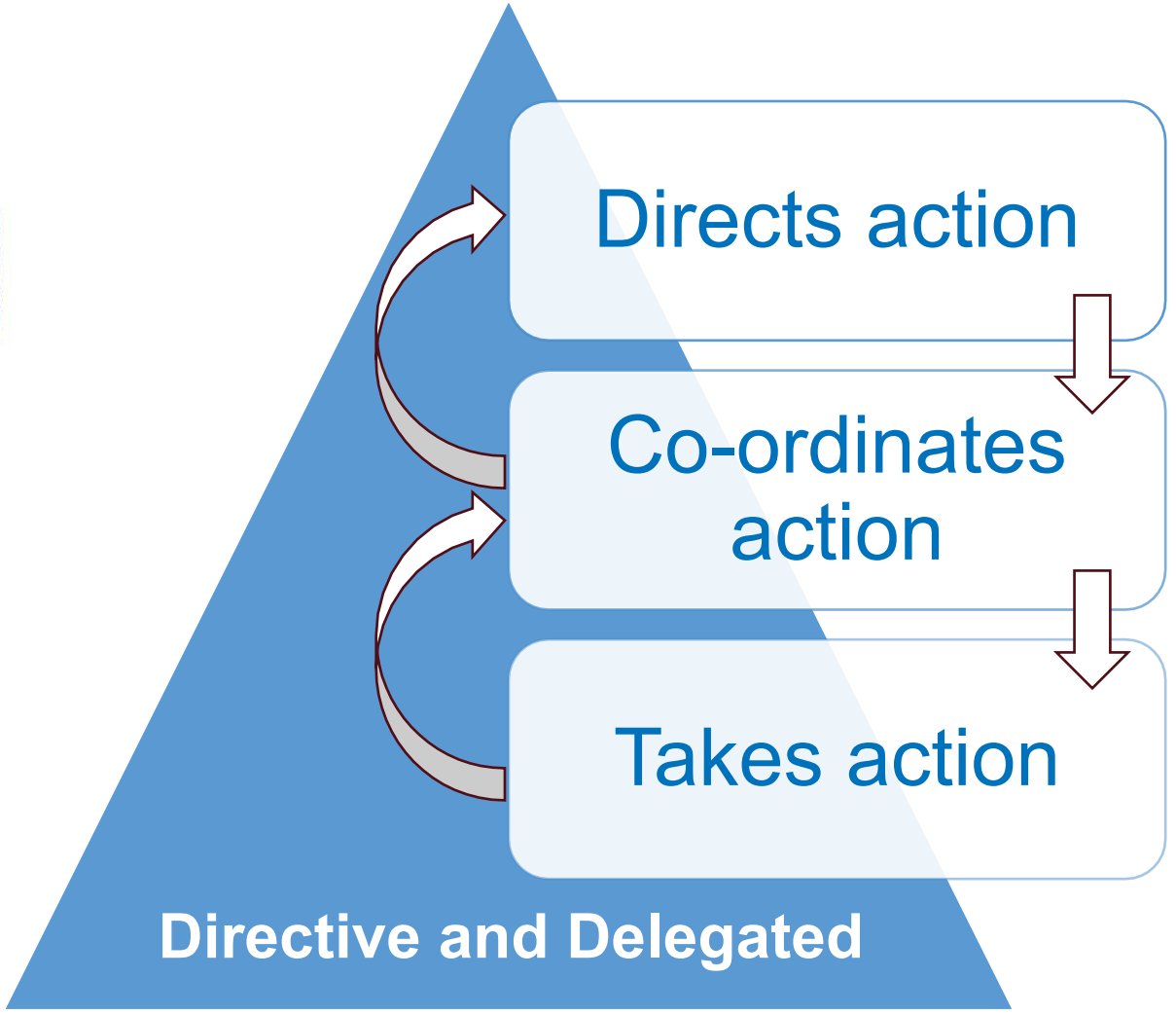
# Our Leadership Models

## Shaping our system and making choices
e.g. transformation, partnerships, safety


Shropshire, Telford and Wrekin ICB use the leadership model above to execute our responsibilities, modelling our commitment to our values and behaviours by empowering our staff to deliver to our purpose and priorities.

However, in circumstances where we are responding to immediate requirements, we adopt the leadership model to the right to enable clear and rapid action to be taken, empowering those nearest the incident to draw on the support needed to effect change.

## Specific responses
e.g. critical incident management



# Our Design Principles

Working with our staff we have developed the following design principles which underpin how we design our functions to deliver our purpose

| | |
|---|---|
| **Outcome focussed** | Design for our four purposes and unique role in the ICS |
| **Positive future mindset** | Design for how we want to work in the future |
| **Affordable** | Align our resources to our priorities and live within our means |
| **Clear** | 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)<br>Support colleagues to be intelligent consumers of specialism and design to serve 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 in turn form the principles for how we design our operating processes:

- Strategy will be grounded in population health management approaches, have measurable outcomes, clearly laid out contributions to its implementation, draw on experience and insight from across the ICS and align resources to priorities.
- Our relationships within the ICS will be grounded in mutual support our shared success and making 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 we and they can make decisions and how they 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.

# Our Design Principles: Shaping Our Teams

## Redistribution of executive portfolios

- Portfolio responsibilities and span of control have been realigned to ensure that they are proportional, coherent and manageable.
- The most significant changes are to the Chief Delivery Officer (formerly Executive Director of Delivery and Transformation) where the portfolio has been rationalised to focus on key system priorities and responsibilities in Service Improvement and operations (including the System Control Centre and Emergency Planning, Preparedness and Response).
- All quality and nurse delivered functions are now brought together with the Chief Nursing Officer.
- Medical, Pharmacy, Optometry and Dental functions are brought together with the Chief Medical Officer.
- Commissioning is the responsibility of the entire organisation. However, we have consolidated Strategic Commissioning, Contracting, Planning, Performance and Business Intelligence with the Chief Finance Officer

## Matrix working and sharing expertise

- We will work together across teams to ensure that all our teams have access to effective decision support and input from colleagues which brings together insight from engagement, lived experience, finance, quality, safety, commissioning, individual commissioning, planning, performance, business intelligence, service improvement and operations.

## Rethinking our teams and functions

- We have created coherent portfolios, aligned to the four purposes, which address legacy role grading, and enable new ways of working.
- We are bringing colleagues with similar roles and a shared focus together to make it easier for them to combine their efforts.
- We have teams operating manual processes which were designed to address challenges experienced in the past. These processes were designed with the technology available and for the structures and relationships at the time. We plan to introduce digital alternatives to reduce the number of manual systems which we are reliant on.

## Collaborating with colleagues across the Integrated Care System

- We have reshaped our teams to focus on the key responsibilities of the ICB and support the continuing development of the Integrated Care System through the empowerment of Place and Provider Collaboratives.
- We have identified functions which may benefit from deeper collaboration and a system approach, and we are exploring the development of more resilient shared approaches.
- The ICB also commissions support services for the running of the organisation, see Appendix 3 for more information.

# Our Ways of Working: Key Changes

## Align all functions to delivery of the four purposes of the ICB and the commissioning cycle

- Refine the Chief Delivery Officer portfolio to enable focus and grip
- Align strategic commissioning activities across the ICB to a single function where it is protected from the distorting effect of day-to-day system flow and performance issues
- Create structures which are easily transferred or transitioned as the Provider Collaboratives and Places mature and take on more responsibilities
- Bring the running of the organisation into a central team to enable this focus

## Develop relationships and collaboration which support the four purposes of the ICB

- Implement the new leadership model to empower staff and support Places and Provider Collaboratives to act
- Streamline point to point relationships and build clarity on contributions e.g. contracting and performance management
- Drive and support implementation of decisions through the new governance approaches
- Develop integrated business functions with partners across the integrated care system to reduce duplication and increase resilience such as communications and engagement, programme management office and service improvement activity, emergency planning, resilience and responsiveness, digital, estates, pharmacy and more.

## Modernise working practices

- Support the new agile working policy and headquarters arrangements with increased use of collaboration technology e.g. MS Teams functionality
- Explore digital options for manual processes e.g. prescription (NHS App) and booking processes and consider transferring responsibility to providers

## Align core processes to the four purposes of the ICB

- Investment in business intelligence and analytics including quality, patient experience, workforce and population engagement threads to drive the commissioning cycle
- Implement values-based recruitment and behaviours component to the appraisal and development processes along with wider ‘living the values’ work

# The 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 Integrated Care System 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.

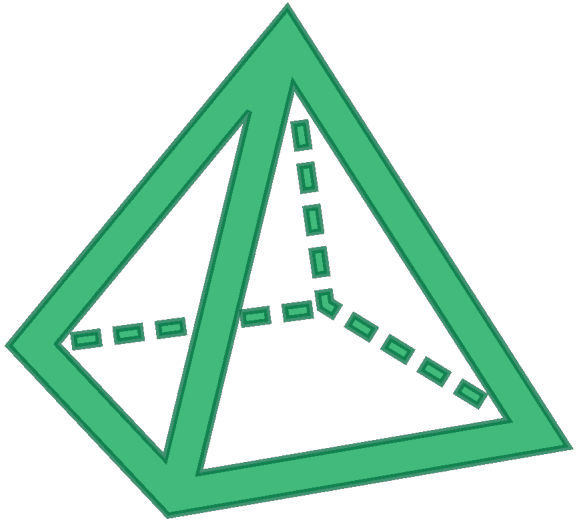

The fundamentals of commissioning (in its fullest sense) remain crucial in structuring health services. However, how we commission is being transformed. The introduction of the provider selection regime requires a new function within the ICB that can collaborate with partners in a different way. We will use the commissioning cycle to align the efforts and contributions of each function in the ICB to the achievement of our commissioning objectives.

# Our ICB Commissioning Activity

**Leading the 'What'**

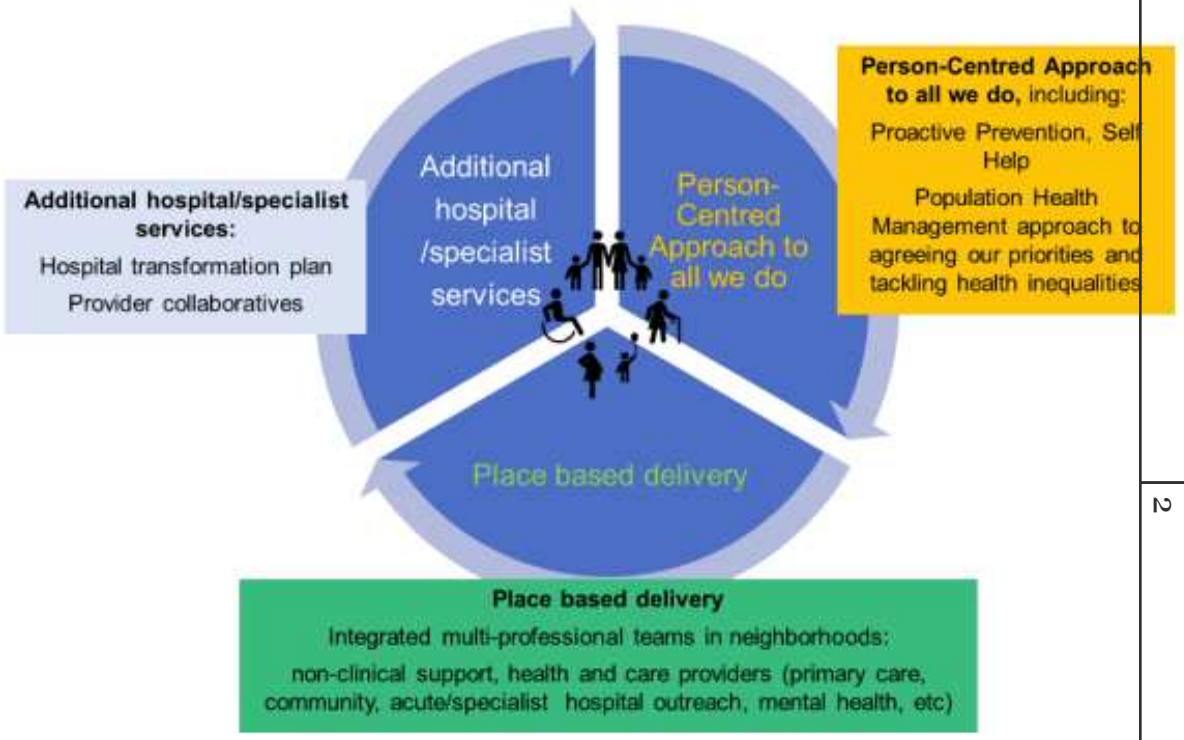
The ICB will drive the commissioning cycle by determining what should be done including:

- Setting the vision and outcomes
- Developing the system operating model
- Leading strategic design of contracts
- Undertaking predictive modelling and trend analysis
- Leading system operational planning
- Leading system quality and improvement activity
- Leading financial planning and management
- Addressing population health management and health inequalities
- Leading collective risk management
- Managing any substantial service change including consultation
- Shaping the market
- Undertaking whole system procurement



# Our Places

- TWIPP (Telford and Wrekin Integrated Place Partnership) and ShIP (Shropshire Integrated Place Partnership) are our system's two Place-based partnership boards. They are based on the well-established relationships with our local authority partners. Our Joint Forward Plan describes the actions and ambitions to deliver the Place-based strategies over the coming five years.
- The members of our Place partnerships include Primary Care Network Clinical Directors, Voluntary Community and Social Enterprise sector providers, Healthwatch, NHS Providers and Local Authority colleagues across public health, adult and children's social care.
- 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 published in March 23 signed off by the Integrated Care Partnership).




- Governance arrangements for our Places are currently developing to reflect the increasing maturity of the partnerships and the system ambition to raise the profile and importance of Place-based delivery. The revised arrangement will address:
  - ShIP and TWIP reporting directly to the Board of the ICB for assurance, delivery, quality and finance.
  - Attendance at the STW Integrated Care Board as the Place-based leaders.
  - Attendance at the STW Integrated Care Partnership.
  - Attendance at the Health and Wellbeing Board in recognition of the connections between the HWBB, ICB and the ICP.

# The Work of Our Places and Neighbourhoods

**Current priorities for our Places are:**

- children and young people.
- long term conditions.
- primary and secondary prevention linked to the local care and Integrated Neighbourhood Team approaches.


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

Our neighbourhoods are delivering local care through Integrated Neighbourhood Teams which use a 'Team of Teams' approach. This approach brings together teams from different disciplines to ensure an integrated approach to meeting local needs.

The partnerships are using performance dashboards supported by the ICB team to monitor delivery and performance of the local Health and Wellbeing Strategy and local plans (including Integrated Neighbourhood Teams).

**Leading the 'How'**

Our Places will contribute to the commissioning cycle by determining how our strategy is realised including:

- Provider Collaborative Planning and Delivery
- Local quality monitoring and delivery e.g. Elective Care, UEC, MH
- Challenging and improving performance across system partners and multi-agency working to identify solutions
- Development of outcome-based Service Specifications
- Management of Delegated budgets when this has been jointly agreed

# Our Provider Collaborative

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.

Formalising Provider Collaboratives is intended to support system working to address the complex challenges facing health and social care.

In July 2022, all NHS trusts providing acute and mental health services were required to join a Provider Collaborative. NHS community and ambulance trusts and non-NHS providers, such as voluntary, community and social enterprise (VCSE) sector organisations or independent providers, are offered the opportunity to take part where this will benefit patients and makes sense for the providers.

NHS England has set out guiding principles that should underpin collaboratives. These include:

- a shared vision and commitment to collaborate
- strong accountability mechanisms for members
- building on existing successful governance arrangements
- efficient decision-making
- embedding clinical and community voices
- streamlining ways of working.

In STW a Committees in Common (CiC) structure has been established to support our Provider Collaboratives using a Provider Leadership Model.

The collaborative is made up of:

- Shrewsbury and Telford Hospital NHS Trust
- Shropshire Community Health NHS Trust
- Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
- Midlands Partnership University NHS Trust
- Each of the four Providers have delegated authority to their own Committee Members who will meet in common to share oversight and decision making.

This structure will enable the providers to work together to further join up services and drive improvement aligned to the Integrated Care Strategy and Joint Forward Plan priorities.

Our providers have established collaboratives with others now developing around clinical priority areas or supporting integrated provision of services provided beyond the boundaries of Shropshire, Telford and Wrekin.

# The Work of Our Provider Collaborative

**Vision and Purpose**

***Working together as providers to achieve tangible improvements to the way care is delivered,***
supporting the quadruple aim of:
**Adding value** to the ICS by:

- developing and **delivering collaborative approaches to specific challenges** within providers' gift to resolve
- developing **partnership relationships**, strengthening communication between providers, sharing approaches to challenges and opportunities
- addressing **efficiency, productivity and sustainability** through collaborative working, integration or the consolidation of service delivery or corporate functions
- **reducing inequalities of access and unwarranted variation**, where provider collaboration can best achieve this
- adopting some **commissioning responsibilities** within the ICS where this will align better with operational delivery and transformation**, improve decision making and accelerate change**

**Planned Developments**

- Further developing shared governance, risk management, accountability and reporting
- Aligning existing programme infrastructure to priority work areas
- Aligning and addressing key improvement indicators for the Committee in Common
- Aligning the shared work programme to the ICB commissioning intentions
- Developing and resourcing the Provider Collaborative Office

**Leading the 'How'**

Our Provider Collaboratives will contribute to the commissioning cycle by determining how our strategy will be realised including:

- Provider Collaborative Planning and Delivery
- Local quality monitoring and delivery e.g. Elective Care, UEC
- Challenging and improving performance across system partners and multi-agency working to identify solutions
- Development of outcome-based Service Specifications
- Management of Delegated budgets

# Chapter 4: Our Structures

# Our Board Structure

The board of our ICB is a unitary board at the centre of the ICB governance framework and is accountable for the performance and assurance of the NHS and the wider integrated care system 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 Integrated Care System 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

# ICS Portfolios

## Planned Care, Diagnostics & Cancer

Executive Lead:

Stacey Keegan CEO, Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

## Urgent & Emergency Care

Executive Lead:

Louise Barnett CEO, Shrewsbury and Telford Hospital NHS Trust

## Children & Young People

Executive Co-Leads:

David Sidaway CEO, Telford & Wrekin Council

Andy Begley CEO, Shropshire Council

## Mental Health, Learning Disability & Autism

Executive Lead:

Neil Carr CEO, Midlands Partnership University Foundation NHS Trust

## Financial Improvement

Executive Lead:

Simon Whitehouse CEO, NHS Shropshire, Telford and Wrekin

## Workforce Transformation

Executive lead:

Stacey Keegan CEO, Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

## Hospital Transformation Programme

Executive Lead:

Louise Barnett CEO, Shrewsbury and Telford Hospital NHS Trust

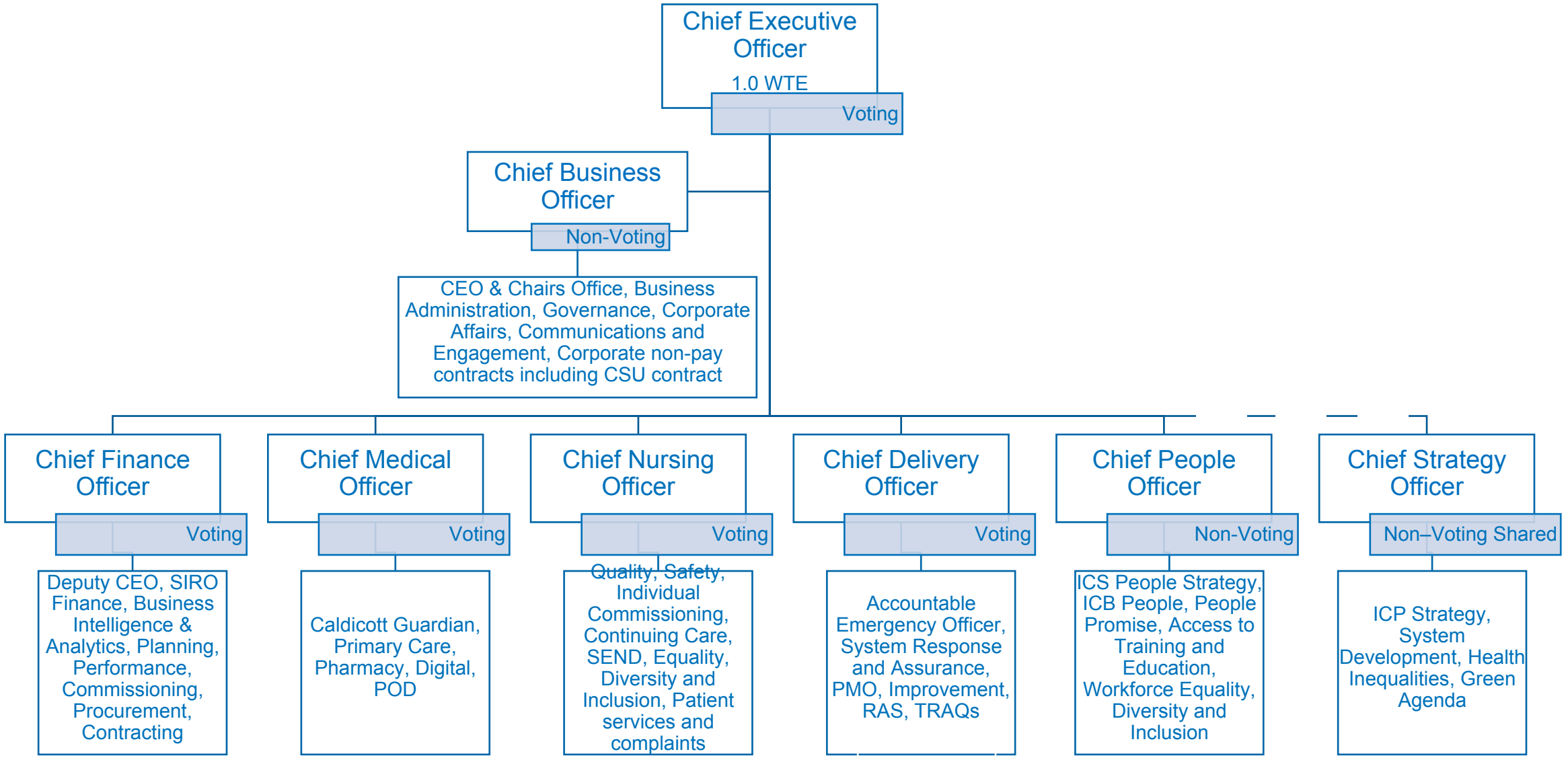
## Local Care

Executive Lead:

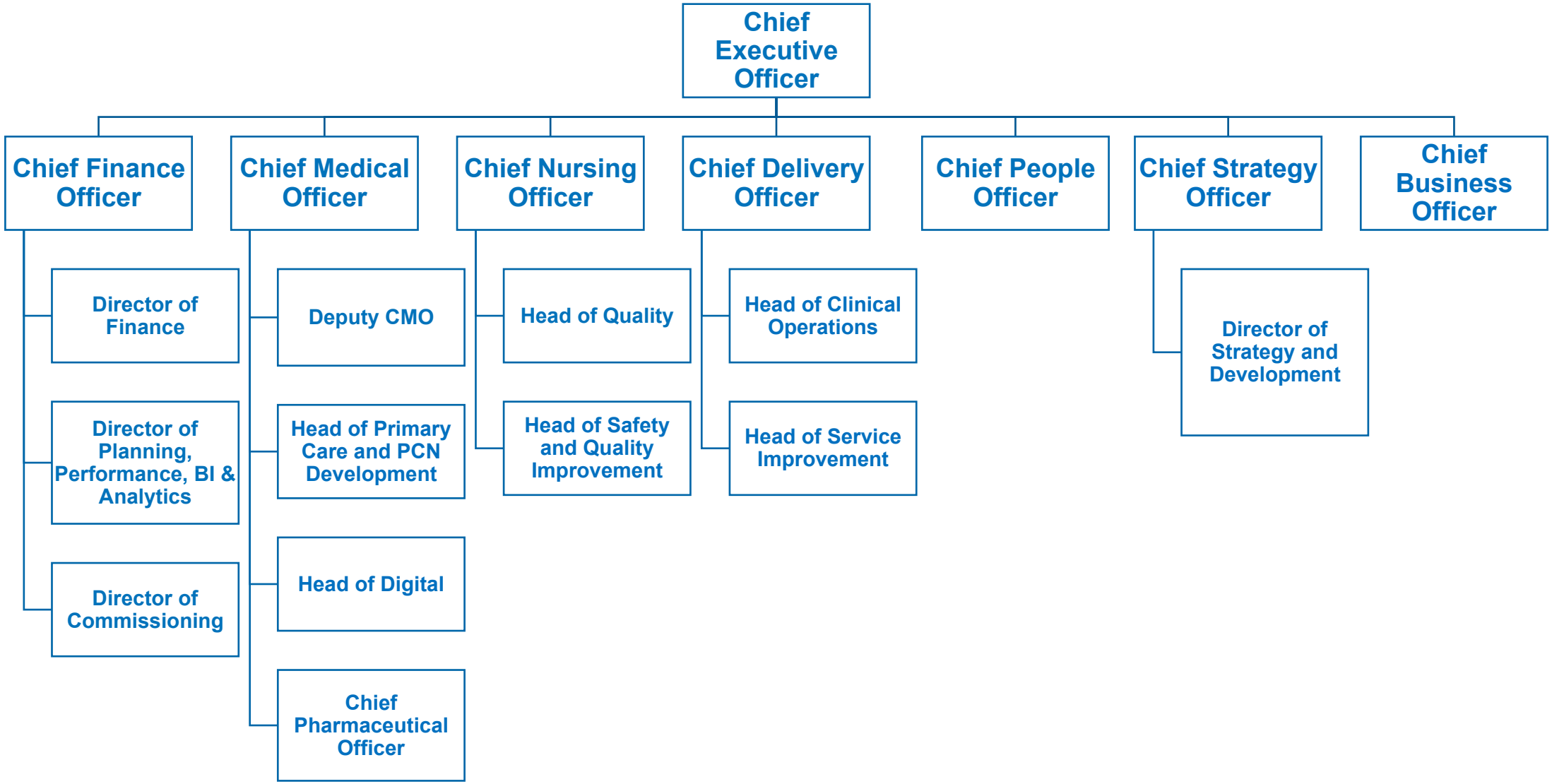
Patricia Davies CEO, Shropshire Community Health NHS Trust

Our ICS has established eight portfolios to focus on our priorities for transformation and delivery. We have appointed a CEO from the ICS to lead each portfolio to ensure focus, drive and accountability.

# Executive Team



# Senior Leadership Team



# Chapter 5: Our Governance

# How we work together to take decisions and deliver (Functions and Decisions)

## Our Integrated Care System

### Integrated Care Partnership

The ICBs, Local Authorities and partners set the strategy for the Integrated Care System

### Healthwatch

Independent champion for the voice of local people to help improve care

### Integrated Care Board

Sets the strategy and oversees delivery for the NHS within the ICS to improve outcomes, tackle inequalities, improve value for money and productivity and support broader economic and social development

### Our Integrated Care Board (NHS STW)

### Board Committees

Assure quality, performance, finance, audit, remuneration, people, management of change and transformation of services, and delegated commissioning responsibilities

### Health and Wellbeing Boards

Where leaders from health and care come together with local Councillors to improve the health and wellbeing of the community

### People of Shropshire, Telford & Wrekin

Contribute their expertise and experience to shape local priorities and how services are designed and delivered

### Place

Sets local priorities and plans focussing on improving population health with the Local Authority

### Overview and Scrutiny Committees

Where local Councillors hold the local system to account

### Local Authorities

Responsible for planning and allocation resources for social care, public health, schools, housing, planning, waste collection and more

### Our Local Authorities

### NHS England

Sets national strategy and guidance for the NHS, oversees the performance of ICBs and NHS providers and supports delivery of the NHS Long Term Plan

### NHS Trusts & Foundation Trusts

Statutory providers responsible for ensuring consistently safe, high quality, compassionate and sustainable care

### Primary Care Networks

Collaboration between general medical providers to shape and bring services nearer to home

### Provider Collaboratives

Collaborative working between providers of services in the same clinical area to work at scale to deliver joined up services and reduce inequalities

### Primary Care Providers

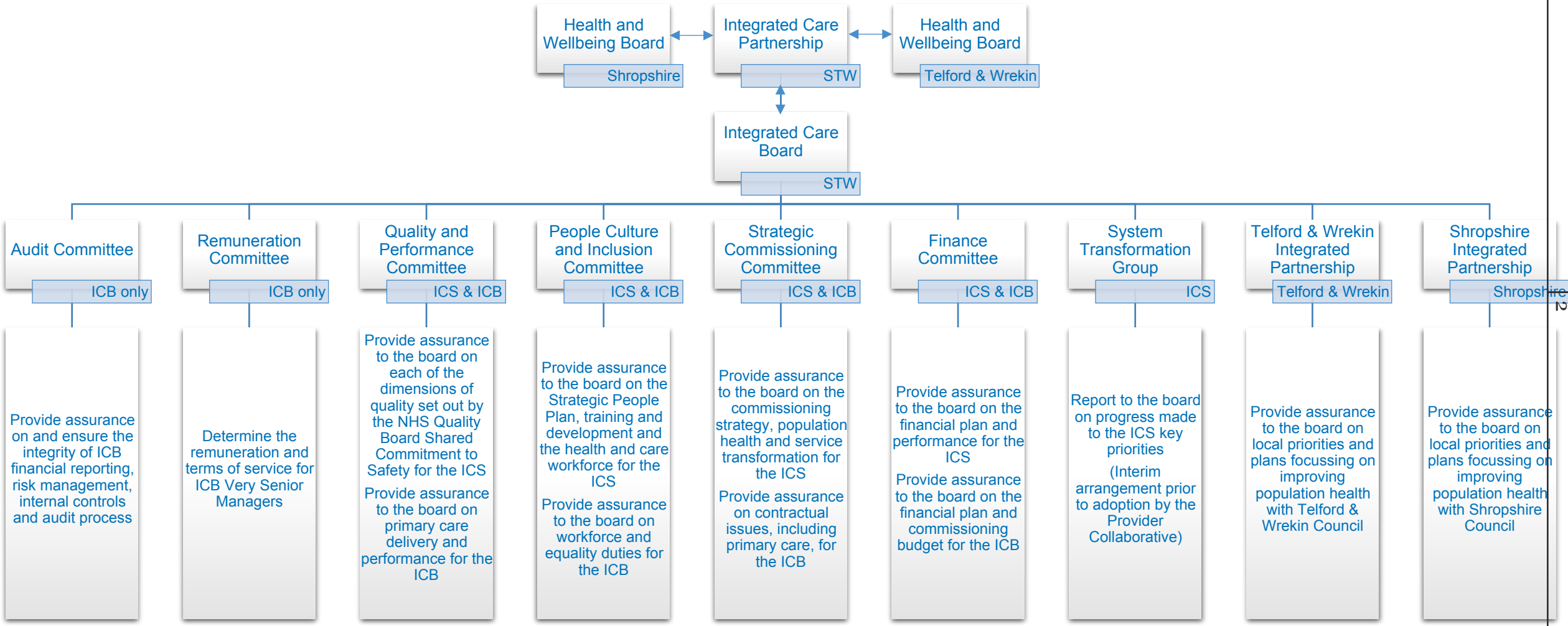
Comprehensive delivery of care by general medical, pharmacy, optometry and primary dental services teams

### VCSE Providers

Providers of care grounded in their local communities who shape and contribute to delivery of services designed to meet specific needs

### Our NHS Delivery System

# Board Governance Structure – Our Stage 1 Intention




This diagram sets out our stage 1 intention for the governance structure one level above and below the board of the ICB during the next period of development of Place. Our governance handbook and supporting governance maps set out detailed arrangements for governance of programmes and other structures and priorities.

