Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

STW Integrated Care Board - Appendices

MEETING
27 March 2024 15:10 GMT

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22 March 2024

Agenda

Location	Date	Time
The Sovereign Suite, Shrewsbury Town Football Club, Cloud Meadow, Oteley Road, Shrewsbury, SY2 6ST	27 Mar 2024	15:10 GMT

Contents

Agenda Item

ICB 27-03-023

Delegation of Specified Specialised Acute Service Lines

Dated 2024

(1) **NHS ENGLAND**

- and -

(2) **NHS SHROPSHIRE, TELFORD AND WREKIN ICB INTEGRATED CARE BOARD**

Delegation Agreement between NHS England and NHS Shropshire, Telford and Wrekin ICB in relation to Specialised Commissioning Functions

Table of contents

Clause heading and number Page number:

Contents

DELEGATION AGREEMENT FOR SPECIFIED FUNCTIONS

1. **PARTICULARS**

1.1 This Agreement records the particulars of the agreement made between NHS England and the Integrated Care Board (ICB) named below.

Integrated Care Board	NHS Shropshire, Telford and Wrekin ICB
Area	The area covered by the ICB is aligned with the two unitary authorities: County of Shropshire and Borough of Telford and Wrekin
Date of Agreement	[Date]
ICB Representative	[Insert details of name of manager of this Agreement for the ICB]
ICB Email Address for Notices	[Insert Address]
NHS England Representative	Dale Bywater, Regional Director (Midlands)
NHS England Email Address for Notices	england.midlandscorporate@nhs.net

1.2 This Agreement comprises:

1.2.1 the Particulars (Clause 1);

1.2.2 the Terms and Conditions (Clauses 2 to 32);

1.2.3 the Schedules; and

1.2.4 the Mandated Guidance

Signed by **NHS England**

DALE BYWATER

REGIONAL DIRECTOR - MIDLANDS

(for and on behalf of NHS England)

Signed by **NHS Shropshire, Telford and Wrekin Integrated Care Board**

[Insert name of Authorised Signatory]

[Insert title of Authorised Signatory]

[for and on behalf of] NHS Shropshire, Telford and Wrekin Integrated Care Board

TERMS AND CONDITIONS

2. INTERPRETATION

2.1 This Agreement is to be interpreted in accordance with SCHEDULE 1 *(Definitions and Interpretation)*.

2.2 If there is any conflict or inconsistency between the provisions of this Agreement, that conflict or inconsistency must be resolved according to the following order of priority:

2.2.1 the Developmental Arrangements;

2.2.2 the Particulars and Terms and Conditions (Clauses 1 to 32);

2.2.3 Mandated Guidance;

2.2.4 all Schedules excluding Developmental Arrangements and Local Terms; and

2.2.5 Local Terms.

2.3 This Agreement constitutes the entire agreement and understanding between the Parties relating to the Delegation and supersedes all previous agreements, promises and understandings between them, whether written or oral, relating to its subject matter.

2.4 Where it is indicated that a provision in this Agreement is not used, that provision is not relevant and has no application in this Agreement.

2.5 Where a particular clause is included in this Agreement but is not relevant to the ICB because that clause relates to matters which do not apply the ICB (for example, if the clause only relates to functions that are not Delegated Functions in respect of the ICB), that clause is not relevant and has no application to this Agreement.

3. BACKGROUND

3.1 NHS England has statutory functions (duties and powers) conferred on it by legislation to make arrangements for the provision of prescribed services known as Specialised Services. These services support people with a range of rare and complex conditions. They are currently set out in the Prescribed Specialised Services Manual. The legislative basis for identifying these Specialised Services is Regulation 11 and Schedule 4 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996.

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

3.3 Pursuant to section 65Z5 of the NHS Act, NHS England is able to delegate responsibility for carrying out its Commissioning Functions to an ICB. NHS England will remain accountable to Parliament for ensuring that statutory requirements to commission all Specialised Services, and duties set out in the mandate, are being met.

3.4 By this Agreement, NHS England delegates the functions of commissioning certain Specialised Services (the “Delegated Functions”) to the ICB under section 65Z5 of the NHS Act.

3.5 This Agreement also sets out the elements of commissioning those Specialised Services for which NHS England will continue to have responsibility (the “Reserved Functions”).

3.6 Arrangements made under section 65Z5 may be made on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the ICB.

3.7 This Agreement sets out the terms that apply to the exercise of the Delegated Functions by the ICB. It also sets out each Party's responsibilities and the measures required to ensure the effective and efficient exercise of the Delegated Functions and Reserved Functions.

4. TERM

4.1 This Agreement has effect from the Date of Agreement set out in the Particulars and will remain in force unless terminated in accordance with Clause 27 *(Termination)* below.

5. PRINCIPLES

5.1 In complying with the terms of this Agreement, NHS England and the ICB must:

5.1.1 at all times have regard to the Triple Aim;

5.1.2 at all times act in good faith and with integrity towards each other;

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

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

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

5.1.6 act in a timely manner;

5.1.7 share information and Best Practice, and work collaboratively to identify solutions and enhance the evidence base for the commissioning and provision of health services, eliminate duplication of effort, mitigate risk and reduce cost; and

5.1.8 have regard to the needs and views of the other Party and as far as is lawful and reasonably practicable, take such needs and views into account.

6. DELEGATION

6.1 In accordance with its statutory powers under section 65Z5 of the NHS Act, NHS England hereby delegates the exercise of the Delegated Functions to the ICB to empower it to commission a range of services for its Population, as further described in this Agreement ("Delegation").

6.2 The Delegated Functions are the functions described as being delegated to the ICB as have been identified and included within Schedule 3 to this Agreement but excluding the Reserved Functions set out within Schedule 4.

6.3 The Delegation in respect of each Delegated Function has effect from the Effective Date of Delegation.

6.4 Decisions of the ICB in respect of the Delegated Functions and made in accordance with the terms of this Agreement shall be binding on NHS England and the ICB.

6.5 Unless expressly provided for in this Agreement, the ICB is not authorised by this Agreement to take any step or make any decision in respect of Reserved Functions. Any such purported decision of the ICB is invalid and not binding on NHS England unless ratified in writing by NHS England in accordance with the NHS England Scheme of Delegation and Standing Financial Instructions.

6.6 NHS England may, acting reasonably and solely to the extent that the decision relates to the Delegated Functions, substitute its own decision for any decision which the ICB purports to make where NHS England reasonably considers that the impact of the ICB decision could, in relation to the Delegated Functions, cause the ICB to be acting unlawfully, in breach of this Agreement including Mandated Guidance, or in breach of any Contract. The ICB must provide any information, assistance and support as NHS England requires to enable it to determine whether to make any such decision.

6.7 The terms of Clauses 6.5 and 6.6 are without prejudice to the ability of NHS England to enforce the terms of this Agreement or otherwise take action in respect of any failure by the ICB to comply with this Agreement.

7. EXERCISE OF DELEGATED FUNCTIONS

7.1 The ICB must establish effective, safe, efficient and economic arrangements for the discharge of the Delegated Functions.

7.2 The ICB agrees that it will exercise the Delegated Functions in accordance with:

7.2.1 the terms of this Agreement;

7.2.2 Mandated Guidance;

7.2.3 any Contractual Notices;

7.2.4 the Local Terms;

7.2.5 any Developmental Arrangements;

7.2.6 all applicable Law and Guidance;

7.2.7 the ICB's constitution;

7.2.8 the requirements of any assurance arrangements made by NHS England; and

7.2.9 Good Practice.

7.3 The ICB must perform the Delegated Functions in such a manner:

7.3.1 so as to ensure NHS England's compliance with NHS England's statutory duties in respect of the Reserved Functions and to enable NHS England to fulfil its Reserved Functions; and

7.3.2 having regard to NHS England's accountability to the Secretary of State and Parliament in respect of both the Delegated Functions and Reserved Functions; and

7.3.3 so as to ensure that the ICB complies with its statutory duties and requirements including those duties set out in Section 14Z32 to Section 14Z44 and the NICE Regulations.

7.4 In exercising the Delegated Functions, the ICB must comply with all Mandated Guidance as set out in this Agreement or as otherwise may be issued by NHS England

from time to time including, but not limited to, ensuring compliance with National Standards and following National Specifications.

7.5 Where Developmental Arrangements conflict with any other term of this Agreement, the Developmental Arrangements shall take precedence until such time as NHS England agrees to the removal or amendment of the relevant Developmental Arrangements in accordance with Clause 26 (*Variations*).

7.6 The ICB must develop an operational scheme(s) of delegation defining those individuals or groups of individuals, including committees, who may discharge aspects of the Delegated Functions. For the purposes of this clause, the ICB may include the operational scheme(s) of delegation within its general organisational scheme of delegation.

7.7 NHS England may by Contractual Notice allocate Contracts to the ICB such that they are included as part of the Delegation. The Delegated Functions must be exercised both in respect of the relevant Contract and any related matters concerning any Specialised Service Provider that is a party to a Contract. NHS England may add or remove Contracts where this is associated with an extension or reduction of the scope of the Delegated Functions.

7.8 Subsequent to the Effective Date of Delegation and for the duration of this Agreement, unless otherwise agreed any new Contract entered into in respect of the Delegated Functions shall be managed by the ICB in accordance with the provisions of this Agreement.

7.9 Subject to the provisions of this Agreement, the ICB may determine the arrangements for the exercise of the Delegated Functions.

8. REQUIREMENT FOR ICB COLLABORATION ARRANGEMENT

8.1 Subject to the provisions of Clause 12 *(Further Arrangements)*, the ICB must establish appropriate ICB Collaboration Arrangements with other ICBs in order to ensure that the commissioning of the Delegated Services can take place across an appropriate geographical footprint for the nature of each particular Delegated Service with consideration of population size, provider landscape and patient flow. Such ICB arrangements in respect of the Delegated Functions must be approved in advance by NHS England.

8.2 The ICB must establish, as part of or separate to the arrangements set out in Clause 8.1, an agreement that sets out the arrangements in respect of the Commissioning Team as required by Clause 13.

8.3 The ICB must participate in discussions, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view with the other ICBs within the ICB Collaboration Arrangement. The members of the ICB Collaboration Arrangement shall have a collective responsibility for the operation of the ICB Collaboration Arrangement.

8.4 The ICB shall ensure that any ICB Collaboration Arrangement is documented and such documentation must include (but is not limited to) the following:

8.4.1 membership which is limited solely to ICBs unless otherwise approved by NHS England;

8.4.2 clear governance arrangements including reporting lines to the ICBs' Boards;

8.4.3 provisions for independent scrutiny of decision making;

8.4.4 the Delegated Functions or elements thereof which are the subject of the arrangements;

8.4.5 the Delegated Services which are subject to the arrangements;

8.4.6 financial arrangements and any pooled fund arrangements;

8.4.7 data sharing arrangements including evidence of a Data Protection Impact Assessment;

8.4.8 terms of reference for decision making; and

8.4.9 limits on onward delegation.

8.5 The ICB must not terminate an ICB Collaboration Arrangement in respect of the Delegated Functions without the prior written approval of NHS England.

9. PERFORMANCE OF THE RESERVED FUNCTIONS AND COMMISSIONING SUPPORT ARRANGEMENTS

9.1 NHS England will remain responsible for the performance of the Reserved Functions.

9.2 For the avoidance of doubt, the Parties acknowledge that the Delegation may be amended, and additional functions may be delegated to the ICB, in which event consequential changes to this Agreement shall be agreed with the ICB pursuant to Clause 26 (*Variations*) of this Agreement.

9.3 Where it considers appropriate NHS England will work collaboratively with the ICB when exercising the Reserved Functions.

9.4 If there is any conflict or inconsistency between functions that are named as Delegated Functions and functions that are named as Reserved Functions, then such functions shall be interpreted as Reserved Functions unless and until NHS England confirms otherwise. If an ICB identifies such a conflict or inconsistency, it will inform NHS England as soon as is reasonably practicable.

9.5 The Parties acknowledge that they may agree for the ICB to provide Administrative and Management Services to NHS England in relation to certain Reserved Functions and Retained Services in order to assist in the efficient and effective exercise of such functions. Any such Commissioning Team Arrangements shall be set out in writing.

9.6 Notwithstanding any arrangement for or provision of Administrative and Management Services in respect of the Retained Services and Reserved Functions, NHS England shall retain statutory responsibility for, and be accountable for, the commissioning of the Retained Services.

9.7 The Parties acknowledge that they may agree for NHS England to provide Administrative and Management Services to ICBs in relation to certain Delegated Functions and Delegated Services in order to assist in the efficient and effective exercise of such Delegated Functions. Any such Administrative and Management Services shall be set out in writing.

9.8 Notwithstanding any arrangement for or provision of Administrative and Management Services in respect of the Delegated Services, the ICB shall retain delegated responsibility for the commissioning of the Delegated Services.

10. FINANCE

10.1 Without prejudice to any other provision in this Agreement, the ICB must comply with the Finance Guidance and any such financial processes as required by NHS England

for the management, reporting and accounting of funds used for the purposes of the Delegated Functions.

10.2 The ICB acknowledges that it will receive funds from NHS England in respect of the Delegated Functions (the "Delegated Funds") and that these are in addition to the funds allocated to it within its Annual Allocation.

10.3 Subject to Clause 10.4 and any provisions in the Schedules or Mandated Guidance, the ICB may use:

10.3.1 its Annual Allocation and the Delegated Funds in the exercise of the Delegated Functions; and

10.3.2 the Delegated Funds and its Annual Allocation in the exercise of the ICB's Functions other than the Delegated Functions.

10.4 The ICB's expenditure on the Delegated Functions must be sufficient to:

10.4.1 ensure that NHS England is able to fulfil its functions, including without limitation the Reserved Functions, effectively and efficiently;

10.4.2 meet all liabilities arising under or in connection with all Contracts in so far as they relate to the exercise of the Delegated Functions;

10.4.3 appropriately commission the Delegated Services in accordance with Mandatory Guidance, National Specifications, National Standards and Guidance; and

10.4.4 meet national commitments from time to time on expenditure on specific Delegated Functions.

10.5 NHS England may increase or reduce the Delegated Funds in any Financial Year, by sending a notice to the ICB of such increase or decrease:

10.5.1 in order to take into account any monthly adjustments or corrections to the Delegated Funds that NHS England considers appropriate, including without limitation, adjustments following any changes to the Delegated Functions, changes in allocations, changes in Contracts, to implement Mandated Guidance or otherwise;

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

10.5.3 to take into account any Losses of NHS England for which the ICB is required to indemnify NHS England under Clause 17 (*Claims and Litigation)*;

10.5.4 to take into account any adjustments that NHS England considers appropriate (including without limitation in order to make corrections or otherwise to reflect notional budgets) to reflect funds transferred (or that should have been transferred) to the ICB in respect of the Delegated Functions or funds transferred (or that should have been transferred) to the ICB in respect of Administrative and Management Services; and

10.5.5 in order to ensure compliance by NHS England with its obligations under the NHS Act (including, Part 11 of the NHS Act) or any action taken or direction made by the Secretary of State in respect of NHS England under the NHS Act.

10.6 NHS England acknowledges that the intention of Clause 10.5 is to reflect genuine corrections and adjustments to the Delegated Funds and may not be used to change

the allocation of the Delegated Funds unless there are significant or exceptional circumstances that would require such corrections or adjustments.

10.7 The ICB acknowledges that it must comply with its statutory financial duties, including those under Part 11 of the NHS Act to the extent that these sections apply in relation to the receipt of the Delegated Funds.

10.8 NHS England may in respect of the Delegated Funds:

10.8.1 notify the ICB regarding the required payment of sums by the ICB to NHS England in respect of charges referable to the valuation or disposal of assets and such conditions as to records, certificates or otherwise;

10.8.2 by notice, require the ICB to take such action or step in respect of the Delegated Funds, in order to ensure compliance by NHS England of its duties or functions under the NHS (including Part 11 of the NHS Act) or any action taken or direction made by the Secretary of State under the NHS Act.

10.9 The Schedules to this Agreement may identify further financial provisions in respect of the exercise of the Delegated Functions.

10.10 NHS England may issue Mandated Guidance in respect of the financial arrangements in respect of the Delegated Functions.

10.11 NHS England will pay the Delegated Funds to the ICB using the revenue transfer process as used for the Annual Allocation or such other process as notified to the ICB from time to time.

10.12 Without prejudice to any other obligation upon the ICB, for the purposes of the Delegated Functions the ICB agrees that it must use its resources in accordance with:

10.12.1 the terms and conditions of this Agreement including any Mandated Guidance issued by NHS England from time to time in relation to the use of resources for the purposes of the Delegated Functions (including in relation to the form or contents of any accounts);

10.12.2 any NHS payment scheme published by NHS England;

10.12.3 the business rules as set out in NHS England's planning guidance or such other documents issued by NHS England from time to time;

10.12.4 any Capital Investment Guidance;

10.12.5 the HM Treasury Guidance *Managing Public Money* (dated September 2022) as replaced or updated from time to time; and

10.12.6 any other Guidance published by NHS England with respect to the financial management of Delegated Functions.

10.13 Without prejudice to any other obligation upon the ICB, the ICB agrees that it must provide:

10.13.1 all information, assistance and support to NHS England in relation to the audit and/or investigation (whether internal or external and whether under Law or otherwise) in relation to the use of or payment of resources for the purposes of the Delegated Functions and the discharge of those functions;

10.13.2 such reports in relation to the expenditure on the Delegated Functions as set out in Mandated Guidance, the Schedules to this Agreement or as otherwise required by NHS England.

Pooled Funds

10.14 Subject to the provisions of this Agreement, the ICB may, for the purposes of exercising the Delegated Functions under this Agreement, establish and maintain a pooled fund(s) in respect of any part of the Delegated Funds with:

10.14.1 NHS England in accordance with sections 13V or 65Z6 of the NHS Act;

10.14.2 one or more ICBs in accordance with section 65Z6 of the NHS Act as part of a Further Arrangement; or

10.14.3 NHS England and one or more ICBs in accordance with section 13V of the NHS Act; and

10.15 NHS England and one or more ICBs in accordance with section 65Z6 of the NHS Act. Where the ICB has decided to enter into arrangements under Clause 10.14 the agreement must be in writing and must specify:

10.15.1 the agreed aims and outcomes of the arrangements;

10.15.2 the payments to be made by each partner and how those payments may be varied;

10.15.3 the specific Delegated Functions which are the subject of the arrangements;

10.15.4 the Delegated Services which are subject to the arrangements;

10.15.5 the duration of the arrangements and provision for the review or variation or termination of the arrangements;

10.15.6 the arrangements in place for governance of the pooled fund; and

10.15.7 the arrangements in place for assuring, oversight and monitoring of the ICB's exercise of the functions referred to in 10.15.3.

10.16 At the date of this Agreement, details of the pooled funds (including any terms as to the governance and payments out of such pooled fund) of NHS England and the ICB are set out in the Local Terms.