# Chapter 6: Our Practice

# How We Work Together to Improve Outcomes

Review and understand baseline position and opportunities led by **ICB**

Undertaking gap analysis and modelling to review the whole system and identify what is needed in the future led by **ICB**

Service reviews including public and patient input for continuous service improvement by **Place and Provider Collaboratives**

Monitoring delivery of outcomes led by **ICB**


Informing and contributing to the Integrated Care Partnership Strategy and setting of strategic and local commissioning intentions led by **ICB**

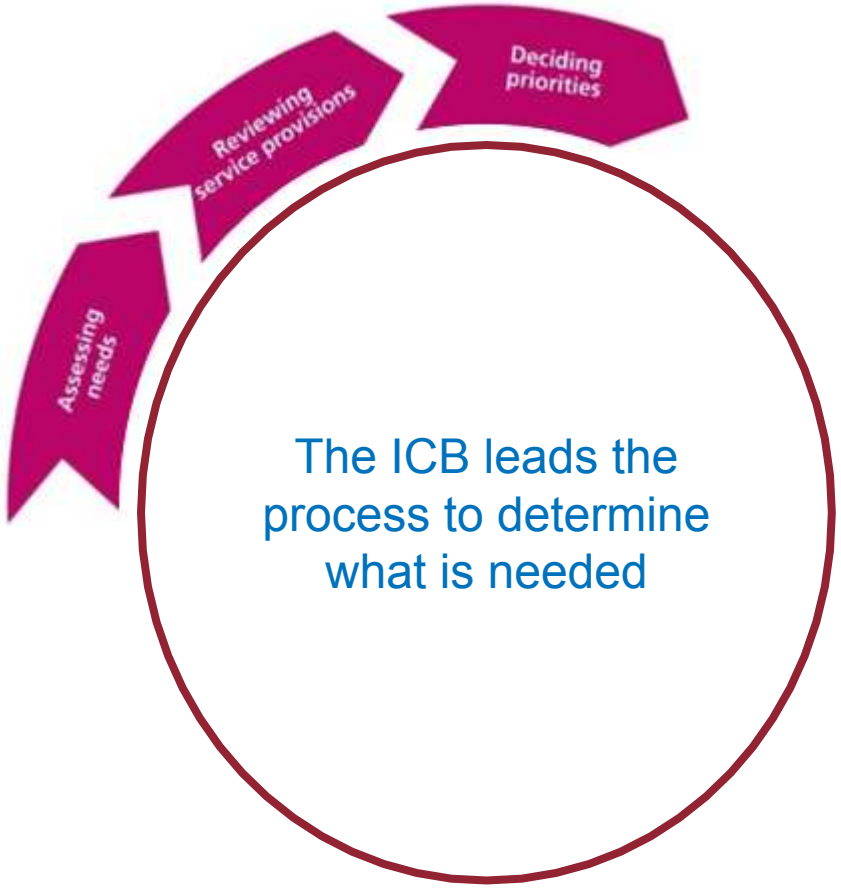
Coproduction, impact assessments and design led by **Place and Provider Collaboratives**

Specifications and commissioning for outcomes led by **ICB and Place and Provider Collaboratives**

Service delivery model and implementation including monitoring of delivery at a **Place** level/through **Provider Collaboratives** or contracts (where Provider Collaboratives are not yet in place e.g. delegated service commissioning)
Workforce planning, development, education and training led by **ICS**

We use matrix working approaches to draw on the specialist knowledge and skills of specialist teams within and beyond the ICB to power delivery of our objectives

# Team of Teams: Strategic Planning




- **Business Intelligence** use data to identify the needs and inequalities to be prioritised
- **Strategy** use Core20Plus5 and other tools to identify priority action on health inequalities
- **Clinical leadership** work out which changes and actions could have the greatest impact on outcomes through prevention or intervention
- **Planning** identify how much capacity is needed and where long waits exist
- **Performance** identify where current service gaps exist
- **Quality and Safety** share where improvements are needed
- **Communications and Engagement** find out what matters to people
- **Service Improvement** identify what could work in practice locally and **Commissioning** identify any strategic changes which may be required and create commissioning strategy for prevention and intervention to improve outcomes and to address inequalities
- **Digital** identify any technology developments which could enable the proposed changes from the Commissioning and Service Improvement teams
- **Pharmacy** identify any medication improvement opportunities to support the change
- **Finance** work out the funding possibilities and **Business Administration** advise on governance and decision-making processes and record keeping
- **Commissioning** pull all this together with intelligence from **Place, Provider Collaboratives and Primary Care** to work out the ICB priorities and commissioning intentions for the short, medium and long term
- **Commissioning** work with **Strategy** to inform any ICP Strategy and Joint Forward Plan updates and **Planning** develop the strategic and annual plans
- **People Team** determine the workforce planning opportunities and change support needs

# Team of Teams: Procuring Services


- **Commissioning** lead any strategic changes at scale setting the outcomes for commissioning including generation of commissioning intentions (and intended impact on health inequalities) supported by **Communications and Engagement** to undertake engagement and consultation, **Business Intelligence and Performance** to track capacity and demand, **Contracting** and **Procurement** for engaging the market
- **Place and Provider Collaboratives** will lead coproduction of design and undertake impact assessments
- **Place and Provider Collaboratives** develop outcome-based service specifications supported by **Clinical Leadership, Quality and Safety and Pharmacy**
- **Place and Provider Collaboratives** supported by **Digital, Service Improvement and PMO** to plan the implementation of changes as needed
- **Place and Provider Collaboratives** work with **People**, **Finance and Planning** to map the implications of planned changes
- **Primary Care** work with PCNs and wider primary care to develop their capability to deliver local service components in Place and Neighbourhoods
- **Place and Provider Collaboratives** develop and implement the delivery model, tracking and managing capacity and demand
- **Individual Commissioning** works with **Commissioning** to shape the market to meet the requirements for individual packages of care
- **People Team** lead the development of the workforce plan and associated support for the planned changes

# Team of Teams: Monitoring and Evaluation

The ICB coordinates the monitoring and evaluation of services

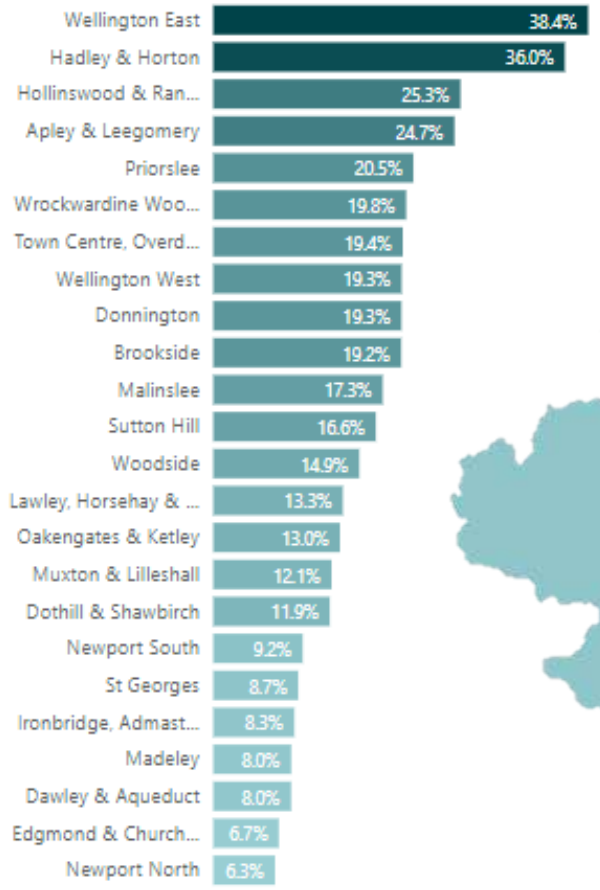

- **RAS/TRAQs** support patient choice and booking
- **Prescription Ordering** support timely access to repeat medications
- **Clinical Operations** support the system under times of pressure to improve flow in the system and support timely access to services, including signposting to alternative provision identified by **Commissioning**
- **Business Intelligence** analyse data to determine the impact of services and service change, **Performance** review progress to plan, **Quality and Safety** provide oversight of lived experience of services and **Commissioning** monitor delivery of outcomes and impact on health inequalities
- **Communications and Engagement** provide insight about population preference for service locations and modes (e.g. virtual) which inform ongoing development of choice options
- **Place and Provider Collaboratives** undertake service reviews drawing on population views and lived experience to inform continuous service improvement
- **Commissioning** draw together the information about the effectiveness of the service and determine whether further action is needed to meet the health priority which the service, and any changes, are intended to meet
- **Business Administration** ensure that assurance requirements are fulfilled throughout
- **People Team** ensure that equality, inclusion and experience, engagement and well-being of staff is understood and responded to

# Appendices for further information

# Appendix 1

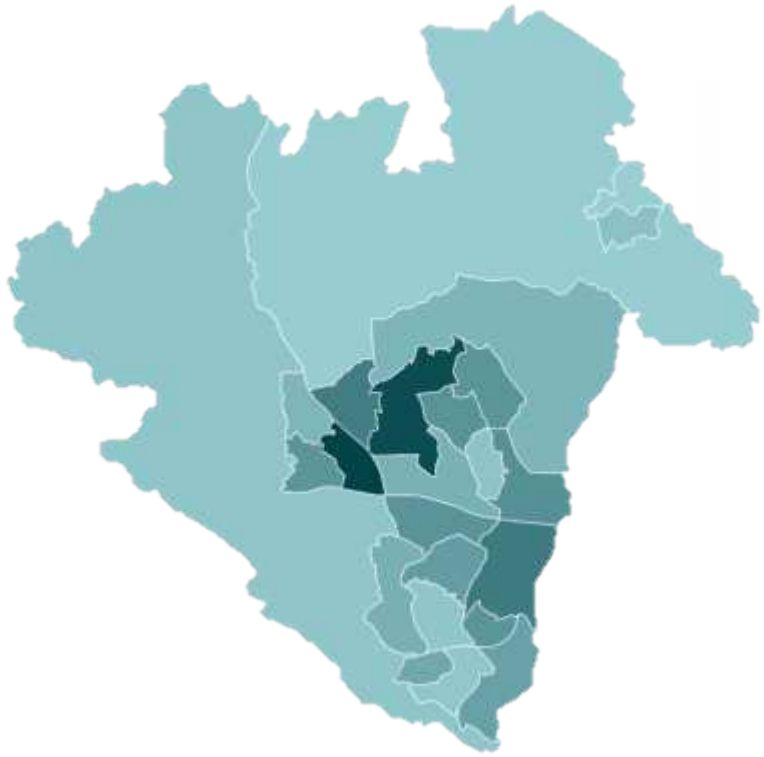
## Demographics, Health Inequalities and Wider Determinants of Health in Shropshire, Telford and Wrekin

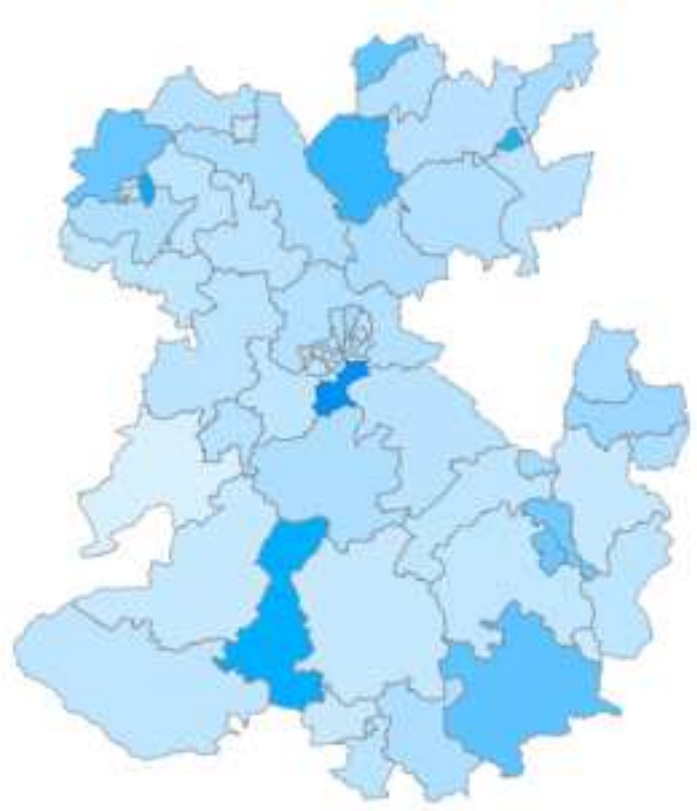
# Minority Ethnic Populations




Census 2021: population from a non-white British ethnic background

- Telford and Wrekin 17.0%
- Shropshire 6.7%

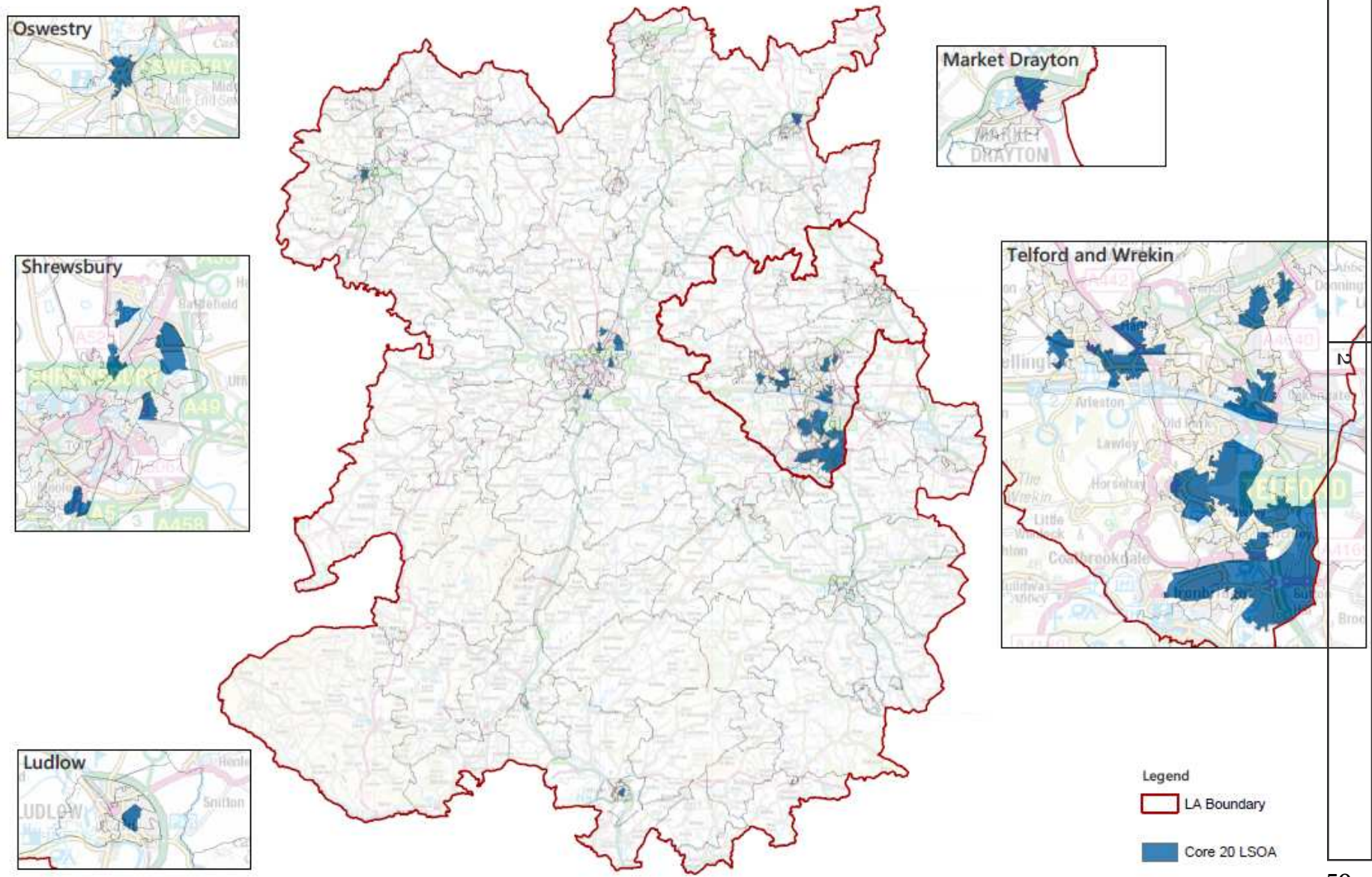




# Areas of deprivation (in the England top 20%)

According to the 2021 Census, **12% (60,100) of people in Shropshire, Telford & Wrekin live in geographical areas considered to be in the 20% most deprived areas across England.**

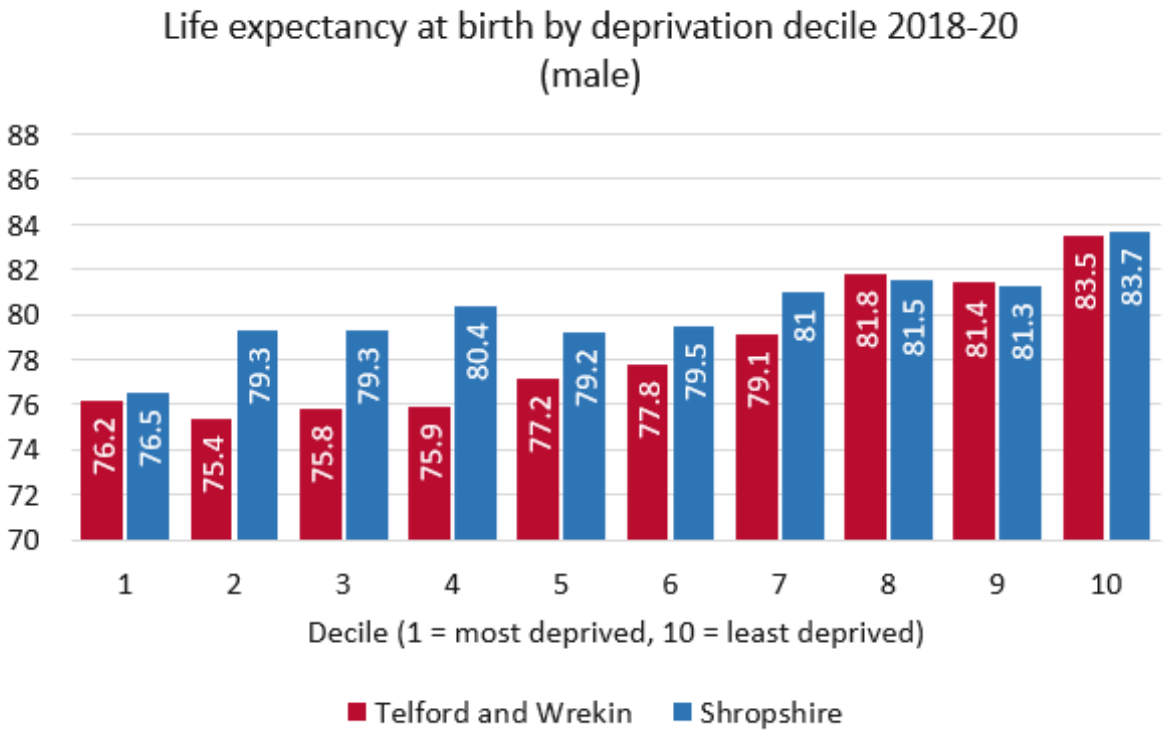
**45,400** of those people currently reside in in Telford & Wrekin (approximately 24% of the population) and **14,700** live in Shropshire (approximately 5% of the population).

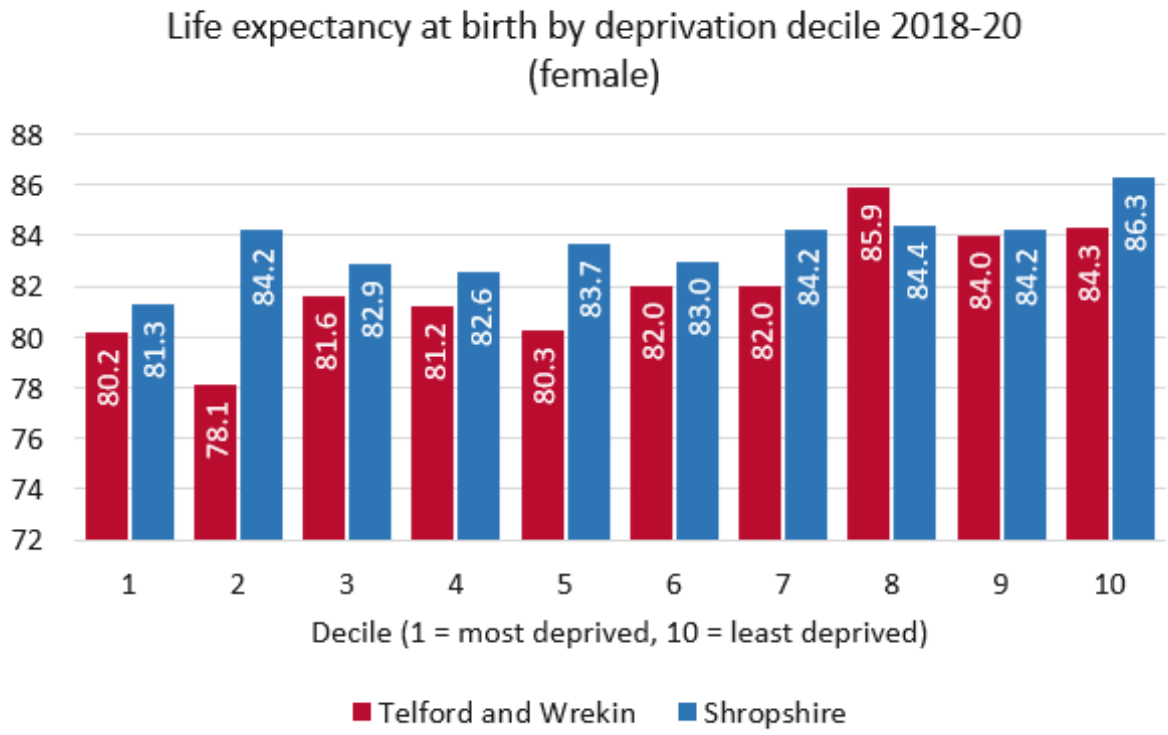



© Crown copyright and database rights 2023 OS AC0000808501

# Life Expectancy

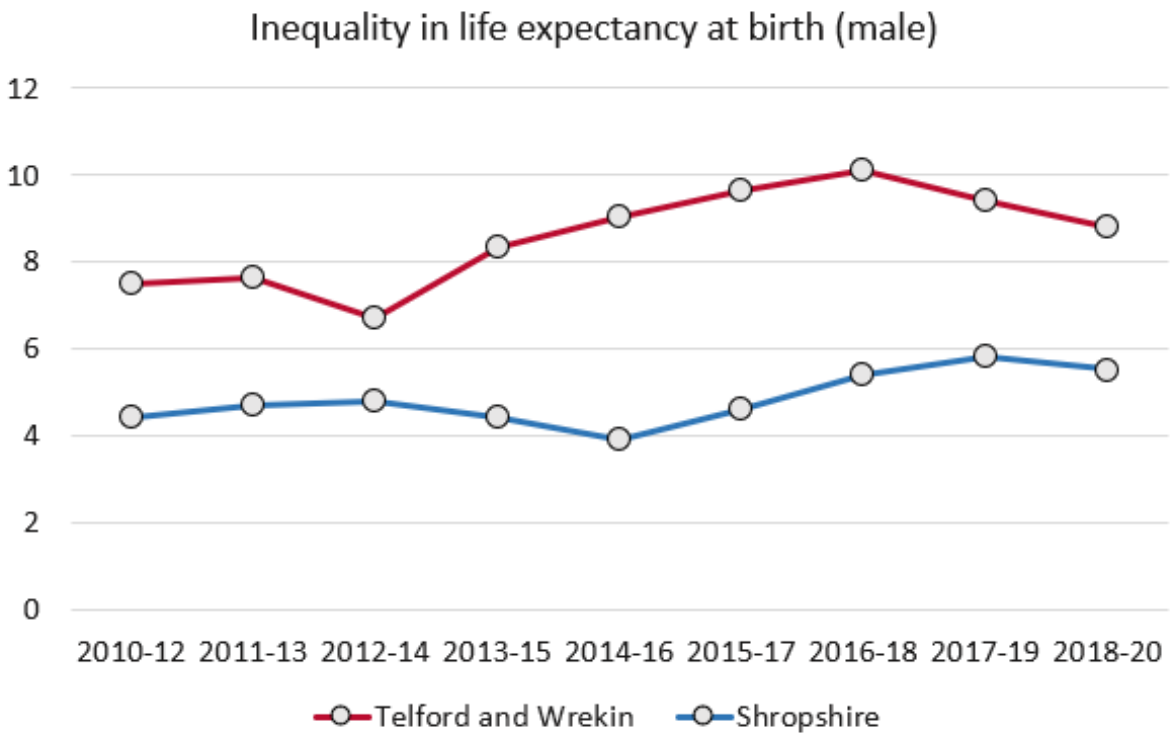
In Shropshire, Telford & Wrekin, life expectancy is lowest in areas considered to be in the 20% most deprived areas across England (decile 1 & 2 in the graphs below). There is a gradient in life expectancy by deprivation in both Telford & Wrekin and Shropshire, meaning the more deprived the area, the lower the life expectancy.

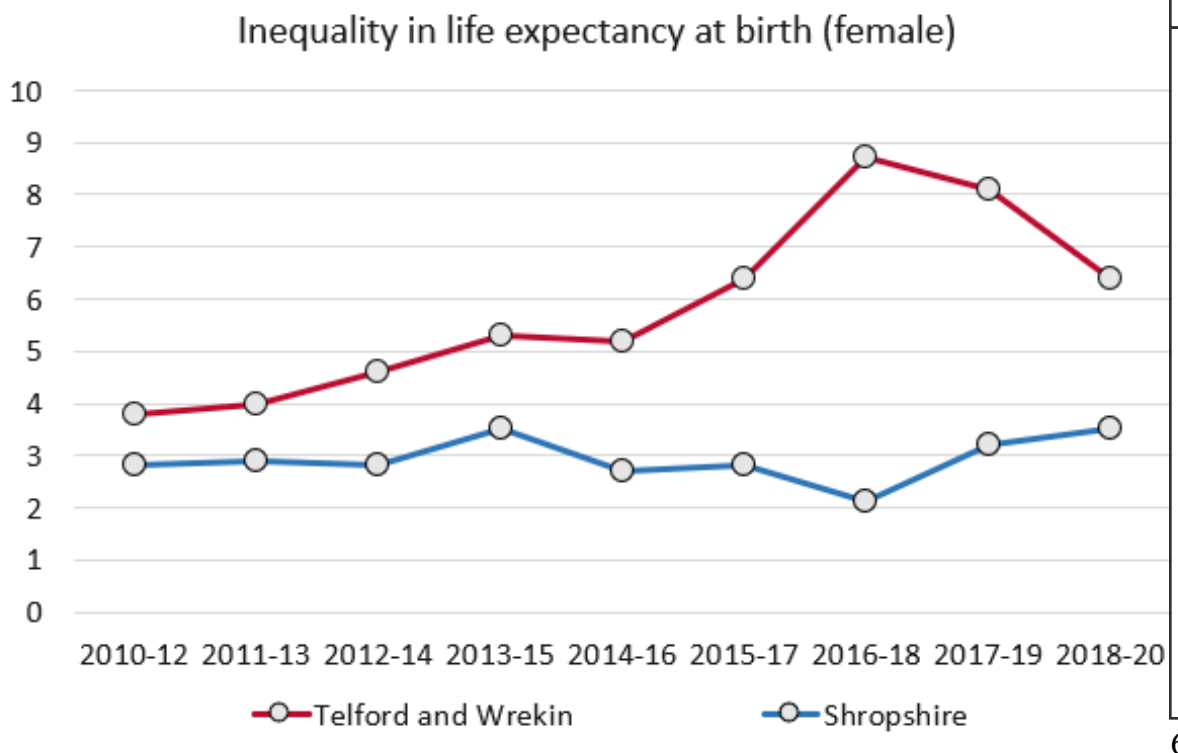


# Healthy Life Expectancy

Inequality in life expectancy (the difference in years of life expectancy between most deprived and least deprived areas) is largest in Telford & Wrekin compared to Shropshire. This inequality has been increasing over the last decade, however, in 2016-18, inequality in life expectancy in Telford & Wrekin started to decrease.