11. INFORMATION, PLANNING AND REPORTING

11.1 The ICB must provide to NHS England:

11.1.1 such information or explanations in relation to the exercise of the Delegated Functions; as required by NHS England from time to time; and

11.1.2 all such information (and in such form), that may be relevant to NHS England in relation to the exercise by NHS England of its other duties or functions including, without limitation, the Reserved Functions.

11.2 The provisions of this Clause 11 are without prejudice to the ability of NHS England to exercise its other powers and duties in obtaining information from and assessing the performance of the ICB.

Forward Plan and Annual Report

11.3 Before the start of each Financial Year, the ICB must describe in its joint forward plan prepared in accordance with section 14Z52 of the NHS Act how it intends to exercise the Delegated Functions.

11.4 The ICB must report on its exercise of the Delegated Functions in its annual report prepared in accordance with section 14Z58 of the NHS Act.

Risk Register

11.5 The ICB must maintain a risk register in respect of its exercise of the Delegated Functions and periodically review its content. The risk register must follow such format as may be notified by NHS England to the ICB from time to time.

12. FURTHER ARRANGEMENTS

12.1 In addition to any ICB Collaboration Arrangement agreed in accordance with Clause 8 (*ICB Collaboration Arrangements*) the ICB must give due consideration to whether any of the Delegated Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under section 65Z5 and section 75 of the NHS Act ("Further Arrangements").

12.2 The ICB may only make Further Arrangements with another person (a "Sub-Delegate") with the prior written approval of NHS England.

12.3 The approval of any Further Arrangements may:

12.3.1 include approval of the terms of the proposed Further Arrangements; and

12.3.2 require conditions to be met by the ICB and the Sub-Delegate in respect of that arrangement.

12.4 All Further Arrangements must be made in writing.

The ICB must not terminate Further Arrangements without the prior written approval of NHS England.

12.5 If the ICB enters into a Further Arrangement it must ensure that the Sub-Delegate does not make onward arrangements for the exercise of any or all of the Delegated Functions without the prior written approval of NHS England.

12.6 The terms of this Clause 12 do not prevent the ICB from making arrangements for assistance and support in the exercise of the Delegated Functions with any person, where such arrangements reserve the consideration and making of any decision in respect of a Delegated Function to the ICB.

12.7 Where Further Arrangements are made, and unless NHS England has otherwise given specific prior written agreement, any obligations or duties on the part of the ICB under this Agreement that are relevant to those Further Arrangements shall also require the ICB to ensure that all Sub-Delegates comply with such obligations or duties and support the ICB in doing so.

13. STAFFING, WORKFORCE AND COMMISSIONING TEAMS

13.1 Where there is an arrangement for NHS England to provide Administrative and Management Services to the ICB, the ICB shall provide full co-operation with NHS England and enter into any necessary arrangements with NHS England and, where appropriate, other ICBs in respect of the Specialised Services Staff.

13.2 The ICB shall, if and where required by NHS England, enter into appropriate arrangements with NHS England in respect of the transfer of Specialised Services Staff.

13.3 The ICB shall, where appropriate, enter into an agreement with other ICBs, in order to establish arrangements in respect of the Commissioning Team Where appropriate, this

agreement may be included as part of the ICB Collaboration Arrangement entered into in accordance with Clause 8.

14. **BREACH**

14.1 If the ICB does not comply with the terms of this Agreement, then NHS England may:

14.1.1 exercise its rights under this Agreement; and

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

14.2 Without prejudice to Clause 14.1, if the ICB does not comply with the terms of this Agreement (including if the ICB exceeds its delegated authority under the Delegation), NHS England may (at its sole discretion):

14.2.1 waive its rights in relation to such non-compliance in accordance with Clause 14.3;

14.2.2 ratify any decision in accordance with Clause 6.5;

14.2.3 substitute a decision in accordance with Clause 6.6;

14.2.4 amend Developmental Arrangements or impose new Developmental Arrangements;

14.2.5 revoke the whole or part of the Delegation and terminate this Agreement in accordance with Clause 27 *(Termination)* below;

14.2.6 exercise the Escalation Rights in accordance with Clause 155 *(Escalation Rights)*; and/or

14.2.7 exercise its rights under common law.

14.3 NHS England may waive any non-compliance by the ICB with the terms of this Agreement provided that the ICB provides a written report to NHS England as required by Clause 14.4 and, after considering the ICB's written report, NHS England is satisfied that the waiver is justified.

14.4 If:

14.4.1 the ICB does not comply with this Agreement;

14.4.2 the ICB considers that it may not be able to comply with this Agreement;

14.4.3 NHS England notifies the ICB that it considers the ICB has not complied with this Agreement; or

14.4.4 NHS England notifies the ICB that it considers that the ICB may not be able to comply with this Agreement,

then the ICB must provide a written report to NHS England within ten (10) Operational Days of the non-compliance (or the date on which the ICB identifies that it may not be able to comply with this Agreement) setting out:

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

14.4.6 a plan for how the ICB proposes to remedy the non-compliance.

15. **ESCALATION RIGHTS**

15.1 If the ICB does not comply with this Agreement, NHS England may exercise the following Escalation Rights:

15.1.1 NHS England may require a suitably senior representative of the ICB to attend a review meeting within ten (10) Operational Days of NHS England becoming aware of the non-compliance; and

15.1.2 NHS England may require the ICB to prepare an action plan and report within twenty (20) Operational Days of the review meeting (to include details of the non-compliance and a plan for how the ICB proposes to remedy the non-compliance).

15.2 If NHS England does not comply with this Agreement, the ICB may require a suitably senior representative of NHS England to attend a review meeting within ten (10) Operational Days of the ICB making NHS England aware of the non-compliance.

15.3 Nothing in Clause 15 *(Escalation Rights)* will affect NHS England's right to substitute a decision in accordance with Clause 6.76, revoke the Delegation or terminate this Agreement in accordance with Clause 27 *(Termination)* below.

16. LIABILITY AND INDEMNITY

16.1 NHS England is liable in respect of any Losses arising in respect of NHS England's negligence, fraud, recklessness or deliberate breach in respect of the Delegated Functions and occurring after the Effective Date of Delegation and, if the ICB suffers any Losses in respect of such actions by NHS England, NHS England shall make such adjustments to the Annual Allocation (or other amounts payable to the ICB) in order to reflect any Losses suffered by the ICB (except to the extent that the ICB is liable for such Losses pursuant to Clause 16.3).

16.2 For the avoidance of doubt, NHS England remains liable for a Claim relating to facts, events or circumstances concerning the Delegated Functions before the Effective Date of Delegation.

16.3 The ICB is liable to (and shall pay) NHS England for any Losses suffered by NHS England that result from or arise out of the ICB's negligence, fraud, recklessness or breach of the Delegation (including any actions that are taken that exceed the authority conferred by the Delegation) or this Agreement. In respect of such Losses, NHS England may, at its discretion and without prejudice to any other rights, either require payment from the ICB or make such adjustments to the Delegated Funds pursuant to Clause 10.5. The ICB shall not be liable to the extent that the Losses arose prior to the Effective Date of Delegation.

16.4 Each Party acknowledges and agrees that any rights acquired, or liabilities (including liabilities in tort) incurred, in respect of the exercise by the ICB of any Delegated Function are enforceable by or against the ICB only, in accordance with section 65Z5(6) of the NHS Act.

16.5 Each Party will at all times take all reasonable steps to minimise and mitigate any Losses or other matters for which one Party is entitled to be indemnified by or to bring a claim against the other under this Agreement.

17. CLAIMS AND LITIGATION

17.1 Nothing in this Clause 17 *(Claims and Litigation)* shall be interpreted as affecting the reservation to NHS England of the Reserved Functions.

17.2 Except in the circumstances set out in Clause **Error! Reference source not found.**17.5 and subject always to compliance with this Clause 17 *(Claims and Litigation)*, the ICB shall be responsible for and shall retain the conduct of any Claim.

17.3 The ICB must:

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

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

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

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

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

17.4 Subject to Clauses 17.3 and 17.5 the ICB is entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit.

NHS England Stepping into Claims

17.5 NHS England may, at any time following discussion with the ICB, send a notice to the ICB stating that NHS England will take over the conduct of the Claim and the ICB must immediately take all steps necessary to transfer the conduct of such Claim to NHS England unless and until NHS England transfers conduct back to the ICB. In such cases:

17.5.1 NHS England shall be entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit, provided that if NHS England wishes to invoke Clause 17.5.3 it agrees to seek the ICB's views on any proposal to pay or settle that Claim prior to finalising such payment or settlement; and

17.5.2 the Delegation shall be treated as being revoked to the extent that and for so long as NHS England has assumed responsibility for exercising those of the Delegated Functions that are necessary for the purposes of having conduct of the Claim; and

17.5.3 NHS England may, at its discretion and without prejudice to any other rights, either require payment from the ICB for such Claim Losses or make an adjustment to the Delegated Funds pursuant to Clause 10.5.3 for the purposes of meeting any Claim Losses associated with that Claim.

Claim Losses

17.6 The ICB and NHS England shall notify each other as soon as reasonably practicable of becoming aware of any Claim Losses.

17.7 The ICB acknowledges that NHS England will pay to the ICB the funds that are attributable to the Delegated Functions. Accordingly, the ICB acknowledges that it must pay any Claim Losses out of either the Delegated Funds or its Annual Allocation. NHS

England may, in respect of any Claim Losses, at its discretion and without prejudice to any other rights, either require payment from the ICB for such Claim Losses or pursuant to Clause 10.5.3 make such adjustments to the Delegated Funds to take into account the amount of any Claim Losses (other than any Claim Losses in respect of which NHS England has retained any funds, provisions or other resources to discharge such Claim Losses). For the avoidance of doubt, in circumstances where NHS England suffers any Claim Losses, then NHS England shall be entitled to recoup such Claim Losses pursuant to Clause 10.5.3. If and to the extent that NHS England has retained any funds, provisions or other resources to discharge such Claim Losses, then NHS England may either use such funds to discharge the Claim Loss or make an upward adjustment to the amounts paid to the ICB pursuant to Clause 10.5.3.

18. DATA PROTECTION, FREEDOM OF INFORMATION AND TRANSPARENCY

18.1 The Parties must ensure that all Personal Data processed by or on behalf of them while carrying out the Delegated Functions and Reserved Functions is processed in accordance with the relevant Party's obligations under Data Protection Legislation and Data Guidance and the Parties must assist each other as necessary to enable each other to comply with these obligations.

18.2 The ICB must respond to any information governance breach in accordance with Information Governance Guidance for Serious Incidents. If the ICB is required under Data Protection Legislation to notify the Information Commissioner's Office or a Data Subject of an information governance breach then as soon as reasonably practical and in any event on or before the first such notification is made the ICB must fully inform NHS England of the information governance breach. This clause does not require the ICB to provide NHS England with information which identifies any individual affected by the information governance breach where doing so would breach Data Protection Legislation.

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

18.4 NHS England may, from time to time, issue a data sharing protocol or update a protocol previously issued relating to the data sharing in relation to the Delegated Functions and/or Reserved Functions. The ICB shall comply with such data sharing protocols.

18.5 Each Party acknowledges that the other is a public authority for the purposes of the Freedom of Information Act 2000 ("FOIA") and the Environmental Information Regulations 2004 ("EIR").

18.6 Each Party may be required by statute to disclose further information about the Agreement and the Relevant Information in response to a specific request under FOIA or EIR, in which case:

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

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

18.6.3 subject only to Clause 17 *(Claims and Litigation)*, each Party acknowledges that the final decision as to the form or content of the response to any request is a matter for the Party to whom the request is addressed.

18.7 NHS England may, from time to time, issue a FOIA or EIR protocol or update a protocol previously issued relating to the handling and responding to of FOIA or EIR requests in

relation to the Delegated Functions. The ICB shall comply with such FOIA or EIR protocols.

18.8 Delegated **Services**

NHS England delegates to the ICB the statutory function for commissioning the Specialised Services set out in this Schedule 2 (*Delegated Services*) subject to the reservations set out in Schedule 4 (*Retained Functions*) and the provisions of any Developmental Arrangements set out in Schedule 9.

The following Specialised Services will be delegated to the ICB on 1 April 2024:

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
2	Adult congenital heart disease services	13X	Adult congenital heart disease services (non-surgical)
		13Y	Adult congenital heart disease services (surgical)
3	Adult specialist pain management services	31Z	Adult specialist pain management services
4	Adult specialist respiratory services	29M	Interstitial lung disease (adults)
		29S	Severe asthma (adults)
		29L	Lung volume reduction (adults)
5	Adult specialist rheumatology services	26Z	Adult specialist rheumatology services
7	Adult Specialist Cardiac Services	13A	Complex device therapy
		13B	Cardiac electrophysiology & ablation
		13C	Inherited cardiac conditions
		13E	Cardiac surgery (inpatient)
		13F	PPCI for ST- elevation myocardial infarction
		13H	Cardiac magnetic resonance imaging
		13T	Complex interventional cardiology (adults)
		13Z	Cardiac surgery (outpatient)
9	Adult specialist endocrinology services	27E	Adrenal Cancer (adults)
		27Z	Adult specialist endocrinology services
11	Adult specialist neurosciences services	08O	Neurology (adults)
		08P	Neurophysiology (adults)
		08R	Neuroradiology (adults)
		08S	Neurosurgery (adults)
		08T	Mechanical Thrombectomy
		58A	Neurosurgery LVHC national: surgical removal of clival chordoma and chondrosarcoma
		58B	Neurosurgery LVHC national: EC-IC bypass(complex/high flow)
		58C	Neurosurgery LVHC national: transoral excision of dens
		58D	Neurosurgery LVHC regional: anterior skull based tumours
		58E	Neurosurgery LVHC regional: lateral skull based tumours
		58F	Neurosurgery LVHC regional: surgical removal of brainstem lesions
		58G	Neurosurgery LVHC regional: deep brain stimulation
		58H	Neurosurgery LVHC regional: pineal tumour surgeries - resection
		58I	Neurosurgery LVHC regional: removal of arteriovenous malformations of the nervous system
		58J	Neurosurgery LVHC regional: epilepsy
		58K	Neurosurgery LVHC regional: insula glioma's/ complex low grade glioma's
		58L	Neurosurgery LVHC local: anterior lumbar fusion
	Adult specialist neurosciences services (continued)	58M	Neurosurgery LVHC local: removal of intramedullary spinal tumours

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
		58N	Neurosurgery LVHC local: intraventricular tumours resection
		58O	Neurosurgery LVHC local: surgical repair of aneurysms (surgical clipping)
		58P	Neurosurgery LVHC local: thoracic discectomy
		58Q	Neurosurgery LVHC local: microvascular decompression for trigeminal neuralgia
		58R	Neurosurgery LVHC local: awake surgery for removal of brain tumours
		58S	Neurosurgery LVHC local: removal of pituitary tumours including for Cushing's and acromegaly
12	Adult specialist ophthalmology services	37C	Artificial Eye Service
		37Z	Adult specialist ophthalmology services
13	Adult specialist orthopaedic services	34A	Orthopaedic surgery (adults)
		34R	Orthopaedic revision (adults)
15	Adult specialist renal services	11B	Renal dialysis
		11C	Access for renal dialysis
16	Adult specialist services for people living with HIV	14A	Adult specialised services for people living with HIV
17	Adult specialist vascular services	30Z	Adult specialist vascular services
18	Adult thoracic surgery services	29B	Complex thoracic surgery (adults)
		29Z	Adult thoracic surgery services: outpatients
30	Bone conduction hearing implant services (adults and children)	32B	Bone anchored hearing aids service
		32D	Middle ear implantable hearing aids service
35	Cleft lip and palate services (adults and children)	15Z	Cleft lip and palate services (adults and children)
36	Cochlear implantation services (adults and children)	32A	Cochlear implantation services (adults and children)
40	Complex spinal surgery services (adults and children)	06Z	Complex spinal surgery services (adults and children)
		08Z	Complex neuro-spinal surgery services (adults and children)
54	Fetal medicine services (adults and adolescents)	04C	Fetal medicine services (adults and adolescents)
58	Specialist adult gynaecological surgery and urinary surgery services for females	04A	Severe Endometriosis
		04D	Complex urinary incontinence and genital prolapse
58A	Specialist adult urological surgery services for men	41P	Penile implants
		41S	Surgical sperm removal
		41U	Urethral reconstruction
59	Specialist allergy services (adults and children)	17Z	Specialist allergy services (adults and children)
61	Specialist dermatology services (adults and children)	24Z	Specialist dermatology services (adults and children)
62	Specialist metabolic disorder services (adults and children)	36Z	Specialist metabolic disorder services (adults and children)
63	Specialist pain management services for children	23Y	Specialist pain management services for children
64	Specialist palliative care services for children and young adults	E23	Specialist palliative care services for children and young adults
65	Specialist services for adults with infectious diseases	18A	Specialist services for adults with infectious diseases

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
		18E	Specialist Bone and Joint Infection (adults)
72	Major trauma services (adults and children)	34T	Major trauma services (adults and children)
78	Neuropsychiatry services (adults and children)	08Y	Neuropsychiatry services (adults and children)
83	Paediatric cardiac services	23B	Paediatric cardiac services
94	Radiotherapy services (adults and children)	01R	Radiotherapy services (Adults)
		51R	Radiotherapy services (Children)
		01S	Stereotactic Radiosurgery / radiotherapy
105	Specialist cancer services (adults)	01C	Chemotherapy
		01J	Anal cancer (adults)
		01K	Malignant mesothelioma (adults)
		01M	Head and neck cancer (adults)
		01N	Kidney, bladder and prostate cancer (adults)
		01Q	Rare brain and CNS cancer (adults)
		01U	Oesophageal and gastric cancer (adults)
		01V	Biliary tract cancer (adults)
		01W	Liver cancer (adults)
		01Y	Cancer Outpatients (adults)
		01Z	Testicular cancer (adults)
		04F	Gynaecological cancer (adults)
		19V	Pancreatic cancer (adults)
		24Y	Skin cancer (adults)
		19C	Biliary tract cancer surgery (adults)
		19M	Liver cancer surgery (adults)
		19Q	Pancreatic cancer surgery (adults)
		51A	Interventional oncology (adults)
		51B	Brachytherapy (adults)
		51C	Molecular oncology (adults)
		61M	Head and neck cancer surgery (adults)
		61Q	Ophthalmic cancer surgery (adults)
		61U	Oesophageal and gastric cancer surgery (adults)
		61Z	Testicular cancer surgery (adults)
		33C	Transanal endoscopic microsurgery (adults)
		33D	Distal sacrectomy for advanced and recurrent rectal cancer (adults)
106	Specialist cancer services for children and young adults	01T	Teenage and young adult cancer
		23A	Children's cancer
106A	Specialist colorectal surgery services (adults)	33A	Complex surgery for faecal incontinence (adults)
		33B	Complex inflammatory bowel disease (adults)
107	Specialist dentistry services for children	23P	Specialist dentistry services for children
108	Specialist ear, nose and throat services for children	23D	Specialist ear, nose and throat services for children
109	Specialist endocrinology services for children	23E	Specialist endocrinology and diabetes services for children
110	Specialist gastroenterology, hepatology and nutritional support services for children	23F	Specialist gastroenterology, hepatology and nutritional support services for children
112	Specialist gynaecology services for children	73X	Specialist paediatric surgery services - gynaecology

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

SCHEDULE 3: Delegated Functions

1 Introduction

1.1 Subject to the reservations set out in Schedule 4 (*Reserved Functions*) and the provisions of any Developmental Arrangements, NHS England delegates to the ICB the statutory function for commissioning the Delegated Services. This Schedule 3 sets out the key powers and duties that the ICB will be required to carry out in exercise of the Delegated Functions being, in summary:

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

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

1.1.3 undertaking reviews of Delegated Services in respect of the Population;

1.1.4 supporting the management of the Specialised Commissioning Budget;

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

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

1.2 When exercising the Delegated Functions, ICBs are not acting on behalf of NHS England but acquire rights and incur any liabilities in exercising the functions.

2 General Obligations

2.1 The ICB is responsible for planning the commissioning of the Delegated Services in accordance with this Agreement. This includes ensuring at all times that the Delegated Services are commissioned in accordance with the National Standards.

2.2 The ICB shall put in place arrangements for collaborative working with other ICBs in accordance with Clause 8 (*Requirement for ICB Collaboration Arrangement*).

2.3 The Developmental Arrangements set out in Schedule 9 shall apply.

Specific Obligations

3 Assurance and Oversight

3.1 The ICB must at all times operate in accordance with:

3.1.1 the Oversight Framework published by NHS England;

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

3.1.3 any other relevant NHS oversight and assurance guidance;

collectively known as the “Assurance Processes”.

3.2 The ICB must:

3.2.1 develop and operate in accordance with mutually agreed ways of working in line with the Assurance Processes;

3.2.2 oversee the provision of Delegated Services and the outcomes being delivered for its Population in accordance with the Assurance Processes;

3.2.3 assure that Specialised Service Providers are meeting, or have an improvement plan in place to meet, National Standards;

3.2.4 provide any information and comply with specific actions in relation to the Delegated Services, as required by NHS England, including metrics and detailed reporting.

4 Attendance at governance meetings

4.1 The ICB must ensure that there is appropriate representation at forums established through the ICB Collaboration Arrangement.

4.2 The ICB must ensure that an individual(s) has been nominated to represent the ICB at the Delegated Commissioning Group (DCG) and regularly attends that group. This could be a single representative on behalf of the members of an ICB Collaboration Arrangement. Where that representative is not an employee of the ICB, the ICB must have in place appropriate arrangements to enable the representative to feedback to the ICB.

4.3 The ICB should also ensure that they have a nominated representative with appropriate subject matter expertise to attend National Standards development forums as requested by NHS England. This could be a single representative on behalf of the members of an ICB Collaboration Arrangement. Where that representative is not an employee of the ICB, the ICB must have in place appropriate arrangements to enable the representative to feedback to the ICB.

5 Clinical Leadership and Clinical Reference Groups

5.1 The ICB shall support the development of clinical leadership and expertise at a local level in respect of Specialised Services.

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

6 Clinical Networks

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

6.2 The ICB will be involved in the development and agreement of a single annual plan for the Relevant Clinical Network.

6.3 The ICB shall monitor the implementation of the annual plan and receive an annual report from the Relevant Clinical Network that considers delivery against the annual plan.

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

6.5 The ICB shall support NHS England in the management of Relevant Clinical Networks.

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

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

6.8 The ICB shall ensure that network reports are considered where relevant as part of exercising the Delegated Functions.

7 Complaints

7.1 The ICB shall provide full co-operation with NHS England in relation to any complaints received in respect of the Delegated Services which shall retain the function of complaints management in respect of the Delegated Services.

7.2 The ICB shall provide the relevant individuals at NHS England with appropriate access to data held by the ICB necessary to carry out the complaints function.

7.3 At such time as agreed between the ICB and NHS England, the management of complaints function in respect of the Delegated Services shall be delegated to the ICB and the following provisions shall apply:

7.3.1 NHS England shall provide the relevant individuals at the ICB with appropriate access to complaints data held by NHS England necessary to carry out the complaints function as set out in the Complaints Sharing Protocol.

7.3.2 The ICB shall provide information relating to key performance indicators ("KPIs") as requested by NHS England. These KPIs shall include information reporting on the following:

7.3.2.1 acknowledgements provided within three (3) Operational Days;

7.3.2.2 responses provided within forty (40) Operational Days;

7.3.2.3 response not provided within six (6) months;

7.3.2.4 open cases with the Parliamentary and Health Services Ombudsman and providing information on any fully or partly upheld complaints; and

7.3.2.5 overall activity by volume (not as a KPI).

7.3.3 The ICB shall co-operate with NHS England in respect of the review of complaints related to the Delegated Services and shall, on request, share any learning identified in carrying out the complaints function.

7.3.4 The ICB shall take part in any peer review process put in place in respect of the complaints function.

7.4 Where NHS England has provided the ICB with a protocol for sharing complaints in respect of any or all Specialised Services then those provisions shall apply and are deemed to be part of this Agreement.

8 Commissioning and optimisation of High Cost Drugs

8.1 The ICB must ensure the effective and efficient commissioning of High Cost Drugs for Delegated Services.

8.2 Where necessary the ICB must collaborate with NHS England in respect of the payment arrangements for High Cost Drugs.

8.3 The ICB must develop and implement Shared Care Arrangements across the Area of the ICB.

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

8.5 The ICB must ensure:

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

8.5.2 effective introduction of new medicines;

8.5.3 compliance with all NHS England commercial processes and frameworks for High Cost Drugs;

8.5.4 Specialised Services Providers adhere to all NHS England commercial processes and frameworks for High Cost Drugs;

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

8.5.6 consistency of prescribing and unwarranted prescribing variation are addressed.

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

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

8.8 The ICB must provide support to prescribing networks and forums, including but not limited to, Immunoglobulin Assessment panels, prescribing networks and medicines optimisation networks.

9 Contracting

9.1 The ICB shall be responsible for ensuring appropriate arrangements are in place for the commissioning of the Delegated Services which for the avoidance of doubt includes:

9.1.1 co-ordinating or collaborating in the award of appropriate Specialised Service Contracts;

9.1.2 drafting of the contract schedules so that it reflects Mandatory Guidance, National Specifications and any specific instructions from NHS England; and

9.1.3 management of Specialised Services Contracts.

9.2 In relation to the contracting for NHS England Retained Services where the ICB has agreed to act as the co-ordinating commissioner, to implement NHS England's instructions in relation to those Retained Services and, where appropriate, put in place a Collaborative Commissioning Agreement with NHS England as a party.

10 Data Management and Analytics

10.1 The ICB shall:

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

10.1.2 lead on the provision of data and analytical services to support commissioning of Delegated Services;

10.1.3 ensure collaborative working across partners on agreed programmes of work focusing on provision of pathway analytics;

10.1.4 share expertise and existing reporting tools with partner ICBs in the ICB Collaboration Arrangement;

10.1.5 ensure interpretation of data is made available to NHS England and other ICBs within the ICB Collaboration Arrangement;

10.1.6 ensure data and analytics teams within ICBs and NHS England work collaboratively on jointly agreed programmes of work focusing on provision of pathway analytics;

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

11 Finance

11.1 The provisions of Clause 10 (*Finance*) of this Agreement set out the financial requirements in respect of the Delegated Functions.

12 Freedom of Information and Parliamentary Requests

12.1 The ICB shall lead on the handling, management and response to all Freedom of Information and parliamentary correspondence relating to Delegated Services.

13 Incident Response and Management

13.1 The ICB shall:

13.1.1 lead on local incident management for Delegated Services as appropriate to the stated incident level;

13.1.2 support national and regional incident management relating to Specialised Services; and

13.1.3 ensure surge events and actions relating to Specialised Services are included in ICB escalation plans.

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

14 Individual Funding Requests

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

15 Innovation and New Treatments

15.1 The ICB shall support local implementation of innovative treatments for Delegated Services.

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

16.1 The ICB shall co-operate fully with NHS England in the development, management and operation of mental health, learning disability and autism NHS-led Provider Collaboratives including, where requested by NHS England, to consider the Provider Collaborative arrangements as part of the wider pathway delivery.

17 Provider Selection and Procurement

17.1 The ICB shall:

17.1.1 run appropriate local provider selection and procurement processes for Delegated Services;

17.1.2 align all procurement processes with any changes to national procurement policy (for example new legislation) for Delegated Services;

17.1.3 support NHS England with national procurements where required with subject matter expertise on provider engagement and provider landscape; and

17.1.4 monitor and provide advice, guidance and expertise to NHS England on the overall provider market and provider landscape.

17.2 In discharging these responsibilities, the ICB must comply at all times with Law and any relevant Guidance including but not limited to Mandated Guidance; any applicable procurement law and Guidance on the selection of, and award of contracts to, providers of healthcare services.

17.3 When the ICB makes decisions in connection with the awarding of Specialised Services Contracts, it should ensure that it can demonstrate compliance with requirements for the award of such Contracts, including that the decision was:

17.3.1 made in the best interest of patients, taxpayers and the Population;

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

17.3.3 made transparently; and

17.3.4 compliant with relevant Guidance and legislation.

18 Quality

18.1 The ICB must ensure that appropriate arrangements for quality oversight are in place. This must include:

18.1.1 clearly defined roles and responsibilities for ensuring governance and oversight of Delegated Services;

18.1.2 defined roles and responsibilities for ensuring robust communication and appropriate feedback, particularly where Delegated Services are commissioned through an arrangement with one or more other ICBs;

18.1.3 working with providers and partner organisations to address any issues relating to Delegated Services and escalate appropriately if such issues cannot be resolved;

18.1.4 developing and standardising processes that align with regional systems to ensure oversight of the quality of Delegated Services, and participating in local System Quality Groups and Regional Quality Groups, or their equivalent;

18.1.5 ensuring processes are robust and concerns are identified, mitigated and escalated as necessary;

18.1.6 ensuring providers are held to account for delivery of safe, patient-focused and quality care for Delegated Services, including mechanisms for monitoring patient complaints, concerns and feedback; and

18.1.7 the implementation of the Patient Safety Incident Response Framework for the management of incidents and serious events, appropriate reporting of any incidents, undertaking any appropriate patient safety incident investigation and obtaining support as required.

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

18.3 The ICB must ensure that the oversight of the quality of the Delegated Services is integrated with wider quality governance in the local system and aligns with the NHS England National Quality Board's recommended quality escalation processes.

18.4 The ICB must ensure that there is a System Quality Group (or equivalent) to identify and manage concerns across the local system.

18.5 The ICB must ensure that there is appropriate representation at any Regional Quality Groups or their equivalent.

18.6 The ICB must have in place all appropriate arrangements in respect of child and adult safeguarding and comply with all relevant Guidance.

19 Service Planning and Strategic Priorities

19.1 The ICB is responsible for setting local commissioning strategy, policy and priorities and planning for and carrying out needs assessments for the Delegated Services.

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

19.3 The ICB must ensure that it works with Specialised Service Providers and Provider Collaboratives to translate local strategic priorities into operational outputs for Delegated Services.

19.4 The ICB shall provide input into any consideration by NHS England as to whether the commissioning responsibility in respect of any of the Retained Services should be delegated.

20 National Standards, National Specifications and Clinical Commissioning Policies

20.1 The ICB shall provide input into national decisions on National Standards and national transformation regarding Delegated Services through attendance at governance meetings.

20.2 The ICB shall facilitate engagement with local communities on National Specification development.

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

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

20.5 The ICB must have appropriate mechanisms in place to ensure National Standards and National Specifications are being adhered to.

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

21 Transformation

21.1 The ICB shall:

21.1.1 prioritise pathways and services for transformation according to the needs of its Population and opportunities for improvement in ICB commissioned services and for Delegated Services;

21.1.2 lead ICB and ICB Collaboration Arrangement driven transformation programmes across pathways for Delegated Services;

21.1.3 lead the delivery locally of transformation in areas of national priority (such as Cancer, Mental Health and Learning Disability and Autism), including supporting delivery of commitments in the NHS Long Term Plan;

21.1.4 support NHS England with agreed transformational programmes for Retained Services;

21.1.5 support NHS England with agreed transformational programmes and identify future transformation programmes for consideration and prioritisation for Delegated Services where national co-ordination and enablement may support transformation;

21.1.6 work collaboratively with NHS England on the co-production and co-design of transformation and improvement interventions and solutions in those areas prioritised; and

21.1.7 ensure Relevant Clinical Networks and other clinical networks use levers to facilitate and embed transformation at a local level for Delegated Services.

SCHEDULE 4: Reserved Functions

Introduction

1. Reserved Functions in Relation to the Delegated Services

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

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

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

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

2. Retained Services

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

3. Reserved Specialised Service Functions

3.1. NHS England shall carry out the functions set out in this Schedule 4 in respect of the Delegated Services.

Reserved Functions

4. Assurance and Oversight

4.1. NHS England shall:

4.1.1. have oversight of what ICBs are delivering (inclusive of Delegated Services) for their Populations and all patients;

4.1.2. design and implement appropriate assurance of ICBs' exercise of Delegated Functions including the Assurance Processes;

4.1.3. help the ICB to coordinate and escalate improvement and resolution interventions where challenges are identified (as appropriate);

4.1.4. ensure that the NHS England Board is assured that Delegated Functions are being discharged appropriately;

4.1.5. ensure specialised commissioning considerations are appropriately included in NHS England frameworks that guide oversight and assurance of service delivery; and

4.1.6. host a Delegated Commissioning Group ("DCG") that will undertake an assurance role in line with the Assurance Processes. This assurance role shall include assessing and monitoring the overall coherence, stability and sustainability of the commissioning model of Specialised Services at a

national level, including identification, review and management of appropriate cross-ICB risks.

5. Attendance at governance meetings

5.1. NHS England shall ensure that there is appropriate representation in respect of Reserved Functions and Retained Services at local governance forums (for example, the Regional Leadership Team) and at NCG.

5.2. NHS England shall:

5.2.1. ensure that there is appropriate representation by NHS England subject matter expert(s) at National Standards development forums;

5.2.2. ensure there is appropriate attendance by NHS England representatives at nationally led clinical governance meetings; and

5.2.3. co-ordinate, and support key national governance groups.

6. Clinical Leadership and Clinical Reference Groups

6.1. NHS England shall be responsible for the following:

6.1.1. developing local leadership and support for the ICB relating to Specialised Services;

6.1.2. providing clinical leadership, advice and guidance to the ICB in relation to the Delegated Services;

6.1.3. providing point-of-contact and ongoing engagement with key external bodies, such as interest groups, charities, NICE, DHSC, and Royal Colleges; and enabling access to clinical trials for new treatments and medicines.

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

6.2.1. Clinical Commissioning Policies;

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

7. Clinical Networks

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

7.2. NHS England shall ensure development of multi-ICB, and multi-region (where necessary) governance and oversight arrangements for Relevant Clinical Networks that give line of sight between all clinical networks and all ICBs whose Population they serve.

7.3. NHS England shall be responsible for:

7.3.1. developing national policy for the Relevant Clinical Networks;

7.3.2. developing and approving the specifications for the Relevant Clinical Networks;

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

7.3.4. convening or supporting national networks of the Relevant Clinical Networks;

7.3.5. agreeing the annual plan for each Relevant Clinical Network with the involvement of the ICB and Relevant Clinical Network, ensuring these reflect national and regional priorities;

7.3.6. managing Relevant Clinical Networks jointly with the ICB; and

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

8. Complaints

8.1. NHS England shall manage all complaints in respect of the Delegated Services at the date of this Agreement and until such time as it agrees the delegation of complaints to the ICB.

8.2. NHS England shall manage all complaints in respect of the Reserved Services.

9. Commissioning and optimisation of High Cost Drugs

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

9.1.1. comply as appropriate with the centralised process for the reimbursement of Specialised Services High Cost Drugs and, where appropriate, ensuring that only validated drugs spend is reimbursed, there is timely drugs data and drugs data quality meets the standards set nationally;

9.1.2. support the ICB on strategy for access to medicines used within Delegated Services, minimising barriers to health inequalities;

9.1.3. provide support, as reasonably required, to the ICB to assist it in the commissioning of High Cost Drugs for Delegated Services including shared care agreements;

9.1.4. seek to address consistency of prescribing in line with national commissioning policies, introduction of new medicines, and addressing unwarranted prescribing variation;

9.1.5. provide input into national procurement, homecare and commercial processes;

9.1.6. provide expert medicines advice and input into immunoglobin assessment panels and support to the national Programmes of Care and Clinical Reference Groups;

9.1.7. provide expert medicines advice and input into the Individual Funding Request process for Delegated Services; and

9.1.8. collaborate with commissioners of health and justice services to ensure detained people can access High Cost Drugs using the NHS England or ICB commissioning policies in line with community patient access, including who prescribes and supplies the medicine.

10. Contracting

10.1. NHS England shall retain the following obligations in relation to contracting for Delegated Services:

10.1.1. ensure Specialised Services are included in national NHS England contracting and payment strategy (for example, Aligned Payment Incentives);

10.1.2. provide advice for ICBs on schedules to support the Delegated Services;

10.1.3. set, publish or make otherwise available the Contracting Standard Operating Procedure and Mandated Guidance detailing contracting strategy and policy for Specialised Services; and

10.1.4. provide and distribute contracting support tools and templates to the ICB.

10.2. In respect of the Retained Services, NHS England shall:

10.2.1. where appropriate, ensure a Collaborative Commissioning Agreement is in place between NHS England and the ICB(s); and

10.2.2. where appropriate, construct model template schedules for Retained Services and issue to ICBs.

11. Data Management and Analytics

11.1. NHS England shall:

11.1.1. support the ICB by collaborating with the wider data and analytics network (nationally) to support development and local deployment or utilisation of support tools;

11.1.2. support the ICB to address data quality and coverage needs, accuracy of reporting Specialised Services activity and spend on a Population basis to support commissioning of Specialised Services;

11.1.3. ensure inclusion of Specialised Services data strategy in broader NHS England, DHSC and government data strategies;

11.1.4. lead on defining relevant contractual content of the information schedule (Schedule 6) of the NHS Standard Contract for Clinical Services;

11.1.5. work collaboratively with the ICB to drive continual improvement of the quality and coverage of data used to support commissioning of Specialised Services;

11.1.6. provide a national analytical service to support oversight and assurance of Specialised Services, and support (where required) the national Specialised Commissioning team, Programmes of Care and Clinical Reference Groups; and

11.1.7. provide access to data and analytic subject matter expertise to support the ICB when considering local service planning, needs assessment and transformation.

12. Finance

12.1. The provisions of Clause 10 shall apply in respect of the financial arrangements in respect of the Delegated Functions.

13. Freedom of Information and Parliamentary Requests

13.1. NHS England shall:

13.1.1. lead on handling, managing and responding to all national FOIA and parliamentary correspondence relating to Retained Services; and

13.1.2. co-ordinate a response when a single national response is required in respect of Delegated Services.