# Core20PLUS5: Targeted Action to Reduce Healthcare Inequalities

**CORE20**

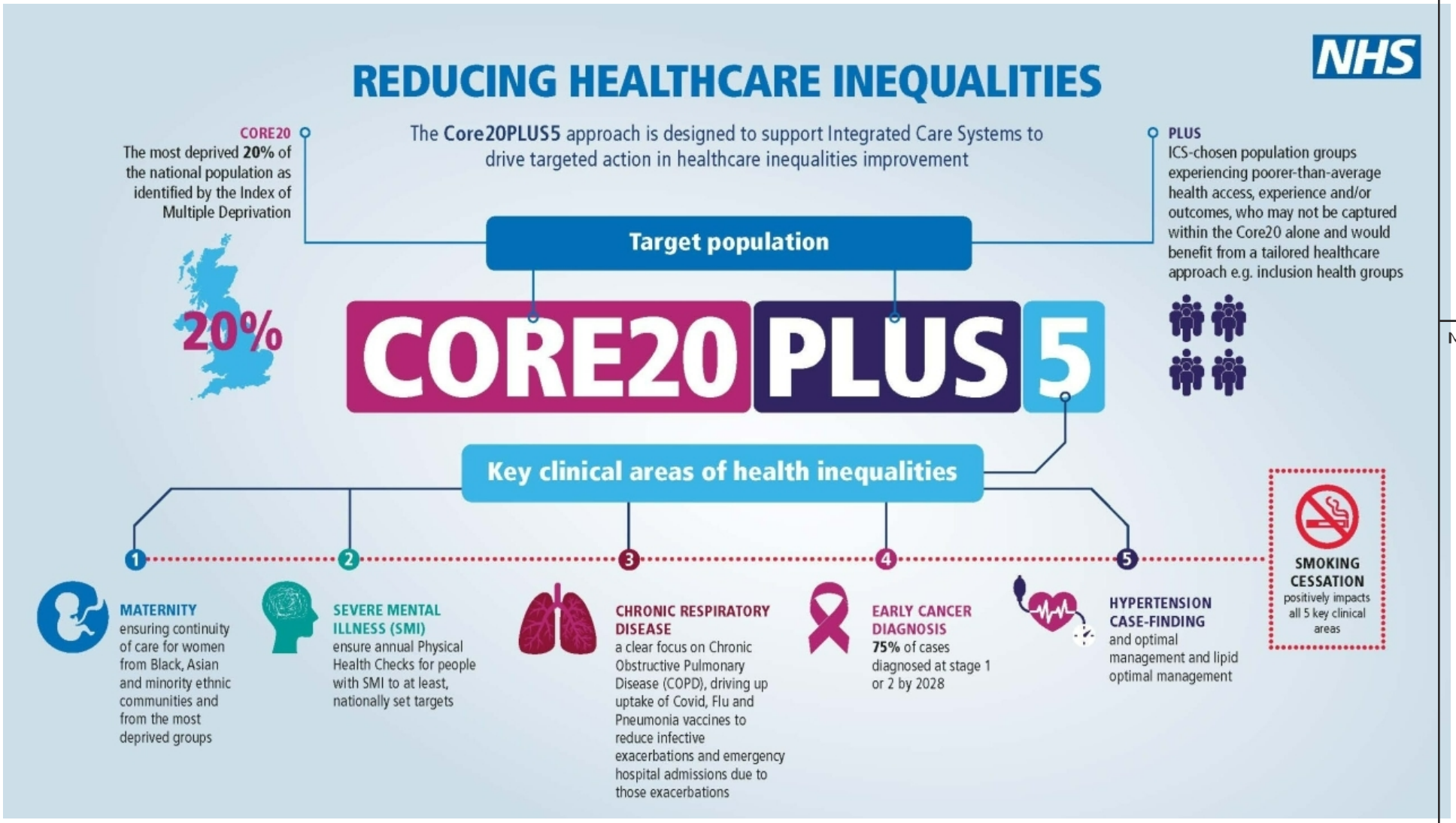
The 20% most deprived areas across the UK.

**PLUS**

Population groups who experience poorer than average health access, experience and outcomes.

**5**

5 key clinical areas where we can make a difference.



# Children and Young People: Targeted Action to Reduce Healthcare Inequalities

# Healthcare Inequalities & Prevention Priorities (CORE20PLUS5 & LTP)

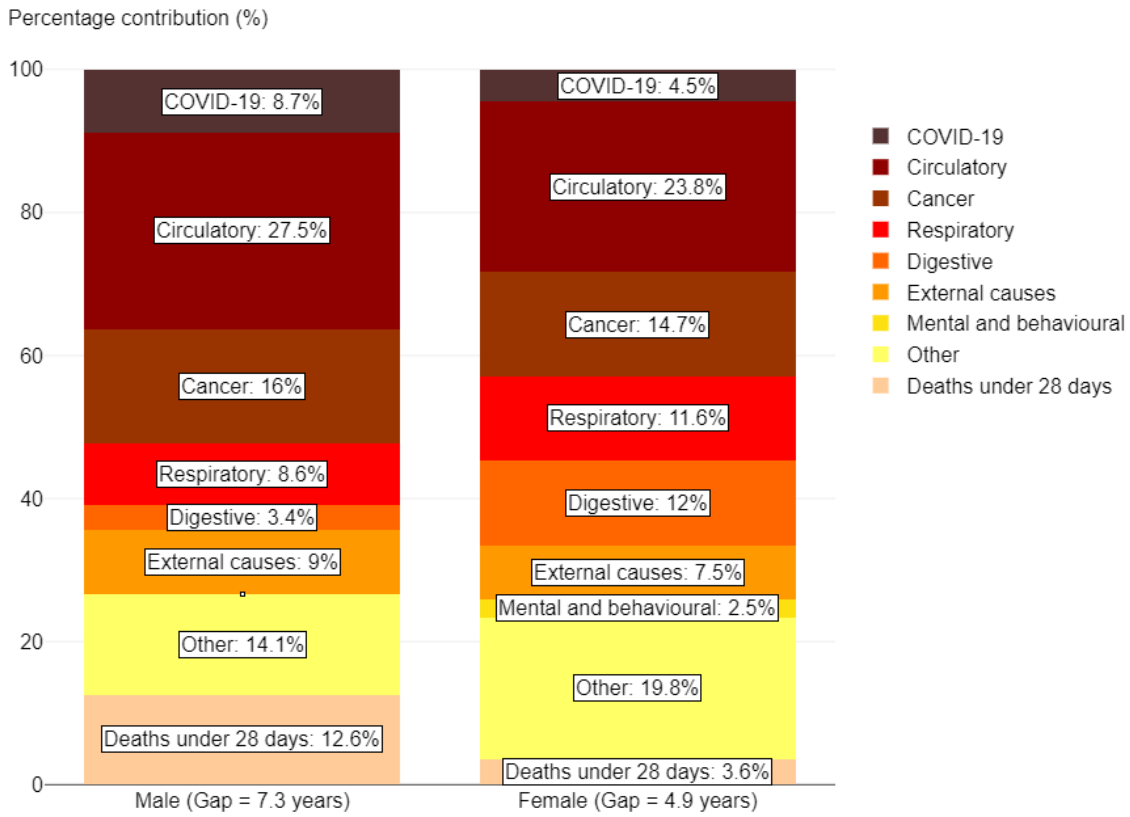
| | Public Health Outcomes Framework Indicator | Telford & Wrekin | Shropshire | NHSE health inequalities & prevention priorities |
|---|---|---|---|---|
| Prevention | Adults classified as overweight or obese 2021/22 | 71.4 | 67.4 | • HI 5 key clinical areas: hypertension case finding<br>• LTP accelerate diabetes & CVD prevention programmes<br>• LTP NHS prevention priority healthy weight |
| | Diabetes diagnosis rate (estimate) 2018 | 85.6 | 71.4 | |
| | Early mortality from preventable CVD 2021 | 38.4 | 25.8 | |
| | Early diagnosis cancer (stages 1 and 2) 2020 | 53.6 | 50.3 | |
| | Cancer screening coverage – cervical cancer 2022 | 70.8 | 75.2 | • HI 5 key clinical areas: early cancer diagnosis |
| | Cancer screening coverage – bowel cancer 2022 | 69.4 | 73.9 | |
| | Early mortality from preventable cancers 2021 | 46.0 | 37.3 | |
| | Early mortality from preventable respiratory disease 2021 | 19.9 | 9.8 | • HI 5 key clinical areas: chronic respiratory disease |
| | Flu vaccination coverage – at risk individuals 2022/23 | 47.8 | 57.3 | |
| | Flu vaccination coverage – aged 65 and over 2022/23 | 78.3 | 83.2 | |
| | Spring COVID booster uptake 2023 | 68.5 | 73.4 | |
| | Early mortality in adults with severe mental illness 2018-20 | 134.4 | 89.0 | • HI 5 key clinical areas: severe mental illness |
| | Excess mortality in adults with severe mental illness 2018-20 | 475.4 | 477.6 | |
| | Emergency hospital admissions for self harm 2021/22 | 156.8 | 128.1 | |
| | Admissions for alcohol related conditions 2021/22 | 546 | 513 | • LTP NHS prevention priority: alcohol care team |
| | Early mortality from preventable liver disease 2021 | 18.7 | 16.6 | |
| | Smoking attributable mortality 2017-19 | 246.1 | 173.7 | • LTP NHS prevention priority: NHS tobacco dependency programme |
| | Smoking attributable hospital admissions 2019/20 | 1,944 | 1,475 | |
| | Smoking prevalence routine & manual occupations 2022 | 26.5 | 17.6 | |

# Healthcare Inequalities & Prevention Priorities (CORE20PLUS5 & LTP) – Maternity and Early Years

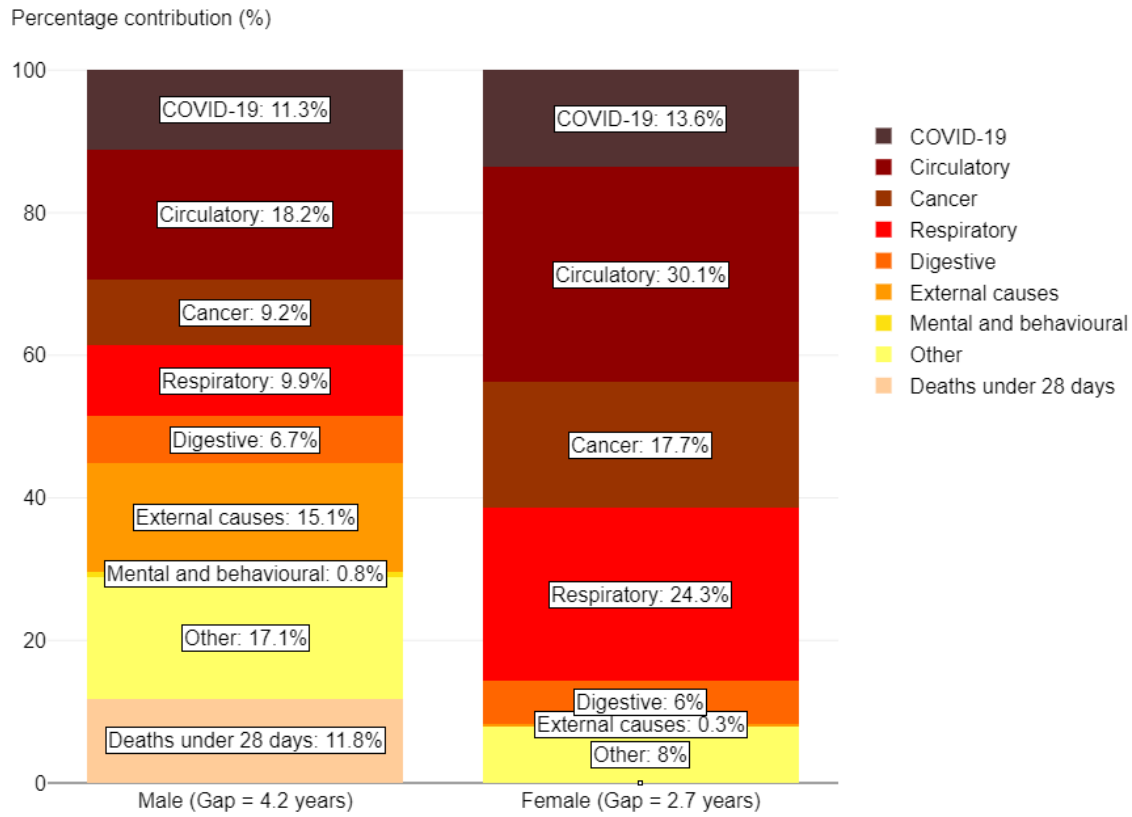
| | Public Health Outcomes Framework Indicator | Telford & Wrekin | Shropshire | NHSE health inequalities & prevention priorities |
|---|---|---|---|---|
| Maternity & Early Years | Teenage pregnancy 2021 | 19.5 | 12.5 | • HI 5 key clinical areas: maternity<br>• LTP NHS prevention priority health weight |
| | Obesity in early pregnancy 2018/19 | 29.5 | 24.1 | |
| | Baby's first feed breastmilk 2020/21 | 66.0 | 74.8 | |
| | Smoking at time of delivery 2021/22 | 12.0 | 12.0 | |
| | Children overweight (including obese) – reception 2021/22 | 27.3 | 22.5 | |
| | Children overweight (including obese) – year 6 2021/22 | 40.8 | 33.1 | |
| | Hospital admissions for asthma 0-9 years 2021/22 | 380.7 | 327.1 | |
| | Hospital admissions for epilepsy 0-9 years 2021/22 | 134.4 | 49.1 | |
| | Hospital admissions for diabetes 0-9 years 2021/22 | Data suppressed | 32.7 | |
| | 5 year olds with obvious dentinal decay 2021/22 | 19.1 | 14.6 | |

# Inequalities

## Cardiovascular disease is the most significant cause driving inequality in life expectancy in Shropshire, Telford and Wrekin.




Telford and Wrekin




Shropshire

# Appendix 2

ICB Core Functions informed by legislation and national guidance

NHS England expectations of ICBs

# NHS STW has 20 core functions informed by legislation and national guidance (1/2)

| Functions of NHS STW | |
|---|---|
| 1 | Supporting the ICP and system partners to develop the integrated care strategy through the provision of resources and advising on requirements as set out in national guidance |
| 2 | Using joined-up data and digital capabilities to understand local priorities, track delivery of plans, monitor and address variation and inequalities, and drive continuous improvement in performance and outcomes |
| 3 | Establishing population health intelligence and analytical capabilities to generate insight and report on variable population needs and inequalities across the system |
| 4 | Developing a plan to meet the health needs of the population within STW, including setting out the activities required to deliver the strategy, who is responsible for these, phasing of these activities, monitoring requirements and financial management arrangements |
| 5 | Establishing and operating governance arrangements to support collective accountability between partner organisations. for whole-system delivery and performance, to ensure the plan is implemented effectively, within a system financial envelope set by NHS England |
| 6 | Establishing and supporting joint working arrangements with partners, that embeds collaboration as the basis for delivery of joint priorities within the plan |
| 7 | Allocating resources to deliver the plan across the system, including allocating resources to Provider Collaboratives and Place-based partnerships based on population needs and priorities |
| 8 | Ensuring annual budget, revenue, capital limits and running cost allowance for NHS STW are not exceeded, conducting accounting and banking in line with legal requirements and providing relevant financial information to NHSE |
| 9 | Commissioning hospital and community NHS services, as well as additional services NHS England will be delegating (e.g. specialised, primary medical, mental health, community pharmacy, ophthalmology and dental) |

NHS STW function required to fulfil statutory duties

NHS STW statutory function

NHS STW additional functions, as set out in guidance.

# NHS STW has 20 core functions informed by legislation and national guidance (2/2)

| Functions of NHS STW | |
|---|---|
| 10 | Working alongside councils to invest in local community organisations and infrastructure and, through joint working between health, social care and other partners, ensuring that the NHS plays a full part in influencing the wider determinants of health such as social and economic development and environmental sustainability |
| 11 | Supporting the delivery of public health and population health management across the ICS - taking account of relevant public health laws, regulations and governance structures, and advancing public health research and investment |
| 12 | Arranging for the provision of health and care services in line with the allocated resources across the ICS through a range of STW-wide and Place-level activities |
| 13 | Planning for, responding to, and leading recovery from incidents (EPRR), to ensure NHS and partner are joined up at times of greatest need, including taking on incident coordination responsibilities as delegated by NHS England. |
| 14 | Leading communications and public engagement to seek public and patient views on experience to inform service planning and redesign |
| 15 | Leading system implementation of the People Plan by aligning partners across each ICS to develop and support the 'one workforce' approach |
| 16 | Leading system-wide action on data and digital, working across the partnership to put in place smart digital and data foundations to connect health and care services and ultimately transform care to put the citizen at the centre of their care |
| 17 | Driving joint work on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support these wider goals of development and sustainability |
| 18 | Promote education and training in the healthcare workforce and prospective workforce |
| 19 | Meet their legal obligations as an employer including those relating to employment, health and safety, equality, data protection and information governance and sector specific legislation |
| 20 | Fulfilling additional legal duties of NHS STW as set out in various Acts |

NHS STW function required to fulfil statutory duties

NHS STW statutory function

NHS STW additional functions, as set out in guidance.

# NHS England Expectations of ICBs

## What do we need to deliver?

- Effective system leadership which balances immediate and longer-term priorities.
- Oversight of the NHS delivery of strategies and plans, ensuring progress toward and achievement of objectives for annual planning and Long-Term Plan priorities.
- Oversight of the budget for NHS services in the STW system.
- Delivery of the ICB core statutory function of arranging health services for the population of STW and compliance with other statutory duties.
- Stewardship, with local authorities, of local population health outcomes and equity.

## Who do we account/provide assurance to?

Within the NHS:

- NHS England, via Regional Directors – including for delivery of the outcomes and priorities expressed in the Joint Forward Plan
- NHS England, as regulator (with associated statutory powers)
- Care Quality Commission (CQC) as part of the ICS (not as individual organisations) for leadership, quality, safety and integration of services.

Locally:

- People, communities and service users.

## What are our roles?

- Working with partners to set system-level strategy and plans
- Working with partners to ensure effective arrangements are in place across the system for joint working to deliver plans, performance, outcomes and transformation
- Commissioning, agreeing and managing contracts, delegation and partnership agreements with providers and primary care
- Contributing to long term workforce planning
- Informing national goals and mandate
- Delivering Integrated Care Partnership strategies and our joint 5 year forward plan

## Who and what do we oversee?

- First line oversight of health providers across the ICS to oversee performance and contribution to overarching plans
- Coordinate/help tailor any support for providers
- Assurance/input to regulator assessment
- Liaison/escalation of issues to NHS England

## What are our specific legal powers in relation to other bodies?

- In relation to providers and partners, our powers are operated through contracts, delegation, and joint working agreements
- Agree joint 5 year forward plan and joint capital plan with partner trusts

# Appendix 3

Key healthcare commissioning arrangements

Key corporate commissioning arrangements

# Key Health and Care Services Commissioning Arrangements

| Memoranda of Understanding | Delegation Agreements | Terms of Reference for committees and joint committees | Lead provider and alliance contracts | Section 75 agreements between the NHS and Local Authorities | NHS Standard Contract (Major Providers) |
|---|---|---|---|---|---|
| •COVID-19 Vaccination Programme<br>•ICB oversight arrangements | •General medical practice<br>•General dental practice, optometry and community pharmacy<br><br>•Anticipated 2024/25:<br>•Specialised Commissioning<br>•Vaccination and immunisation | •ICB:<br>•Board Committees<br>•ICB Executive Group<br><br>•Joint:<br>•Integrated Care Partnership<br>•Place sub-committees<br><br>•Note:<br>•Each local authority also convenes a Health and Wellbeing Board with membership from Local Councillors, Local Authority Officers and NHS members | •Lead Provider Contracts:<br>•Virtual Wards – Shropshire Community Health NHS Trust<br>•Integrated Discharge Team – Shropshire Community Health NHS Trust (TBC)<br><br>•Locally Commissioned Services Framework:<br>•Including ad hoc public health treatment requests | •Better Care Fund with Telford and Wrekin Council<br>•Better Care Fund with Shropshire Council | •Shrewsbury and Telford Hospital NHS Trust<br>•Shropshire Community Health NHS Trust<br>•Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust<br>•Midlands Partnership University NHS Foundation Trust<br>•West Midlands Ambulance Service University NHS Foundation Trust<br>•Midlands and Lancashire Commissioning Support Unit (GP IT)<br>•Large scale public health response, provider to be determined |

# Corporate Services Commissioning Arrangements

## Midlands and Lancashire Commissioning Support Unit Contracted Services

- Business Intelligence
- Human Resources
- Payroll and Employment
- Finance
- Procurement (healthcare services)
- Health & Safety
- Information Governance
- Information Technology
- Freedom of Information
- Communications and Engagement
- Serious Incidents
- Resilience
- Regional Capacity Management Team

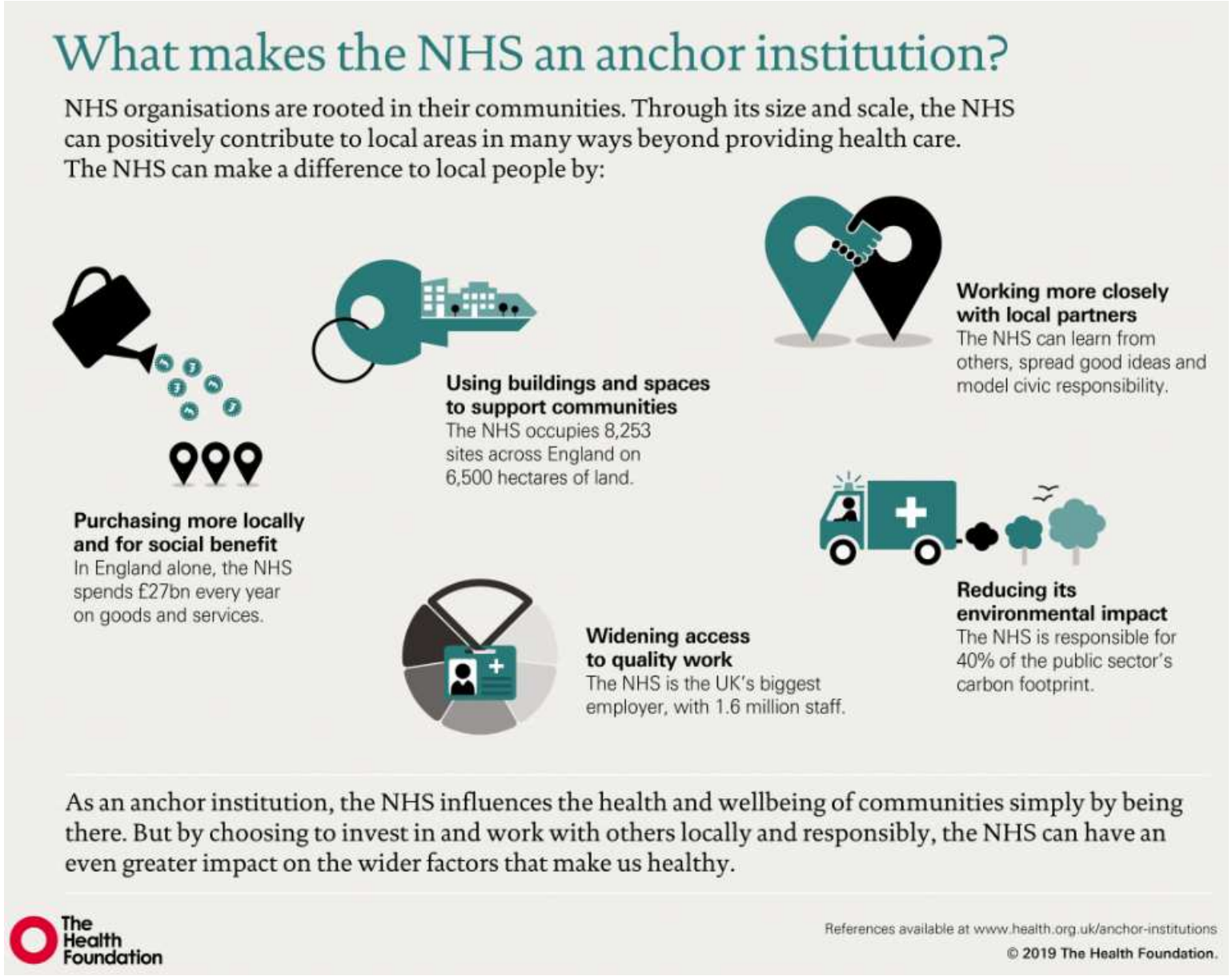
## Professional Services

- External audit – Grant Thornton
- Internal audit – 360 Assurance
- Counter Fraud – 360 Assurance
- Legal Services – Mills and Reeve
- Non-Contract Procurement - TBC

# Appendix 4

## Our Wider Commitments

# We have a responsibility to look after our community and the place that we live




As part of our commitment to make a difference to local people through our role as an anchor institution beyond our core duties as an ICB we also commit to:

- Supporting Net Zero for the NHS through supporting our ICS partners in carbon reduction activities, management of our supply chain (e.g. requiring carbon reduction approaches through procurement) and addressing our own carbon emissions (through agile working, consolidating office space and more).
- The NHS Equality, Diversity and Inclusion Plan including the High Impact Actions.
- NHS Smoke Free, including supporting our staff to quit smoking.
- Be menopause friendly aligned to the NHS England guidance.
- Work with education providers and local partners to provide meaningful work and purposeful training opportunities.