14. Incident Response and Management

14.1. NHS England shall:

14.1.1. provide guidance and support to the ICB in the event of a complex incident;

14.1.2. lead on national incident management for Specialised Services as appropriate to stated incident level and where nationally commissioned services are impacted;

14.1.3. lead on monitoring, planning and support for service and operational resilience at a national level and provide support to the ICB; and

14.1.4. respond to specific service interruptions where appropriate; for example, supplier and workforce challenges and provide support to the ICB in any response to interruptions.

15. Individual Funding Requests

15.1. NHS England shall be responsible for:

15.1.1. leading on Individual Funding Requests (IFR) policy, IFR governance and managing the IFR process for Delegated Services and Retained Services;

15.1.2. taking decisions in respect of IFRs at IFR Panels for both Delegated Services and Retained Services; and

15.1.3. providing expertise for IFR decisions, including but not limited to pharmacy, public health, nursing and medical and quality.

16. Innovation and New Treatments

16.1. NHS England shall support the local implementation of innovative treatments for Delegated Services.

16.2. NHS England shall ensure services are in place for innovative treatments such as advanced medicinal therapy products recommended by NICE technology appraisals within statutory requirements.

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

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

17.1. NHS England shall commission and design NHS-led Provider Collaborative arrangements for mental health, learning disability and autism services. Where it considers appropriate, NHS England shall seek the input of the ICB in relation to relevant Provider Collaborative arrangements.

18. Provider Selection and Procurement

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

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

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

18.1.3. where appropriate, running provider selection and procurement processes for Specialised Services.

19. Quality

19.1. In respect of quality, NHS England shall:

19.1.1. work with the ICB to ensure oversight of Specialised Services through quality surveillance and risk management and escalate as required;

19.1.2. work with the ICB to seek to ensure that quality and safety issues and risks are managed effectively and escalated to the National Specialised Commissioning Quality and Governance Group (QGG), or other appropriate forums, as necessary;

19.1.3. work with the ICB to seek to ensure that the quality governance and processes for Delegated Services are aligned and integrated with broader clinical quality governance and processes in accordance with National Quality Board Guidance;

19.1.4. facilitate improvement when quality issues impact nationally and regionally, through programme support, and mobilising intensive support when required on specific quality issues;

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

19.1.6. support the ICB to identify key themes and trends and utilise data and intelligence to respond and monitor as necessary;

19.1.7. report on quality to both NCG and DCG as well as QGG and Executive Quality Group as required;

19.1.8. facilitate and support the national quality governance infrastructure (for example, the QGG); and

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

20. National Standards, National Specifications and Clinical Commissioning Policies

20.1. NHS England shall carry out:

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

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

20.1.3. maintenance and publication of the Prescribed Specialised Services Manual and engagement with the DHSC on policy matters; and

20.1.4. determination of content for national clinical registries.

21. Transformation

21.1. NHS England shall be responsible for:

21.1.1. co-ordinating and enabling ICB-led specialised service transformation programmes for Delegated Services where necessary;

21.1.2. supporting the ICB to implement national policy and guidance across its Populations for Retained Services;

21.1.3. supporting the ICB with agreed transformational programmes where national transformation support has been agreed for Delegated Services;

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

21.1.5. co-production and co-design of transformation programmes with the ICB and wider stakeholders; and

21.1.6. providing access to subject matter expertise including Clinical Reference Groups, national clinical directors, Programme of Care leads for the ICB where it needs support, including in relation to local priority transformation.

SCHEDULE 5: Retained Services

NHS England shall retain the function of commissioning the Specialised Services that are not Delegated Services and as more particularly set out by NHS England and made available from time to time.

18.9 6 (*Further Information Governance and Sharing* Provisions) makes further provision about information sharing, information governance and the Data Sharing Agreement.

19. IT INTER-OPERABILITY

19.1 The Parties will work together to ensure that all relevant IT systems they operate in respect of the Delegated Functions and Reserved Functions are inter-operable and that data may be transferred between systems securely, easily and efficiently.

19.2 The Parties will use their respective reasonable endeavours to help develop initiatives to further this aim.

20. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY

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

20.2 Without prejudice to the general obligations set out in Clause 20.1, the ICB must maintain a register of interests in respect of all persons making decisions concerning the Delegated Functions. This register must be publicly available. For the purposes of this clause, the ICB may rely on an existing register of interests rather than creating a further register.

21. PROHIBITED ACTS AND COUNTER-FRAUD

21.1 The ICB must not commit any Prohibited Act.

21.2 If the ICB or its Staff commits any Prohibited Act in relation to this Agreement with or without the knowledge of NHS England, NHS England will be entitled:

21.2.1 to revoke the Delegation;

21.2.2 to recover from the ICB the amount or value of any gift, consideration or commission concerned; and

21.2.3 to recover from the ICB any loss or expense sustained in consequence of the carrying out of the Prohibited Act.

21.3 The ICB must put in place and maintain appropriate arrangements, including without limitation, Staff training, to address counter-fraud issues, having regard to any relevant Guidance, including from the NHS Counter Fraud Authority.

21.4 If requested by NHS England or the NHS Counter Fraud Authority, the ICB must allow a person duly authorised to act on behalf of the NHS Counter Fraud Authority or on behalf of NHS England to review, in line with the appropriate standards, any counter-fraud arrangements put in place by the ICB.

21.5 The ICB must implement any reasonable modifications to its counter-fraud arrangements required by a person referred to in Clause 21.4 in order to meet the appropriate standards within whatever time periods as that person may reasonably require.

21.6 The ICB must, on becoming aware of:

21.6.1 any suspected or actual bribery, corruption or fraud involving public funds; or

21.6.2 any suspected or actual security incident or security breach involving Staff or involving NHS resources;

promptly report the matter to NHS England and to the NHS Counter Fraud Authority.

21.7 On the request of NHS England or NHS Counter Fraud Authority, the ICB must allow the NHS Counter Fraud Authority or any person appointed by NHS England, as soon as it is reasonably practicable and in any event not later than five (5) Operational Days following the date of the request, access to:

21.7.1 all property, premises, information (including records and data) owned or controlled by the ICB; and

21.7.2 all Staff who may have information to provide.

relevant to the detection and investigation of cases of bribery, fraud or corruption, or security incidents or security breaches directly or indirectly in connection with this Agreement.

22. CONFIDENTIAL INFORMATION OF THE PARTIES

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

22.2 Subject to Clauses 22.3 to 22.5, the receiving Party agrees:

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

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

22.2.3 to maintain the confidentiality of the disclosing Party's Confidential Information.

22.3 The receiving Party may disclose the disclosing Party's Confidential Information:

22.3.1 in connection with any dispute resolution procedure under Clause 25;

22.3.2 in connection with any litigation between the Parties;

22.3.3 to comply with the Law;

22.3.4 to any appropriate Regulatory or Supervisory Body;

22.3.5 to its Staff, who in respect of that Confidential Information will be under a duty no less onerous than the Receiving Party's duty under Clause 22.2;

22.3.6 to NHS bodies for the purposes of carrying out their functions;

22.3.7 as permitted under or as may be required to give effect to Clause 21 (*Prohibited Acts and Counter-Fraud*); and

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

22.4 The obligations in Clauses 22.1 and 22.2 will not apply to any Confidential Information which:

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

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

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

22.5 This Clause 22 does not prevent NHS England making use of or disclosing any Confidential Information disclosed by the ICB where necessary for the purposes of exercising its functions in relation to the ICB.

22.6 The Parties acknowledge that damages would not be an adequate remedy for any breach of this Clause 22 by the receiving Party, and in addition to any right to damages the disclosing Party will be entitled to the remedies of injunction, specific performance and other equitable relief for any threatened or actual breach of this Clause 22.

22.7 This Clause 222 will survive the termination of this Agreement for any reason for a period of five (5) years.

22.8 This Clause 22 will not limit the application of the Public Interest Disclosure Act 1998 in any way whatsoever.

23. INTELLECTUAL PROPERTY

23.1 The ICB grants to NHS England a fully paid-up, non-exclusive, perpetual licence to use the ICB Deliverables for the purposes of the exercise of its statutory and contractual functions.

23.2 NHS England grants the ICB a fully paid-up, non-exclusive licence to use the NHS England Deliverables for the purpose of performing this Agreement and the Delegated Functions.

23.3 The ICB must co-operate with NHS England to enable it to understand and adopt Best Practice (including the dissemination of Best Practice to other commissioners or providers of NHS services), and must supply such materials and information in relation to Best Practice as NHS England may reasonably request, and (to the extent that any Intellectual Property Rights ("IPR") attaches to Best Practice) grants NHS England a fully paid-up, non-exclusive, perpetual licence for NHS England to use Best Practice IPR for the commissioning and provision of NHS services and to share any Best Practice IPR with other commissioners of NHS services (and other providers of NHS services) to enable those parties to adopt such Best Practice.

24. NOTICES

24.1 Any notices given under this Agreement must be sent by e-mail to the other Party's address set out in the Particulars or as otherwise notified by one Party to another as the appropriate address for this Clause 24.1.

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

25. DISPUTES

25.1 This clause does not affect NHS England's right to exercise its functions for the purposes of assessing and addressing the performance of the ICB.

25.2 If a Dispute arises out of, or in connection with, this Agreement then the Parties must follow the procedure set out in this clause:

25.2.1 either Party must give to the other written notice of the Dispute, setting out its nature and full particulars ("Dispute Notice"), together with relevant supporting documents. On service of the Dispute Notice, the Agreement Representatives must attempt in good faith to resolve the Dispute;

25.2.2 if the Agreement Representatives are, for any reason, unable to resolve the Dispute within twenty (20) Operational Days of service of the Dispute Notice, the Dispute must be referred to the Chief Executive Officer (or equivalent person) of the ICB and a director of or other person nominated by NHS England (and who has authority from NHS England to settle the Dispute) who must attempt in good faith to resolve it; and

25.2.3 if the people referred to in Clause 25.2.2 are for any reason unable to resolve the Dispute within twenty (20) Operational Days of it being referred to them, the Parties may attempt to settle it by mediation in accordance with the CEDR model mediation procedure. Unless otherwise agreed between the Parties, the mediator must be nominated by CEDR. To initiate the mediation, a Party must serve notice in writing ('Alternative Dispute Resolution' ("ADR) notice") to the other Party to the Dispute, requesting a mediation. A copy of the ADR notice should be sent to CEDR. The mediation will start no later than ten (10) Operational Days after the date of the ADR notice.

25.3 If the Dispute is not resolved within thirty (30) Operational Days after service of the ADR notice, or either Party fails to participate or to continue to participate in the mediation before the expiration of the period of thirty (30) Operational Dys, or the mediation terminates before the expiration of the period of thirty (30) Operational Days, the Dispute must be referred to the NHS England Board, who shall resolve the matter and whose decision shall be binding upon the Parties.

26. VARIATIONS

26.1 The Parties acknowledge that the scope of the Delegated Functions may be reviewed and amended from time to time including by revoking this Agreement and making alternative arrangements.

26.2 NHS England may vary this Agreement without the ICB's consent where:

26.2.1 it is reasonably satisfied that the variation is necessary in order to comply with Legislation, NHS England's statutory duties, or any requirements or direction given by the Secretary of State;

26.2.2 where variation is as a result of amendment to or additional Mandated Guidance;

26.2.3 it is satisfied that any Developmental Arrangements are no longer required;

26.2.4 it reasonably considers that Developmental Arrangements are required under Clause 14 (*Breach*); or

26.2.5 it is satisfied that such amendment or Developmental Arrangement is required in order to ensure the effective commissioning of the Delegated Services or other Specialised Services.

26.3 Where NHS England wishes to vary the Agreement in accordance with Clause 26.2 it must notice in writing to the ICB of the wording of the proposed variation and the date on which that variation is to take effect which must, unless it is not reasonably practicable, be a date which falls at least thirty (30) Operational Days after the date on which the notice under that clause is given to the ICB.

26.4 For the avoidance of doubt, NHS England may issue or update Mandated Guidance at any point during the term of the Agreement.

26.5 Either Party ("the Proposing Party") may notify the other Party (the "Receiving Party") of a Variation Proposal in respect of this Agreement including, but not limited to the following:

26.5.1 a request by the ICB to add, vary or remove any Developmental Arrangement; or

26.5.2 a request by NHS England to include additional Specialised Services or NHS England Functions within the Delegation; and

the Proposing Party will identify whether the proposed variation may have the impact of changing the scope of the Delegated Functions or Reserved Functions so that NHS England can establish the requisite level of approval required.

26.6 The Variation Proposal will set out the variation proposed and the date on which the Proposing Party requests the variation to take effect.

26.7 When a Variation Proposal is issued in accordance with 26.6, the Receiving Party must respond within thirty (30) Operational Days following the date that it is issued by serving notice confirming either:

26.7.1 that it accepts the Variation Proposal; or

26.7.2 that it refuses to accept the Variation Proposal and setting out reasonable grounds for that refusal.

26.8 If the Receiving Party accepts the Variation Proposal issued in accordance with Clause 26.5, the Receiving Party agrees to take all necessary steps (including executing a variation agreement) in order to give effect to any variation by the date on which the proposed variation will take effect as set out in the Variation Proposal.

26.9 If the Receiving Party refuses to accept a Variation Proposal submitted in accordance with 26.5 to 26.7, or to take such steps as are required to give effect to the variation, then the provisions of Clause 15 (*Escalation Rights*) shall apply.

26.10 When varying the Agreement in accordance with Clause 26, the Parties must consider the impact of the proposed variation on any ICB Collaboration Arrangements and any Further Arrangements.

27. TERMINATION

27.1 The ICB may:

27.1.1 notify NHS England that it requires NHS England to revoke the Delegation; and

27.1.2 terminate this Agreement;

with effect from the end of 31 March in any calendar year, provided that:

27.1.3 on or before 30 September of the previous calendar year, the ICB sends written notice to NHS England of its requirement that NHS England revoke the Delegation and its intention to terminate this Agreement; and

27.1.4 the ICB meets with NHS England within ten (10) Operational Days of NHS England receiving the notice set out at Clause 27.1.3 above to discuss

arrangements for termination and transition of the Delegated Functions to a successor commissioner in accordance with Clause 28.2; and

27.1.5 the ICB confirms satisfactory arrangements for terminating any ICB Collaboration Arrangements or Further Agreements in whole or part as required including agreed succession arrangements for Commissioning Teams,

in which case NHS England shall revoke the Delegation and this Agreement shall terminate with effect from the end of 31 March in the next calendar year.

27.2 NHS England may revoke the Delegation in whole or in part with effect from 23.59 hours on 31 March in any year, provided that it gives notice to the ICB of its intention to terminate the Delegation on or before 30 September in the year prior to the year in which the Delegation will terminate, and in which case Clause 27.4 will apply.

27.3 The Delegation may be revoked in whole or in part, and this Agreement may be terminated by NHS England at any time, including in (but not limited to) the following circumstances:

27.3.1 the ICB acts outside of the scope of its delegated authority;

27.3.2 the ICB fails to perform any material obligation of the ICB owed to NHS England under this Agreement;

27.3.3 the ICB persistently commits non-material breaches of this Agreement;

27.3.4 NHS England is satisfied that its intervention powers under section 14Z61 of the NHS Act apply;

27.3.5 to give effect to legislative changes, including conferral of any of the Delegated or Reserved Functions on the ICB;

27.3.6 failure to agree to a variation in accordance with Clause 26 *(Variations)*;

27.3.7 NHS England and the ICB agree in writing that the Delegation shall be revoked and this Agreement shall terminate on such date as is agreed; and/or

27.3.8 the ICB merges with another ICB or other body.

27.4 This Agreement will terminate upon revocation or termination of the full Delegation (including revocation and termination in accordance with this Clause 277 *(Termination)*) except that the provisions referred to in Clause 299 (*Provisions Surviving Termination*) will continue in full force and effect.

27.5 Without prejudice to Clause 14.3 and to avoid doubt, NHS England may waive any right to terminate this Agreement under this Clause 27 *(Termination)*. Any such waiver is only effective if given in writing and shall not be deemed a waiver of any subsequent right or remedy.

27.6 As an alternative to termination of the Agreement in respect of all the Delegated Functions, NHS England may terminate the Agreement in respect of specified Delegated Functions (or aspects of such Delegated Functions) only, in which case this Agreement shall otherwise remain in effect.

28. CONSEQUENCE OF TERMINATION

28.1 Termination of this Agreement, or termination of the ICB's exercise of any of the Delegated Functions, will not affect any rights or liabilities of the Parties that have

accrued before the date of that termination or which later accrue in respect of the term of this Agreement. For the avoidance of doubt, the ICB shall be responsible for any Claims or other costs or liabilities incurred in the exercise of the Delegated Functions during the period of this Agreement unless expressly agreed otherwise by NHS England.

28.2 Subject to Clause 28.4, on or pending termination of this Agreement or termination of the ICB's exercise of any of the Delegated Functions, NHS England, the ICB and, if appropriate, any successor delegate will:

28.2.1 agree a plan for the transition of the Delegated Functions from the ICB to the successor delegate, including details of the transition, the Parties' responsibilities in relation to the transition, the Parties' arrangements in respect of the Staff engaged in the Delegated Functions and the date on which the successor delegate will take responsibility for the Delegated Functions;

28.2.2 implement and comply with their respective obligations under the plan for transition agreed in accordance with Clause 28.2.1; and

28.2.3 act with a view to minimising any inconvenience or disruption to the commissioning of healthcare in the Area.

28.3 For a reasonable period before and after termination of this Agreement or termination of the ICB's exercise of any of the Delegated Functions, the ICB must:

28.3.1 co-operate with NHS England and any successor delegate to ensure continuity and a smooth transfer of the Delegated Functions; and

28.3.2 at the reasonable request of NHS England:

28.3.2.1 promptly provide all reasonable assistance and information to the extent necessary for an efficient assumption of the Delegated Functions by a successor delegate;

28.3.2.2 deliver to NHS England all materials and documents used by the ICB in the exercise of any of the Delegated Functions; and

28.3.2.3 use all reasonable efforts to obtain the consent of third parties to the assignment, novation or termination of existing contracts between the ICB and any third party which relate to or are associated with the Delegated Functions.

28.4 Where any or all of the Delegated Functions or Reserved Functions are to be directly conferred on the ICB, the Parties will co-operate with a view to ensuring continuity and a smooth transfer to the ICB.

29. PROVISIONS SURVIVING TERMINATION

29.1 Any rights, duties or obligations of any of the Parties which are expressed to survive, including those referred to in Clause 29.2, or which otherwise by necessary implication survive the termination for any reason of this Agreement, together with all indemnities, will continue after termination, subject to any limitations of time expressed in this Agreement.

29.2 The surviving provisions include the following clauses together with such other provisions as are required to interpret and give effect to them:

29.2.1 Clause 10 (*Finance*);

29.2.2 Clause 13 (*Staffing, Workforce and Commissioning Teams*);

29.2.3 Clause 16 *(Liability and Indemnity*);

29.2.4 Clause 17 (*Claims and Litigation*);

29.2.5 Clause 18 (*Data Protection, Freedom of Information and Transparency*);

29.2.6 Clause 25 (*Disputes*);

29.2.7 Clause 27 (*Termination*);

29.2.8 Schedule 6 (*Further Information Governance and Sharing Provisions*).

30. **COSTS**

30.1 Each Party is responsible for paying its own costs and expenses incurred in connection with the negotiation, preparation and execution of this Agreement.

31. **SEVERABILITY**

31.1 If any provision or part of any provision of this Agreement is declared invalid or otherwise unenforceable, that provision or part of the provision as applicable will be severed from this Agreement. This will not affect the validity and/or enforceability of the remaining part of that provision or of other provisions.

32. **GENERAL**

32.1 Nothing in this Agreement will create a partnership or joint venture or relationship of principal and agent between NHS England and the ICB.

32.2 A delay or failure to exercise any right or remedy in whole or in part shall not waive that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy.

32.3 This Agreement does not give rise to any rights under the Contracts (Rights of Third Parties) Act 1999 to enforce any term of this Agreement.

SCHEDULE 1: Definitions and Interpretation

1. The headings in this Agreement will not affect its interpretation.

2. Reference to any statute or statutory provision, Law, Guidance, Mandated Guidance or Data Guidance, includes a reference to that statute or statutory provision, Law, Guidance, Mandated Guidance or Data Guidance as from time to time updated, amended, extended, supplemented, re-enacted or replaced in whole or in part.

3. Reference to a statutory provision includes any subordinate legislation made from time to time under that provision.

4. References to clauses and schedules are to the clauses and schedules of this Agreement, unless expressly stated otherwise.

5. References to any body, organisation or office include reference to its applicable successor from time to time.

6. Any references to this Agreement or any other documents or resources includes reference to this Agreement or those other documents or resources as varied, amended, supplemented, extended, restated and/or replaced from time to time and any reference to a website address for a resource includes reference to any replacement website address for that resource.

7. Use of the singular includes the plural and vice versa.

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

9. Use of the term "including" or "includes" will be interpreted as being without limitation.

10. The following words and phrases have the following meanings:

"Administrative and Management Services"	means administrative and management support provided in accordance with Clause 9.5 or 9.7;
"Agreement"	means this agreement between NHS England and the ICB comprising the Particulars, the Terms and Conditions, the Schedules and the Mandated Guidance;
"Agreement Representatives"	means the ICB Representative and the NHS England Representative as set out in the Particulars or such person identified to the other Party from time to time as the relevant representative;
"Annual Allocation"	means the funds allocated to the ICB annually under section 223G of the NHS Act;
"Area"	means the geographical area covered by the ICB;
"Assurance Processes"	has the definition given in paragraph 3.1 of Schedule 3;
"Best Practice"	means any methodologies, pathway designs and processes relating to this Agreement or the Delegated Functions developed by the ICB or its Staff for the purposes of delivering the Delegated Functions and which are capable of wider use in

	the delivery of healthcare services for the purposes of the NHS, but not including inventions that are capable of patent protection and for which patent protection is being sought or has been obtained, registered designs, or copyright in software;
"Capital Investment Guidance"	means any Mandated Guidance issued by NHS England from time to time in relation to the development, assurance and approvals process for proposals in relation to: - the expenditure of Capital, or investment in property, infrastructure or information and technology; and - the revenue consequences for commissioners or third parties making such investment;
"CEDR"	means the Centre for Effective Dispute Resolution;
"Claims"	means, for or in relation to the Delegated Functions (i) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal or the Secretary of State, any governmental, regulatory or similar body, or any department, board or agency or (ii) any dispute with, or any investigation, inquiry or enforcement proceedings by, any governmental, regulatory or similar body or agency;
"Claim Losses"	means all Losses arising in relation to any Claim;
"Clinical Commissioning Policies"	means a nationally determined clinical policy setting out the commissioning position on a particular clinical treatment issue and defines accessibility (including a not for routine commissioning position) of a medicine, medical device, diagnostic technique, surgical procedure or intervention for patients with a condition requiring a specialised service;
"Clinical Reference Groups"	means a group consisting of clinicians, commissioners, public health experts, patient and public voice representatives and professional associations, which offers specific knowledge and expertise on the best ways that Specialised Services should be provided;
"Collaborative Commissioning Agreement"	means an agreement under which NHS Commissioners set out collaboration arrangements in respect of commissioning Specialised Services Contracts;
"Commissioning Functions"	means the respective statutory functions of the Parties in arranging for the provision of services as part of the health service;
"Commissioning Team"	means those Specialised Services Staff that support the commissioning of Delegated Services immediately prior to this Agreement and, at the point that Staff transfer from NHS England to an identified ICB, it shall mean those NHS England Staff and such other Staff appointed by that ICB to carry out a role in respect of commissioning the Delegated Services;

Commissioning Team Arrangements	means the arrangements through which the services of a Commissioning Team are made available to another NHS body for the purposes of commissioning the Delegated Services;
Confidential Information	means any information or data in whatever form disclosed, which by its nature is confidential or which the disclosing Party acting reasonably states in writing to the receiving Party is to be regarded as confidential, or which the disclosing Party acting reasonably has marked 'confidential' (including, financial information, strategy documents, tenders, employee confidential information, development or workforce plans and information, and information relating to services) but which is not information which is disclosed in response to an FOIA request, or information which is published as a result of NHS England or government policy in relation to transparency;
Contracts	means any contract or arrangement in respect of the commissioning of any of the Delegated Services;
"Contracting Standard Operating Procedure"	means the Contracting Standard Operating Procedure produced by NHS England in respect of the Delegated Services;
"Contractual Notice"	means a contractual notice issued by NHS England to the ICB, from time to time and relating to allocation of contracts for the purposes of the Delegated Functions;
"CQC"	means the Care Quality Commission;
"Data Controller"	shall have the same meaning as set out in the UK GDPR;
"Data Guidance"	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement regarding information governance, confidentiality, privacy or compliance with Data Protection Legislation to the extent published and publicly available or their existence or contents have been notified to the ICB by NHS England and/or any relevant Regulatory or Supervisory Body. This includes but is not limited to guidance issued by NHS Digital, the National Data Guardian for Health & Care, the Department of Health and Social Care, NHS England, the Health Research Authority, the UK Health Security Agency and the Information Commissioner;
"Data Protection Impact Assessment"	means an assessment to identify and minimise the data protection risks in relation to any data sharing proposals;
"Data Protection Officer"	shall have the same meaning as set out in the Data Protection Legislation;
"Data Processor"	shall have the same meaning as set out in the UK GDPR;
"Data Protection Legislation"	means the UK GDPR, the Data Protection Act 2018 and all applicable Law concerning privacy, confidentiality or the processing of personal data including but not limited to the Human Rights Act 1998, the Health and Social Care (Safety and Quality) Act 2015, the common law duty of confidentiality and

	the Privacy and Electronic Communications (EC Directive) Regulations 2003;
"Data Sharing Agreement"	means a data sharing agreement which should be in substantially the same form as a Data Sharing Agreement template approved by NHS England;
"Data Subject"	shall have the same meaning as set out in the UK GDPR;
"Delegated Commissioning Group (DCG)"	means the advisory forum in respect of Delegated Services set up by NHS England currently known as the Delegated Commissioning Group for Specialised Services;
"Delegated Functions"	means the statutory functions delegated by NHS England to the ICB under the Delegation and as set out in detail in this Agreement;
"Delegated Funds"	means the funds defined in Clause 10.2;
"Delegated Services"	means the services set out in Schedule 2 of this Agreement and which may be updated from time to time by NHS England;
"Delegation"	means the delegation of the Delegated Functions from NHS England to the ICB as described at Clause 6.1;
"Developmental Arrangements"	means the arrangements set out in Schedule 9 as amended or replaced;
"Dispute"	a dispute, conflict or other disagreement between the Parties arising out of or in connection with this Agreement;
"Effective Date of Delegation"	means for the Specialised Services set out in Schedule 2, the date set out in Schedule 2 as the date delegation will take effect in respect of that particular Specialised Service and for any future delegations means the date agreed by the parties as the date that the delegation will take effect;
"EIR"	means the Environmental Information Regulations 2004;
"Escalation Rights"	means the escalation rights as defined in Clause 15 *(Escalation Rights)*;
"Finance Guidance"	means the guidance, rules and operating procedures produced by NHS England that relate to these delegated arrangements, including but not limited to the following: - Commissioning Change Management Business Rules; - Contracting Standard Operating Procedure; - Cashflow Standard Operating Procedure; - Finance and Accounting Standard Operating Procedure; - Service Level Framework Guidance;

"Financial Year"	shall bear the same meaning as in section 275 of the NHS Act;
"FOIA"	means the Freedom of Information Act 2000;
"Further Arrangements"	means arrangements for the exercise of Delegated Functions as defined at Clause 12;
"Good Practice"	means using standards, practices, methods and procedures conforming to the law, reflecting up-to-date published evidence and exercising that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced commissioner;
"Guidance"	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the ICB has a duty to have regard (and whether specifically mentioned in this Agreement or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified to the ICB by any relevant Regulatory or Supervisory Body but excluding Mandated Guidance;
"High Cost Drugs"	means medicines not reimbursed though national prices and identified on the NHS England high cost drugs list;
"Host ICB"	means the ICB that employs the Commissioning Team as part of the Commissioning Team Arrangements;
"ICB"	means an Integrated Care Board established pursuant to section 14Z25 of the NHS Act and named in the Particulars;
"ICB Collaboration Arrangement"	means an arrangement entered into by the ICB and at least one other ICB under which the parties agree joint working arrangements in respect of the exercise of the Delegated Functions;
"ICB Deliverables"	all documents, products and materials developed by the ICB or its Staff in relation to this Agreement and the Delegated Functions in any form and required to be submitted to NHS England under this Agreement, including data, reports, policies, plans and specifications;
"ICB Functions"	the Commissioning Functions of the ICB;
"Information Governance Guidance for Serious Incidents"	means the checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incidents Requiring Investigation' (2015) as may be amended or replaced;
"Indemnity Arrangement"	means either: (i) a policy of insurance; (ii) an arrangement made for the purposes of indemnifying a person or organisation; or (iii) a combination of (i) and (ii);

"IPR"	means intellectual property rights and includes inventions, copyright, patents, database right, trademarks, designs and confidential know-how and any similar rights anywhere in the world whether registered or not, including applications and the right to apply for any such rights;
"Law"	means any applicable law, statute, rule, bye-law, regulation, direction, order, regulatory policy, guidance or code, rule of court or directives or requirements of any regulatory body, delegated or subordinate legislation or notice of any regulatory body (including any Regulatory or Supervisory Body);
"Local Terms"	means the terms set out in Schedule 8 *(Local Terms)* and/or such other Schedule or part thereof as designated as Local Terms;
"Losses"	means all damages, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services) proceedings, demands and charges whether arising under statute, contract or common law;
"Managing Conflicts of Interest in the NHS"	the NHS publication by that name available at: https://www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-guidance-for-staff-and-organisations/ ;
"Mandated Guidance"	means any protocol, policy, guidance, guidelines, framework or manual relating to the exercise of the Delegated Functions and issued by NHS England to the ICB as Mandated Guidance from time to time, in accordance with Clause 7.35 which at the Effective Date of Delegation shall include the Mandated Guidance set out in Schedule 7;
"National Commissioning Group (NCG)"	means the advisory forum in respect of the Retained Services currently known as the National Commissioning Group for Specialised, Health and Justice and Armed Forces Services;
"National Standards"	means the service standards for each Specialised Service, as set by NHS England and included in Clinical Commissioning Policies or National Specifications;
"National Specifications"	the service specifications published by NHS England in respect of Specialised Services;
"Need to Know"	has the meaning set out in paragraph 1.2 of Schedule 6 (*Further Information Governance and Sharing Provisions)*;
"NICE Regulations"	means the National Institute for Health and Care Excellence (Constitution and Functions) and the Health and Social Care Information Centre (Functions) Regulations 2013 as amended or replaced;
"NHS Act"	means the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022 and other legislation from time to time);

"NHS Counter Fraud Authority"	means the Special Health Authority established by and in accordance with the NHS Counter Fraud Authority (Establishment, Constitution, and Staff and Other Transfer Provisions) Order 2017/958;
"NHS Digital Data Security and Protection Toolkit"	means the toolkit published by NHS Digital and available on the NHS Digital website at: https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/data-security-and-protection-toolkit ;
"NHS England"	means the body established by section 1H of the NHS Act;
"NHS England Deliverables"	means all documents, products and materials NHS England in which NHS England holds IPRs which are relevant to this Agreement, the Delegated Functions or the Reserved Functions in any form and made available by NHS England to the ICB under this Agreement, including data, reports, policies, plans and specifications;
"NHS England Functions"	means all functions of NHS England as set out in legislation excluding any functions that have been expressly delegated;
"Non-Personal Data"	means data which is not Personal Data;
"Operational Days"	a day other than a Saturday, Sunday, Christmas Day, Good Friday or a bank holiday in England;
"**Oversight Framework**"	means the NHS Oversight Framework, as may be amended or replaced from time to time, and any relevant associated Guidance published by NHS England;
"Party/Parties"	means a party or both parties to this Agreement;
"Patient Safety Incident Response Framework"	means the framework published by NHS England and made available on the NHS England website at: https://www.england.nhs.uk/patient-safety/incident-response-framework/ ;
"Personal Data"	shall have the same meaning as set out in the UK GDPR and shall include references to Special Category Personal Data where appropriate;
"Population"	means the individuals for whom the ICB has responsibility in respect of commissioning the Delegated Services;
"Prescribed Specialised Services Manual"	means the document which may be amended or replaced from time to time which is currently known as the prescribed specialised services manual which describes how NHS England and ICBs commission specialised services and sets out the identification rules which describe how NHS England and ICBs identify Specialised Services activity within data flows;
"Provider Collaborative"	means a group of Specialised Service Providers who have agreed to work together to improve the care pathway for one or more Specialised Services;

"Provider Collaborative Guidance"	means the guidance published by NHS England in respect of Provider Collaboratives;
"Prohibited Act"	means the ICB: (i) offering, giving, or agreeing to give NHS England (or an of their officers, employees or agents) any gift or consideration of any kind as an inducement or reward for doing or not doing or for having done or not having done any act in relation to the obtaining of performance of this Agreement, the Reserved Functions, the Delegation or any other arrangement with the ICB, or for showing or not showing favour or disfavour to any person in relation to this Agreement or any other arrangement with the ICB; and (ii) in connection with this Agreement, paying or agreeing to pay any commission, other than a payment, particulars of which (including the terms and conditions of the agreement for its payment) have been disclosed in writing to NHS England; or (iii) committing an offence under the Bribery Act 2010;
"Regional Quality Group"	means a group set up to act as a strategic forum at which regional partners from across health and social care can share, identify and mitigate wider regional quality risks and concerns as well as share learning so that quality improvement and best practice can be replicated;
"Regulatory or Supervisory Body"	means any statutory or other body having authority to issue guidance, standards or recommendations with which the relevant Party and/or Staff must comply or to which it or they must have regard, including: (i) CQC; (ii) NHS England; (iii) the Department of Health and Social Care; (iv) the National Institute for Health and Care Excellence; (v) Healthwatch England and Local Healthwatch; (vi) the General Medical Council; (vii) the General Dental Council; (viii) the General Optical Council; (ix) the General Pharmaceutical Council; (x) the Healthcare Safety Investigation Branch; and (xi) the Information Commissioner;

"**Relevant Clinical Networks"**	means those clinical networks identified by NHS England as required to support the commissioning of Specialised Services for the Population;
"Relevant Information"	means the Personal Data and Non-Personal Data processed under the Delegation and this Agreement, and includes, where appropriate, "confidential patient information" (as defined under section 251 of the NHS Act), and "patient confidential information" as defined in the 2013 Report, The Information Governance Review – "*To Share or Not to Share?"*);
"Reserved Functions"	means statutory functions of NHS England that it has not delegated to the ICB including but not limited to those set out in the Schedules to this Agreement;
"Retained Services"	means those Specialised Services for which NHS England shall retain commissioning responsibility, as set out in Schedule 5;
"Secretary of State"	means the Secretary of State for Health and Social Care;
"Shared Care Arrangements"	means arrangements put in place to support patients receiving elements of their care closer to home, whilst still ensuring that they have access to the expertise of a specialised centre and that care is delivered in line with the expectation of the relevant National Specification;
"Single Point of Contact"	means the member of Staff appointed by each relevant Party in accordance with Paragraph 9.6 of Schedule 6;
"Special Category Personal Data"	shall have the same meaning as in UK GDPR;
"Specialised Commissioning Budget"	means the budget identified by NHS England for the purpose of exercising the Delegated Functions;
"Specialised Commissioning Functions"	means the statutory functions conferred on NHS England under Section 3B of the NHS Act and Regulation 11 and Schedule 4 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996 (as amended or replaced);
"Specialised Services"	means the services commissioned in exercise of the Specialised Commissioning Functions;
"Specialised Services Contract"	means a contract for the provision of Specialised Services entered into in the exercise of the Specialised Commissioning Functions;
"Specialised Services Provider"	means a provider party to a Specialised Services Contract;
"Specialised Services Staff"	means the Staff of roles identified as carrying out the Delegated Services Functions immediately prior to the date of this Agreement;

"Specified Purpose"	means the purpose for which the Relevant Information is shared and processed, being to facilitate the exercise of the ICB's Delegated Functions and NHS England's Reserved Functions as specified in paragraph **Error! Reference source not found.** of Schedule 6 *(Further Information Governance and Sharing Provisions)* to this Agreement;
"Staff or Staffing"	means the Parties' employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of either Party (whether or not the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors' and their sub-contractors' personnel;
"Sub-Delegate"	shall have the meaning in Clause 12.2;
"System Quality Group"	means a group set up to identify and manage concerns across the local system. The system quality group shall act as a strategic forum at which partners from across the local health and social care footprint can share issues and risk information to inform response and management, identify and mitigate quality risks and concerns as well as share learning and best practice;
"Triple Aim"	means the duty to have regard to wider effect of decisions, which is placed on each of the Parties under section 13NA (as regards NHS England) and section 14Z43 (as regards the ICB) of the NHS Act;
"UK GDPR"	means Regulation (EU) 2016/679 of the European Parliament and of the Council of 27th April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018;
"Variation Proposal"	means a written proposal for a variation to the Agreement, which complies with the requirements of Clause 26.5.

SCHEDULE 2: Delegated Services

Delegated Services

NHS England delegates to the ICB the statutory function for commissioning the Specialised Services set out in this Schedule 2 (*Delegated Services*) subject to the reservations set out in Schedule 4 (*Retained Functions*) and the provisions of any Developmental Arrangements set out in Schedule 9.