# Appendix 5

## Executive team roles and responsibilities

# Responsibilities: Chief Executive Officer

| Functions | Responsibilities |
|---|---|
| Corporate Affairs<br>• Business administration<br>• Executive administration services<br>• MP correspondence<br>Communications and Engagement<br>• Tactical, operational & strategic communications for the ICB and ICS<br>• Staff and Stakeholder engagement & Relationship management<br>• Media Management<br>• Internal Communications<br>• Public Campaigns<br>• Website development and governance<br>Governance<br>• Board Secretariat<br>• Maintain constitution and governance handbook<br>• Annual reporting<br>• NHSE MOU oversight<br>• Information governance<br>• Records Management<br>• Freedom of Information<br>• Subject Access Requests<br>• Risk management<br>• Board Assurance Framework<br>• Conflicts of Interest<br>• Freedom to Speak Up<br>ICB Business Continuity and Emergency Planning, Preparedness and Response<br>• Incident management<br>ICB Estates<br>• Health and safety<br>• Facilities management<br>• Security management<br>Legal services<br>Non pay corporate procurement<br>• CSU contract management | • Quadruple aim<br>• ICB general powers and discharge of functions<br>• Duty to exercise functions effectively, efficiently and economically<br>• Investment<br>• Joint Working Arrangements<br>• Joint Working with Combined Authority<br>• Joint exercise of functions with Local Health Boards<br>• Duty to cooperate and provide information<br>• Appointment to and cooperation with Health and Wellbeing Boards<br>• Corporate Manslaughter<br>• Compliance with NHSE directions<br>• Cooperation with NHSE and others<br>• Application to become Care Trust<br>• Public engagement and involvement<br>• Reputation management<br>• Input to EDI<br>• Co-production and co-design<br>• Crisis Communication Response<br>• Population Health / behaviour change Communication<br>• Statutory consultation<br>• Branding<br>• Engagement with the community, voluntary sector and Healthwatch<br>• EDI – EDS2 Process<br>• Support Arrangements with Secretary of State<br>• Duty to have regard to NHS Constitution<br>• Duty to promote the NHS Constitution<br>• Response to Healthwatch reports<br>• Requests for Information from Healthwatch<br>• Board member appraisals and Fit and Proper Person Test<br>• Duties to have regard to the wider effects of decisions, including in inequalities issues (section 14Z43 of the NHS Act 2006).<br>• Safeguarding (Working Together 2023) |

# Responsibilities: Chief Finance Officer

| Functions | Responsibilities |
|---|---|
| Finance<br>• Financial Strategy & planning (monitoring & delivery)<br>• Financial modelling/new payment structures<br>• Financial system leadership and management (including ICS)<br>• Financial accounting<br>• External & Internal Audit<br>• Counter Fraud<br>• Fraud Investigations<br>• Capital Resource Planning<br>• Recovery of Charges<br>• Recovery of Debts<br>• Quality Payments<br>Performance, Planning and Business Intelligence<br>• Integrated performance reporting including vaccination and immunisations<br>• Integrated (Business and service) intelligence, incl. risk stratification and demand and capacity modelling<br>• Data analysis and decision support (Business Intelligence, Population Health Management)<br>• Production and delivery of annual operational plan<br>Commissioning<br>• Health & Care Needs Assessment<br>• Development of outcome measures (including metrics)<br>• Contract management & negotiation transformation<br>• Mental Health, Learning Disabilities & Autism commissioning and transformation<br>• Autism Strategy<br>• Specialised Commissioning<br>• Joint commissioning agreements<br>• Decommissioning Policy<br>• Section 75 Arrangements including BCF<br>• Arranging Services<br>• Production commissioning intentions<br>• Section 7a public health functions, winter vaccinations and outbreak response<br>Procurement<br>Strategic Estates | • SIRO<br>• Financial Sustainability<br>• Health economics/Actuarial development<br>• System Performance review and management<br>• Statutory reporting<br>• NOF co-ordination and overall performance delivery & improvement<br>• System incentive realignment<br>• Procurement innovation<br>• Payments to Providers<br>• Financial Balance<br>• Use of Support Monies<br>• Additional Income<br>• Fundraising<br>• Development Agreements<br>• Publicity for public interest reports<br>• Contribution to NHSE fund<br>• Payment of charges<br>• Grant and Loans<br>• Banking Arrangements<br>• Joint Financial Duties<br>• Duty to promote innovation<br>• Power to make grants<br>• Payments to 3rd Sector Organisations<br>• Regard to Welsh Code on additional Learning Needs<br>• Duties to provide information and other help<br>• Supply of services to Local Authorities<br>• Continued Provision<br>• Co-operating generally: local authority functions<br>• Performance of functions outside England<br>• Provision of vehicles for disabled people<br>• Facilities for Voluntary Groups<br>• Payments to LAs for Social Services |

# Responsibilities: Chief Medical Officer

| Functions | Responsibilities |
|---|---|
| Medical professional leadership<br>• Management<br>• CPD<br>• Wellbeing<br>System clinical engagement<br>Medical advice and support to delivery of ICB functions, especially quality, service improvement, commissioning, performance and partnerships<br>Clinical prioritisation<br>Primary Care commissioning and improvement<br>• Primary Care Estates<br>• Primary Care Network Development<br>• Primary Medical Services<br>• Primary Dental Services<br>• Pharmacy Services<br>• Optometry Services<br>• Prescription ordering<br>Pharmacy and Medicines Optimisation<br>• Vaccinations and Immunisations<br>Digital<br>• ICS Digital Portfolio and Strategy<br>• Cyber Lead<br>• Corporate Digital<br>• GP IT | • Caldlicott Guardian<br>• Exercise of Secretary of State Public Health Functions<br>• System Mortality Surveillance<br>• Responsible Officer for Prescribed connections<br>• Primary Care Secondary Care Interface<br>• Learning from Deaths<br>• Veterans healthcare<br>• Joint working: "Delegation Agreement: Primary Care Contracts"<br>• Duty in respect of research<br>• Appointment of Medical Examiners: "Appointment of Examiner if required Monitoring of Performance"<br>• Performers list<br>• Individual Funding Requests<br>• Medical Record Provision<br>• Duties to provide information and other help<br>• Permitted Disclosures<br>• Disclosure of Information<br>• Medical Examiner Payments<br>• Notices of Birth<br>• Delivery of ICB components of Section 7a public health functions, winter vaccinations and outbreak response |

# Responsibilities: Chief Nursing Officer

| Functions | Responsibilities |
|---|---|
| Nursing and non-medical Professional Leadership, management and CPD<br>System quality oversight and assurance<br>• Quality improvement incl. CQUINs<br>• LeDeR oversight<br>• Patient experience<br>• SEND<br>• Quality Reporting<br>Safety<br>• Safeguarding (Working Together 2023)<br>• Support to LAs with safeguarding responsibilities<br>• Children in Care<br>• Children accommodated by health authorities and local education authorities<br>• Inspection of Looked After children accommodation<br>• MCA/DOLs<br>• LMNS<br>• Counter-Terrorism<br>System leadership of IPC<br>Individual Commissioning<br>• Continuing healthcare assessment and arrangement of packages, review panels and cooperation with Local Authorities<br>• Funded nursing care assessment and payments<br>• Personal Health Budgets and Direct Payments<br>Guidance and interpretation<br>Establishment and conduct of reviews<br>PALS and complaints<br>After care<br>Assessments<br>• Assist Local Authority assessments<br>• Adoption<br>Nomination of IRP Members<br>CQC notifications and investigations | • Co-operating in specific cases: local authority functions<br>• Duty to participate in Anti-Social Behaviour Case Reviews<br>• Public sector equality duty<br>• Comply with Human Rights Responsibilities<br>• Duty as to improvement in quality of services<br>• Duty to obtain appropriate advice<br>• Provide CQC with information<br>• Disclosure of Information from Medical Inspector<br>• Cooperation with HSSIB<br>• Duty to have regard to need to safeguard and promote the welfare of children<br>• Duty of NHS bodies to cooperate with the Prison Service<br>• Membership of a Safeguarding Adult or Children Boards<br>• Duty bring certain children to local authority's attention<br>• Duty of local authority and relevant partners to work together<br>• Co-operation to improve wellbeing<br>• Arrangements to safeguard and promote welfare<br>• Local arrangements for safeguarding and promoting welfare of children<br>• Combining safeguarding partner areas and delegating functions<br>• Combining child death review partner areas and delegating functions<br>• Arrangements for assessing etc risks posed by certain offenders<br>• Authorities responsible for crime and disorder strategies<br>• Duty to collaborate with provision of youth justice services<br>• Duty to collaborate in the establishment of youth offending teams<br>• Duty to cooperate with Youth Justice Board<br>• Duty to act in accordance with guidance<br>• Co-operation between authorities<br>• Local authority's duty to investigate<br>• Duty to co-operate with Commissioner<br>• Information of Children accommodation<br>• Information about Children in need<br>• Information about Accommodated Children<br>• Cooperation for Wellbeing of Children and Young People<br>• Duty to have regard to code of practice<br>• Duties to provide information and other help |

# Responsibilities: Chief Delivery Officer

| Functions | Responsibilities |
|---|---|
| Accountable Emergency Officer<br>• System Control Centre<br>• Emergency Preparedness, Resilience and Response<br>• Integrated Business Continuity<br>• Incident Management<br>Service Improvement<br>• Programme Management Office and project support<br>• Elective Care service improvement<br>• Cancer Care service improvement<br>• UEC service improvement<br>• MH.LD&A, CYP service improvement<br>• Financial improvement<br>RAS/ TRAQs<br>Guidance on NHSE investigations<br>Overview & Scrutiny | • Category 1 response<br>• Secretary of State Emergency Directions<br>• Persons discharged from hospital<br>• Information as to hospitals<br>• Notification of hospitals having arrangements for special cases<br>• Access to Authorised Representatives<br>• Duty to promote innovation<br>• Patient Choice - Offering and promoting<br>• NHSE Investigations<br>• Waiting Times<br>• Alternative Provider<br>• Urgent Cancer Referrals<br>• Alternative Provider - Cancer<br>• Duty in relation to assisting and supporting NHSE to discharge duty in relation to quality of primary medical services<br>• Co-operation with Local Authorities<br>• Patient Choice Standing Rules<br>• Access to Postal Packages<br>• Provision of Accommodation to those in need<br>• Responsible Authority - Crime and Disorder<br>• Duties to provide information and other help |

# Responsibilities: Chief People Officer

| Functions | Responsibilities |
|---|---|
| ICS workforce<br>• NHS People promise<br>• Development of system people strategy and workforce plans including recruitment, learning and development, career pathways, and career entry points<br>• Delivery of plans to achieve the NHS people strategy, People Promise and associated HR Futures programmes<br>• System Development and ICB organisational development including Board development, talent management, culture and values<br>• Organisational development to support transformational change and quality improvement<br>• System retention plans<br>• Leadership development & talent management<br>• Education and training<br>• Equality, diversity and inclusion (workforce)<br>• Trade union liaison<br>• Collaboration with education partners<br>• NHSE & Education Provider relationships<br>• General Practice Workforce Training Hub<br>ICB workforce<br>• Legal compliance – employment, health and safety, equality, data protection and information governance and sector specific laws<br>• HR management and colleague relationships<br>• Staff Experience and Engagement: including annual NHS and system staff survey response<br>• Equality: WRES. WDES. Gender Pay Gap<br>• Trade Union liaison<br>• Other Remuneration<br>• Employment of Staff | ICS Workforce:<br>• Conduct Fit and Proper Person Test<br>• Duty to promote education and training<br>• Facilities for Universities<br>• Employment Rights<br>• Employees Rights - Public Duties<br>• Continuity of Employment<br>• Duties to provide information and other help<br>• Supporting health and wellbeing of staff<br>• Growing the workforce for the future and enabling adequate workforce supply<br>• Supporting inclusion and belonging for all, creating a great experience for staff<br>• Driving and supporting broader social and economic development<br>• Transforming people services and supporting the people professions<br>• Supporting system design and development<br>ICB workforce:<br>• ICB organisation development<br>• Valuing and supporting leadership at all levels and lifelong learning<br>• Leading workforce transformation and new ways of working<br>• Education training and development people and managing talent<br>• Leading co-ordinated workforce planning and intelligence |

# Responsibilities: Chief Strategy Officer

| Functions | Responsibilities |
|---|---|
| Strategy<br>• Integrated Care Partnership Strategy<br>• Joint Forward Plan<br>• Health Inequalities<br>• Green agenda<br>System Development<br>• Integrated Care System development<br>• Place development<br>• Neighbourhood development<br>• Provider Collaborative development | • Sustainable development agreements<br>• Climate Change and environmental sustainability including carbon net zero and water waste<br>• Duties to provide information and other help<br>• Duty to promote innovation<br>• ICB Partnership arrangements<br>• Ensure that planned changes consider and reduce existing health inequalities<br>• Ensure that equality impact assessments are undertaken for changes to services<br>• Duty to report information on health inequalities<br>• Core 20 Plus5<br>• The duty, as a member of an integrated care partnership, to produce, publish and keep under review an integrated care strategy, under section 116ZA of the Local Government and Public Involvement in Health Act 2007. The Secretary of State published statutory guidance on the creation and content of the strategy, including matters relating to health inequalities.<br>• The duty of an ICB to have regard to reducing inequalities in the exercise of functions (in section 14Z35 of the NHS Act 2006), including by reference to access and outcomes.<br>• General duties under the public sector equality duty in section 149 of the Equality Act 2010, and the specific duties to create and report equalities information further to the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017.<br>• The responsibility (jointly with upper tier local authorities) to produce joint strategic needs assessments, and health and wellbeing strategies, and to have regard to them, under section 116 and section 116A of the Local Government and Public Involvement in Health Act 2007.<br>• Addressing “health disparities” as described in the NHS Mandate for 2023 |

Agenda Item

ICB 24-04-036b

Amendments to Governance Handbook following Good Governance Institute (GGI) governance review

# Appendix 1
# NHS Shropshire, Telford and Wrekin

# Strategic Commissioning Committee

# Terms of Reference

## 1. Constitution

1.1 The Strategic Commissioning Committee ('the Committee') is established by the Board of NHS Shropshire, Telford and Wrekin (the Board or NHS STW) as a Committee of the Board in accordance with its Constitution

1.2 These Terms of Reference (ToR), which must be published on NHS STW website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

1.3 The Committee's members, including those who are not members of the Board, are bound by the Standing Orders and other policies of NHS STW.

## 2. Authority

2.1 The Committee is authorised by the Board to:

2.1.1 Exercise the ICB's duties and powers to commission certain health services, as set out in sections 3 and 3A of the NHS Act 2006 (as amended by the Health and Care Act 2022), other than those explicitly delegated elsewhere.

2.1.2 Discharge in accordance with section 65Z5 of the NHS Act the relevant requirements as set out within the Delegation Agreement between NHS England and the ICB (Primary Medical Services), insofar as they relate to the planning, design and commissioning of primary medical services.

2.1.3 Promote the engagement of the boards of all organisations across the ICS to support the delivery of the Joint Forward Plan and Integrated Care Strategy.

2.1.4 Monitor the ICS's progress against the System Oversight Framework Segment 4 (SOF4) Exit Criteria, holding the relevant committees and partners accountable.

2.1.5 Accelerate the delivery of the ICS's strategic aims, objectives and plans with the ambition of driving improvement in quality and safety, strengthen workforce resilience, reduce duplication and drive productivity improvements and cost reduction.

2.1.5 Promote a system-wide approach and cross functional alignment to the ICS's strategic activities

2.1.6 Ensure alignment of strategic activities with the ICS's Ten Pledges and its objectives outlined in the Joint Forward Plan.

2.1.7 Work to ensure that the roles and individuals required to support the delivery of agreed strategically-focused tasks, projects, work-streams or actions are identified and resourced and that the requirement to provide sufficient resources is understood at System and organisational level.

2.1.8 Provide strategic oversight to delegated primary care services delegated to the ICB from NHS England; including General Medical Services (GMS), Pharmacy, Optometry and Dentistry and some prescribed specialised commissioned services.

2.1.9 Provide oversight and approval of contracting within approved budgets for all health and care commissioned services by the ICB/ICS, including Primary General Medical Services. (Contracting for Pharmacy, Optometry, Dentistry and Specialised Commissioned services will be via the Joint West Midlands ICBs Committee).

2.1.10 The Strategic Commissioning Committee is authorised by the Board to:

- Investigate any activity within its terms of reference
- Seek any information it requires within its remit, from any employee or member of NHS STW (who are directed to co-operate with any request made by the Committee) as outlined in these terms of reference
- Commission any reports it deems necessary to help fulfil its obligations,
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by NHS STW for obtaining legal or professional advice
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with NHS STW's constitution, Standing Orders and Scheme of Reservation and Delegation (SoRD) but may not delegate any decisions to such groups.
- For the avoidance of doubt, the Committee will comply with NHS STW Standing Orders, Standing Financial Instructions and the SoRD

## 3. Purpose

3.1 The duties of the Committee will be driven by NHS STW's objectives and the associated risks. An annual programme of business will be agreed before the start of the financial year; however this will be flexible to new and emerging priorities and risks.

3.2 The Committee will oversee development of the Joint Forward Plan Plan (owned by NHS STW and approved by the Board) which will be informed by the Integrated Care Partnership's Integrated Care Strategy, the key needs of the STW population and the NHS mandated priorities.

3.3 The Committee will provide strategic oversight of commissioning of health and care services by the ICB/ICS, which includes Primary General Medical services (GMS) delegated to the ICB from NHS England. This includes recommendation of clinical and non clinical system strategies within the Committtee's remit to the Board for approval and approval of clinical and non clinical commissioning policies and approval of contracting decisions within approved budgets to include:

- Approval of contracts/contract variation for any healthcare services within approved budgets
- Approval that NHS STW proceeds to procurement for healthcare services which will include the approval of the timeline for procurement, the proposal for procurement and the service specification.
- Approval of the award of healthcare services procurement
- Approval of extension of healthcare contracts, where provision for an extension has been made within the contact terms.
- Approval of the policies and procedures to support the arrangements for discharging the statutory and delegated duties associated with its clinical and non clinical commissioning functions.
- Approval of the ICB's Commissioning Intentions provided these are within the scope of the Joint Forward Plan.
- Arranging for the provision of health services in line with allocated resources across the ICS by putting contracts and agreements in place to secure delivery of its plan by providers.
- Co-ordinating a common approach to the commissioning and delivery of Primary General Medical Services with other health and social care bodies in respect of the area where appropriate.
- Such other ancillary activities that are necessary in order to exercise the Primary General Medical delegated functions.
- Arranging for the provision of health services in line with allocated resources across the ICS by supporting the development of primary care networks (PCNs) as the foundations of out of hospital care and building blocks of place based partnerships including through investment in PCN management support, data and digital capabilities, workforce development and estate.

- Decisions in relation to the commissioning and management of Primary General Medical Services.
- Approval of budget plan for managing Primary General Medical Service delegated funds in respect of the area and strategic management of funds outside approved budget.
- Overseeing reviews of Primary General Medical Services in respect of the area.
- Arranging for the provision of health services in line with allocated resources across the ICS by working with local authority and voluntary, community and social enterprises sector (VCSE) partners to put in place personalised care for people, including assessment and provision of continuing healthcare and funded nursing care and agreeing personal health budgets and direct payments for care.
- Provide oversight and approval of the arrangements for managing exceptional funding requests.

3.4 To ensure risks associated with the remit of the Committee are incorporated in the System Board Assurance Framework and the Strategic Operational Risk Register as appropriate, and oversight of mitigation and action on gaps in control is maintained.

3.5 The Committee will provide strategic oversight, alignment and scrutiny to the development of the following system-wide programmes of work:

- Data and Digital
    - Ensure the development and delivery of our STW ICS Digital Strategy , underpinned by the Data and Digital Transformation Plan
    - Leading system wide action on data and digital; working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services to put the citizen at the centre of their care.
    - Using joined up data and digital capabilities to understand local priorities, track delivery of plans, monitor and address unwarranted variation, health inequalities and drive continuous improvement in performance and outcomes.

- Estates and Procurement
    - Review the strategic alignment of the One Public Estates' plans with other strategic estates programmes, such as the Healthier Together Programme (HTP).

- Driving joint work on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support wider goals of development and sustainability.

- People and Culture
    - Ensure alignment of our One People Plan (previously our People Plan and Workforce Transformation Programme) with other strategic priority areas.

- System Oversight
    - Monitor the system's progress against the key areas of the System Oversight Framework Segment 4 (SOF4) Exit Criteria, as described by NHSEI

- Delegated Commissioning
    - Monitor the strategic implementation of our Commissioning practice in alignment with national policy and our Operating Model for delegated commissioning: Pharmacy, Optometry and Dentistry and from 1st April 2024 some Specialised Commissioned services.

- Primary Care Services
    - Ensure the alignment of system plans relating to Primary Care: General Medical services, Pharmacy, optometry and Dentistry with the Joint Forward Plan and other strategic programmes of work in NHS STW
- System-wide Service Transformation Programmes
    - Ensure the alignment of system-wide programmes of work to the Joint Forward Plan and primary care service plans to include but not limited to: Hospitals Transformation Programme (HTP) and Local Care Programme (LCP)

- Health Inequalities

- Ensure that health inequalities are addressed in the ICB's strategic objectives and that the Joint Forward Plan seeks to improve the outcomes in STW population's health

- Population Health Management
  - Ensure that the population health management data available in the system is used as a key enabler to help drive data led focus on person centred care through integrated services, to inform the development of the Joint Forward Plan and locally commissioned services at Place and neighbourhoods.

Climate Change

- Ensure the development and delivery of our STW ICS Green Plan.
- Leading system wide action on climate change; working with partners across the NHS and with local authorities to put in place foundations to address climate change risks.

## 4. Membership and attendance

4.1 The committee members will be appointed by the Board in accordance with NHS STW Constitution.

4.2 The Board will appoint no fewer than 4 members of the Committee. Other members of the Committee need not be members of the Board.

4.3 When determining the membership of the Committee, active consideration will be made to diversity and equality.

4.4.1 The Committee members shall be appointed by the Board in accordance with the constitution.

4.5 The Membership of the Committee is:

- The Chair – either an NHS provider Non Executive Director or an ICB Non Executive Director
- Vice Chair - either an NHS provider Non Executive Director or an ICB Non Executive Director
- ICB Chief Strategy Officer
- ICB Chief Finance Officer or deputy
- ICB Chief Medical Officer or deputy
- ICB Chief Nursing Officer or deputy

- A nominated Senior Executive strategy lead from:
    - Shropshire Community Healthcare NHS Trust
    - Shrewsbury and Telford NHS Trust
    - The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
    - Midlands Partnership University NHS Foundation Trust
- A nominated non-executive director from:
    - Shropshire Community Healthcare NHS Trust
    - Shrewsbury and Telford NHS Trust
    - The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
    - Midlands Partnership University NHS Foundation Trust
- A representative from Shropshire Council
- A representative from Telford and Wrekin Council
- One representative of General Practice Primary Care Providers who will be one of the Board General Practice Partners
- One representative from the VCS

If a member is unable to attend then they may nominate a deputy:

- The deputy for non-executive members must be a non-executive director from the member's own organisation;
- The deputy for the General Practice Primary Care Providers must be another individual from a General Practice Primary are Provider.
- The deputy for other members must have delegated authority on behalf of the organisation they represent
- The deputy shall be treated as a full member, and count toward quoracy.

4.6 The chairs of the Operational Groups that report into the Committee will be responsible for escalating issues or risks to the Committee.

4.7 Attendees

4.7.1 Only members of the Committee have the right to attend Committee meetings, however all the meetings of the Committee may be attended by individuals who are not members of the committee.

4.7.2 Additional attendees shall be invited as required at the discretion of the Chair and specifically the following:

4.7.3

- Clinical representatives - on the advice of the ICB Chief Medical Officer and Chief Nursing Officer.
- ICS Digital Lead
- ICB Director of Planning and Performance
- ICB Director of Commissioning
- ICB Director of Strategy and Development
- ICS Chief Pharmacist
- Healthwatch Shropshire
- Healthwatch Telford and Wrekin

4.8 Chair and Vice Char

4.8.1 In accordance with the Constitution, the Committee will be chaired by either a Non Executive Director of an NHS Provider Trust or an ICB Non Executive Director, appointed on account of their specific knowledge, skills and experience making them suitable to chair the Committee.

4.8.2 The Vice Chair of the Committee shall be either an NHS Provider Trust non Executive Director or an ICB Non Executive Director.

4.8.3 In the event that the Chair is unavailable, the Vice Chair will chair the meeting. Where the Chair and Vice Chair are not in attendance, committee members may appoint a temporary Chair who is qualified and appropriate to lead the meeting in their absence.

4.8.4 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference.

4.9 Attendance

4.9.1 Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable alternative attendee may be agreed with the Chair.

## 5. Meetings, quoracy and decisions

5.1 Meetings

5.1.1 The Committee will meet remotely, members attending using electronic means will be counted towards the quorum.

5.1.2 Meetings will take place in private.

5.1.3 The Committee shall meet a minimum of four times per year.

5.1.4 Due to the nature of the item on an agenda the Chair may direct that items are taken in confidential session where this is in the public interest; this includes but not limited to, award of contracts and other commercially sensitive contractual discussions. Only voting members will be invited to this part of a meeting. The Chair may invite attendees to the meeting where they are contributing specific knowledge of the items under discussion. This part of the meeting will be minuted separately and approval of the minutes will be by voting members present at the next confidential meeting.

5.2 Quorum

5.2.1 For a meeting to be quorate a minimum of 50% members is required, including the Chair or Vice Chair (or a deputy elected from the voting members present).

5.2.2 If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

5.2.3 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

5.2.4 Decisions deemed by the Chair to be 'urgent' can be taken outside of the meeting via email communication, and with the agreement of a quorate number of members.

5.3 Decision-making and voting

5.3.1 Decisions will be taken in accordance with the standing orders.

5.3.2 The expectation is that the Committee shall ordinarily reach conclusion by consensus when making decisions

5.3.3 If consensus cannot be achieved each member may cast a vote

5.3.4 Only members of the committee may vote. Each member is allowed one vote and a majority will be conclusive on any matters.

5.3.5 If a majority cannot be reached by voting, the Chair shall have a second, deciding vote.

## 6. Responsibilities of the Committee

6.1 Development of the Joint Forward Plan.

6.1.1 The Committee will recommend the overall strategic direction of the ICS to the Board, and oversee the development of the ICS Joint Forward Plan, working in collaboration with the Statutory Boards, including:

- Formulation of a clear approach to developing and delivering the Joint Forward Plan agreed with all organisational boards
- Development of a decision-making approach in conjunction with organisation boards to agreed any additions to costs across the STW system and to pursue opportunities for cost reduction. This will be in conjunction with both the Integrated Delivery Committee and Finance Committee.
- Benchmarking against regional and national population health outcomes data to develop future opportunities
- Approve the involvement arrangements for the Joint Forward Plan.
- Recommend the commissioning strategic intent for the ICB to the Board.
- Recommend the Joint Forward Plan to the Board and approve any revisions to it.
- Leading system wide action on data and digital: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services to put the citizen at the centre of their care.
- Using joined up data and digital capabilities to understand local priorities, track delivery of plans, monitor and address unwarranted variation, health inequalities and drive continuous improvement in performance and outcomes
- Driving joint work on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support wider goals of development and sustainability.

6.2 System Improvement Plan

6.2.1 The Committee will oversee the development and monitor the delivery of the System Improvement Plan to deliver financial balance including:

- Establishment of robust decision-making processes for agreement of investments within the affordable funding envelope, in conjunction with the Finance Committee and System Transformation Group.
- Development of an integrated approach to system planning processes
- Development of a financial model for the system, in conjunction with the Finance Committee.
- Development of performance processes to provide oversight of SOF Exit criteria to include metrics and improvement plans in conjunction with the System Transformation Group.

6.3 Delegated Assurance Activity

6.3.1 The Committee will provide oversight and assurance of any other activity delegated to it by the ICS Board or, at the discretion of the Chair, at the request of any system member organisation.

6.3.2 Public and Patient Involvement

- The Committee will oversee and assure at least annually that the ICB is discharging its statutory responsibilities for involvement of its population in service planning and decision making and that this is meeting the Public Sector Equality Duty under the Equalities Act 2010.

6.3.3 To ensure risks associated with the remit of the Committee are incorporated in the System Board Assurance Framework and the Strategic Operational Risk Register as appropriate, and oversight of mitigation and action on gaps in control is maintained.

## 7. Behaviours and conduct

7.1 ICB Values

7.1.1 Members will be expected to conduct business in line with NHS STW values and objectives.

7.1.2 Members of, and those attending, the Committee shall behave in accordance with NHS STW's Constitution, Standing Orders, Conflicts of Interest Policy and Standards of Business Conduct Policy.

7.2 Equality and Diversity

7.2.1 Members must demonstrably consider the equality and diversity implications of decisions they make.

## 8 Accountability and reporting

8.1 The Committee shall report to the Integrated Care Board on how it discharges its responsibilities.

8.2 The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board in accordance with the Standing Orders.

8.3 The Chair will provide assurance reports to the Board at each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

8.4 The Committee will provide an annual report to the Board to describe how it has fulfilled its terms of reference, details on progress and a summary of key achievements in delivering its responsibilities.

8.5 The following sub committees and groups will report into this Committee:

- Commissioning Working Group
- Primary Care Access and Transformation Group
- Strategy Leads Group
- Equality and Involvement Assurance Sub Committee (annually)
- Population Health Management Group
- Health Inequalities Group
- Strategic Digital Group
- Strategic Estates Working Group
- Workforce Transformation Group

## 9 Secretariat and administration

9.1 Agenda and Papers

- The Agenda for each meeting shall be approved by the Chair.

- Final agendas and relevant papers will be circulated electronically to members in advance of each meeting.

9.2 Secretariat

- The production of papers, agendas and minutes shall be supported by a secretariat provided by the STW ICS.

- The secretariat function will ensure that:
    - The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;
    - Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;
    - Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;
    - Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept;
    - The Chair is supported to prepare and deliver reports to the Board;

- The Committee is updated on pertinent issues/ areas of interest/ policy developments;
- Action points are taken forward between meetings and progress against those actions is monitored.

## 10 Review

10.1 The Committee will review its effectiveness at least annually.

10..2 These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to NHS STW for approval.

# Appendix 2
# NHS Shropshire, Telford and Wrekin

## System Transformation Group

## Terms of Reference

### 1. Constitution

1.1 The System Transformation Group ('the Group') is established by the Board of NHS Shropshire, Telford and Wrekin (the Board or NHS STW) as a Management Group reporting to the Board in accordance with its Constitution.

1.2 These Terms of Reference (ToR), which must be published on the NHS STW website, set out the membership, the remit, responsibilities and reporting arrangements of the Group and may only be changed with the approval of the Board.

1.3 The Group's 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 Group is authorised by the Board to:

- Oversee the development and delivery of the Transformation Programme and the individual projects and programmes that reflect the Joint Forward Plan including:
    - Urgent and Emergency Care
    - Elective Care, Cancer and Diagnostics
    - Children and Young People
    - Workforce (agency and recruitment)
    - Hospital Transformation Programme
    - Local Care Programme
    - Mental health, Learning Disability and Autism
    - Financial Improvement
    - other transformation programmes as they develop.

  CEO SRO's will provide exception reporting at each meeting of the Group and deep dive reports as outlined in a forward plan for the year to System Transformation Group:

    - Urgent and Emergency Care – Louise Barnett
    - Elective Care, Cancer and Diagnostics - Stacey Lee Keegan
    - Children and Young People – to be confirmed
    - Workforce (agency and recruitment) – Stacey Lee Keegan
    - Hospital Transformation Programme – Matthew Neal

- Local Care Programme – Patricia Davies
- Mental health, Learning Disability and Autism – Neil Carr delegated to Cathy Riley
- Financial Improvement – Simon Whitehouse

- Oversee the delivery of the ICS performance against the underlying financial deficit.
- Accelerate the delivery of the sustainability programme through the delivery of agreed programmes to drive improvement in quality and safety, strengthen workforce resilience, reduce duplication and drive productivity improvements and cost reduction.
- Agreement of key delivery responsibilities at organisation and system level with project plans to ensure clarity and delivery.
- Provide oversight to the Investment Panel and ensure rigorous evaluation of benefits realisation and return on new investment.
- Promote a system-wide approach to the delivery of transformation programmes.
- Work to ensure that the roles and individuals required to support the delivery of agreed tasks, projects, work-streams or actions are identified and resourced and appropriate resources are identified from all system partners as appropriate.
- Put in place processes to monitor and address relevant risks and issues, particularly in relation to the under-delivery of agreed actions and system delivery against NHS mandated standards and targets.
- 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 Group) as outlined in these terms of reference
- Commission any reports it deems necessary to help fulfil its obligations,
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Group must follow any procedures put in place by NHS STW for obtaining legal or professional advice
- Create sub groups and task and finish sub-groups to take forward specific programmes of work as considered necessary by the Group's members. The

Group shall determine the membership and terms of reference of any such sub group or 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, the Group will comply with NHS STW Standing Orders, Standing Financial Instructions and the SoRD.

**3. Purpose**

3.1 The duties of the Group will be driven by NHS STW's objectives, Joint Forward Plan and any associated risks. An annual programme of business will be agreed before the start of the financial year. However, this will be flexible to new and emerging priorities and risks.