The following Specialised Services will be delegated to the ICB on 1 April 2024:

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
2	Adult congenital heart disease services	13X	Adult congenital heart disease services (non-surgical)
		13Y	Adult congenital heart disease services (surgical)
3	Adult specialist pain management services	31Z	Adult specialist pain management services
4	Adult specialist respiratory services	29M	Interstitial lung disease (adults)
		29S	Severe asthma (adults)
		29L	Lung volume reduction (adults)
5	Adult specialist rheumatology services	26Z	Adult specialist rheumatology services
7	Adult Specialist Cardiac Services	13A	Complex device therapy
		13B	Cardiac electrophysiology & ablation
		13C	Inherited cardiac conditions
		13E	Cardiac surgery (inpatient)
		13F	PPCI for ST- elevation myocardial infarction
		13H	Cardiac magnetic resonance imaging
		13T	Complex interventional cardiology (adults)
		13Z	Cardiac surgery (outpatient)
9	Adult specialist endocrinology services	27E	Adrenal Cancer (adults)
		27Z	Adult specialist endocrinology services
11	Adult specialist neurosciences services	08O	Neurology (adults)
		08P	Neurophysiology (adults)
		08R	Neuroradiology (adults)
		08S	Neurosurgery (adults)
		08T	Mechanical Thrombectomy
		58A	Neurosurgery LVHC national: surgical removal of clival chordoma and chondrosarcoma
		58B	Neurosurgery LVHC national: EC-IC bypass(complex/high flow)
		58C	Neurosurgery LVHC national: transoral excision of dens
		58D	Neurosurgery LVHC regional: anterior skull based tumours
		58E	Neurosurgery LVHC regional: lateral skull based tumours
		58F	Neurosurgery LVHC regional: surgical removal of brainstem lesions
		58G	Neurosurgery LVHC regional: deep brain stimulation
		58H	Neurosurgery LVHC regional: pineal tumour surgeries - resection
		58I	Neurosurgery LVHC regional: removal of arteriovenous malformations of the nervous system
		58J	Neurosurgery LVHC regional: epilepsy
		58K	Neurosurgery LVHC regional: insula glioma's/ complex low grade glioma's
		58L	Neurosurgery LVHC local: anterior lumbar fusion

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
	Adult specialist neurosciences services (continued)	58M	Neurosurgery LVHC local: removal of intramedullary spinal tumours
		58N	Neurosurgery LVHC local: intraventricular tumours resection
		58O	Neurosurgery LVHC local: surgical repair of aneurysms (surgical clipping)
		58P	Neurosurgery LVHC local: thoracic discectomy
		58Q	Neurosurgery LVHC local: microvascular decompression for trigeminal neuralgia
		58R	Neurosurgery LVHC local: awake surgery for removal of brain tumours
		58S	Neurosurgery LVHC local: removal of pituitary tumours including for Cushing's and acromegaly
12	Adult specialist ophthalmology services	37C	Artificial Eye Service
		37Z	Adult specialist ophthalmology services
13	Adult specialist orthopaedic services	34A	Orthopaedic surgery (adults)
		34R	Orthopaedic revision (adults)
15	Adult specialist renal services	11B	Renal dialysis
		11C	Access for renal dialysis
16	Adult specialist services for people living with HIV	14A	Adult specialised services for people living with HIV
17	Adult specialist vascular services	30Z	Adult specialist vascular services
18	Adult thoracic surgery services	29B	Complex thoracic surgery (adults)
		29Z	Adult thoracic surgery services: outpatients
30	Bone conduction hearing implant services (adults and children)	32B	Bone anchored hearing aids service
		32D	Middle ear implantable hearing aids service
35	Cleft lip and palate services (adults and children)	15Z	Cleft lip and palate services (adults and children)
36	Cochlear implantation services (adults and children)	32A	Cochlear implantation services (adults and children)
40	Complex spinal surgery services (adults and children)	06Z	Complex spinal surgery services (adults and children)
		08Z	Complex neuro-spinal surgery services (adults and children)
54	Fetal medicine services (adults and adolescents)	04C	Fetal medicine services (adults and adolescents)
58	Specialist adult gynaecological surgery and urinary surgery services for females	04A	Severe Endometriosis
		04D	Complex urinary incontinence and genital prolapse
58A	Specialist adult urological surgery services for men	41P	Penile implants
		41S	Surgical sperm removal
		41U	Urethral reconstruction
59	Specialist allergy services (adults and children)	17Z	Specialist allergy services (adults and children)
61	Specialist dermatology services (adults and children)	24Z	Specialist dermatology services (adults and children)
62	Specialist metabolic disorder services (adults and children)	36Z	Specialist metabolic disorder services (adults and children)
63	Specialist pain management services for children	23Y	Specialist pain management services for children
64	Specialist palliative care services for children and young adults	E23	Specialist palliative care services for children and young adults

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
65	Specialist services for adults with infectious diseases	18A	Specialist services for adults with infectious diseases
		18E	Specialist Bone and Joint Infection (adults)
72	Major trauma services (adults and children)	34T	Major trauma services (adults and children)
78	Neuropsychiatry services (adults and children)	08Y	Neuropsychiatry services (adults and children)
83	Paediatric cardiac services	23B	Paediatric cardiac services
94	Radiotherapy services (adults and children)	01R	Radiotherapy services (Adults)
		51R	Radiotherapy services (Children)
		01S	Stereotactic Radiosurgery / radiotherapy
105	Specialist cancer services (adults)	01C	Chemotherapy
		01J	Anal cancer (adults)
		01K	Malignant mesothelioma (adults)
		01M	Head and neck cancer (adults)
		01N	Kidney, bladder and prostate cancer (adults)
		01Q	Rare brain and CNS cancer (adults)
		01U	Oesophageal and gastric cancer (adults)
		01V	Biliary tract cancer (adults)
		01W	Liver cancer (adults)
		01Y	Cancer Outpatients (adults)
		01Z	Testicular cancer (adults)
		04F	Gynaecological cancer (adults)
		19V	Pancreatic cancer (adults)
		24Y	Skin cancer (adults)
		19C	Biliary tract cancer surgery (adults)
		19M	Liver cancer surgery (adults)
		19Q	Pancreatic cancer surgery (adults)
		51A	Interventional oncology (adults)
		51B	Brachytherapy (adults)
		51C	Molecular oncology (adults)
		61M	Head and neck cancer surgery (adults)
		61Q	Ophthalmic cancer surgery (adults)
		61U	Oesophageal and gastric cancer surgery (adults)
		61Z	Testicular cancer surgery (adults)
		33C	Transanal endoscopic microsurgery (adults)
		33D	Distal sacrectomy for advanced and recurrent rectal cancer (adults)
106	Specialist cancer services for children and young adults	01T	Teenage and young adult cancer
		23A	Children's cancer
106A	Specialist colorectal surgery services (adults)	33A	Complex surgery for faecal incontinence (adults)
		33B	Complex inflammatory bowel disease (adults)
107	Specialist dentistry services for children	23P	Specialist dentistry services for children
108	Specialist ear, nose and throat services for children	23D	Specialist ear, nose and throat services for children
109	Specialist endocrinology services for children	23E	Specialist endocrinology and diabetes services for children
110	Specialist gastroenterology, hepatology and nutritional support services for children	23F	Specialist gastroenterology, hepatology and nutritional support services for children

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
112	Specialist gynaecology services for children	73X	Specialist paediatric surgery services - gynaecology
113	Specialist haematology services for children	23H	Specialist haematology services for children
115B	Specialist maternity care for adults diagnosed with abnormally invasive placenta	04G	Specialist maternity care for women diagnosed with abnormally invasive placenta
118	Neonatal critical care services	NIC	Specialist neonatal care services
119	Specialist neuroscience services for children	23M	Specialist neuroscience services for children
		07Y	Paediatric neurorehabilitation
		08J	Selective dorsal rhizotomy
120	Specialist ophthalmology services for children	23N	Specialist ophthalmology services for children
121	Specialist orthopaedic services for children	23Q	Specialist orthopaedic services for children
122	Paediatric critical care services	PIC	Specialist paediatric intensive care services
125	Specialist plastic surgery services for children	23R	Specialist plastic surgery services for children
126	Specialist rehabilitation services for patients with highly complex needs (adults and children)	07Z	Specialist rehabilitation services for patients with highly complex needs (adults and children)
127	Specialist renal services for children	23S	Specialist renal services for children
128	Specialist respiratory services for children	23T	Specialist respiratory services for children
129	Specialist rheumatology services for children	23W	Specialist rheumatology services for children
130	Specialist services for children with infectious diseases	18C	Specialist services for children with infectious diseases
131	Specialist services for complex liver, biliary and pancreatic diseases in adults	19L	Specialist services for complex liver diseases in adults
		19P	Specialist services for complex pancreatic diseases in adults
		19Z	Specialist services for complex liver, biliary and pancreatic diseases in adults
		19B	Specialist services for complex biliary diseases in adults
132	Specialist services for haemophilia and other related bleeding disorders (adults and children)	03X	Specialist services for haemophilia and other related bleeding disorders (Adults)
		03Y	Specialist services for haemophilia and other related bleeding disorders (Children)
134	Specialist services to support patients with complex physical disabilities (excluding wheelchair services) (adults and children)	05P	Prosthetics (adults and children)
135	Specialist paediatric surgery services	23X	Specialist paediatric surgery services - general surgery
136	Specialist paediatric urology services	23Z	Specialist paediatric urology services
139A	Specialist morbid obesity services for children	35Z	Specialist morbid obesity services for children
139AA	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital	04P	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital
ACC	Adult Critical Care	ACC	Adult critical care

SCHEDULE 3: Delegated Functions

22 Introduction

22.1 Subject to the reservations set out in Schedule 4 (*Reserved Functions*) and the provisions of any Developmental Arrangements, NHS England delegates to the ICB the statutory function for commissioning the Delegated Services. This Schedule 3 sets out the key powers and duties that the ICB will be required to carry out in exercise of the Delegated Functions being, in summary:

22.1.1 decisions in relation to the commissioning and management of Delegated Services;

22.1.2 planning Delegated Services for the Population, including carrying out needs assessments;

22.1.3 undertaking reviews of Delegated Services in respect of the Population;

22.1.4 supporting the management of the Specialised Commissioning Budget;

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

22.1.6 such other ancillary activities that are necessary to exercise the Specialised Commissioning Functions.

22.2 When exercising the Delegated Functions, ICBs are not acting on behalf of NHS England but acquire rights and incur any liabilities in exercising the functions.

23 General Obligations

23.1 The ICB is responsible for planning the commissioning of the Delegated Services in accordance with this Agreement. This includes ensuring at all times that the Delegated Services are commissioned in accordance with the National Standards.

23.2 The ICB shall put in place arrangements for collaborative working with other ICBs in accordance with Clause 8 (*Requirement for ICB Collaboration Arrangement*).

23.3 The Developmental Arrangements set out in Schedule 9 shall apply.

Specific Obligations

24 Assurance and Oversight

24.1 The ICB must at all times operate in accordance with:

24.1.1 the Oversight Framework published by NHS England;

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

24.1.3 any other relevant NHS oversight and assurance guidance;

collectively known as the “Assurance Processes”.

24.2 The ICB must:

24.2.1 develop and operate in accordance with mutually agreed ways of working in line with the Assurance Processes;

24.2.2 oversee the provision of Delegated Services and the outcomes being delivered for its Population in accordance with the Assurance Processes;

24.2.3 assure that Specialised Service Providers are meeting, or have an improvement plan in place to meet, National Standards;

24.2.4 provide any information and comply with specific actions in relation to the Delegated Services, as required by NHS England, including metrics and detailed reporting.

25 Attendance at governance meetings

25.1 The ICB must ensure that there is appropriate representation at forums established through the ICB Collaboration Arrangement.

25.2 The ICB must ensure that an individual(s) has been nominated to represent the ICB at the Delegated Commissioning Group (DCG) and regularly attends that group. This could be a single representative on behalf of the members of an ICB Collaboration Arrangement. Where that representative is not an employee of the ICB, the ICB must have in place appropriate arrangements to enable the representative to feedback to the ICB.

25.3 The ICB should also ensure that they have a nominated representative with appropriate subject matter expertise to attend National Standards development forums as requested by NHS England. This could be a single representative on behalf of the members of an ICB Collaboration Arrangement. Where that representative is not an employee of the ICB, the ICB must have in place appropriate arrangements to enable the representative to feedback to the ICB.

26 Clinical Leadership and Clinical Reference Groups

26.1 The ICB shall support the development of clinical leadership and expertise at a local level in respect of Specialised Services.

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

27 Clinical Networks

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

27.2 The ICB will be involved in the development and agreement of a single annual plan for the Relevant Clinical Network.

27.3 The ICB shall monitor the implementation of the annual plan and receive an annual report from the Relevant Clinical Network that considers delivery against the annual plan.

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

27.5 The ICB shall support NHS England in the management of Relevant Clinical Networks.

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

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

27.8 The ICB shall ensure that network reports are considered where relevant as part of exercising the Delegated Functions.

28 Complaints

28.1 The ICB shall provide full co-operation with NHS England in relation to any complaints received in respect of the Delegated Services which shall retain the function of complaints management in respect of the Delegated Services.

28.2 The ICB shall provide the relevant individuals at NHS England with appropriate access to data held by the ICB necessary to carry out the complaints function.

28.3 At such time as agreed between the ICB and NHS England, the management of complaints function in respect of the Delegated Services shall be delegated to the ICB and the following provisions shall apply:

28.3.1 NHS England shall provide the relevant individuals at the ICB with appropriate access to complaints data held by NHS England necessary to carry out the complaints function as set out in the Complaints Sharing Protocol.

28.3.2 The ICB shall provide information relating to key performance indicators ("KPIs") as requested by NHS England. These KPIs shall include information reporting on the following:

28.3.2.1 acknowledgements provided within three (3) Operational Days;

28.3.2.2 responses provided within forty (40) Operational Days;

28.3.2.3 response not provided within six (6) months;

28.3.2.4 open cases with the Parliamentary and Health Services Ombudsman and providing information on any fully or partly upheld complaints; and

28.3.2.5 overall activity by volume (not as a KPI).

28.3.3 The ICB shall co-operate with NHS England in respect of the review of complaints related to the Delegated Services and shall, on request, share any learning identified in carrying out the complaints function.

28.3.4 The ICB shall take part in any peer review process put in place in respect of the complaints function.

28.4 Where NHS England has provided the ICB with a protocol for sharing complaints in respect of any or all Specialised Services then those provisions shall apply and are deemed to be part of this Agreement.

29 Commissioning and optimisation of High Cost Drugs

29.1 The ICB must ensure the effective and efficient commissioning of High Cost Drugs for Delegated Services.

29.2 Where necessary the ICB must collaborate with NHS England in respect of the payment arrangements for High Cost Drugs.

29.3 The ICB must develop and implement Shared Care Arrangements across the Area of the ICB.

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

29.5 The ICB must ensure:

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

29.5.2 effective introduction of new medicines;

29.5.3 compliance with all NHS England commercial processes and frameworks for High Cost Drugs;

29.5.4 Specialised Services Providers adhere to all NHS England commercial processes and frameworks for High Cost Drugs;

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

29.5.6 consistency of prescribing and unwarranted prescribing variation are addressed.

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

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

29.8 The ICB must provide support to prescribing networks and forums, including but not limited to, Immunoglobulin Assessment panels, prescribing networks and medicines optimisation networks.

30 Contracting

30.1 The ICB shall be responsible for ensuring appropriate arrangements are in place for the commissioning of the Delegated Services which for the avoidance of doubt includes:

30.1.1 co-ordinating or collaborating in the award of appropriate Specialised Service Contracts;

30.1.2 drafting of the contract schedules so that it reflects Mandatory Guidance, National Specifications and any specific instructions from NHS England; and

30.1.3 management of Specialised Services Contracts.

30.2 In relation to the contracting for NHS England Retained Services where the ICB has agreed to act as the co-ordinating commissioner, to implement NHS England's instructions in relation to those Retained Services and, where appropriate, put in place a Collaborative Commissioning Agreement with NHS England as a party.

31 Data Management and Analytics

31.1 The ICB shall:

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

31.1.2 lead on the provision of data and analytical services to support commissioning of Delegated Services;

31.1.3 ensure collaborative working across partners on agreed programmes of work focusing on provision of pathway analytics;

31.1.4 share expertise and existing reporting tools with partner ICBs in the ICB Collaboration Arrangement;

31.1.5 ensure interpretation of data is made available to NHS England and other ICBs within the ICB Collaboration Arrangement;

31.1.6 ensure data and analytics teams within ICBs and NHS England work collaboratively on jointly agreed programmes of work focusing on provision of pathway analytics;

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

32 Finance

32.1 The provisions of Clause 10 (*Finance*) of this Agreement set out the financial requirements in respect of the Delegated Functions.

33 Freedom of Information and Parliamentary Requests

33.1 The ICB shall lead on the handling, management and response to all Freedom of Information and parliamentary correspondence relating to Delegated Services.

34 Incident Response and Management

34.1 The ICB shall:

34.1.1 lead on local incident management for Delegated Services as appropriate to the stated incident level;

34.1.2 support national and regional incident management relating to Specialised Services; and

34.1.3 ensure surge events and actions relating to Specialised Services are included in ICB escalation plans.

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

35 Individual Funding Requests

35.1 The ICB shall provide any support required by NHS England in respect of determining an Individual Funding Request and shall implement the decision of the Individual Funding Request panel.

36 Innovation and New Treatments

36.1 The ICB shall support local implementation of innovative treatments for Delegated Services.

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

37.1 The ICB shall co-operate fully with NHS England in the development, management and operation of mental health, learning disability and autism NHS-led Provider Collaboratives including, where requested by NHS England, to consider the Provider Collaborative arrangements as part of the wider pathway delivery.

38 Provider Selection and Procurement

38.1 The ICB shall:

38.1.1 run appropriate local provider selection and procurement processes for Delegated Services;

38.1.2 align all procurement processes with any changes to national procurement policy (for example new legislation) for Delegated Services;

38.1.3 support NHS England with national procurements where required with subject matter expertise on provider engagement and provider landscape; and

38.1.4 monitor and provide advice, guidance and expertise to NHS England on the overall provider market and provider landscape.

38.2 In discharging these responsibilities, the ICB must comply at all times with Law and any relevant Guidance including but not limited to Mandated Guidance; any applicable procurement law and Guidance on the selection of, and award of contracts to, providers of healthcare services.

38.3 When the ICB makes decisions in connection with the awarding of Specialised Services Contracts, it should ensure that it can demonstrate compliance with requirements for the award of such Contracts, including that the decision was:

38.3.1 made in the best interest of patients, taxpayers and the Population;

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

38.3.3 made transparently; and

38.3.4 compliant with relevant Guidance and legislation.

39 Quality

39.1 The ICB must ensure that appropriate arrangements for quality oversight are in place. This must include:

39.1.1 clearly defined roles and responsibilities for ensuring governance and oversight of Delegated Services;

39.1.2 defined roles and responsibilities for ensuring robust communication and appropriate feedback, particularly where Delegated Services are commissioned through an arrangement with one or more other ICBs;

39.1.3 working with providers and partner organisations to address any issues relating to Delegated Services and escalate appropriately if such issues cannot be resolved;

39.1.4 developing and standardising processes that align with regional systems to ensure oversight of the quality of Delegated Services, and participating in local System Quality Groups and Regional Quality Groups, or their equivalent;

39.1.5 ensuring processes are robust and concerns are identified, mitigated and escalated as necessary;

39.1.6 ensuring providers are held to account for delivery of safe, patient-focused and quality care for Delegated Services, including mechanisms for monitoring patient complaints, concerns and feedback; and

39.1.7 the implementation of the Patient Safety Incident Response Framework for the management of incidents and serious events, appropriate reporting of any incidents, undertaking any appropriate patient safety incident investigation and obtaining support as required.

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

39.3 The ICB must ensure that the oversight of the quality of the Delegated Services is integrated with wider quality governance in the local system and aligns with the NHS England National Quality Board's recommended quality escalation processes.

39.4 The ICB must ensure that there is a System Quality Group (or equivalent) to identify and manage concerns across the local system.

39.5 The ICB must ensure that there is appropriate representation at any Regional Quality Groups or their equivalent.

39.6 The ICB must have in place all appropriate arrangements in respect of child and adult safeguarding and comply with all relevant Guidance.

40 Service Planning and Strategic Priorities

40.1 The ICB is responsible for setting local commissioning strategy, policy and priorities and planning for and carrying out needs assessments for the Delegated Services.

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

40.3 The ICB must ensure that it works with Specialised Service Providers and Provider Collaboratives to translate local strategic priorities into operational outputs for Delegated Services.

40.4 The ICB shall provide input into any consideration by NHS England as to whether the commissioning responsibility in respect of any of the Retained Services should be delegated.

41 National Standards, National Specifications and Clinical Commissioning Policies

41.1 The ICB shall provide input into national decisions on National Standards and national transformation regarding Delegated Services through attendance at governance meetings.

41.2 The ICB shall facilitate engagement with local communities on National Specification development.

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

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

41.5 The ICB must have appropriate mechanisms in place to ensure National Standards and National Specifications are being adhered to.

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

42 Transformation

42.1 The ICB shall:

42.1.1 prioritise pathways and services for transformation according to the needs of its Population and opportunities for improvement in ICB commissioned services and for Delegated Services;

42.1.2 lead ICB and ICB Collaboration Arrangement driven transformation programmes across pathways for Delegated Services;

42.1.3 lead the delivery locally of transformation in areas of national priority (such as Cancer, Mental Health and Learning Disability and Autism), including supporting delivery of commitments in the NHS Long Term Plan;

42.1.4 support NHS England with agreed transformational programmes for Retained Services;

42.1.5 support NHS England with agreed transformational programmes and identify future transformation programmes for consideration and prioritisation for Delegated Services where national co-ordination and enablement may support transformation;

42.1.6 work collaboratively with NHS England on the co-production and co-design of transformation and improvement interventions and solutions in those areas prioritised; and

42.1.7 ensure Relevant Clinical Networks and other clinical networks use levers to facilitate and embed transformation at a local level for Delegated Services.

SCHEDULE 4: Reserved Functions

Introduction

22. Reserved Functions in Relation to the Delegated Services

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

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

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

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

23. Retained Services

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

24. Reserved Specialised Service Functions

24.1. NHS England shall carry out the functions set out in this Schedule 4 in respect of the Delegated Services.

Reserved Functions

25. Assurance and Oversight

25.1. NHS England shall:

25.1.1. have oversight of what ICBs are delivering (inclusive of Delegated Services) for their Populations and all patients;

25.1.2. design and implement appropriate assurance of ICBs' exercise of Delegated Functions including the Assurance Processes;

25.1.3. help the ICB to coordinate and escalate improvement and resolution interventions where challenges are identified (as appropriate);

25.1.4. ensure that the NHS England Board is assured that Delegated Functions are being discharged appropriately;

25.1.5. ensure specialised commissioning considerations are appropriately included in NHS England frameworks that guide oversight and assurance of service delivery; and

25.1.6. host a Delegated Commissioning Group ("DCG") that will undertake an assurance role in line with the Assurance Processes. This assurance role shall include assessing and monitoring the overall coherence, stability and sustainability of the commissioning model of Specialised Services at a

national level, including identification, review and management of appropriate cross-ICB risks.

26. Attendance at governance meetings

26.1. NHS England shall ensure that there is appropriate representation in respect of Reserved Functions and Retained Services at local governance forums (for example, the Regional Leadership Team) and at NCG.

26.2. NHS England shall:

26.2.1. ensure that there is appropriate representation by NHS England subject matter expert(s) at National Standards development forums;

26.2.2. ensure there is appropriate attendance by NHS England representatives at nationally led clinical governance meetings; and

26.2.3. co-ordinate, and support key national governance groups.

27. Clinical Leadership and Clinical Reference Groups

27.1. NHS England shall be responsible for the following:

27.1.1. developing local leadership and support for the ICB relating to Specialised Services;

27.1.2. providing clinical leadership, advice and guidance to the ICB in relation to the Delegated Services;

27.1.3. providing point-of-contact and ongoing engagement with key external bodies, such as interest groups, charities, NICE, DHSC, and Royal Colleges; and enabling access to clinical trials for new treatments and medicines.

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

27.2.1. Clinical Commissioning Policies;

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

28. Clinical Networks

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

28.2. NHS England shall ensure development of multi-ICB, and multi-region (where necessary) governance and oversight arrangements for Relevant Clinical Networks that give line of sight between all clinical networks and all ICBs whose Population they serve.

28.3. NHS England shall be responsible for:

28.3.1. developing national policy for the Relevant Clinical Networks;

28.3.2. developing and approving the specifications for the Relevant Clinical Networks;

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

28.3.4. convening or supporting national networks of the Relevant Clinical Networks;

28.3.5. agreeing the annual plan for each Relevant Clinical Network with the involvement of the ICB and Relevant Clinical Network, ensuring these reflect national and regional priorities;

28.3.6. managing Relevant Clinical Networks jointly with the ICB; and

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

29. Complaints

29.1. NHS England shall manage all complaints in respect of the Delegated Services at the date of this Agreement and until such time as it agrees the delegation of complaints to the ICB.

29.2. NHS England shall manage all complaints in respect of the Reserved Services.

30. Commissioning and optimisation of High Cost Drugs

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

30.1.1. comply as appropriate with the centralised process for the reimbursement of Specialised Services High Cost Drugs and, where appropriate, ensuring that only validated drugs spend is reimbursed, there is timely drugs data and drugs data quality meets the standards set nationally;

30.1.2. support the ICB on strategy for access to medicines used within Delegated Services, minimising barriers to health inequalities;

30.1.3. provide support, as reasonably required, to the ICB to assist it in the commissioning of High Cost Drugs for Delegated Services including shared care agreements;

30.1.4. seek to address consistency of prescribing in line with national commissioning policies, introduction of new medicines, and addressing unwarranted prescribing variation;

30.1.5. provide input into national procurement, homecare and commercial processes;

30.1.6. provide expert medicines advice and input into immunoglobin assessment panels and support to the national Programmes of Care and Clinical Reference Groups;

30.1.7. provide expert medicines advice and input into the Individual Funding Request process for Delegated Services; and

30.1.8. collaborate with commissioners of health and justice services to ensure detained people can access High Cost Drugs using the NHS England or ICB commissioning policies in line with community patient access, including who prescribes and supplies the medicine.

31. Contracting

31.1. NHS England shall retain the following obligations in relation to contracting for Delegated Services:

31.1.1. ensure Specialised Services are included in national NHS England contracting and payment strategy (for example, Aligned Payment Incentives);

31.1.2. provide advice for ICBs on schedules to support the Delegated Services;

31.1.3. set, publish or make otherwise available the Contracting Standard Operating Procedure and Mandated Guidance detailing contracting strategy and policy for Specialised Services; and

31.1.4. provide and distribute contracting support tools and templates to the ICB.

31.2. In respect of the Retained Services, NHS England shall:

31.2.1. where appropriate, ensure a Collaborative Commissioning Agreement is in place between NHS England and the ICB(s); and

31.2.2. where appropriate, construct model template schedules for Retained Services and issue to ICBs.

32. Data Management and Analytics

32.1. NHS England shall:

32.1.1. support the ICB by collaborating with the wider data and analytics network (nationally) to support development and local deployment or utilisation of support tools;

32.1.2. support the ICB to address data quality and coverage needs, accuracy of reporting Specialised Services activity and spend on a Population basis to support commissioning of Specialised Services;

32.1.3. ensure inclusion of Specialised Services data strategy in broader NHS England, DHSC and government data strategies;

32.1.4. lead on defining relevant contractual content of the information schedule (Schedule 6) of the NHS Standard Contract for Clinical Services;

32.1.5. work collaboratively with the ICB to drive continual improvement of the quality and coverage of data used to support commissioning of Specialised Services;

32.1.6. provide a national analytical service to support oversight and assurance of Specialised Services, and support (where required) the national Specialised Commissioning team, Programmes of Care and Clinical Reference Groups; and

32.1.7. provide access to data and analytic subject matter expertise to support the ICB when considering local service planning, needs assessment and transformation.

33. Finance

33.1. The provisions of Clause 10 shall apply in respect of the financial arrangements in respect of the Delegated Functions.

34. Freedom of Information and Parliamentary Requests

34.1. NHS England shall:

34.1.1. lead on handling, managing and responding to all national FOIA and parliamentary correspondence relating to Retained Services; and

34.1.2. co-ordinate a response when a single national response is required in respect of Delegated Services.

35. Incident Response and Management

35.1. NHS England shall:

35.1.1. provide guidance and support to the ICB in the event of a complex incident;

35.1.2. lead on national incident management for Specialised Services as appropriate to stated incident level and where nationally commissioned services are impacted;

35.1.3. lead on monitoring, planning and support for service and operational resilience at a national level and provide support to the ICB; and

35.1.4. respond to specific service interruptions where appropriate; for example, supplier and workforce challenges and provide support to the ICB in any response to interruptions.

36. Individual Funding Requests

36.1. NHS England shall be responsible for:

36.1.1. leading on Individual Funding Requests (IFR) policy, IFR governance and managing the IFR process for Delegated Services and Retained Services;

36.1.2. taking decisions in respect of IFRs at IFR Panels for both Delegated Services and Retained Services; and

36.1.3. providing expertise for IFR decisions, including but not limited to pharmacy, public health, nursing and medical and quality.

37. Innovation and New Treatments

37.1. NHS England shall support the local implementation of innovative treatments for Delegated Services.

37.2. NHS England shall ensure services are in place for innovative treatments such as advanced medicinal therapy products recommended by NICE technology appraisals within statutory requirements.

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

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

38.1. NHS England shall commission and design NHS-led Provider Collaborative arrangements for mental health, learning disability and autism services. Where it considers appropriate, NHS England shall seek the input of the ICB in relation to relevant Provider Collaborative arrangements.

39. Provider Selection and Procurement

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

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

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

39.1.3. where appropriate, running provider selection and procurement processes for Specialised Services.

40. Quality

40.1. In respect of quality, NHS England shall:

40.1.1. work with the ICB to ensure oversight of Specialised Services through quality surveillance and risk management and escalate as required;

40.1.2. work with the ICB to seek to ensure that quality and safety issues and risks are managed effectively and escalated to the National Specialised Commissioning Quality and Governance Group (QGG), or other appropriate forums, as necessary;

40.1.3. work with the ICB to seek to ensure that the quality governance and processes for Delegated Services are aligned and integrated with broader clinical quality governance and processes in accordance with National Quality Board Guidance;

40.1.4. facilitate improvement when quality issues impact nationally and regionally, through programme support, and mobilising intensive support when required on specific quality issues;

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

40.1.6. support the ICB to identify key themes and trends and utilise data and intelligence to respond and monitor as necessary;

40.1.7. report on quality to both NCG and DCG as well as QGG and Executive Quality Group as required;

40.1.8. facilitate and support the national quality governance infrastructure (for example, the QGG); and

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

41. National Standards, National Specifications and Clinical Commissioning Policies

41.1. NHS England shall carry out:

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

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

41.1.3. maintenance and publication of the Prescribed Specialised Services Manual and engagement with the DHSC on policy matters; and

41.1.4. determination of content for national clinical registries.

42. Transformation

42.1. NHS England shall be responsible for:

42.1.1. co-ordinating and enabling ICB-led specialised service transformation programmes for Delegated Services where necessary;

42.1.2. supporting the ICB to implement national policy and guidance across its Populations for Retained Services;

42.1.3. supporting the ICB with agreed transformational programmes where national transformation support has been agreed for Delegated Services;

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

42.1.5. co-production and co-design of transformation programmes with the ICB and wider stakeholders; and

42.1.6. providing access to subject matter expertise including Clinical Reference Groups, national clinical directors, Programme of Care leads for the ICB where it needs support, including in relation to local priority transformation.

SCHEDULE 5: Retained Services

NHS England shall retain the function of commissioning the Specialised Services that are not Delegated Services and as more particularly set out by NHS England and made available from time to time.

SCHEDULE 6: Further Information Governance And Sharing Provisions

PART 1

1. Introduction

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

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

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

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

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

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

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

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

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

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

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

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

2. Purpose

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

2.2. Each Party must ensure that they have in place appropriate Data Sharing Agreements to enable data to be received from any third party organisations from which the Parties must obtain data in order to achieve the Specified Purpose. Where necessary specific

and detailed purposes must be set out in a Data Sharing Agreement that complies with all relevant legislation and Guidance.

3. Benefits of information sharing

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

4. Lawful basis for sharing

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

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

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

5. Restrictions on use of the Shared Information

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

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

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

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

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

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

6. Ensuring fairness to the Data Subject

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

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

6.1.2. amendment of respective privacy notices and policies to reflect the processing of data carried out further to this Agreement, including covering the requirements of articles 13 and 14 UK GDPR and providing these (or making them available to) Data Subjects;

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

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

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

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

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

7. Governance: Staff

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

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

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

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

7.5. The Parties shall ensure that:

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

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

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

8. Governance: Protection of Personal Data

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

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

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

8.4. If any Party becomes aware of:

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

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

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

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

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

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

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

8.6. The Parties shall act generally in accordance with Data Protection Legislation requirements. This includes implementing, maintaining and keeping under review appropriate technical and organisational measures to ensure and demonstrate that the processing of Personal Data is undertaken in accordance with Data Protection

Legislation, and in particular to protect Personal Data (and Special Category Personal Data) against unauthorised or unlawful processing, and against accidental loss, destruction, damage, alteration or disclosure. These measures shall:

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

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

8.7. In particular, each Party shall:

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

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

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

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

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

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

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

8.10. The Parties' Single Points of Contact set out in paragraph **Error! Reference source not found.** will be the persons who, in the first instance, will have oversight of third party security measures.

9. Governance: Transmission of Information between the Parties

9.1. This paragraph supplements paragraph 8 of this Schedule.

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

9.3. Wherever possible, Personal Data should be transmitted and held in pseudonymised form, with only reference to the NHS number in 'clear' transmissions. Where there are significant consequences for the care of the patient, then additional data items, such as

the postcode, date of birth and/or other identifiers should also be transmitted, in accordance with good information governance and clinical safety practice, so as to ensure that the correct patient record and/or data is identified.

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

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

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

10. Governance: Quality of Information

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

11. Governance: Retention and Disposal of Shared Information

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

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

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

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

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

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

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

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

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

12. Governance: Complaints and Access to Personal Data

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

12.2. Complaints about information sharing shall be reported to the Single Points of Contact and the ICB. Complaints about information sharing shall be routed through each Parties' own complaints procedure unless otherwise provided for in the Agreement or determined by the ICB.

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

12.4. Basic details of the Agreement shall be included in the appropriate log under each Party's publication scheme.

13. Governance: Single Points of Contact

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

14. Monitoring and review

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

SCHEDULE 6: Further Information Governance And Sharing Provisions

PART 2

Data Sharing Agreement

GUIDANCE NOTE:

The Parties may enter details in this schedule about the arrangements for sharing data, including any Data Sharing Agreement.

SCHEDULE 7: Mandated Guidance

Generally applicable Mandated Guidance

- National Guidance on System Quality Groups.
- Managing Conflicts of Interest in the NHS.
- Arrangements for Delegation and Joint Exercise of Statutory Functions.
- Guidance relating to procurement and provider selection.
- Information Governance Guidance relating to serious incidents.
- All other applicable IG and Data Protection Guidance.
- Any applicable Freedom of Information protocols.
- Any applicable Guidance on Counter Fraud, including from The NHS Counter Fraud Authority.
- Any applicable Guidance relating to the use of data and data sets for reporting.
- Guidance relating to the processes for making and handling individual funding requests, including:
    - Commissioning policy: Individual funding requests;
    - Standard operating procedures: Individual funding requests.

Workforce

- Guidance on the Employment Commitment.

Finance

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

Specialised Services Mandated Guidance

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

SCHEDULE 8: Local Terms

None – local terms are described as part of the Collaboration Agreement and Operating Framework which includes a pooled budget established by the ICBs

General

Where there is a Dispute as to the content of this Schedule, the Parties should follow the Disputes procedure set out at Clause 25.

Following signature of the Agreement, this Schedule can be amended by the Parties using the Variations procedure at Clause 26.

NHS England can amend this Schedule without the ICB's consent by using the variation procedure set out in Clause 26.2 but the expectation is that variations should be by consent.

SCHEDULE 9: Developmental Arrangements

These Development Arrangements take precedence over the terms of this Agreement including other Schedules, and the Agreement shall be read as varied by these Developmental Arrangements. Save as varied by these Developmental Arrangements the Agreement remains in full force and effect.

The Developmental Arrangements

The following Developmental Arrangements apply to this Agreement:

Finance
Ringfencing – Delegated specialised commissioning allocations will be ringfenced to be spent only on specialised commissioning services. This includes reserves and discretionary growth funding as well as existing contractual spend, both block and variable elements. This does not determine which specialised services those allocations are spent on. Any variation of this condition would need to be to be approved by the regional Director of Commissioning or Director of Finance.

Review
Review and removal of the delegation arrangement is the responsibility of the Regional Director of Finance and Regional Director of Commissioning Integration. This will be carried out based on the regional and individual ICB financial position and following and agreed assurance process.

Quality

Where ICBs are in NOF 4, NHSE commit to offer additional/supplementary clinical and quality support and will work jointly with ICB colleagues to fulfil their responsibilities in line with the NQB Shared Commitment to Quality and Risk Response and Escalation Guidance. This will include where delegated Services are deemed as requiring enhanced or intensive level support.
NHSE will arrange access to identified key contacts from both a clinical and quality perspective to provide professional, clinical advice and support including with

- Regional Medical Director for Specialised Services
- Deputy Director of Nursing
- Assistant Director of Nursing & Quality for Acute Specialised Services

NHSE will support options for potential buddying arrangements with other ICB Clinical and Quality leads and provide support with the joint development of Improvement/Action Plans and the supporting of Quality Improvement Groups and/or Rapid Quality Review meetings as required.