3.2 The purpose of the Group is to:

3.2.1 Provide assurance, oversight and support to the development and delivery of the STW ICS Transformation Programmes, the Financial Improvement Plan and Cost Improvement Plan to ensure that transformation is achieved at the required pace and remains aligned to Joint Forward Plan. Ensure allocation of resources to support delivery.

3.2.2 Provide assurance, oversight and support to the enabling and support services workstreams that contribute to the Transformation Programmes and upon which the programmes are dependent to achieve the required outcomes.

3.2.3 Serve as the point of escalation for operational transformation groups created by the Group specifically including for the following areas:

- Urgent and Emergency Care
- Elective Care, Cancer and Diagnostics
- Children and Young People
- Workforce (agency and recruitment)
- Hospital Transformation Programme
- Local Care Programme
- Mental health, Learning Disability and Autism
- Financial Improvement

3.2.4 Address interdependencies across STW transformation programmes and ensure continued congruence of programmes with operational activities.

3.2.5 Ensure that the transformation programmes remain aligned to delivery of the Financial Strategy.

3.2.6 Provide oversight to the Investment Panel and ensure that that investment decisions across the ICS remain compliant with the requirements of the national Recovery Support Programme and adhere to the agreed System process.

3.2.7 Establishing joint working arrangements with partners that embed collaboration as the basis for delivery within the plan.

3.2.8 Arranging for the provision of health services in line with allocated resources across the ICS by convening and supporting providers (working both at scale and at place) to lead major service transformation programmes to achieve agreed outcomes

3.2.9 Oversee the delivery of the ICS performance against the underlying financial deficit, to include;

- Recovery Support Programme
- Financial Improvement Plan
- System Cost Improvement Programme:
  - Oversight of combined provider and commissioner delivery
  - Oversight and assurance of system financial improvement programmes i.e. medicines management, procurement, estates and joint commissioning as required.

3.2.10 To ensure risks associated with the remit of the Group are incorporated in the System Board Assurance Framework and the Strategic Operational Risk Register as appropriate, and oversight of mitigation and action on gaps in control is maintained.

3.3 Out of Scope

3.3.1 Organisation-specific transformation programmes, although interdependencies will be tracked by the Group to manage risks to delivery of the transformation programmes

3.3.2 Organisation-specific financial efficiency programmes, although interdependencies will be tracked by the Group to manage risks to delivery of the transformation programmes

3.3.3 Operational performance that is within the remit of the operational groups reporting into System Transformation Group.

## 4. Membership and Attendance

4.1 Membership

4.1.1 The Group members shall be appointed by the Board in accordance with the constitution.

4.1.2 The Board will appoint no fewer than 7 members of the Group. Other members of the Group need not be members of the Board.

4.1.3 The voting membership of the Group is:

- ICB CEO (Chair)
- ICB Chief Finance Officer (Vice Chair)
- CEO, Midlands Partnership University NHS Foundation Trust
- CEO, Shrewsbury and Telford Hospital NHS Trust
- CEO, Shropshire Community Health NHS Trust
- CEO, Shropshire Council
- CEO, Telford & Wrekin Council
- CEO of The Robert Jones an Agnes Hunt (RJAH) Orthopaedic Hospital NHS Foundation Trust

4.1.4 If a member is unable to attend then they may nominate a deputy:

- The deputy for Group members must have delegated authority on behalf of the organisation they represent.
- The deputy shall be treated as a full member, and count toward quoracy.

4.1.5 The chairs of the Operational Groups reporting into The Group will be responsible for escalating issues or risks to The Group within their monthly exception reporting.

4.1 <u>Attendees</u>

4.2.1 Only members of the Group have the right to attend Group meetings, however all the meetings of the Group will be attended by individuals who are not members of the Group as follows:

- ICB Chief Delivery Officer
- ICB Chief Medical Officer
- ICB Chief Nursing Officer
- ICB Chief Strategy Officer
- Director of Hospital Transformation Programme - SaTH

4.2.2 Additional attendees who are senior managers who support SROs and lead on the programme areas at the discretion of the Chair, shall be invited as required at the discretion of the Chair.

4.3 Chair and Vice Chair

4.3.1 The Group will be chaired by the NHS STW Chief Executive Officer.

4.3.2 The Vice Chair of the Group shall be NHS STW Chief Finance Officer.

4.3.3 If the Chair and Vice Chair are unavailable, Group members may appoint at the beginning of the meeting a temporary Chair from the voting members of the Group who is qualified and appropriate to lead the meeting in the absence of the Chair and Vice Chair.

4.3.4 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference.

4.4 Attendance

4.4.1 Where an attendee of the Group (who is not a member of the Group) is unable to attend a meeting, a suitable deputy may be agreed with the Chair.

## 5. Meetings, quoracy and decisions

### 5.1 Meetings

5.1.1 The Group will meet in person, however where this is not possible the Group will meet remotely and members attending using electronic means will be counted towards the quorum.

5.1.2 Meetings will take place in private.

5.1.3 The Group shall meet a minimum of four times per year, but with the expectation that meetings occur monthly except for August and December.

5.1.4 Arrangements and notice for calling meetings are set out in the Standing Orders.

5.1.5 Additional meetings may take place as required; The Board, Chair or Chief Executive may ask the Group to convene further meetings to discuss particular issues on which they want the Group's advice.

### 5.2 Quorum

5.2.1 For a meeting to be quorate a minimum of 50% members is required, including either the Chair or Vice Chair or the deputy chair where this has been agreed with the Chair and the members of the meeting.

5.2.2 If any member of the Group has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

5.2.3 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

5.2.4 Decisions deemed by the Chair to be 'urgent' can be taken outside of the meeting via email communication, and with the agreement of a quorate number of members. Any such decisions must be reported to the next scheduled meeting.

### 5.3 Decision-making and voting

5.3.1 Decisions will be taken in accordance with the standing orders.

5.3.2 The expectation is that the Group shall ordinarily reach conclusion by consensus when making decisions

5.3.3 If consensus cannot be achieved each member may cast a vote

5.3.4 Only members of the Group may vote. Each member is allowed one vote and a majority will be conclusive on any matters.

5.3.5 If a majority cannot be reached by voting, the Chair shall have a second, deciding vote.

5.3.6 The Group may resolve to hold a meeting in confidential private session where;

- it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or
- voting members and non-voting attendees of the Group have conflicts of interest with items on the agenda such, that they would be required to absent themselves from the meeting.

Where items are discussed in private confidential session a separate agenda with papers and minutes will be created. Distribution of agenda, papers and minutes will be limited to those that are voting members with no conflicts of interest and those specifically invited attendees which will be agreed with the Chair.

## 6 Responsibilities of the Group

6.1 Development and implementation of the STW ICS Transformation Programmes, the Financial Improvement Programme & Enabling Workstreams

6.1.1 The purpose of the Group is to provide oversight of and support to the development and delivery of the STW ICS Sustainability Transformation Programmes and Financial Improvement Programme to:

6.1.2 Ensure that they achieve the financial and quality outcomes expected within time and budgetary constraints

6.1.3 Monitor key risks and ensure that appropriate mitigating action is in place and achieving desired impact

6.1.4 Review and resolve escalated issues as required

6.1.5 Ensure sufficient resources are allocated including across enabling activities

6.1.6 Identify and monitor interdependencies to ensure effective management including:

- Interdependencies with other System-wide or organisation-specific transformation programmes

- Dependencies on enabling workstreams

6.1.7 Ensure that the programmes remain aligned to Joint Forward Plan and other System strategies as they emerge inc. the financial strategy and the clinical strategy and that programmes support delivery of the ten System pledges

6.1.8 Oversight of interdependencies with the STW ICS operational groups specifically in relation to the System Transformation programmes through receipt of chair reports and escalated risks and issues

6.1.9 Oversight of enabling groups and workstreams that contribute to the Transformation programmes and upon which the programmes are dependent to achieve the required outcomes

6.1.10 Ensure delivery plans are developed that achieve accelerated implementation

6.1.11 Development of a collective approach to delivery of transformation priorities, reframing the deliverables, impact evaluation and accountabilities

6.2 Monitor delivery of Financial Efficiency Programme

6.2.1 Oversight of the Efficiency Programme to ensure alignment with the Sustainability Transformation Programmes

6.2.2 Oversight of the Investment Panel to ensure that investment decisions remain aligned to the Financial Strategy and meet the requirements of the national Recovery Support Programme

6.3 Delegated Assurance Activity

6.3.1 The Group will provide oversight and assurance of any other activity delegated to it by NHS STW or, at the discretion of the Chair, at the request of any system member organisation.

## 7 Behaviours and conduct

7.1 ICB Values

7.1.1 Members will be expected to conduct business in line with NHS STW values and objectives.

7.1.2 Members of, and those attending, the Group shall behave in accordance with NHS STW's Constitution, Standing Orders, Conflicts of Interest Policy and Standards of Business Conduct Policy.

7.2 Conflicts of interest

7.2.1 In discharging duties transparently, conflicts of interest must be considered, recorded and managed.

7.2.2 Members should have regard to both the ICB's policies and national guidance on managing conflicts of interest.

7.2.3 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.

7.3 Equality and Diversity

7.3.1 Members must demonstrably consider the equality and diversity implications of decisions they make.

## 8 Accountability and reporting

8.1 Reporting

8.1.1 The Group shall report to the Integrated Care Board on how it discharges its responsibilities.

8.1.2 The minutes of the meeting shall be formally recorded by the secretary and submitted to the Board in accordance with the Standing Orders.

8.1.3 The Chair will provide assurance reports to the Board at each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

8.2 Accountability

8.2.1 The Group is accountable to the Integrated Care Board.

## 9. Secretariat and administration

9.1 Agenda and Papers

9.1.1 The agenda for each meeting shall be approved by the Chair.

9.1.2 Final agendas and relevant papers will be circulated electronically to members in advance of each meeting.

9.2 Secretariat

9.2.1 The production of papers, agendas and minutes shall be supported by a secretariat function provided by the STW ICS

9.2.2 The secretariat function will ensure that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead
- Attendance of those invited to each meeting is monitored and that meetings that do not meet minimum requirements are highlighted to the Chair
- Records of members' appointments and renewal dates are maintained and that the Board is prompted to renew membership and identify new members where necessary
- Good quality minutes are taken in accordance with the standing orders and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept
- The Chair is supported to prepare and deliver reports to the Board
- The Group is updated on pertinent issues/ areas of interest/ policy developments
- Action points are taken forward between meetings and progress against those actions is monitored.

## 10.Review

10.1 The Group will review its effectiveness at least annually.

10..2 These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to NHS STW for approval.

## 2. Scheme of Reservation and Delegation (SoRD)

**Key:**

CEO – Chief Executive
CFO – Chief Finance Officer
CMO – Chief Medical Officer
CNO – Chief Nurse Officer
CDO – Chief Delivery Officer
CSO – Chief Strategy Officer
CPO – Chief People Officer

### NHS Shropshire, Telford and Wrekin - Scheme of Reservation and Delegation

| Decision / Function | Delegation | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Reserved by the Board | Committee | Chair | CEO | Director | Joint Committees | Other Statutory Committees | PLACE based / Provider Collaborative committees |
| **1. STRATEGY AND PLANNING** | | | | | | | | |
| Agree the vision and values of the ICS | ✓ | | | | | | | |
| Approve the overall strategic direction of the ICS | ✓ | | | | | | | |
| Develop an integrated care strategy to inform the strategic direction of the ICS. | | | | | | ICP | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Recommend the overall strategic direction of the ICS to the Board | | **Strategic Commissioning Committee** | | | | | | |
| Approval of the consultation arrangements for the commissioning plan. | | **Strategic Commissioning Committee** | | | | | | |
| Approve the commissioning plan. | ✓ | | | | | | | |
| Recommend the commissioning plan to the board | | **Strategic Commissioning Committee** | | | | | | |
| Approve any revisions to Commissioning plans | | **Strategic Commissioning Committee** | | | | | | |
| Approval of the ICS operating structure. | ✓ | | | | | | | |
| Recommend for approval to the Board key clinical and non clinical strategies to support the arrangements for discharging the statutory duties associated with its clinical and non-clinical commissioning functions. | | **Strategic Commissioning Committee** | | | | | | |
| Approval of key strategies | ✓ | | | | | | | |
| Agree a plan to meet the health and healthcare needs of the population, having regard to the Partnership integrated care strategy and place health and wellbeing strategies. | ✓ | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Agree a plan to meet the health and healthcare needs of the population within each place, having regard to the Partnership Integrated Care Strategy and respective Local Authority Health and wellbeing Strategies | ✓ | | | | | | | |
| Recommend allocation of strategic resources to deliver the plan across the system determining what resources should be available to meet population need in each place and setting principles for how they should be allocated across services and providers (both revenue and capital) | | Finance Committee | | | | | | |
| Allocate resources to deliver the plan across the **system** determining what resources should be available to meet population need in each place and setting principles for how they should be allocated across services and providers (both revenue and capital) | ✓ | | | | | | | |
| Allocate resources to deliver the plan in each **place**, determining what resources should be available to meet population need and setting principles for how they should be allocated across services and providers (both revenue and capital) | ✓ | | | | | | | |
| Arrange for the provision of health services in line with the allocated resources across the ICS | ✓ | | | | | | | |
| **2. CONSTITUTION AND GOVERNANCE** | | | | | | | | |
| Establish and approve terms of reference and membership for ICB Committees and groups that report into the Board | ✓ | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Approve NHS STW scheme of reservation and delegation (SoRD) which sets out those decisions reserved to the Board, committees and sub-committees, groups, individuals or specified persons | ✓ | | | | | | | |
| Approve NHS STW financial scheme of delegation, which sets out those key operational decisions delegated to individuals or specified persons | ✓ | | | | | | | |
| Agree any functions delegated to other statutory bodies | ✓ | | | | | | | |
| Establish joint working arrangements with partners that embed collaboration as the basis for delivery within the plan. | ✓ | | | | | | | |
| Establish governance arrangements to support collective accountability between partner organisations for place-based system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations | ✓ | | | | | | | |
| Exercise or delegate those functions of NHS STW which have not been retained as reserved by NHS STW Board or delegated to its Committees and sub-committees or delegated to named other individuals as set out in this document | | | | ✓ | | | | |
| Approve the arrangements for discharging NHS STW's functions to have regard to and act in a way that promotes the NHS Constitution | | | | ✓ | | | | |
| Approve the arrangements for discharging NHS STW's functions to exercise its functions effectively, efficiently and economically | | | | ✓ | | | | |
| Approve the arrangements for discharging NHS STW's functions in relation to children including safeguarding and promoting welfare | | | | | CNO | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Approve the arrangements for discharging NHS STW's functions in relation to Equality, including the public-sector equality duty | | | | | CNO | | | |
| Approve the arrangements for discharging NHS STW's functions in relation to Information law | | | | ✓ | | | | |
| Approve the arrangements for discharging NHS STW's functions under the Civil Contingencies Act 2004 | | | | ✓ | | | | |
| Approve the arrangements for discharging NHS STW's functions to secure improvement in quality of services | | | | | CNO | | | |
| Approve system-level arrangements to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes | | | | | CMO | | | |
| Approve the arrangements for discharging NHS STW's functions to reduce inequalities | | | | | CSO | | | |
| Approve the arrangements for discharging NHS STW's functions to obtain appropriate advice from Directors of Public Health | | | | | CSO | | | |
| Approve the arrangements for discharging NHS STW's functions to regard to effect of decisions | ✓ | | | | | | | |
| Approve the arrangements for discharging NHS STW's functions relating to Public involvement and consultation | | | | ✓ | | | | |
| Approve the arrangements for discharging NHS STW's functions to have regard to assessments and strategies | | | | | CNO | | | |
| Approve arrangements for complying with the NHS Provider Selection Regime | ✓ | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Agree implementation in Place of the arrangements for complying with the NHS Provider Selection Regime. | ✓ | | | | | | | |
| Approval of the annual report and annual accounts. | ✓ | | | | | | | |
| Recommend the annual report and accounts for approval to the Board | | Audit Committee | | | | | | |
| Approve the arrangements for discharging the statutory financial duties | | | | | CFO | | | |
| Approve the arrangements for discharging the statutory health and safety duties as an employer. | | | | | CPO | | | |
| Preparation of proposed amendments to the constitution and standing orders | | | | ✓ | | | | |
| Approval to submit proposed amendments to the constitution and standing orders to NHS England for final approval | ✓ | | | | | | | |
| Preparation of proposed amendments to the Governance Handbook | | | | ✓ | | | | |
| Approval of proposed amendments to the Governance Handbook | ✓ | | | | | | | |
| Approval of the arrangements, policies and procedures, for the management of conflicts of interest (contained in the Governance Handbook) | ✓ | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Propose changes to terms of reference for the committees | | All Committees as required | | | | All, as required | | |
| Propose changes to terms of reference for the sub-committees | | All Sub committees as required | | | | All, as required | | |
| Approve the appointment of the Deputy Chair of NHS STW from amongst the Non Executive Directors except for the Audit Committee Chair. | ✓ | | | | | | | |
| Approve changes to terms of reference for committees | ✓ | | | | | | | |
| Approve changes to terms of reference for sub committees, groups and task and finish groups | | Parent Committee | | | | | | |
| Approve membership of committees | | | ✓ | | | | | |
| Approve membership of sub committees | | | ✓ | | | | | |
| Approve arrangements and appointments of Board membership | | | ✓ | | | | | |
| Prepare the scheme of reservation and delegation contained in the Governance Handbook | | | | ✓ | | | | |
| Discharge an urgent decision where a meeting of NHS STW cannot be convened consulting with as many members as possible given the circumstances | | | ✓ | ✓ | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Approve (including any changes) the scheme of reservation and delegation contained in the Governance Handbook | ✓ | | | | | | | |
| Execute a document by signature/use of seal | | | ✓ | ✓ | CFO | | | |
| Approval of changes to the provision or delivery of audit assurance services to the Board | ✓ | | | | | | | |
| Propose changes to the provision or delivery of audit assurance services to the Board | | Auditor Panel | | | | | | |
| Approve proposals for action on litigation against or on behalf of the Board | | | | ✓ | CFO, CNO, CMO, CDO, CSO | | | |
| Responsibility for overseeing discharge of statutory responsibilities in relation to safeguarding | | Quality and Performance Committee | | | | | | |
| Receive and approve annual internal and external audit plans | | Audit Committee | | | | | | |
| Receive and approve internal and external audit reports and recommendations | | Audit Committee | | | | | | |
| | | Audit Committee | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Approve NHS STW's policy management arrangements and oversight, including the policy on the management of policies, supporting plans, policies and procedures. | | | | | | | | |
| **3. FINANCE. CONTRACTING AND PROCUREMENT** | | | | | | | | |
| Preparation of Finance policies and Procedures | | | | | CFO | | | |
| Approval of Finance Policies and Procedures | | Finance Committee | | | | | | |
| Development of Standing financial instructions | | | | | CFO | | | |
| Approval of Standing Financial Instructions as part of the Governance Handbook | ✓ | | | | | | | |
| Determine the strategic financial framework of NHS STW and monitor performance against | | Finance Committee | | | | | | |
| Develop an approach to distribute the resource allocation through commissioning and direct allocation to drive agreed change based on NHS STW strategy | | Finance Committee | | | | | | |
| Approve an approach to distribute the resource allocation through commissioning and direct allocation to drive agreed change based on NHS STW strategy | ✓ | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Develop a medium- and long-term financial plan for recommendation to the Board which demonstrates ongoing value and recovery | | Finance Committee | | | | | | |
| Approve a medium- and long-term financial plan | ✓ | | | | | | | |
| Oversee the management of the system financial target and NHS STW 's own financial targets against the Finance Plan | | Finance Committee | | | | | | |
| Develop a system finance staff development strategy | | | | | CFO | | | |
| Approve a system finance staff development strategy | | Finance Committee | | | | | | |
| Monitor arrangements for risk sharing and or risk pooling with other organisations (for example arrangements for pooled funds with other Group's or pooled budget arrangements under section 75 of the NHS Act 2006). | | Finance Committee | | | | | | |
| Approve arrangements for managing exceptional funding requests. | | **Strategic Commissioning Committee** | | | | | | |
| Approve exceptional individual funding requests | | Individual Funding Request Panel | | | | | | |
| Determine whether proper process has been followed by the Individual Funding Panel when considering an individual funding request. | | Individual Funding Request Appeal Panel | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Approval of the banking arrangements | | | | | CFO | | | |
| Approve the counter fraud and security management arrangements, including supporting plans, policies and procedures | | Audit Committee | | | | | | |
| Approval of contracts/contract variations for any healthcare services within approved budgets to include GMS, PMS and APMS under delegation from NHS England | | **Strategic Commissioning Committee** | | | | | | |
| Approval of non-healthcare contracts outside approved budgets. | | | | ✓ | Or CFO | | | |
| Approval of non-healthcare contracts within approved budgets. | | As per budget holder delegation outlined in the Standing Financial Instructions | | | | | | |
| Recommend approval of healthcare contracts outside approved budgets. | | Finance Committee | | | | | | |
| Approval of healthcare contracts outside approved budgets. | ✓ | | | | | | | |
| To approve, that NHS STW proceeds to procurement for healthcare services which will include the approval of the timeline for procurement, the proposal for procurement and the service specification. | | **Strategic Commissioning Committee** | | | | | | |
| To approve the award of healthcare services procurement. | | **Strategic Commissioning Committee** | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| To approve the extension of a non-healthcare contract, where provision for an extension has been made within the contract terms. | | | | ✓ | or one of: CFO, CMO, CNO, ED CDO, CSO | | | |
| To approve the extension of a healthcare contract, where provision for an extension has been made within the contract terms. | | **Strategic Commissioning Committee** | | | | | | |
| To approve procurement for non-healthcare services which will include the approval of the timeline for procurement, the proposal for procurement and the service specification. | | | | ✓ | Or one of: CFO, CMO, CNO, CDO, CSOI | | | |
| To approve the award of non-healthcare services procurement within approved budgets. | | | | ✓ | Or one of: CFO, CMO, CNO, CDO, CSO | | | |
| Approval of tenders and contracts | In line with financial limits set within Standing Financial Instructions | | | | | | | |
| **4. COMMISSIONING** | | | | | | | | |
| Approve the policies and procedures to support the arrangements for discharging the statutory duties associated with its clinical and non-clinical commissioning functions. | | **Strategic Commissioning Committee** | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Developing a plan to meet the health and healthcare needs of the population (all ages) within NHS STW area having regard to the Integrated Care strategy | | **Strategic Commissioning Committee** | | | | | | |
| Establishing joint working arrangements with partners that embed collaboration as the basis for delivery within the plan. | ✓ | | | | | | | |
| Arranging for the provision of health services in line with allocated resources across the ICS by putting contracts and agreements in place to secure delivery of its plan by providers | | **Strategic Commissioning Committee** | | | | | | |
| Arranging for the provision of health services in line with allocated resources across the ICS by supporting the development of primary care networks (PCNs) as the foundations of out of hospital care and building blocks of place based partnerships including through investment in PCN management support, data and digital capabilities, workforce development and estates | | **Strategic Commissioning Committee** | | | | | | |
| Arranging for the provision of health services in line with allocated resources across the ICS by working with local authority and voluntary, community and social enterprise (VCSE) sector partners to put in place personalised care for people, including assessment and provision of continuing healthcare and funded nursing care and agreeing personal health budgets and direct payments for care. | | **Strategic Commissioning Committee** | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Leading system wide action on data and digital: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services to put the citizen at the centre of their care | | **Strategic Commissioning Committee** | | | | | | |
| Using joined up data and digital capabilities to understand local priorities, track delivery of plans, monitor and address unwarranted variation, health inequalities and drive continuous improvement in performance and outcomes | | **Strategic Commissioning Committee** | | | | | | |
| Through joint working between health, social care and other partners including police, housing, safeguarding partnerships, employment and welfare services, ensuring that the NHS plays a full part in achieving wider goals of social and economic development and environmental sustainability | ✓ | | | | | | | |
| Driving joint work on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support wider goals of development and sustainability. | | **Strategic Commissioning Committee** | | | | | | |
| Planning for, responding to and leading recovery from incidents (EPRR) to ensure the NHS and partner organisations are joined up at times of greatest need, including taking on incident co-ordination responsibilities as delegated by NHS England | | | | ✓ | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Approval of delegated responsibilities by NHS England in relation to specialised commissioning | | | | | | Joint West Midlands NHS Delegated Commissioning Committee | | |
| Preparing a performance assurance framework (PAF) | | Quality and Performance Committee | | | | | | |
| Approving a performance assurance framework (PAF) | ✓ | | | | | | | |
| **5. PEOPLE** | | | | | | | | |
| Develop ICS System People Plan | | ICS People, Culture and Inclusion Committee | | | | | | |
| Approval of ICS System People Plan | ✓ | | | | | | | |
| Leading system implementation of people priorities including delivery of people plan and People Promise by aligning partners across the ICS to develop and support "one workforce" including through closer collaboration across the health and care sector with local government the voluntary and community sector and volunteers. | | ICS People, Culture and Inclusion Committee | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Approval of arrangements to discharge the ICB's People /HR and Equality, Diversity and Inclusion responsibilities as an employer; | | | | ICB Executive Group | | | |
| Approval of arrangements to discharge the ICB's Equality, Diversity and Inclusion responsibilities as an employer | | | | ICB Executive Group | | | |
| Approval of arrangements to discharge the ICB's Health and Safety responsibilities as an employer; | | | | ICB Executive Group | | | |
| Preparation of HR systems, policies and procedures to support the arrangements for discharging the statutory duties of NHS STW as an employer. | | | | CPO | | | |
| Preparation of Equality, Diversity and Inclusion systems, policies and procedures to support the arrangements for discharging the statutory duties of NHS STW as an employer. | | | | CPO | | | |
| Preparation of Health and Safety systems, policies and procedures to support the arrangements for discharging the statutory duties of NHS STW as an employer. | | | ✓ | | | | |
| Approve the policies and procedures to support the arrangements for discharging the statutory duties of NHS STW as an employer to include but not limited to:<br>• HR/People Equality,<br>• Diversity and Inclusion and<br>• Health and Safety. | | | | ICB Executive Group | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Approve the annual evidence submissions on behalf of the Board for:<br>• Equality Delivery System 2 (EDS2)<br>• Workforce Race Equality Standard (WRES)<br>• Workforce Disability Equality Standard (WDES) | | | | | ICB Executive Group | | | |
| Recommend the terms and conditions, remuneration and travelling or other allowances, including pensions and gratuities of staff on agenda for change. | | | | ✓ | CPO | | | |
| Approve the terms and conditions, remuneration and travelling or other allowances, including pensions and gratuities of staff on agenda for change. | | Remuneration Committee | | | | | | |
| Recommend pensions, remuneration, fees and allowances payable to employees and to other persons providing services to NHS STW not covered by Agenda for Change. | | | ✓ | ✓ | CPO | | | |
| Approve pensions, remuneration, fees and allowances payable to employees and to other persons providing services to NHS STW not covered by Agenda for Change. | | Remuneration Committee | | | | | | |
| Recommend the financial arrangements for termination of employment, including the terms of any compensation packages and other contractual terms, excluding ill health and normal retirement, for all employees | | | ✓ | ✓ | CPO | | | |
| Approve the financial arrangements for termination of employment, including the terms of any compensation | | Remuneration Committee | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| packages and other contractual terms, excluding ill health and normal retirement, for all employees | | | | | | | | |
| Recommend the business cases for staff who wish to retire and then return to employment that have been considered and recommended by the Executive team. | | | | ✓ | CPO | | | |
| Approve business cases for staff who wish to retire and return to employment | | Remuneration Committee | | | | | | |
| Recommend disciplinary arrangements for employees, including the Executive Officers and for other persons working on behalf of NHS STW | | | | ✓ | CPO | | | |
| Approve disciplinary arrangements for employees, including the Executive Officers and for other persons working on behalf of NHS STW | ✓ | | | | | | | |
| **6. QUALITY AND SAFETY** | | | | | | | | |
| Approve arrangements, including supporting strategies and plans, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes. | | Quality and Performance Committee | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Approve arrangements for supporting NHS England in discharging its responsibilities in relation to securing continuous improvement in the quality of general medical services. | | **Quality and Performance Committee** | | | | | | |
| Preparation the Quality Strategy | | Quality and Performance Committee | | | | | | |
| Approve the policies and procedures to support the arrangements for discharging the statutory duties associated with and including, but not limited to; quality, safety, safeguarding and IPC | | Quality and Performance Committee | | | | | | |
| Approval of the Quality Strategy | ✓ | | | | | | | |
| Oversee the implementation of the Quality Strategy | | Quality and Performance Committee | | | | | | |
| Oversee the effective reporting and learning from safety incidents | | Quality and Performance Committee | | | | | | |
| Monitor feedback from compliments and complaints and provide assurance to the Board regarding their timely management | | Quality and Performance Committee | | | | | | |
| **7. RISK MANAGEMENT** | | | | | | | | |
| Prepare the arrangements, policies and procedures in relation to risk management | | | | | CEO | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Approve the arrangements, policies and procedures in relation to risk management | | Audit Committee | | | | | | |
| Approval of the risk appetite of the ICS/ICB | ✓ | | | | | | | |
| Approve arrangements for risk sharing and or risk pooling with other organisations (for example arrangements for pooled funds with other Group's or pooled budget arrangements under section 75 of the NHS Act 2006). | ✓ | | | | | | | |
| Approve a comprehensive system of internal control, including budgetary control, which underpins the effective, efficient and economic operation of the ICS | | Audit Committee | | | | | | |
| Approve the arrangements, including supporting plans, policies and procedures for business continuity and EPRR. | | Audit Committee | | | | | | |
| Approve the use of resources out of hours for exceptional circumstances and limited to situations of necessity | | | | | Director on Call | | | |
| **8. INFORMATION GOVERNANCE** | | | | | | | | |
| Develop arrangements, including supporting policies and procedures, for handling Freedom of Information requests. | | | | | CEO | | | |
| Approve arrangements, including supporting policies and procedures, for handling Freedom of Information requests. | | Audit Committee | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Recommend arrangements, including supporting policies and procedures for ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data. | | | | | CEO | | | |
| Approval of arrangements, including supporting policies and procedures for ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data. | | Audit Committee | | | | | | |
| Oversee the management of IG breaches and the reporting of IG Breaches, where appropriate, to the ICO | | | | | CFO (as SIRO) | | | |
| **9. PARTNERSHIP WORKING** | | | | | | | | |
| To the extent permitted by law, authority to enter into arrangements with one or more relevant Local Authority in respect of:<br>• delegating specified commissioning functions to the Local Authority;<br>• exercising specified commissioning functions jointly with the Local Authority;<br>• exercising any specified health-related functions on behalf of the Local Authority. | ✓ | | | | | | | |
| Agree formal and legal arrangements to make payments to, or receive payments from, a Local Authority or pool funds for the purpose of joint commissioning. | ✓ | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| For the purposes of collaborative commissioning arrangements with a Local Authority, make the services of its employees or any other resources available to the Local Authority; and receive the services of the employees or the resources from the Local Authority. | ✓ | | | | | | | |
| For the purposes of joint commissioning arrangements with other ICSs, to<br>• delegate any of the ICSs commissioning functions to another ICS<br>• exercise any of the Commissioning Functions of another ICS; or<br>• exercise jointly the Commissioning Functions of the ICS and another ICS;<br><br>and for the purposes of the above; to:<br>• make payments to, or receive payments from, another ICS; or<br>• make the services of its employees or any other resources available to another ICS; or<br>• receive the services of the employees or the resources available to another ICS. | ✓ | | | | | | | |
| For the purposes of joint commissioning arrangements with other ICSs, to establish and maintain a pooled fund made up of contributions by all of the ICSs working together jointly. | ✓ | | | | | | | |
| Approve decisions that individual members or employees participating in joint arrangements can take. Such delegated decisions must be disclosed in this scheme of reservation and delegation. | ✓ | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Authority to enter into strategic or other transformation discussions with its partner organisations | ✓ | | | | | | | |
| **10. DELEGATED FUNCTIONS RELATED TO THE COMMISSIONING OF PRIMARY MEDICAL SERVICES UNDER SECTION 83 OF THE NHS ACT** | | | | | | | | |
| Discharge of the delegated commissioning by NHS England of primary care commissioning in accordance with section 65Z5 of the NHS Act and as outlined in the NHSE delegation agreement dated March 2023 where this relates to the planning, design and commissioning of services. | | **Strategic Commissioning Committee** | | | | | | |
| Decisions in relation to the commissioning and management of Primary Medical Services; | | **Strategic Commissioning Committee** | | | | | | |
| Planning Primary Medical Care Services in the Area | | **Strategic Commissioning Committee** | | | | | | |
| Undertaking reviews of Primary Medical Care Services in respect of the Area; | | **Strategic Commissioning Committee** | | | | | | |
| Approval of budget and plan for management of the Delegated Funds in the Area and management of Delegated Funds outside of approved budget; | | **Strategic Commissioning Committee** | | | | | | |
| Management of the Delegated Funds in the Area within approved budget and plan. | | **Primary Access and Transformation Group** | | | | | | |
| Co-ordinating a common approach to the commissioning and delivery of Primary Medical Care Services with other health and social care bodies in respect of the Area where appropriate; and | | **Strategic Commissioning Committee** | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Such other ancillary activities that are necessary in order to exercise the Delegated Functions. | | **Strategic Commissioning Committee** | | | | | | |
| **11. DELEGATED FUNCTIONS TO THE WEST MIDLANDS ICBs JOINT COMMITTEE** | | | | | | | | |
| The ICB's Chief Executive Officer or their designated representative where they are unable to attend, has full authority to act on behalf of the ICB within the delegation outlined in this section below at the West Midlands ICBs Joint Committee. | | The West Midlands ICBs Joint Committee | | ✓ | | | | |
| Discharge of the delegated commissioning by NHS England of primary care commissioning in accordance with section 65Z5 of the NHS Act and as outlined in the NHSE delegation agreement dated March 2023, schedule 4 and in the Schedule of Services in the Agreement in relation to the establishment and operation of the joint working arrangements - Tier One Joint Committee West Midlands:<br><br>Decisions in relation to the commissioning and management of:<br>a) Primary Prescribed Community Dental Services<br>b) Primary Prescribed Community Pharmaceutical Services; and<br>c) Primary Ophthalmic Services. | | The West Midlands ICBs Joint Committee | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Primary Prescribed Community Dental Services:<br><br>• Decisions in relation to the commissioning and management of Primary Prescribed Community Dental Services;<br>• Planning Primary Prescribed Community Dental Care Services in the Area, including carrying out needs assessments;<br>• Undertaking reviews of Primary Prescribed Community Dental Care Services in respect of the Area;<br>• Management of the Delegated Funds in the Area;<br>• Co-ordinating a common approach to the commissioning and delivery of Primary Prescribed Community Dental Care Services with other health and social care bodies in respect of the Area where appropriate; and<br>• Such other ancillary activities that are necessary in order to exercise the Delegated Functions. | | The West Midlands ICBs Joint Committee | | | | | | |
| Primary Prescribed Community Pharmaceutical Services:<br>• Decisions in relation to the commissioning and management of Primary Prescribed Community Pharmaceutical Services;<br>• Planning Primary Prescribed Community Pharmaceutical Services in the Area, including carrying out needs assessments;<br>• Undertaking reviews of Primary Prescribed Community Pharmaceutical Services in respect of the Area; | | The West Midlands ICBs Joint Committee | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| • Management of the Delegated Funds in the Area;<br>• Co-ordinating a common approach to the commissioning and delivery of Primary Prescribed Community Pharmaceutical Services with other health and social care bodies in respect of the Area where appropriate; and<br>• Such other ancillary activities that are necessary in order to exercise the Delegated Functions. | | | | | | | | |
| Primary Ophthalmic Services<br>• Decisions in relation to the commissioning and management of Primary Ophthalmic Services;<br>• Planning Primary Ophthalmic Services in the Area, including carrying out needs assessments;<br>• Undertaking reviews of Primary Ophthalmic Services in respect of the Area;<br>• Management of the Delegated Funds in the Area;<br>• Co-ordinating a common approach to the commissioning and delivery of Primary Ophthalmic Care Services with other health and social care bodies in respect of the Area where appropriate; and<br>• Such other ancillary activities that are necessary in order to exercise the Delegated Functions. | | The West Midlands ICBs Joint Committee | | | | | | |
| NHS England delegates to the ICB the statutory function for commissioning the **Specialised Services** in delegation agreement dated 31st March 2024 and set out in the Schedule 2 (*Delegated Services*) subject to the reservations set out in Schedule 4 (*Retained Functions*) and the provisions of any Developmental Arrangements set out in Schedule 9. | | The West Midlands ICBs Joint Committee | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 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:<br><br>• decisions in relation to the commissioning and management of Delegated Services;<br>• planning Delegated Services for the Population, including carrying out needs assessments;<br>• undertaking reviews of Delegated Services in respect of the Population;<br>• supporting the management of the Specialised Commissioning Budget;<br>• 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<br>• such other ancillary activities that are necessary to exercise the Specialised Commissioning Functions. | | | | | | | | |
| Provision of a forum for collective discussion, agreement and decisions by the constituent members of the committee that is consistent with the delegated limits of each ICB's standing financial orders. So enabling the ICBs to collaborate on areas of work and opportunities that arise. | | The West Midlands ICBs Joint Committee | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Determination of the most appropriate commissioning governance and operation arrangements for any functions and services delegated to the committee by the six ICBs. | | The West Midlands ICBs Joint Committee | | | | | | |
| Determination of the most appropriate working group arrangements, reporting into the joint committee to enable the efficient and effective operation of the responsibilities that have been delegated to the committee by the six ICBs. | | The West Midlands ICBs Joint Committee | | | | | | |

Agenda Item

ICB 24-04-037.1

Quality & Performance Committee

Minutes of meeting held on 29 February 2024

**NHS Shropshire Telford and Wrekin**
**ICS Quality & Performance Committee Meeting**

**Thursday, 29th February, 2024**

Via Microsoft Teams

**Present:**

| | |
|---|---|
| Meredith Vivian | Chair & Non-Executive Director, NHS STW |
| Vanessa Whatley | Interim Chief Nursing Officer& Director of Quality and Safety/Deputy Chief Nurse, NHS STW |
| Julie Garside | Director of Performance and Delivery, NHS STW |
| Rosi Edwards | Non-Executive Director, SaTH |
| Jill Barker | Associate Non-Executive Director, SCHT |
| Sara Reeve | Deputy Director of Quality, MPFT |
| Maria Arthur | Group Deputy Director of Assurance, Walsall & Wolverhampton NHS Trust |
| Liz Noakes | Director of Public Health, Telford Local Authority |

**Attendees:**

| | |
|---|---|
| Sara Ellis-Anderson | Deputy Director of Nursing – Quality & Deputy DIPC – deputising for Clair Hobbs |
| Sara Bailey | Deputy Chief Nurse, SaTH – Representing Hayley Flavell, Director of Nursing. |
| Sam Cook | Deputy Director of Performance NHS STW |
| Sue Bull | STW local maternity and neonatal system programme manager |
| Maureen Wain | STW _ Director of Elective Care |
| Fiona Smith | STW Transformation & Commissioning Partner - Community |
| Lisa Rowley | PA to CNO, note taker, NHS STW |

**1.0 Minute No. QPC-24-02.17- Welcome/Apologies by: Meredith Vivian**

1.1 The Chair of the Committee welcomed members and attendees to the meeting and introductions were made.

**2.0 Minute No. QPC-24.02.18 Apologies:**

Anne Maclachlan, Clinical & Care Director MPFT - Sara Reeve representing
Liz Lockett - Sara Reeve Representing
Dr Ganesh - Shropcom
Clair Hobbs - Shropcom
Ruth Longfellow - RJAH
Tracey Slater - STW
Hayley Flavell - SaTH
Paul Kavanagh Fields - RJAH

DRAFT

## 3.0 QPC-24-02.19 - Members' Declarations of Interests

3.1 No new declarations of interest were noted.

## 4.0 Minute No. QPC-24-02.20- Minutes of Meeting held on 25th January 2024

4.1 The minutes of the meeting held on 25th January 3024 were reviewed and accepted as an accurate record of the meeting subject to the amendments advised by Meredith Vivian and Rosie Edwards. Meredith Vivian advised the note taker of amendments that were required to be made to the minutes via email. The minutes of 25th January have been updated to include Meredith Vivians and Rosi Edwards comments and have since been forwarded to the chair for approval and sign off.

## 5.0 Minute No. QPC-24-02.21 - Matters Arising and Action Log

5.1 Actions have been updated and are outlined on the action log.

## 6.0 Minute No QPC-24-02.22 – Performance Exception Report – Julie Garside

The report was taken as read and the following key points were highlighted:

6.1 Julie Garside informed the Committee that this would be Sam Cook's last QPC meeting. Sam Cook will be leaving the ICB on 20th March and wished to say a personal thank you to her for her leadership and support and her work in the development of the performance report.

6.2 Julie Garside drew the Committee's attention to the developments around the primary care reporting and in particular seeing evidence of impact and improvement as a result of the primary care access plans with improvement noted at practice visits around waiting times for patients who are ringing practices because of the improved telephony; however this will not be rolled out to all practices until the end of April 2024 due to the capacity of the telephony provider. Consideration is being given with regards to communication to patients and the public regarding the improvement in telephone access as a result of the roll out of digital telephony.

6.3 Lynn Cawley responded to the comments made about primary care and said that there is a myth out in public that no one can get an appointment in primary care and commented that it is how, as a system, this myth is corrected rather than being perpetuated.

6.4 Julie Garside responded that it would take time to change people's mindset about not being able to get appointments and it will take time to get the public's confidence back.

6.5 Julie Garside referred to urgent and emergency care and commented that the system has now been put into Tier one and the benefit of this has started to be felt. There is real support coming through now with GIRFT and also support in terms of project management support for SaTH around the improvement plans and associated projects. There is going to be a refresh in terms of the UEC improvement plan to reflect the Tier 1/GIRFT priorities.; There remains one positive that the initial time to assessment is still being maintained above the regional average. Improvements are being seen albeit gradual in most of the underlying flow measures, there has been a reduction in the number of patients with no criteria to reside (NCTR); and in the average length of stay on the NCTR list the data in the report is just above 3 days in February, and now it is closer to 2.5 days which needs to be maintained. There should also have been the benefit of the sub-acute with regard to the additional beds brought into the system in early January which are not yet manifesting into an improvement in the four-hour performance or in a reduction in the use of escalation capacity.

6.6 Julie Garside referred to patients in our Emergency departments for over 12 hours and ambulance delays. There are no signs of improvement here. The GIRFT and the Tier one support will help provide an understanding why the improvement in flow is not translating into the much-needed improvement in ED.

6.7 Cancer continues to do well. The faster diagnosis standard is continuing to be achieved. The 62 day backlog at the time of writing the report was slightly behind trajectory. This is now back on trajectory for achieving the backlog of 212 by the end of this year and is showing a sustainable improvement which needs to be closely monitored.

6.8 Julie Garside highlighted that the report included analysis about CHC and fast track, showing the distribution of how long fast track patients are waiting for packages. Julie commented that she would check if there is any benchmarking data available now that it is known what the distribution curve looks like as currently there is no comparative to other systems. Julie asked for comments from the Committee in terms of whether the analysis is sufficient and how assurance can be sought in terms of how this can be improved.

6.9 Julie Garside referred to the recommendations in the report asking for reassurance directly from MPFT regarding talking therapies. There has been a lot of challenges during the year in terms of capacity, coding and counting. The revised plan has been received and from the ICB's Commissioners perspective, here are concerns about being adrift of the revised plan. Julie said she thought it appropriate that assurance is sought why that is continuing however, it is known and expected that improvements will be made in the next year and asked how confidence can be gained going into 2024/2025.

6.10 Sara Reeve commented that she is not intimate with the detail and therefore could not provide assurance on behalf of MPFT . Sara suggested that she and Ann Maclachlan provides QPC with an update at the next meeting in March in terms of the detail and added that she is aware that it is being closely monitored and there are some improvements in some areas.

6.11 Meredith Vivian asked if the update could include something tangible, i.e., certain things that we know are going to happen and when they are going to happen so we can look back in a period of time and see that they have happened.

6.12 Sara Reeve pointed out that her assumption based on what she has heard is that assurance is not being received through the contracting performance route.

6.13 Julie Garside commented that she would be open to picking this issue up with Sara Reeve outside of the meeting regarding issues surrounding the talking therapies plan and added that the issues lie around the planning rather than the contractual performance.

6.14 Lynn Cawley made the following comments on the Performance Report and said that she appreciated how clear it was and felt that the glossary was so helpful in understanding the terminology that she has shared it with her Healthwatch colleagues. Lynn asked if there should be a box under each of the performance metrics outlining outcomes and impact as she felt that this would be helpful in understanding how all the work being done is making a difference.

6.15 Julie Garside responded that the intention is that the impact will start to feed through in the SPC and that the assurance matrix in the report shows failings and achievements and what is heading in the right direction. It is the intention that ultimately metrics are gathered in that bottom right hand corner which shows the real impact.

6.16 Sam Cook added that the ICB are trying to simplify a really complex set of work and what has been done with SPC is to make it a little more transparent. What can be done is to extend that so when actions are put in place that have made a difference, the SPC charts can be annotated to show at what point that happened. This is an evolving process where those SPC's will continue to be used to full effect and to document on the chart at what point changes have been made as it is important to know if something has been put in place that has delivered against the milestones but has not had the impact as expected.

6.17 Liz Noakes said that building on Lynn Cawley's comment she liked the format of the report and the grid at the beginning is helpful. Liz raised two points in relation to primary care and in particular primary care access and said she wanted to understand whether assurance can be given that the ICB is targeting the action to those practices that need it most and are those improving in terms of patient experience and access.

6.18 Julie Garside responded that the practices are being targeted in terms of those needing greatest levels if support to improve their access and patient experience. The primary care team have structured the follow up visits with the practices after receiving and signing off their access recovery plans and have targeted the practices that need the most support and require the greatest level of improvement.

6.19 Liz Noakes said that in future if the variation between practices and PCNs could be reported, perhaps a similar pattern would emerge and that in time a quality and an outcome

improvement that we can see happening within primary care will have an impact on population outcomes as part of secondary prevention.

6.20 Julie Garside said that she would feed Liz's comments back to the team to see how it could be developed.

6.21 Vanessa Whatley referred to the CHC and the fast track performance. CHC is on the risk register and there has been a big challenge to get that corrected and back on track and that is improving and commented that she is concerned that the fast track says because there are no performance issues, there are no actions being taken, however there is one patient that has waited 23 days to get onto fast track, and also it said it is measured by 1 to 0 to one day, and that 56% of patients have their fast track achieved in zero to 1 day, a proportion of these should be arranged within 4 hours. Actions being taken should be quality improvement ones. Vanessa said she would be happy to have a conversation with Brett Toro-Pearce regarding actions being taken.

6.22 Julie Garside said that she would feed Vanessa's comments back to the team. Julie suggested that it may be worth both her and Vanessa having a conversation with Brett to see how this can be supported as the CHC team are struggling with capacity and finding it hard to get through the backlog of getting cases seen.

6.23 Meredith Vivian referred to health checks for adults with severe mental illness and asked for reassurance that as the plan is not on trajectory whether will be sorted out before the end of March.

6.24 Julie Garside commented that only limited assurance could be given, and Primary Care has a commitment to get that fixed. However, the real solution is in the new process that has now been agreed to come in place from 1st April, which means that we will still rely on the practice in terms of entering information on a patient's record, but the whole process of calling the patient for the check and delivering all elements of the check will sit with MPFT going forward, whereas previously it was a hybrid model between Primary Care and MPFT which just added a level of complexity and issues. This was approved at the Commissioning Working Group meeting in January. There is confidence that the underlying process will start to improve considerably from April however, the performance will not be where it needs to be by the end of March 24. Performance will be monitored in the new year with the new process and the feedback that was provided to the Commissioning Working Group was that it would be a better joined up health assessment which would make it much easier for individuals and in that context it is hoped that a greater level of performance is achieved, ensuring individuals are receiving their health checks.

6.25 Sara Reeve added that the only additional assurance she could add is that this is one of the metrics that is closely scrutinised by their Trust Board which is also on their dashboard.

6.26 Meredith Vivian advised the Committee that he has approached the GP board to ask for a representative from a general practice to sit on the Quality and Performance Committee as general practice has a fundamental part to play in the successful delivery but unfortunately no-one is available. Meredith said that he would pursue this.

6.27 Vanessa Whatley commented that this was the discussion at the last terms of reference review.

The Committee:

- The Q&P Committee members noted the content of the report regarding performance of key metrics against national standards and local targets. Where performance falls short of national standards and locally agreed targets, the Committee is asked to note the actions being taken and that risks are being appropriately mitigated and provide the necessary assurance.
- Noted that the Performance 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 report presentation to ensure the report meets the needs of the Committee.

**7.0 <u>Minute No QPC-24-02.23 -</u> System Risk Register – Vanessa Whatley**

The paper was taken as read and the following points were highlighted: -

7.1 Meredith Vivian opened the discussion by referring to the Controls and assurance.

sections of the register and asked that those sections are started with brief sentences such as “no control over this; or there are no measures on this; or there is no assurance otherwise it just looks like a list of stuff. As there is a gap in assurance.

**Action : Vanessa Whatley to write to the risk owners asking them to review those columns specifically when they are doing their general monthly review because people need to take ownership of the risk updates**

.

7.2 Lynn Cawley referred to the ADHD risk and asked what the ADHD offer was supposed to be as it would be helpful to see where this risk sits.
Vanessa Whatley responded that she would need to go back to the specialists to obtain that information.

7.3 Vanessa Whatley referred to the paediatric risk and highlighted that between December 21 and March 23, there were six serious incidents reported in the system which related to paediatric deaths; partners were involved. One child was particularly primary care focused and that was an SI investigated by primary care. And then the other five were investigated by SaTH. In addition, three of the children had social care history, either been looked after children or on the child in need register, and saTH carried out a deep dive into those three which resulted in a thematic review. They all had RCA’s, and all had immediate actions, and longer term actions. The findings can be read in the thematic review along with previous CQC findings into paediatric care and other findings, particularly from the paediatric network and quality visits carried out All of those actions were put together, and a paediatric assurance group was commenced at SaTH which brought all of those together. They did not include the immediate actions because we confirmed that those were closed apart from a couple that were wrongly Badgeless; any outstanding actions were pulled together into that group and the group used a staff tried and tested methodology which looks at each action and then takes appropriate action. In addition, there was a rapid quality review in the system, which looks at wider actions involving social care colleagues, particularly with the looked after children element and also looked at things that NHS England were doing because clearly there is a real challenge in getting a paediatric rapid outreach team from Birmingham Children's to Telford in a timely way if they've got multiple calls from other trusts that are en route. There have been some delays in that. There is a regional review going on into what is provided at Birmingham children's and what is achievable because children's care has become more acute since the COVID years. This work is ongoing; contract measures have been signed off and recently finalised and these will fall into risk reporting The last case was in March 2023, so a year ago. The discussion at the System Quality Group was that on the frequency of the incident, This risk should reduced from 20, which is an extreme risk on our grid down to 15 because although the outcome would still be catastrophic, the frequency of it was far less likely now and the things that have affected that they have been clear actions around staffing; nurse staffing levels have improved in paediatrics and the Trust have doubled the on call Tier 2 Doctor. So instead of having one doctor out of hours, that covers neonatal unit, ED and paediatrics for and the paediatric inpatient areas, .therefore if a doctor gets caught up in an emergency C-section, there is still another doctor available, which had previously been a challenge. The other important action has been the introduction of the sepsis trusts paediatric sepsis tool, whereas previously it was an adult tool that was had been amended

to fit Paediatrics and therefore lots of the sections were not applicable which was confusing for staff. All of that education has been carried out and this is being monitored as part of those quality metrics going forward. There has been a lot of good, focussed work is being carried out in SaTH and in the wider learning. The work that came out of the GP audit was about improvements in communication and we know that as patients go to outpatients back out in the Community then to the ward, back out into the community. And sometimes children that have got asthma or epilepsy might do that several times a year.

7.4 SaTH also have plans to improve their observation in relation to their blood pressure, pulse, temperature, etc and they have also amended their documentation to listen more to parent's concerns which is important. A further review of this risk will be carried out in three months' time with the aim of reducing this risk further.

7.5 Liz Noakes commented that there are still high numbers of child mortality compared to previous years and said that in terms of child deaths, not necessary within SaTH but at a system level there are those higher-than-normal numbers and rates of child mortality.

7.6 Vanessa Whatley responded that quarterly child mortality workshops have been established which are focused on quality improvement projects; all the intelligence has not been brought together across Shropshire, Telford and Wrekin over a number of years. Data has been manipulated to ensure that useful data is collected because in the system there are approximately 40 child deaths a year which is not enough to get real themes and trends. National data has been looked in order to get better trends. As this risk reduces but does not completely go away as an action but it maybe referenced in a wider risk around child mortality in general in the system.

7.7 Meredith Vivian said he would like to see a little bit more about individual commissioning and he would like more focus on the CDIff risk.

The Committee:

- Discussed the risks for assurance of ongoing progress/action.
- Reviewed new risks for further assurance/information required.

**8.0 Minute No QPC-24-02.24 - System Quality Metrics – Vanessa Whatley**

The report was taken as read and the following points were highlighted:-

8.1 Vanessa Whatley highlighted that the metrics are based on the on the risks and are linked in .

8.2 A full Metric report is scheduled to be presented to QPC in March 2024. Urgent Care pressures an harm review findings were discussed at the System Quality Group meeting and there was no specific ask other than the paediatric one from system Quality Group and to QPC.

No questions were raised by members of the Committee.

The Committee:

- Considered additional assurance required in relation to the metrics.

9.0 **Minute No QPC-24-02.25 - System Quality Exception Report – Vanessa Whatley**
The report was taken as read.

9.1 No questions or comments were raised by the Committee.

The Committee:

- Noted the contents of the report.

**10.0 Minute No QPC-24-02-26 – Diabetes – Programme Board Assurance – Fiona Smith/Gemma Smith**

The Report was taken as read and the following key points were highlighted:

10.1 Meredith Vivian opened the discussion by advising the Committee That he had asked Gemma Smith to attend the meeting because there are two aspects to where we stand on diabetes, i.e., What is happening today as he felt that it looked remarkably like it did about a year ago when we first started paying attention to this and there are concerns about the extreme nature of the risk despite lots of work being done, it does not seem to be moving very well.

10.2 Rosi Edwards said she was interested in how the whole system works to deal with diabetes, how performance is improved at the early stages of people with diabetes so that people do not get conditions that end up in acute care and how prevention is dealt with. Rosie added that the risk talks about management and that a shift in thinking needs to move towards prevention. Rosie also added that pre diabetic conditions need to be looked at such as obesity; and the strong link to getting type 2 diabetes later through gestational diabetes. This could perhaps wrap that in with some of the work being done on maternity on how women can be helped to recognise the risk they face.

10.3 Rosi Edwards said that she would like to see how the system could do better on the various tests and what is limiting diabetic patients coming forward to get those checks or is it that GPs or the community who might be providing those checks do not have the resources to do it.

10.4 Meredith Vivian asked Gemma Smith what the longer-term strategic approach to diabetes is.

10.5 Gemma Smith responded that it the current strategy is fragmented, which is one of the challenges we have. There are still have some historic commissioning arrangements from when there were two CCGs, which is one challenge. There are slightly different approaches in primary care and there are services split across a number of providers and organisations that do not necessarily work together and are probably not commissioned to work together,

10.6 Gemma Smith added that there is a lot of work taking place working through the clinical advisory groups around Type one and Type 2 pathways to diabetes, and that an impasse has been reached where things are no able move forward because of the way this service has been delivered historically. One of the things being looked at is benchmarking and looking at gap analysis across our services based upon the pathways that have been developed and starting to look at actually how do we deliver an end to end diabetes pathway that is integrated with in input from social care and from local authority colleagues to look at that prevention and also how a set of outcomes should be developed based upon known data, the impacts that we need to have and where we need to get to. The

proposal being worked up is to have an integrated service that is delivered and supported focused very much upon the role of prevention, the role of primary care, the role of ensuring that care processes are in place, and looking at how we Commission that end to end rather than commissioning through individual organisations, so it reflects the approach we need to take in the LTC strategy, The biggest challenge we're going to have is how the funding is moved.

10.7 Gemma Smith stated that an end-to-end business case is being worked on to look at the benefits analysis around where money is invested and actually how long that will take to deliver. Conversations are being held with providers to think about how this is commissioned versus how best to deliver which is the longer term ambition around diabetes that we need to start to move forward.

10.8 Meredith Vivian asked whether there was scope for targeting general practices in this context.

10.9 Fiona Smith advised that they are currently doing some targeting, speaking with the practices that are doing really well with the eight care processes, finding out what they are doing that is different to some of the other practices and then going out to some of the other practices that are not doing so well to try and find out why that is?

10.10 Rosi Edwards asked if there was any examples from around the country where it is actually being tackled in a good way, working together to a common aim. Fiona Smith responded that Dev. Singh from Wolverhampton has done a lot of work around this and learning from places such as Leicester and Derby about how they they're managing it,

10.11 Sara Bailey sad that in terms of the diabetic foot clinic there is a lot of work being carried out regarding learning across the system in terms of assessments both in acute care and across the community, but to give assurance that in terms and from a staff perspective, the diabetic pathways has been proposed as a quality priority for 2024/25.

10.12 Fiona Smith said that she is working closely with SaTH and Shropcom on the foot pathway and looking at an integrated pathway and what that might look like. this starts with good care. good prevention, good foundation care and stopping patients from needing to go on to have foot ulcers, amputations etc.

10.13 Liz Noakes said that it is a place based solution that is needed but at the heart of that is primary care. In other systems the primary care delivers most of diabetes care and in a good way. Historically Shropshire Telford & Wrekin have not had this so this needs to be developed but also linked into various prevention services that we do have out in the Community and said this was the missing link in terms of the prevention services.

10.14 Meredith Vivian suggested that some form of summit should take place where everyone involved in diabetes prevention and management gets together to work through what the strategy needs to look like, with a clear expectation of signing up to an agreed approach,

10.15 Gemma Smith responded that the approach that needs to be taken is first of all going through our senior leadership team on the 12th of March. So we'll get signed up in terms of the approach around the commissioning. Nothing.

10.16 Vanessa Whatley suggested that a Diabetes progress update is brought to QPC in two months time to maintain some level of oversight.

The Committee:

- Discussed the ongoing issues around diabetes
- Noted the contents of the presentation provided.

**11.0 Minute No. QPC-24-02.27 – Deep Dive – Planned Care – Maureen Wain**

The report was taken as read and the following key points were highlighted.

11.1 Maureen Wain highlighted of all of the cancer diagnostics and elective performance standards we are achieving fairly well and certainly nationally comparative well on our 78 week and 65 week standards. We're not where we want to be from a 65 week perspective, but we are better than where we thought we would be with the impact of industrial action.

11.2 There is good work being undertaken in terms of the faster diagnosis standard and the 62 day backlog and are already at the national standard for the faster diagnosis standard.

11.3 There are some hidden risks because although we achieved the national standard, if we broke it down into those with cancer and those without cancer, it is the patients without cancer that receive their diagnosis faster. So we're doing some work on that in terms of trying to speed up the pathway for those patients with cancer. Getting the right patient on the right pathway and not having such an increased demand in patients coming through who don't have cancer is the route to the success to achieving that.

11.4 In terms of the elective care standards, we are doing very well, but again, the things that we want to work on and need to do better at is outpatient transformation because within outpatient transformation, there are five national standards.

11.5 Advice and guidance will, if done well would reduce the demand that comes into secondary care providers.

11.6 Rosi Edwards referred to slide 17 of the report and noted the excellent progress in relation to fit tests and that there was no significant fall in referral numbers, however, the conversion rate has remained steady, suggesting referrals are appropriate and said she would have expected the conversion rate to go up and the number of referrals to go down because those referring would be using the fit test to guide them, and asked if enough was being done to help those doing the referrals, the GPS to understand that it is not just do a fit test and send in a referral, it's do a fit test and decide if you need to refer therefore referrals would go down thus making the system faster.

11.7 In the last three months a contribution has been received from the West Midlands Cancer Alliance for an ICB cancer team. Who would be that interface between the GP practices and Shrewsbury and Telford as the main provider of cancer services within STW.

The Committee:

- Noted the contents of the report.

**12.0 Minute No QPC-24-01-10 - LMNS Programme Board Update – Sue Bull**

The report was taken as read and the following ksy points were highlighted:-

12.1 Sue Bull stated that the Ockenden Compliance is worth noting and that there are only 41 actions out of the total of the 210 from the two reports that are

outstanding. Work as a system towards delivering these by the completion date, 10 actions were descoped because they lay outside the trusts Responsibility and 11 of them are closely linked to the funding and there is a business case going through so they may not fall in line with the March 24 deadline,

12.2 Rosi Edwards referred to the actions outside the ability of SaTh to complete. One of them is IEA 1.4, which is you cannot have a single maternity service in an LMNS and there was talk within SaTH about taking descoping that and the maternity Transformation Assurance Committee said that it was not a good idea. The Committee that she chairs chair at SaTh agreed that's not a good idea because whilst they have a single maternity service, which was a recommendation from Ockenden . This is something that we should try not to push outside and we just need to keep on pressing for somebody to partner with us and do what is needed, which is to benchmark one another and share good practice. So we would like the help of the system and the region to make that happen and not get into a complacent localised way of doing things.

12.3 Meredith Vivian said that he would be interested to see constant request being made to NHS England, whether it be a regional or national, to say we are desperate to deliver on this one.

12.4 Sue Bull commented that the work to date is that there is an MOU in place between neighbouring LMNS Trusts which include Staffs and Stoke, the Black Country and Derby and Derbyshire, LMNS. Around how best practice is shared. And how we can work with each other? And unfortunately, at the moment it is not that the other parties are not willing it is capacity at the moment that is kind of causing a few issues, but that's not to say that we're still not having those conversations.

12.5 Sue Bull commented that discussions have taken place around having working groups and work streams and buddies have been invited to those work streams. So even though the discussion was around that the whole descope, it was never the intention that that that would stop. We are committed as a system to work with other trusts and other neighbours to learn from and to support each other. This is being progressed with NHS England. To understand what other single LMNS's are doing and how they are achieving this recommendation and working together,

12.6 Sue Bull advised that she sits on the regional groups as well for NHS England and have these conversations with other groups., a lot of these groups have very informal arrangements in place and nobody' is doing it the same way and everybody is doing it differently.

12.7 Sue Bull advised that CNST compliance, is on track to deliver all elements of the 10 CNST's .

12.8 Sue Bull highlighted that there had been an inappropriate admission to the neonatal unit, there were two cases which hd been discussed further at the LMNS board and it was around a nasogastric feeding. They were referred to the neonatal unit for feeding rather than having the support on the ward. There are discussions being had now within SaTH to see whether that support could be on the ward rather than having the referral into the neonatal units.

12.9 Smoking at delivery, decreased during December from November and the Trusts are still working towards supporting pregnant women to stop smoking.

12.10 The neonatal quality dashboard still has issues with the data and the dashboard that comes through to the LMNS board caused by validation of the data This has been a long standing issue and we are now trying to understand when this can be rectified and we will be working with the trust and part of the Workstream work

will be around trying to get this data validated and more reliable. The biggest issue is around neonates not having the full EPR system, which is Badgernet in place In the same way as maternity have, there is a lot of manual input and , a lot of manual recording which is causing the issues with the validation and not being able to being able to pull directly off badgenet. This is being worked through as a system. Neonates have put in a business case for full implementation, the outcome of which is still awaited.

12.11 There is a lot of work taking place in relation to The MNVP maternity and the Neonatal Voices Partnership. The NHS England three-year delivery plan is in place a big element of this plan is around engaging with families and ensuring that users voices is at the centre of all of decision making, a communication engagement strategy is being developed and also the MNVP work plan for 2024/25; this will be a fully costed work plan because there is always been an issue where there has been an expectation to deliver.

12.12 Lynn Cawley commented that Healthwatch is, a partner across all services, who have previously done a piece of work around maternity which fed into the development of the perinatal mental health service. Healthwatch are keen tore engage with that particularly around the engagement in order to gather feedback on services.

12.13 Sue Bull said that she thought Healthwatch ere in part of the work stream membership Lynn Cawley said that she has not received an anything

12.14 Sue Bull said that she will ensure that Healthwatch are included.

12.15 Sue Bull advised the Committee that the maternity and neonatal independence senior advocate (MNISA) will be leaving the ICB on the 20th of March, However there is a commitment from NHS England for funding for 204/25 allowing the ICB to go back out to advert, because as a system it is agreed that this is a role is needed Sue Bull said that she is awaiting ICB approval to go out to advert. An update will hopefully be available on this post next quarter.

12.16 Rosi Edwards responded to those two concerns about data and neonatal data it, this has been discussed at SaTH's Quality & Safety Assurance Committee meeting. So they are aware of that and are aware that there is a discrepancy between the data.

The Committee:

- Discussed and noted the contents of the report.

**13.0 For Information Only -Health Protection Board Assurance Report -.**

The report was taken as read and provided for information purposes only.

13.1 Meredith Vivian referred to the report and reference made The TB and The apps Or diagnosis of TB and subsequent treatment for those people who are placed in hotels in Shropshire, Telford & Wrekin through the immigration process, and asked where the cost of that lies.

13.2 Vanessa Whatley responded that this is the mobile TB and screening that was carried out and that it is a cost pressure within the ICB. and the primary care budget. It did pull out a number of cases of TB that have gone on to be treated. However, there was only a 30% attendance. This does mean that there is potentially six or more cases out there that are not treated who will all be infectious,

**14.0 Minute NO QPC-24-01-13 – Healthwatch Shropshire Update**

14.1 Lynn Cawley provided a verbal update and advised the Committee that Healthwatch Shropshire are drafting a report around domiciliary care and said that it might be worth picking this up with Vanessa Whatley outside of the meeting as she is aware that previously the directors of nursing have been interested in the performance of Domiciliary care and Care Homes, particularly nursing homes.

14.2 Healthwatch Shropshire are carrying out a piece of work around living with cancer, not to pick up on issues around diagnosis etc, but people's experiences of how they are supported to live with cancer, as many people are living for a long time with cancer and how they are supported in Shropshire. Conversations are being had with the Community Trust about how feedback can be gathered on virtual awards. So that an explanation can be given to the public of what that is. A video has been produced around virtual wards; it starts off with patients talking about their experience rather than them being left to the end.

14.3 Lynn Cawley advised the Committee that Healthwatch Shropshire will be outlining their priorities for 2024/25 in March and said it would be helpful to know what the ICB priorities are, and any pieces of work that this committee feels we should be doing within the next year.

14.4 Lynn Cawley stated that Healthwatch Shropshire have a new Officer starting on the 8th of April and is hoping that because of her background she will be up to speed quite quickly.

The Committee:

- Noted the verbal Update.

**15.0 Minute No 24-01.14 Healthwatch Telford & Wrekin Update**

There was no representation at the meeting from Healthwatch Telford & Wrekin to provide an update

**16.0 Minute No QPC-24-01-14 - Items for Escalation/Referral to Other Board Committees**

16.1 Meredith Vivian requested that Diabetes is escalated however this is a very big problem. with long term strategic implications and very poor implications for our patient population. And suggested that an update is provided at a later date

**17.0 Minute No. QPC-24-01.15 Any Other Business (AOB)**

No other business was raised.

**Date and Time of Next Meeting**

Thursday 28th March 2024 2.00pm to 4.00pm via Microsoft Teams.

**SIGNED ..... DATE .....**

Agenda Item

ICB 24-04-037.2

Audit Committee minutes for

meeting held on 17 January 2024

and

Audit Committee Annual Report

**NHS Shropshire, Telford and Wrekin**
**Audit Committee Meeting**

**Wednesday 17 January 2024 at 9.30 a.m.**
**Via Microsoft Teams**

| | |
|---|---|
| **Present:** | |
| **Mr Roger Dunshea (Chair)** | Non-Executive Director, NHS STW ICB |
| **Mr Trevor McMillan** | Non-Executive Director, NHS STW ICB |
| **In Attendance** | |
| **Mr Trevor Purt** | Non-Executive Director, SaTH – ICS Observer |
| **Mrs Claire Skidmore** | Chief Finance Officer, NHS STW ICB |
| **Miss Alison Smith** | Director of Corporate Affairs, NHS STW ICB |
| **Mr Angus Hughes** | Associate Director of Finance, NHS STW ICB |
| **Ms Lisa O'Brien** | Audit Manager, CW Audit Services |
| **Mr Paul Westwood** | Head of Counter Fraud Services, CW Audit Services |
| **Mr Richard Anderson** | Grant Thornton – External Audit |
| **Mr Terry Tobin** | Grant Thornton – External Audit |
| **Mr Samuel Cooper** (Observer) | Finance Management Trainee, NHS STW ICB |
| **Mrs Sam Tilley** | Director of Collaborative Programmes, NHS STW ICB |
| **Mrs Sara Spencer** | Operational IT & IG Manager |
| **Ms Gemma Smith** | Director of Strategic Commissioning |
| **Mr Brett Toro-Pearce** | Associate Director – Individual Commissioning |
| **Mrs Chris Billingham** | Corporate PA (Minute Taker) |
| **Apologies:** | |
| Mrs Niti Pall | Non-Executive Director, NHS STW ICB |
| Mr Meredith Vivian | Non-Executive Director, NHS STW ICB |
| Mrs Laura Clare | Deputy Director of Finance, NHS STW ICB |
| Ms Sarah Swan | Assistant Director, CW Audit Services |
| Mr Andrew Smith | Director, Grant Thornton – External Audit |

## Minute No. AC-24.01.04 – Introductions & Apologies

1.1 Mr Dunshea welcomed Committee members to the meeting.

1.2 He advised that an extraordinary meeting had taken place on 4 January 2024 to discuss Better Care Fund, an Agenda item for today's meeting.

1.3 He requested that today's meeting must finish by 11.00 a.m., after which it would not be quorate. Papers would be taken as read unless authors wished to highlight any key points or key actions required but if so, they should be as brief as possible.

1.4 He commented upon the excessive volume of papers for this meeting and requested that papers should be no more than 100 pages per Committee meeting going forward.

1.5 Apologies received were as noted above.

**Minute No. AC-24.01.05 – Members' Declarations of Interests**

2.1 Members had previously declared their interests, which were listed on the ICB's Register of Interests available to view on the website at:
Register of Interests - NHS Shropshire, Telford and Wrekin (shropshiretelfordandwrekin.nhs.uk)

2.2 Members were asked to confirm any new interests that needed declaring or any existing conflicts of interest that they had relating specifically to the agenda items.

2.3 No additional conflicts of interest were declared, and no existing interests were raised that may conflict with an agenda item.

**Minute No. AC-24.01.06– EPRR Annual Self-Assessment**

3.1 Mrs Tilley's report was taken as read. The Chair confirmed that the Committee was seeking assurances regarding proposed actions as the ICB was clearly non-compliant in a number of areas. The situation required escalation, and implementation of an action plan.

3.2 Mrs Tilley's paper identified headline pieces of work that must be focused upon, not only as an ICB but as a system. Most incidents will require a coordinated response and our plans must not only meet the necessary criteria, but also co-function with system partners in terms of how we manage our response.

3.3 One of the key issues for both the ICB and system partners is the level of resourcing that is available.

3.4 The EPRR agenda has increased significantly over the last 18 months. The annual programme of work required to support it is comparable to the planning cycle for health organisations and must run continuously throughout the year. Our resourcing as an ICB and as a system is absolutely crucial to being able to service the work and deliver the correct outcomes.

3.5 The system is extremely keen that we move towards a system EPRR resource. That option has been with the ICB for some time and consideration is currently being given as to how that would be best managed and where that focus best sits within the ICB in particular.

3.6 Part of this consideration is the combination of emergency planning and urgent and emergency care. Urgent and emergency care needs significant priority and therefore careful consideration must be given as to how we might uncouple the functions so that in the future as we consider our restructuring options both agendas have the resource they need to function appropriately.

It is hoped that consideration by Audit Committee and ICB Board will help to focus that conversation and ensure correct EPRR resourcing going forward.

3.7 Discussion followed regarding the likelihood of achieving a satisfactory assessment the following year.

3.8 Mrs Tilley advised that prior to the change in the core standards assessment regime, CCGs had been substantially compliant for a number of years. There is now a direct relationship with the way the assessment is completed, and the resourcing allocated to the task. Clarity is required regarding resourcing arrangements going forward, but she was confident that the outcome could be significantly improved.

3.9 Mr McMillan suggested that an improvement plan with a timeline and details of those responsible for actions should be prepared.

3.10 Mrs Tilley explained the process is carried out as a self-assessment and then is subject to a process of challenge and confirm with NHS England. The self-assessment positions submitted by the ICB were compliant, but NHS England were not satisfied with certain aspects of them.

Significant debate took place regarding NHS England's own assessment of the ICB's position which we continue to disagree with, and we are providing NHS England with feedback regarding how the process can be improved. Only the Community Trust are compliant by 1%. Everyone else is considered non-compliant by NHSE although our self-assessment positions are in conflict with their position.

3.11 Mr Purt suggested that he and Mrs Tilley should continue discussions offline as he had recently taken this subject through his own Audit Committee in SaTH and believed that SaTH were compliant.

3.12 The Chair requested an improvement plan be circulated to the committee in four weeks' time, particularly highlighting any risks of not achieving the required accreditation.

3.13 The Committee: -

- Noted the content of the report including the outcome of the NHSE Annual Assessment and the improvement work underway.
- Requested a progress and improvement plan be circulated to the Committee in four weeks' time.

**ACTION: Mr Purt and Mrs Tilley to discuss the EPRR submission offline.**
**ACTION: Mrs Tilley to circulate an improvement plan to the Committee in four weeks' time.**

**Minute No. AC-24.01.07– Minutes from the Previous Meeting**

4.1 The minutes of the previous meeting on 9 October 2023 were approved as a true and accurate record of the meeting.

**Minute No. AC-24.01.08– Matters Arising and Action List**

5.1 The Action Log was updated as appropriate.

**Minute No. AC-24.01.09– Better Care Fund**

6.1 Ms Gemma Smith's paper outlining the background, current financial situation, and future plans was taken as read.

6.2 Mr Dunshea provided a brief update on the current situation.

An Extraordinary meeting of the Audit Committee took place on Thursday 4 January 2024 to discuss the relationship with the two Local Authorities and funding streams around payment schedules. A way forward was agreed and is now with Ms Smith and colleagues to reach a negotiated settlement during the remainder of this financial year.

A development session will take place with the Board regarding the next financial year.

**ACTION: Ms Gemma Smith and representatives of both Local Authorities to present to the Board Development session in February 2024.**

**Minute No. AC-24.01.10– Use of Recovery Support Funding**

7.1 Mrs Skidmore's paper was taken as read.

7.2 As the ICB is in NOF4 it attracts a level of support from the national recovery support team. They have requested that, as good practice, Audit Committee have sight of where any funding received is allocated, and that delivery of the expected outcomes is achieved. The paper suggested a rolling review from this Committee moving forward.

7.3 In response to a question from the Chair as to how that review would happen, Mrs Skidmore advised that the ICB currently has a significant internal oversight process by the Executive Team and the Senior Leadership Team. The monitoring information shared within the report is collated by Mrs Garside and her team.

7.4 The key interest of Audit Committee is understanding the resources we have attracted and having the opportunity to challenge, if necessary, about whether the anticipated value is being delivered.

Discussion took place regarding obtaining evidence as to what is actually being achieved and the time frame, and also whether this was a topic for Audit Committee or for Finance Committee.

Mrs Skidmore believed this to be part of process and governance rather than financial impact.

However, Mr McMillan did not agree that Audit Committee should be involved. This was an Executive management issue that would occasionally be challenged through the internal audit process.

7.5 The Chair requested that Mrs Skidmore should further consider reporting, advising that the Committee's interest would focus upon areas where progress is not being achieved and where there is a risk that the expected outcomes will not be achieved or do not provide good value for money.

7.6 The Committee: -

- Noted the allocation of RSP funding received in 23/24 and its intended impact.
- Noted the impact reported to date and the monthly reporting process via the IRM.
- Were unable to approve the process proposed that the Audit committee receives a report at the start of the financial year 24/25 describing the RSP funding allocated to the ICB for the year ahead and a breakdown of its proposed use and anticipated impact with a further report in quarter 4. Committee members queried whether this proposed reporting should be via the Finance Committee as this was focused on outputs rather than process. Mrs Skidmore was asked to review the proposed process and clarify the rationale for the reporting to come through Audit Committee.

**Minute No. AC-24.01.11– Investment Panel**

8.1 The Investment Panel had been in place for several years and was designed to prioritise new recurrent funding requests. It does not make decisions regarding spend, but merely prioritises requests relative to all other cases submitted.

8.2 As a response to certain grip and control issues, the national team had requested that a triple lock is put in place for non-pay expenditure over £25k and also some non-clinical agency expenditure. Finance Committee will keep the Board briefed.

8.3 Discussion took place regarding timescales and next steps.

8.4 Mrs Skidmore intended to revamp what is currently the Commissioning Working Group in the very near future. An updated infrastructure will then be developed to support that group which will include the Investment Panel. The target date for that is Q1 next year.

8.5 The Committee: -

- Noted the arrangements that are currently in place for the system Investment Panel
- Noted future arrangements are being reviewed as part of the overall governance of the ICB/system.

**Minute No. AC-24.01.12– External Audit**

9.1 Mr Tobin introduced Richard Anderson who had been appointed as a Director in Grant Thornton's Public Sector Birmingham team. He would be taking over from Andrew Smith as the engagement lead moving forward.

9.2 Mr Anderson reported that audit planning is well progressed. An audit plan will be submitted to the next Audit Committee in April which will outline risks and the approach for the 2023/24 audit.

9.3 The final accounts audit will take place in April, May, and June to complete the VFM work to the national timetable.

9.4 The Chair asked Mr Anderson to convey the Committee's thanks to Mr Smith for his work with the Committee over the last few years.

9.5 Mr Tobin asked if Committee members wished to add anything further to his paper. Both Mr Dunshea and Mr McMillan confirmed that they had read the paper only briefly and intended to review it again. Any comments they had would be fed back to Mr Tobin.

9.6 Mrs Skidmore confirmed that the paper had been thoroughly curated by the Finance team.

9.7 The Committee noted the contents of the report.

**Minute No. AC-24.01.13– Internal Audit**

*Internal Audit Progress Report*

10.1 Following the previous Audit Committee, the numbers within the report were finalised.

10.2 High level advisory reviews had been implemented of Better Care Fund and Ophthalmology contract management.

10.3 Terms of Reference and a start date for the review of the ICB delegated primary care function's annual health assessment had also been agreed.

10.4 It had been agreed with the ICB and CSU to bring forward work on the Data Security and Protection Toolkit audit and commence the work in March in order to relieve pressure on the CSU team at the beginning of the new financial year. However, the audit will be completed and reported upon during 2024/25. A report will be submitted to the Committee in the new financial year.

10.5 The ICB had achieved 86% with implementation of audit actions which fell due for completion in this financial year. This is considerable progress compared to earlier in the year when overall implementation was below 50%. Overdue actions are mainly as a result of capacity within the relevant team due to a period of planned sickness absence. The latest update against those actions is provided in the report.

10.6 As from 1 April timely implementation of actions will be measured by a process called the first follow up. This will be actions which have been completed on or before their original completion date. Any which are implemented outside of the original date will be marked as non-compliant against its first follow up measure. Going forward into 2024/25 this measure will be used in arriving at the annual head of internal audit opinion.

This is being taken forward for discussion with the client audit lead and the action owners at the point of agreeing the report. As part of these conversations, the need for realistic and achievable completion dates will be highlighted.

10.7 Completion of the strategy and base plan final version is expected towards the end of the financial year.

10.8 The meeting discussed the audit recommendation follow up work and who would be responsible for ensuring that the audit recommendation timetables were met.

10.9 Mrs Skidmore advised that at the present time it will fall to the Finance team to support Internal Audit when they issue reminders.

Periodic reminders are given to Senior Leadership Team regarding timely responses. However, going forward there needs to be a review of the action, whether it is still relevant, and a realistic assessment made of what needs to be done next.

**ACTION: Mrs Skidmore and Ms O'Brien to review the internal reminder process to ensure that actions are still relevant and are implemented.**

10.10 The Chair requested confirmation that the review of the internal process around funding of the GP Board had been carried out. Ms O'Brien confirmed that she had met with Mrs Clare and Mr Hughes. A review was currently being scoped and a Terms of Reference written.

*Continuing Healthcare VFM Report*

10.11 Ms O'Brien's report was taken as read.

10.12 The Chair requested the views of Mr Toro-Pearce regarding the recommendations.

10.13 Mr Toro-Pearce believed that all of the recommendations were very relevant. The majority were already within the CHC service recovery plan, and he was confident that the recommendations could be completed fully.

10.14 The only one that may present a slight challenge is an individual commissioning policy. That will require a significant public consultation and legal review as we challenge the boundaries of what is our commissioning responsibility and what is not.

10.15 The Chair asked Mr Toro-Pearce if he was aware of a lead provider status where one of the providers takes up specialist commissioning in some areas?

10.16 Mr Toro-Pearce replied that continuing healthcare is an area where the ICB cannot actually delegate that responsibility. The service is NHS funded but is not directly provided by the NHS.

*BAF Review*

10.16 The chair invited comments on the BAF review outputs from Miss Smith, who confirmed that she had nothing further to add to the information contained within the report.

10.17 Ms O'Brien advised that this was Stage 1 opinion work and was an initial review. We are now moving on to Stage 2 of the work which will include another review of the BAF and also some high-level risk management.

10.18 Miss Smith advised that she would be presenting the findings of the GGI report to the public Board meeting at the end of the month which will require some changes to our committee structures as some responsibilities will move. Update work will be carried out between now and end of March when she proposed to submit a Governance Handbook and all of the Terms of Reference for all the Committees revised for final sign off by the Board.

*Financial Systems Key Controls Report*

10.19 The Chair invited Mrs Skidmore to comment on the Financial Systems Key Controls report.

10.20 Mrs Skidmore confirmed she was pleased with the report which, going forward, will continue to be improved and refined.

**Minute No. AC-24.01.14– Draft Policy for Management of Policies**

11.1 Miss Smith's report was taken as read. She confirmed that it sought to address all of the issues highlighted in the internal audit report earlier in the year.

11.2 Mr McMillan requested consistency in the documents with regard to font, etc., and to bear in mind that the accessibility needs of visually impaired or dyslexic people to online documents is different from what it is on paper.

11.3 The Committee approved the draft Policy for Management of Policies.

**Minute No. AC-24.01.15– Counter Fraud**

12.1 Mr Westwood highlighted two new issues that had been reported which were highlighted on Page 11 of his report.

12.2 One was around Personal Health Budgets and the other related to suspected contract mismanagement. He had been working with Meryl Flaherty on that issue and will feed back to the Committee in due course.

12.3 The results of the NFI exercise are 95% complete. There are no issues to bring to the attention of the Committee.

12.4 Page 3 of his report detailed a self-assessment against the functional standards. Several were rated as Amber but with an expectation these will move to Green by the end of the financial year. Last year's broad risk assessment is being revisited which will help inform the 2024/25 Counter Fraud Plan.

12.5 Mr Westwood had been unable to update the management system with the actions taken on fraud alerts and fraud prevention notices, etc. because of resourcing issues.

12.6 The draft Fraud Policy had been reviewed and made more robust. It now included the Fraud Response Plan and a few informative appendices, each aligned to the Counter Fraud Authority's 2023/26 strategy.

12.7 The Committee approved the draft Fraud Policy.

**Minute No. AC-24.01.16– Information Governance Update**

13.1 Miss Spencer's Information Governance report was taken as read.

13.2 The only additional item she wished to highlight was multifactor authentication which must be in place by the end of March.

Multifactor authentication is when two elements of data are required to access a network account, e.g., a password and a code sent to your mobile phone.

13.3 The meeting discussed methods used by the ICB to make staff aware of IT issues such as cybersecurity. Methods included mandatory training which for cyber and IG is an annual requirement for all staff. The staff huddle and staff newsletters also provide updates on IT related issues. A phishing exercise had been carried out in 2023 and it is planned to do a slot on Huddle about phishing in order to target some of the potentially higher areas of risk that are down to human error rather than system failure.

13.4 In response to questions regarding the organisation's response to a total system failure, Mrs Skidmore confirmed that that particular scenario had been built into individual teams' business continuity plans.

13.5 Towards the end of 2023 representatives of the ICB and CSU attended a half day system desktop cyber-attack exercise. It was supported by NHS England, and highlighted a number of areas that as a system we need to take forward. The outputs are awaited, and we will review them and identify as an individual organisation what issues need to be addressed.

13.6 Mr Dunshea referred to a test exercise being carried out by the end of January next year to test out how well we can communicate if our main communication servers go.

Mrs Skidmore advised that a similar exercise was carried out in August or September 2023. Mrs Tilley reported back to Senior Leadership Team about where we were unable to contact people but generally, we had a very rapid cascade through telephone and Whatsapp. She was not certain whether there would be value in doing one again so soon but advised that it will be in Mrs Tilley's rolling programme for moving forward.

13.7 The Chair then referred to Page 7 of the report and reference to an IG breach investigation that had been placed on hold regarding an email sent in error.

13.8 Miss Smith suggested taking the breach investigation offline when Ms Spencer will confirm what details could be shared with the Committee without breaching any confidentiality.

**ACTION: Sara Spencer to update Committee members with details of the IG breach relating to an email sent in error.**

13.9 The Committee noted the contents of the report.

**Minute No. AC-24.01.17– Losses, Special Payments and Waivers**

14.1 Mr Hughes had no items to highlight to the Committee.

14.2 3 waivers and no losses were reported in the period.

14.3 The volume of waivers is decreasing from last year and there is much more control and challenge around when waivers are raised.

14.4 Mr Dunshea commented that three waivers were referenced within the report but only one was reported on the accompanying appendix to the report.

**ACTION: Mr Hughes to reissue the appendix to the report to show information on all three waivers.**

14.5 The Committee noted that: -

- There were no losses and no special payments in the period 1st October 2023 – 17th January 2024
- There have been three waivers signed off by the Chief Finance Officer in the period 1st October 2023 – 17th January 2024.

**Minute No. AC-24.01.18– Review of Prime Financial Policies**

15.1 The Finance team were not suggesting any material changes to the prime financial policies at this time. Guidance is still awaited from the national team. If that changes, it will be drawn to the attention of the Committee as part of the conversations regarding the accounts.

15.2 The Committee noted the details of the Chief Finance Officer's verbal update.

**Minute No. AC-24.01.19– Governance Issues / Concerns from Other Committees**

16.1 The Chair reiterated the earlier conversation regarding the possibility of an audit next year across the system on grip and control processes which could inform many discussions around efficiencies, cost savings, etc.

**Minute No. AC-24.01.20– Any Other Business**

17.1 There was no other business.

NHS
Shropshire, Telford and Wrekin

# Audit Committee Annual Report 2023/24

## 1. Introduction

1.1 This is the Annual Report of NHS Shropshire, Telford and Wrekin (NHS STW) Audit Committee for the period of April 2023 to March 2024. The purpose is to provide assurance that the Audit Committee has discharged its responsibilities in accordance with the agreed Terms of Reference (TOR) and reviewed its work and performance during 2023/24.

1.2 The production of an Audit Committee Annual Report represents good governance practice and ensures compliance with the Department of Health's Audit Committee Handbook.

## 2. Role and Effectiveness of the Committee

2.1 The Audit Committee is a formal committee of the NHS STW Integrated Care Board (ICB) and has decision making delegated to it under NHS STW's Constitution and Governance Handbook.

2.2 During the period covered by this annual report the terms of reference for the Audit Committee were reviewed and updated to include policy management oversight. The terms of reference were approved by the Board on 29 November 2023.

2.3 The Audit Committee also assesses its own effectiveness at each meeting.

## 3. Committee Membership

3.1 The Committee is made up exclusively of ICB Non-Executive Directors (NEDs) Board Members:

- Mr Roger Dunshea (Audit Committee Chair)
- Professor Trevor McMillan
- Mr Meredith Vivian
- Dr Niti Pall

3.2 The quorum for the Audit Committee is a minimum of two members and on every occasion the Committee has met, the meetings have been quorate. Each Audit Committee meeting is formally reported through the Chair's report to the following Board meeting, and the minutes are available on request from the Director of Corporate Affairs. Attendance at the meetings during 2023/24 was recorded as follows:

| Names of Audit Committee Members | Meetings attended during 2023/24 |
|---|---|
| **Mr Roger Dunshea (Chair)** | 5 of 5 |
| **Professor Trevor McMillan** | 3 of 5 |
| **Mr Meredith Vivian** | 4 of 5 |
| **Dr Niti Pall** | 3 of 5 |

3.3 For 2023/24 the Audit Committee has met quarterly (i.e. 4 times), which is in line with that stipulated in the terms of reference, and has held an one extra ordinary meeting on 4 January 2024.

3.4 In addition to formal members, the Audit Committee also invites the following to attend on a regular basis to assist in fulfilling its functions:

- Chief Finance Officer
- Deputy Finance Officer
- Associate Director of Finance
- Director of Corporate Affairs
- External Audit
- Internal Audit
- And specialist staff including Local Counter Fraud Specialist, Local Security Management Specialist and Health and Safety Manager as required.

3.5 Other officers of the ICB are invited when the Audit Committee wishes further discussion around certain topics.

3.6 As set out as good practice, the Chair and other Committee members may schedule a private meeting once during the year with Internal and External Audit. This was considered by the members of the Committee in January, but instead members agreed that additional private time would be added to scheduled meetings as required.

## 4. Audit provision

4.1 Internal Audit has been provided by 360 Assurance. External Audit has been provided by Grant Thornton.

## 5. Assurance

5.1 The Audit Committee agenda is constructed in order to provide assurance to the ICB Board across a range of activities including, corporate, commissioning, financial and risk governance and management.

5.2 The Committee has largely continued to concentrate its efforts over the year of ICB operation on ensuring that the ICB has robust internal control processes in place, underpinned by a robust risk management framework.

## 6. Principal Review Areas

6.1 This annual report is divided into six sections reflecting the six key duties of the committee set out in its TOR:

### 6.1.1 Integrated governance, risk management and internal control

- The Committee has reviewed at it's June 2023 meeting relevant disclosure statements, in particular the Governance Statement together with the Head of Internal Audit Opinion, external audit opinion and other appropriate independent assurances and considered that the Governance Statement was consistent with the committee's view on the ICB's system of internal control. Accordingly the Committee received the CCG (months 1–3) and ICB (months 4 –12) Annual Reports and Accounts 2022/23 (including the Governance Statement), which were approved in the June 2023 meeting.

- The Committee has regularly reviewed the System Board Assurance Framework (SBAF) and Strategic Operational Risk Register (SORR). It has noted that the framework used during the year is in line with the Department of Health expectations.

- The Committee has reviewed the completeness of the risk management system and the extent to which it is embedded in the organisation. The Committee believes that whilst adequate systems for risk management are in place, continued work is required to ensure that these are embedded throughout the whole organisation and Integrated Care System (ICS), with sufficient oversight by respective committees.

### 6.1.2 Internal Audit

- The Committee reviewed and approved the Internal Audit Plan at its June 2023 meeting.
- The Committee considered the major findings of internal audits as documented in Appendix A and were assured that management have responded in an appropriate manner and that the Head of Internal Audit Opinion and the Governance Statement reflect any major weaknesses.
- The Head of Internal Audit gave moderate assurance in the Head of Internal Audit Opinion which supports the Committee's concluded assurance.

### 6.1.3 External Audit

- The Committee reviewed and agreed External Audit's Annual Plan at its April 2023 meeting.
- External Audit reviewed and commented on the annual audit of the CCG (months 1–3) and ICB (months 4 –12) Annual Reports and Accounts 2022/23. External Audit opinions for both the CCG and ICB entities were unqualified.

### 6.1.4 Counter Fraud

- Counter Fraud Service is provided by 360 Assurance.
- The Committee has received an annual work plan and regular reports against the plan during the year.
- Assurance has been provided that shows the Counter Fraud Service has continued to work with the ICB through the year to embed an organisational wide culture of combating economic crime and ensure that sufficient controls and management mechanisms are in place within the ICB to mitigate fraud, bribery and corruption risks.
- The Counter Fraud Service has been proactive in responding to investigations/requests as necessary. There have been no investigations carried out during the financial year.
- The Counter Fraud Service has supported the ICB in self assessing against the Government Functional Standards for countering fraud to ensure compliance. The ICB was compliant against 13 criteria with 2 rated as

Amber and the remaining 11 as Green. These Amber ratings will be taken forward as actions in the 2023/24 Fraud plan and Audit Committee will receive regular updates on progress towards compliance against these criteria during the forthcoming year.

- The Counter Fraud Annual Report was presented to the Committee at its June 2023 meeting.

### 6.1.5 Management

- The Committee has received assurance reports from the ICB management and other sources both internally and externally throughout the year, these have included:
    - Assurance gained from and further development of the SBAF and SORR
    - Assurance gained from overseeing the development and recommendation of corporate policies
    - Assurance gained from overseeing the continued development and self-certification of the ICB against the DSPT toolkit and information governance processes and procedures.
    - Assurance on the ICB's emergency planning and business continuity processes.
    - Assurance on the counter fraud measures in place and on continuing work around preventing and addressing fraud.
    - Assurance around the audit outcomes of primary care commissioning audit.
    - Assurance around management of conflicts of interest breaches.
    - Assurance gained from Internal/External Audit reports

### 6.1.6 Financial Reporting

- The Committee has reviewed and approved the annual financial statements before submission to NHS England and the External Auditors and considered them to be accurate.
- The Committee reviewed no losses and one special payment during 2023/24. The Committee reviewed 16 tender waivers during the financial year.

**Audit Committee work plan for 2023-25**

The Audit Committee work plan for 2023-25 is attached for information as Appendix B.

**Conclusion**

The Committee is of the opinion that this annual report is consistent with the ICB's Governance Statement, Head of Internal Audit Opinion and the External Audit end of year audit 2022/23 and there are no matters that the Committee is aware of at this time that have not been disclosed appropriately. The Committee believes it has met its Terms of Reference.

**Appendix A**

## Internal Audit Plan 2023/24 outcomes

| Auditable Area | Level of Assurance |
|---|---|
| **Assurance:** | |
| Board Assurance Framework – CCG | Level A |
| Board Assurance Framework – ICB | Level B |
| Conflicts of Interest Management | Moderate |
| Policy Management | Moderate |
| Financial Systems – Key Controls | Significant |
| Continuing Health Care (CHC) – Value for Money (VFM) | Limited |

**Adult Safeguarding Follow Up Review – March 2023 (presented to Audit Committee April 2023)**

In 2021, Internal Audit we were asked by the (then) CCG to undertake a review of adult safeguarding arrangements. The original review was completed in October 2021 and a **Moderate** assurance was provided. On 01 July 2022, the organisation became an Integrated Care Board (ICB) as part of the wider Integrated Care System (ICS) transition arrangements. While statutory safeguarding duties and responsibilities remain relevant following transition to the ICB, the expectation is now focused on oversight and assurance from the system. A follow up review has been undertaken to assess the progress made.

The follow up review established that of the 14 recommendations raised in October 2021, 10 had been implemented as at January 2023 and the remaining 4 actions had been requested to be closed. For 3 of the 4 closed actions, Internal Audit had assessed these to be partially implemented (2) and not implemented (1) against the agreed recommendations for the CCG. However, Internal Audit had been asked to close these by the Chief Nurse for the ICB to reflect in emphasis of the new organisation.

**Child Safeguarding Follow Up Review – March 2023 (presented to Audit Committee April 2023)**

A review of Child Safeguarding took place in October 2021 under CCG arrangements and Limited assurance was provided. While statutory safeguarding duties and responsibilities remain relevant following transition to NHS Shropshire, Telford and Wrekin Integrated Care Board (ICB) from 01 July 2022 the expectation was now focused on oversight and assurance from the system. The ICB provides a safeguarding function across Shropshire, Telford and Wrekin. The follow up review was undertaken in order to assess progress made with all previously reported recommendations.

The follow up review established that of the 17 recommendations raised in October 2021, 11 had been implemented as at January 2023, 5 requested to be closed and 1 remained outstanding as at January 2023. For 2 of the 5 closed actions, Internal Audit had assessed these to be partially implemented against the agreed recommendations for the CCG. However, Internal Audit had been asked to close these by the Chief Nurse for the ICB to reflect in emphasis of the new organisation.

**Appendix B**

# Audit Committee Annual Work Plan 2023-25

| NHS STW AUDIT COMMITTEE ANNUAL WORKPLAN 2023/24 - 2024/25 V8 | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 2023/24 | | | | | 2024/25 | | | | | | |
| ***Audit Committee Handbook*** | ***Suggested Relevant Agenda Items*** | **Jan-23** | **Apr-23** | **Jun-23** | **Sep-23** | **Jan-24** | **Apr-24** | **Jun-24** | **Sep-24** | **Jan-25** | **Apr-25** | **Jun-25** | **Sep-25** |
| **GOVERNANCE** | | | | | | | | | | | | | |
| Review the assurance framework | Review of System Board Assurance Framework (SBAF) and Strategic Operational Risk Register (SORR) | X | X | | X | X | X | | X | X | X | | |
| Review the risk management system | Review risk management policy in light of Internal | X | | | | X | | | | X | | | |
| Note business of other committees and review inter relationships | Receive governance issues/concerns from other committees | X | X | X | X | X | X | | X | X | X | | |
| Review draft annual Governance Statement | Review draft Annual Governance Statement as part of the draft Annual Report | | X | | | | X | | | | X | | |
| Receive other sources of assurance: | Ad hoc reports from external assurance functions: | | | | | | | | | | | | |
| | NHSE EPRR Annual Self Assessment | | | | X | X | | | X | X | | | |
| Review unaudited draft Annual Report | Draft Annual Report | | X | | | | X | | | | X | | |
| Review Freedom to Speak Up arrangements | Freedom to Speak Up Annual Report | | | | X | | | | X | | | | |
| Review other reports and policies as appropriate- for example changes to standing orders | Review policies: governance/ detailed financial policies/ risk management / security management/ business continuity and emergency planning/ IG / FOI/Counter Fraud/Policy Management/Freedom to Speak Up/Conflicts of Interest | | **As required** | | | | | | | | | | |
| | Review Use of Seal | X | | X | | X | | | | X | | | |
| | Compliance with IG DSPT progress update reports | X | X | X | | X | X | | | X | X | | |
| | STW IG Primary Care Bi-monthly Report | X | X | X | X | X | X | | | X | X | | |
| | STW IG Bi-monthly Service Report | X | X | X | X | X | X | | X | X | X | | |
| | Management of Conflicts of Interest Annual Report | | X | | | | X | | | | X | | |
| **FINANCIAL FOCUS** | | | | | | | | | | | | | |
| Agree final annual report and accounts timetable and plans | Review of annual accounts timetable/plan | X | | | | X | | | | X | | | |
| Review annual report and accounts progress | Draft annual report and accounts | | X | | | | X | | | | X | | |
| Review audited annual accounts and financial statements (including the external audit opinion) | Final annual report and accounts | | | X | | | | X | | | | | |
| Review risks and controls around financial management | Risks and controls around financial management | | | | X | | | | X | | | | |
| Review changes to standing orders, standing financial instructions/prime financial policies and changes to accounting policies | Review Prime Financial Policies | X | | As required | | X | | As required | | X | | | |
| Review losses, special payments and waivers | Losses special payments and waivers | X | X | X | X | X | X | | X | X | X | | |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **INTERNAL AUDIT** | | | | | | | | | | | | | | | |
| Review and approve annual internal audit plan | Internal Audit Plan | | X | | | | X | | | | X | | | | |
| Review internal audit progress reports | Internal Audit Progress reports | X | | X | X | X | | | X | X | | | | | |
| Internal Audit SBAF Review | Internal Audit SBAF review | X | | | | X | | | X | X | | | | | |
| Receive annual internal audit report and Head of Internal Audit Opinion (HOIAO) | Annual Internal Audit report/opinion | | X | X | | | X | X | | | X | | | | |
| **EXTERNAL AUDIT** | | | | | | | | | | | | | | | |
| Agree external audit plans and fees | External Audit Plan | | X | | | | X | | | | X | | | | |
| Review external audit progress reports | External Audit progress reports | X | X | X | X | X | X | | X | X | X | | | | |
| Receive the external auditor's report to those charged with governance | External Audit Report to those charged with governance | | | X | | | | | | | | | | | |
| Receive/consider the external auditor's annual report | External Audit Annual Report | | | X | | | | X | | | | | | | |
| External Audit Review of Annual Report | External Audit Review of Annual Report | | | X | | | | X | | | | | | | |
| **COUNTER FRAUD** | | | | | | | | | | | | | | | |
| Review and approve the annual work plan for counter fraud activity | Annual Counter Fraud Work Plan | | X | | | | X | | | | | | | | |
| Review counter fraud progress reports | Counter fraud Progress Reports | X | X | X | X | X | X | | X | X | X | | | | |
| Review the organisation' s annual self review against NHSCFA's standards | Counter Fraud Self Review Toolkit | | X | | | | | | X | | | | | X | |
| Receive the annual report on counter fraud activity | Counter Fraud Annual Report | | X | | | | | | X | | | | | X | |
| **OTHER ACTIVITIES** | | | | | | | | | | | | | | | |
| Plan how to discharge the committee's duties | Audit Committee Forward Plan to discharge duties | | X | | | | X | | | | X | | | | |
| Self-assess the committee's effectiveness | Audit Committee Self Assessment of Effectiveness | | | | | X | | | | X | | | | | |
| Review the committee's terms of reference | Audit Committee TOR Review | | | | X | | | | X | | | | | | |
| Produce the annual committee report | Annual Audit Committee Report | | | | | | X | | | | X | | | | |
| Private discussions with internal and external auditors (and counter fraud specialists) | Private discussions with internal and external auditors (and counter fraud specialists) | X | **As required** | | | X | **As required** | | | | | | | | |
| Briefing/update sessions | | | **As required** | | | | | | | | | | | | |
| **IN YEAR FOCUSSED ITEMS** | | | | | | | | | | | | | | | |
| Investment Panel Presentation - Claire Skidmore & Laura Clare | | | | | | X | | | | | | | | | |
| Cyber Security - Alison Smith/Claire Skidmore / Masood Ahmed | | | | | X | | | | | | | | | | |
| Current audit policy and approach for the GP contract performance and remittances and PCN payments. | | | | | | X | | | | | | | | | |
| ICS Estates Strategy (Gareth Robinson/New Director of Estates) | | | | | | | X | | | | | | | | |
| Update on Policy for policy management revision following internal Audit report | | | | | | X | X | | | | | | | | |
| EPRR Improvement Plan (Sam Tilley)/Approval of Refreshed EPRR Policies (email 20/3/24) | | | | | | X | X | | X | X | | | | | |

Agenda Item

ICB 24-04-037.3

Finance Committee minutes for

meeting held on 22 February 2024

**NHS Shropshire, Telford, and Wrekin**
**ICB Finance Committee (Section 1) Meeting**
**Thursday 22nd February 2024, at 2.00pm**
**Via Microsoft Teams**

**Present:**

| **Name** | **Title** |
|---|---|
| Trevor McMillan (Chair) | Non-Executive NHS STW |
| Claire Skidmore | Chief Finance Officer NHS STW |
| David Bennett | Non - Executive NHS STW |

**Attendees:**

| | |
|---|---|
| Gareth Robinson | Directory of Delivery and Transformation NHS STW |
| Angela Szabo | Interim Director of Finance NHS STW |
| Kate Owen | Head of PMO NHS STW |
| Laura Clare | Deputy Director of Finance NHS STW |
| Sam Cooper | Apprentice NHS STW (observer) |
| Cynthia Fearon | Corporate PA NHS STW (Note taker). |

**Apologies:**

**Minute No. SFC-24-02.001 – Introduction and Apologies**

1.1 The Chair, **TMcM**, welcomed everyone to the meeting. **TMcM** stated apologies as noted for the meeting,

**Minute No. SFC-24-02.002 – Declarations of Interests**

2.1 No declarations of interest were noted.

**Minute No. SFC-24-02.003 – Minutes from the Previous Meeting held on: 23rd January 2024.**

3.1 **TMcM** asked if there were any points to be raised about the minutes of the previous meeting. There being no amendments, the minutes were taken as a true and accurate record.

**Minute No. SFC-24-02.004 Matters Arising and Action List from Previous Meetings**

4.1 **TMcM** referred to the action list from the previous meeting:

Actions outlined on the action log, were reviewed, and updated accordingly.

**5.0 Minute No. SFC-24-02.005 - ICB M10 Financial position**

**Report received as read.**

**5.1** **LC** stated at Month 10 the ICB is reporting a £20.7m YTD deficit against a £10.6m YTD deficit plan, i.e., a £10.1m adverse variance. As outlined in last month's report, the position now reflects the £4.7m additional national allocation being transferred to SATH/RJAH.

**LC** explained that the main reasons for the adverse variance in the ICB position remain in line with reporting so far this year, significant overspends continue in discharge expenditure (shown in community), individual commissioning and prescribing (particularly due to inflation) and a lack of elective recovery income received from Wales. **LC** added that these pressures are partially offset with an underspend in dental within the POD budget and a number of non-recurrent underspends due to the allocations approval and prior year balance policies implemented in 23/24.

**LC** highlighted that at month 10, there was a deterioration in the CHC forecast. That is due to late notification of charges for children's expenditure with Telford and Wrekin Local Authority. The CHC team are now validating the information received to ensure that there is a robust forecast going forward. They are also looking at governance of this process to avoid a similar issue in the future. **LC** added that at month 10 this increase in cost has been offset by increased non-recurrent delivery in the efficiency programme and also, through use of allocation slippage.

**LC** highlighted that at Month 9 the revised forecast outturn was agreed for the ICB at a £27.8m deficit. At Month 10 the ICB is now reporting that it will hit this re-forecast position but with risk flagged around CHC and prescribing positions, leaving £3.1m unmitigated risk at this point.

**LC** explained that the reforecast ICB position is based on a number of key actions being delivered and weekly forecast outturn recovery meetings continue to monitor those actions with the Senior Leadership Team.

**CS** explained that the 24/25 position is impacted by the significant use of non-recurring benefit in the 23/24 position as this will not be available in the new year.

**TMcM** asked about the presentation of risk in the reporting as the wording suggests that the risk will materialise and therefore impact on the position. **CS** explained that risk is reported in addition to the position and would only impact if it crystallised into spend. She offered to think about how this might be reworded in the reports to make that clearer.

***Action: CS** and **AS** to re-look at the wording on risk in the reports.*

**TMcM** queried expenditure for the people team. **CS** explained that the team were initially funded through Health Education England and costs were included in the ICB financial plan so that they were included within the budget albeit this team perform a function for the System.

**DB** queried about the recently announced allocation of funding for System planning deficits. **CS** stated that this is expected in month 11 and will hopefully come with some guidance. **CS** added that there have been some discussions with Provider DoFs on how the funding should be spilt i.e., aligned to the deficit that was in the original financial plan.

***The ICB Finance Committee noted:***

- The M10 headlines for the ICB financial position (£20.7m YTD deficit, £10.1m adverse position to plan)
- That the ICB is forecasting a deficit of £27.8m by the end of the year
- The remaining level of unmitigated financial risk currently reported alongside the forecast position (£3.1m).
- The key actions that need to be delivered in order for the ICB to meet its re-forecast position and take assurance that a weekly financial recovery meeting is overseeing these actions.

**Minute No. SFC-24-02.006 ICB M10 Efficiency update**

**Report received as read.**

6.1 **KO** highlighted that £21.6m savings have been delivered year to date against a plan of £21.2m. Which provides a positive variance of +£400k.

**KO** explained that the positive position in Month 10 is due to additional savings being identified within the UEC budget as a result of slippage within the winter schemes, further non recurrent savings being identified within the Mental Health budget due to non-recruitment of posts and medicines management programmes (DOAC and DOLCV) delivering savings over and above the expected plan in month which has helped to improve the position further. **KO** stated overall, this has impacted positively on the forecast position which is now reported to deliver £26.7m of efficiencies against an original plan of £26m providing a positive variance of £800k.

**KO** highlighted that the ICB has made significant progress in identifying further savings opportunities to meet the stretch targets set at the beginning of the year.

**KO** stated that they outputs will continue to be monitored closely and she will also look to create a “Lessons Learned Report” to outline what went well and what didn’t go as well.

**DB** noted the really positive news from the efficiency update.

**GR** thanked **KO** for all her hard work regarding pulling the information together for the efficiency reporting for the ICB and the ICS.

**GR** highlighted that we still have a lack of transformational change to deliver savings. **DB** stated this will be a difficult area for next year given that the recovery plans will need to load efficiency plans heavily. We need to ensure that the targets are realistic and deliverable.

***The ICB Finance Committee noted:***

- Month 10 Efficiency delivery and the progress that has been made in bridging the gap in the unidentified savings plans
- The revised efficiency forecast position of £26.7m that has been reported

**7.0 Minute No. SFC-24-02.007 – Budgetary Control Framework**

**Report received as read.**

7.1 **LC** explained that the Budgetary Control Framework has been refreshed to incorporate the following changes:

- Presentation updated to reflect the latest corporate templates.
- Guidance & embedded documents updated to reflect the latest versions of finance policies including the recently implemented 'triple lock' process for approval of expenditure.
- New section added within Pay to include NHSE approval requirements.
- New sections added to detail budget holder responsibilities in respect of off payroll working (IR35), and the new financial standard in respect of finance leases (IFRS16)

She noted that the framework was discussed and recommended for approval at Finance Committee by the Senior Leadership team at the meeting on the 30th January 2024. This was per the request from the Committee last month.

Once approved the revised policy will be disseminated to all budget holders, promoted via the staff huddle, and made available to all staff via the intranet.

***The ICB Finance Committee:***

- Approved the revised Budgetary Control Framework

**8.0 Minute No. SFC-24-02.008 – Any Other Business**

**CS** gave special recognition and thanks to Laura Clare for all her hard work over the many years within the NHS. Laura will be leaving the ICB today to work for BPAS.

Meeting closed at 14.43.

**Date And Time of Next Meeting**

Tuesday 26th March 2024, 2.00pm via Teams.

**NHS Shropshire, Telford and Wrekin**
**Integrated Care System Finance Committee (Section 2) Meeting**
**Thursday 22nd February 2024 at 3.15pm**
**Via Microsoft Teams**

**Present:**

| **Name:** | **Title:** |
|---|---|
| Trevor J McMillian OBE (Chair) | Non-Executive Director NHS STW |
| Claire Skidmore | Chief Finance Officer NHS STW |
| Sarah Lloyd | Chief Finance Officer SCHT |
| Sarfraz Nawaz | Non-Executive - RJAH |
| David Bennett | Non-Executive Director NHS STW |
| Peter Featherstone | Non-Executive SCHT |
| Helen Troalen | Director of Finance SATH |
| Craig MacBeth | Chief Finance Officer – RJAH |

**Attendees:**

| | |
|---|---|
| Gareth Robinson | Director of Delivery and Transformation NHS STW |
| Kate Owen | Head of PMO NHS STW |
| Angela Szabo | Interim - Director of Finance NHS STW |
| Sam Cooper | Apprentice Trainee – NHS STW |
| Cynthia Fearon | Corporate PA NHS STW (Note Taker) |

**Apologies:**

| | |
|---|---|
| Laura Clare | Deputy Chief Finance Officer NHS STW |
| Chris Sands | Chief Finance Officer – MPFT |
| Glenn Head | Deputy Chief Finance Officer – MPFT |
| Richard Miner | Non-Executive – SATH |

**1.0 Minute No. SFC-24-02.001 Introductions and Apologies**

1.1 The Chair, **TMcM,** welcomed everyone to the meeting and apologies were received as noted,

**2.0 Minute No. SFC-24-02.002 Members' Declarations of Interests**

2.1 No Declarations of Interest in addition to those already declared were noted.

**3.0 Minute No.SFC-24.02.003 Minutes of the Previous Meeting held on: 23rd January 2024.**

3.1 **TMcM** asked if there were any points to be raised on errors or accuracy within the minutes of the previous meeting. There being no amendments, the minutes were taken as a true and accurate record.

**4.0 Minute No. SFC-24.02.004 Matters Arising and Action List from Previous Meeting**

4.1 The action list from the previous meeting was reviewed and updated accordingly.

**5.0 Minute No. SFC-24.02.005 - ICS M10 Finance Overview**

5.1 **Report received as read.**

**CS** highlighted that we are now reporting a forecast of just short of £133m which is £3.3m different to the reforecast position that was submitted to NHSE. However, that is due to the additional cost of Industrial Action that took place December to January and NHSE have asked that we report the additional £3.3m separately.

**CS** mentioned that the NHSE national team are planning to give fair share allocations to the system to cover Industrial Action costs. **CS** added that at the moment the allocation value is not confirmed and there is a risk it may fall short of our excess cost. As it stands, none of the Provider organisations could easily provide mitigations that would cover off any shortfall given how much we've already put towards the position in the re-forecast.

**CS** reported that all organisations continue to work through additional phased mitigation plans for the year to address risks to delivery of the position. **CS** added that the remaining unmitigated risk to delivery of the forecast position is reported as £8.5m at Month 10 which is reducing as we travel closer to the end of the year.

**CS** explained the main area of overspend continues to be in SATH and relates to the key drivers around escalation costs, elective activity costs and staffing issues. The ICB also continues to see a year-to-date variance to plan attributable to expenditure in Prescribing and Individual Commissioning, particularly driven by price increases outstripping planned inflation.

**CS** highlighted that at M10 the overall system capital position is £11.7m under planned expenditure (before any impact of IFRS16). All organisations are reporting slippage in phasing of internal programmes. There is also a £1m underspend forecast against the full year plan.

**PF** queried from the financial pack why it was reported that SATH have elective activity costs at £9.2m and why it was noted as 'out of their control'. **HT** responded that it is driven by the elective recovery pressure which SATH have had conversations with NHSE about SATH's elective performance trajectory. The November letter from NHSE clarified that our relative priority is financial performance over elective activity excluding cancer. **HT** added, at that point that gave SATH the grounds on which to stop doing some of the expensive outsourcing work.

**The System Finance Committee noted the following:**

- The M10 headlines for the system financial position (£114.8m YTD deficit, £59.0m adverse to YTD plan).
- That the system is now reporting a forecast deficit of £132.8m including £3.3m of additional industrial action costs. This is recognised by NHSE and has been signed off by individual and System Boards.
- That all organisations continue to work through additional phased mitigation plans for the year to address risks to delivery of the position.

**6.0 Minute No. SFC-24-02.006 ICS M10 Efficiency Update**

**Report received as read.**

**6.1** **KO** highlighted that the efficiency plan across the system is £70m. At month 10 The YTD efficiency position for each organisation demonstrates that £40.8m of savings have been delivered against a year-to-date plan of £50.7m. Therefore, the system reports an adverse variance to plan of -£9.8m**.**

**KO** explained the main underperformance falls within SaTH (-£10.4m YTD) and the majority of slippage directly relates to escalation costs which has been previously reported. SaTH also reported an underperformance on core efficiencies within corporate services, nurse recruitment and corporate estates.

**KO** higjlighted that a review was undertaken in November 2023 to consider the most likely efficiency delivery and a revised forecast position was shared and agreed with NHSE as part of the overall finance position. This reported that the system would deliver £52.9m of efficiencies by March which is 75% of the total plan (-£17m). **KO** added, each partner organisation has remained committed to identifying further opportunities and stretching existing plans where possible. During Month 10 additional non recurrent savings have been identified and reported within the ICB and at SaTH and this has improved the overall forecast position to £54.1m. (77%).

**KO** highlighted that overall, progress has been made in delivering the savings programmes to date and further opportunities have been identified to meet the stretch targets set at the beginning of the year. **KO** added that a revised efficiency forecast of £54m has been reported in Month 10 which is an improvement from last month of £1.2m.

**KO** stated that each partner organisation continues to oversee its own CIP delivery which is managed through local sustainability working groups and monthly reporting is sent through to the Financial Improvement Programme Group for oversight at a system level.

**KO** emphasised that focus is now drawn to developing a robust set of plans for next year and beyond which will help to deliver longer term sustainability, these will need to be ambitious and will require collaboration across all system partners and teams.

**KO** stated that we will continue to monitor the outputs very closely and also look to create a lesson learned report. “What went well and what didn’t go as well”.

**SN** stated it would be interesting to see the kind of track record of efficiency across the system over a number of years. If that information is captured somewhere, it would be interesting to see the plan versus delivery.

**SN** queried whether we are setting ourselves realistic efficiency plans that can be achieved.

**Action: KO to report on the track record for efficiency (plan v's actual) for past years.**

**SN** suggested that we could perhaps look at greater system work and collaboration for example of amalgamation of corporate teams. Given that this is the most challenge system in the country, that seems an obvious area of savings. **SN** added, this could also be considered from a resilience perspective as we are one of the smaller systems in the country.

**GR** stated that we did start to pull together an ambition around this area and the paper was submitted and supported by Chief Execs to focus on a range of areas and predominantly looking at the ones where we felt there was consensus across the ICS and we would be able to find some benefits from aligning corporate services more closely. That took a number of attempts to get launched. **GR** added that previously it had not moved forward as prioritisation of provider and commissioner resource into this area was not made as greater efficiencies were deemed to be available from other areas of focus.

**KO** stated that Corporate Services is a priority for pipeline opportunities for future years.

**HT** acknowledged a place for Corporate Redesign but suggested that we should be really concentrating those resources on designing our pathways that suit our patients best.

**SL** stated that she was totally in agreement with what **HT** had stated. **SL** added that we do share some services, however we need to share more to deliver higher levels of efficiencies.

**PF** stated that he would still like to see a detailed paper regarding the benchmarking of the cost drivers. i.e., where are we working efficiently. Where are we not working efficiently. **PF** added that he would like to see how the modelling work with PA consulting will be implemented as he is aware PA consulting has done that work within the NHS in the Dudley area.

**CS** explained the PA Consulting were commissioned to build the model, not to do the benchmarking work within the STW system. **CS** added that she knows the CFO that oversees the Black Country ICS, so she will liaise with him regarding the benchmarking work that PA Consulting did for them and to see if there is anything relevant that we can take from them.

**Action: CS to find out more about the work that PA Consulting have done in The Black Country.**

**7.0 Minute No. SFC-24.02.007 Any Other Business**

7.1 There were no items raised as AOB.

Meeting closed at 16.12.

**Date and Time of Next Meeting**

Tuesday 26th March 2024, 15,15pm via Teams.