Review
Review and removal of the delegation arrangement is the responsibility of the Regional Director of Nursing and Regional Director of Commissioning Integration. This will be carried out based on the regional and the ICB position and following and agreed assurance process.

SCHEDULE 10: Administrative and Management Services

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Memorandum of Understanding
&
Collaboration Agreement
For the Delegation of Acute Specialised Services
2024-2025

Memorandum of Understanding (MoU)
Delegation of Acute Specialised Services
2024-2025

1.0 Introduction

This Memorandum of Understanding (MoU) sets out the key principles and commitments to supporting the collaborative working model for the 11 ICBs in the Midlands and NHSE Midlands.

The MOU covers the year 2024-25 and is referred to as the transitional year. In this year 59 Acute Specialised Service Lines will be formally delegated (Subject to Board Approval). The MOU should be read in conjunction with the formal Collaboration Agreement which is a mandated requirement of the delegation process.

The Midlands are committed to working together to achieve best outcomes promoting pathway integration and parity of access to drive improvements in population health.

Our aim in this transitional year is to set out the practical ways in which we will work together to mitigate any potential risks and issues and to develop a strong operating model for the future.

2.0 Principles

This MOU is a statement based on principles of co-operation between all organisations including:

- To build strong relationships and an environment based on trust and collaboration.
- To seek to continually improve whole pathways of care and to design and implement effective and efficient integration.
- To share information and best practice and work together to identify solutions, eliminate duplication of effort, mitigate risks, and promote value.
- To have regard to each other's needs and views
- To work within the intentions set out within the Delegation Agreement.
- To commit to continue to work together during 2024/25 to build on the foundation from statutory joint working and learn lessons from previous delegation.

3.0 Responsibilities and Accountabilities

The delegation of specialised commissioning does not change the accountability of the services lines and functions remaining with NHS England.

Upon delegation the services become the responsibility of the 11 Midlands ICBs who are required to commit to working together to commission these services. NHSE remains a partner in this process and is also responsible for the commissioning of retained specialised services.

ICB responsibilities for the delegated services are as follows:

- All delivery is conducted in the name of the ICB, and legal liabilities are the ICBs.
- Decisions in relation to the commissioning and management of the delegated services
- Planning delegated services for the population, including carrying out needs assessments
- Undertaking reviews of delegated services in respect of the population
- Supporting the management of the specialised commissioning budget for delegated services

- 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

NHSE accountabilities and responsibilities for the delegated services are as follows:

- Remains politically accountable to the Secretary of State and parliament, although not directly legally responsible for any shortcomings or delivery failures.
- Has continued responsibilities to support the ICBs in their delegated responsibilities providing guidance and expertise.
- NHSE could be subject to judicial review and challenge.

Joint consideration will be given to the development of a future concordat to underpin future joint working arrangements from 2025/26.

4.0 Pre delegation assurance requirements

A robust programme of work has been underway (jointly managed between NHSE and the ICBs) throughout the year to oversee the delegation of services from April 2024.
Over and above, this work it was agreed that additional due diligence requirements would be enacted to ensure ICBs have all the necessary assurance to allow them to sign off at ICB Boards in March 2024. These include the following:

- **Sender /Receiver Summary report -** One of the key documents to be produced will be a summary of the safe delegation checklist report completed by NHSE (as the sender organisation) approved by the joint working groups summarising the following:
    - Performance – activity /waiting lists against trajectory /improvement plans.
    - Contracts – outstanding issues/disputes
    - Procurements
    - Operational work programme
    - Risk register and mitigations
    - Corporate – complaints /litigations/FoIs
    - Finance – investment /cases
    - Responsibilities around high-cost drugs and devices

- **Service Profiles** – including assessment of quality and fragile services by ICB. This report will be available prior to Board sign off and updated for April 2024.
- **Finance** – Risk managed through a Pooled Fund approach between ICBs in 2024/25, working closely with NHSE to manage the overall financial position of specialised services recognising differential growth between retained and delegated services.
- **Quality Assurance Framework** – outlines the transitional arrangements for quality assurance responsibilities.
- **Benefits of delegation** – set out the practical examples of the benefits of delegation for patients.

Note: current ICB performance analysis already includes specialised activity data

5.0 Working arrangements of the teams /functions in 2024/25

The Specialised Services Standard Operating Framework sets out who the Midlands Specialised Commissioning team are and how they will operate.
This team is committed to the following:

- Agreeing individual joint priorities recognising the breadth of commissioning responsibility for delegated and retained functions. The Director posts will have a single set of priorities on behalf of the 11 ICBs and NHSE.

- Delivering an agreed work plan for the actions agreed for delegated services and retained services.
- Improving specialised services health inequalities through delivering recommendations in the health inequalities strategy.

The team will progress:

- New approaches to working with ICB colleagues to ensure a shared leadership model and learning to enable expertise in specialised services, and system expertise to be combined to improve outcomes.
- Full engagement in joint development opportunities to ensure that the experience across Programmes of Care is maximised and opportunities to drive value are realised.
- Explore ways to further support the staff through the transitional year to maintain the workforce.
- Develop new ways of working during the transition year to reflect the changing environment.

In the transitional year, executive and operational leadership for the Operating Framework will be through:

- A Specialised Services Executive Group (including the East and West ICB CEO Strategic Leads for Specialised Commissioning and the NHSE Regional Director of Commissioning Integration
- A multi-professional Specialised Services Senior Leadership Team function including input from Midlands Specialised Commissioning and East and West ICB professional executive leads.

Recognising 2024/25 as a transitional year prior to delegation of further services, the Operating Model Working Group (OMG) will be responsible for the joint planning for this next phase of delegation, with assurance and escalation through the joint Delegation and Transfer Programme Board and direction from the ICB CEOs/NHSE development sessions.

Decision making will be through ICB Boards and the NHSE Regional Support Group. Connectivity between the current and future agendas will be ensured through the Specialised Executive Group and reports to the Joint Committees.

6.0 Finance and Governance

Formal governance will be through the East and West Midlands Joint Committees who will formally stand-up a sub-group of the committees, these being:

- Midlands Acute Specialised Services Group – Commissioning including Planning Development, Transformation, and Reducing Inequalities
- Finance and Contracting Group – Financial Management and Financial Planning
- Specialised Commissioning Quality Group – Quality Oversight and Assurance

In addition, advisory groups including, the Collaborative Clinical Executive Group will provide clinically lead transformation and improvement advice guidance and recommendations for pathway re-design.

To ensure the integrated planning and decision making around the needs of the Midlands populations, these forums will consider NHSE Midlands retained functions as well as delegated functions; however, decision making for retained functions will be through the Midlands Commissioning Group and / or National Commissioning Group, as appropriate.
The Director of Specialised Commissioning will represent the perspectives of the East and West Midlands Joint Committees at the national NHSE Delegated Commissioning Group.

Finance
During the transitional year it is recognised that the management of financial risks across all ICBs will be mitigated through working with NHSE through several routes:

- Pooled fund arrangements

The ICBs will establish and maintain a mutually agreed pooled fund arrangement for in-year financial management, with a defined contribution based on the allocation received for the 59 delegated specialised services being transferred to the Host ICB, (Birmingham & Solihull ICB) on behalf of the Midlands. The detail of the management of this will be articulated in detail within the Collaboration Agreement.

- Joint contractual meetings

There will be close working relationships across NHSE/ICBs with the aim to have a single contractual meeting with providers to understand the whole position.

The specialised services contracts are operated on a block basis – for the elements of the contracts covered by the block, commissioners will have no financial exposure to activity variance. In 24/25 Elective activity is managed through the Elective Recovery Fund which will be managed on the same basis as 2023/24 with contract values and allocations being adjusted for activity variances. There will be no financial risk to commissioners associated with the application of ERF.

There are a small number of variable services (linked to Best Practice Tariffs) within the contract, these being:

- Chemotherapy
- Diagnostic Imaging
- Nuclear Medicine
- PRT-CT
- Molecular Radiotherapy
- Renal Transplant

These services are paid on a cost per case basis. Opening baselines for variable services will be based on 2023/24 outturn with growth applied based on historic activity.

There remains a potential risk at an ICB and regional level of variance against contract and budget for these services. A contingency of 0.5% will be held in the Pooled budget to manage in year financial risk to mitigate the impact of variable service financial risks.
NHSE will commit to continue to regularly review in partnership with ICBs the overall financial position and risks and ensure the retained /59 acute services are reviewed together.

Data protection – to support and enable the appropriate sharing of information and data to facilitate joint working a DPIA will be approved and signed by each ICB in March 2024 which will be supported by and included in a dedicated schedule within the Collaboration Agreement

Complaints and FoI – All complaints received (on average circa 5-7 per annum across the whole Specialised portfolio including retained services) are managed by the Head of Services with input from subject matter experts with clinical and quality review. Complaints will continue to be managed in this way for ICB and NHSE during 2024/25, with reports to the Tier 2 subgroups. Both the FoI and complaints process will be detailed in the Commissioning Team Agreement and Operating Framework for 2024/25.

The Midlands Specialised Commissioning Team will operate on behalf of all the 11 ICBs and NHSE. It is recognised that relationships and new ways of working will take time to develop but there is a commitment to increasing focus towards and with systems, ensuring increasing shared ownership, access to subject matter expertise and, wherever possible. reducing points of contact for systems and providers. Any changes and/or recruitment will be jointly agreed and coordinated through the joint leadership team.

The Specialised Services Networks are a Midlands resource, whose work plans, reflecting operational and strategic priorities, will be agreed through the Collaborative Clinical Executive and MASCG on behalf of the Joint Committees. The funding/resources for these networks remains with NHSE and will not be delegated to ICBs in 2024/25.
The Specialised Clinical Services Strategy will inform the 2025/26 specialised services operational plan and the priorities for transformational activity. It is currently being jointly developed and is scheduled for completion by the end of Qtr. 2. The Clinical Services Strategy will be agreed through formal governance and subject to final approval by the Joint Committees.

7.0 Development plan

It is recognised that over and above the due diligence requirements put in place to support the delegation process we will commit to putting in place a development plan for 2024/25.

This will clearly set out the key deliverables agreed between ICBs and NHSE to further develop a robust operating model.
The development plan will be initiated and developed through executive and operational working sessions planned from April 2024.

This will be developed further.

Priority Objectives	Commitments to date	Joint SROs
Culture / OD – team development	Develop joint OD plans Collaborative recruitment	Karen Helliwell, Sarah Prema, Alison Kemp
Clinical Strategy	Clinical Networks Agreed clinical strategy and action plan Clinical benefits and outcomes	Clara Day. Nilesh Sanganee, Colette Marshall
Contracting	Integrated performance reporting Integrated commissioning intentions for 2025/26 Integrated contracting a	Ali Kemp, East and West rep leads to be confirmed
Finance	Analysis of impact of differential local pricing in spec com contracts. Reconciliation of Trust cost base between core and specialised services. Impact of needs-based allocations and convergence from 2025/26.	Madi Parmer, Jon Cooke, East CFO To be confirmed

8.0 Assurance

A national assurance framework has been developed and published that provides an approach to assurance that will minimise significant additional contacts and maximise existing NHSE assurance arrangements. ICBs will be requested to self-assess aspects of delivery of specialised provision. The collaborative agreement however sets out how integrated working will be delivered in 2024/25 and ensure that risk is jointly understood, and mitigation is managed through agreed governance.

9.0 Review process during 2024/25

This MoU and Collaboration Agreement will be subject to quarterly review within the ICB CEO Time Out Sessions and reported to Joint Committees.

A formal review will be coproduced and progressed in Q3/402024/25 in preparation for revised agreements, including further delegations, in advance of 2025/26.

There is a commitment to a formal post transactions review in 2026/27

END

Table of contents

Clause heading and number — Page number

THIS AGREEMENT is made on the first day of April 2024

BETWEEN:

(1) **NHS Lincolnshire Integrated Care Board** of Bridge House, The Point, Lions Way, Sleaford, NG34 8GG ("Lincolnshire ICB"); and

(2) **NHS Nottingham & Nottinghamshire Integrated Care Board** of Sir John Robinson House, Sir John Robinson Way, Arnold, Nottingham, NG5 6DA ("Nottingham & Nottinghamshire ICB"); and

(3) **NHS Leicester, Leicestershire & Rutland Integrated Care** Board of Room G30, Pen Lloyd Building, County Hall, Glenfield, Leicester, LE3 8TB ("Leicester, Leicestershire & Rutland ICB"); and

(4) **NHS Northamptonshire Integrated Care Board** of Francis Crick House, 6 Summerhouse Road, Northampton, Northamptonshire, NN3 6BF ("Northamptonshire ICB"); and

(5) **NHS Derby & Derbyshire Integrated Care Board** of Cardinal Square, 10 Nottingham Road, Derby, Derbyshire, DE1 3QT ("Derby & Derbyshire ICB"). **NHS Lincolnshire Integrated Care Board** of Bridge House, The Point, Lions Way, Sleaford, NG34 8GG ("Lincolnshire ICB"); and

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

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

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

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

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

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

(12) **NHS England** of Quarry House, Quarry Hill, Leeds, LS2 7UE (acting under the name NHS England) (**"NHS England"**).

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

Lincolnshire ICB, Nottingham & Nottinghamshire ICB, Leicester, Leicestershire & Rutland ICB, Northamptonshire ICB, Derby & Derbyshire ICB, Birmingham & Solihull ICB, Black Country ICB, Herefordshire & Worcestershire ICB, Coventry & Warwickshire ICB, Shropshire, Telford & Wrekin ICB and Staffordshire & Stoke-on-Trent ICB are together referred to in this Agreement as the "ICBs", and "ICB" shall mean any of them.

BACKGROUND

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

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

(C) Pursuant to section 65Z5 of the NHS Act, NHS England and the ICBs can establish and maintain joint arrangements in respect of the discharge of their Commissioning Functions.

(D) Under the Delegation Agreement made pursuant to section 65Z5, NHS England has delegated the Delegated Functions to each of the ICBs. NHS England has retained responsibility for the NHS England Reserved Functions and commissioning of the Retained Services.

(E) It is agreed that to exercise the Delegated Functions in the most efficient and effective manner, some of the Delegated Services are best commissioned collaboratively between multiple ICBs.

(F) This Agreement sets out the arrangements that will apply between the ICBs and NHS England in relation to the collaborative commissioning of Specialised Services for the ICBs' Populations.

NOW IT IS HEREBY AGREED as follows:

1. **COMMENCEMENT AND DURATION**

1.1 This Agreement has effect from the date of this Agreement and will remain in force unless terminated in accordance with Clause 23 (*Termination & Default)* below.

2. **PRINCIPLES AND AIMS**

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

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

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

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

2.1.4 act always in good faith towards each other.

2.2 The Partners agree:

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

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

2.2.3 to act in a timely manner;

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

2.2.5 to act at all times, ensure the Partners comply with the requirements of the Delegation Agreements including Mandated Guidance;

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

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

2.3 The Partners' aims are:

2.3.1 to maximise the benefits to patients of integrating the Delegated Functions with the ICBs' Commissioning Functions through

designing and commissioning the Specialised Services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim;

3. SCOPE OF THE ARRANGEMENTS

3.1 This Agreement sets out the Joint Working Arrangements through which the Partners will work together to commission Services. This may include one or more of the following commissioning mechanisms (the "Flexibilities") although this list is not exhaustive:

3.1.1 Lead Commissioning Arrangements: where agreed Commissioning Functions are delegated to a lead Partner (Lead Partner);

3.1.2 Aligned Commissioning Arrangements: where there is no further delegation of the Commissioning Functions. However, the Partners agree mechanisms to co-operate in the commissioning of identified Services;

3.1.3 Joint Commissioning Arrangements: where the Partners exercise agreed Commissioning Functions jointly;

3.1.4 the establishment of one or more Joint Committees;

3.1.5 the establishment of one or more Commissioning Teams;

3.1.6 the establishment of one or more Pooled Funds;

3.1.7 the use of one or more Non-Pooled Fund.

3.2 At the Commencement Date the Partners agree that the following Joint Working Arrangements shall be in place:

3.2.1 Delegation by NHS England of the Delegated Functions to each individual ICB in accordance with the relevant Delegation Agreement.

3.2.2 Establishment of the following Joint Working Arrangements:

- Establishment of a Commissioning Team in accordance with Clause 5.1 through which agreed Delegated Services may be commissioned [as set out in the Commissioning Team Agreement and Standard Operating Framework];
- Delegation of responsibilities by the ICBs to the two Joint Committees for the East and West Midlands established under existing multi-ICB Joint Working Agreements;
- Approval of the three schemes for the commissioning of delegated specialised services for the East and West Midlands multi-ICBs and for the collaborative commissioning of retained services as set out in Schedule 3;
- Establishment of financial risk share and pooled budget arrangement as set out in Schedule 4.

4. FUNCTIONS

4.1 The purpose of this Agreement is to establish a framework through which the Partners can secure the commissioning of health services in accordance with the terms of this Agreement.

4.2 This Agreement shall include such Commissioning Functions as shall be agreed from time to time by the Partners and set out in the relevant Scheme Specifications.

4.3 The Scheme Specifications for the Individual Schemes included as part of this Agreement at the Commencement Date are set out in Schedule 3.

4.4 Where the Partners add a new Individual Scheme to this Agreement, a Scheme Specification for each Individual Scheme shall be completed and approved by each Partner in accordance with the variation procedure set out in Clause 13 (*Variations*).

4.5 The Partners shall work in co-operation and shall endeavour to ensure that all Services are commissioned with all due skill, care and attention irrespective of the Joint Working Arrangements utilised.

4.6 Where there are Lead Commissioning Arrangements in respect of any Individual Scheme, unless the Scheme Specification otherwise provides, the Lead Partner shall:

4.6.1 exercise the Functions of each Partner as identified in the relevant Scheme Specification;

4.6.2 endeavour to ensure that all Commissioning Functions included in the relevant Individual Scheme are funded as agreed by each Partner in respect of each Financial Year;

4.6.3 comply with all relevant legal duties and Guidance of all Partners in relation to the Services being commissioned;

4.6.4 perform all commissioning obligations with all due skill, care and attention;

4.6.5 undertake performance management and contract monitoring of all service contracts including (without limitation) the use of contract notices where Services fail to deliver contracted requirements;

4.6.6 make payment of all sums due to a Provider pursuant to the terms of any Services Contract; and

4.6.7 keep the other Partner(s) regularly informed of the effectiveness of the Joint Working Arrangements including any forecasted Overspend or Underspend where there is a Pooled Fund or Non-Pooled Fund.

5. COMMISSIONING TEAM

5.1 The Partners agree to establish a Commissioning Team(s) as set out in Schedule 6 (*Commissioning Team Arrangements*).

6. STAFFING

6.1 The staffing arrangements in respect of each Individual Scheme shall be as set out in the relevant Scheme Specification and/or the Commissioning Team Agreement and Standard Operating Framework.

7. JOINT COMMITTEE

7.1 Where Partners intend to form a Joint Committee then the arrangements for the Joint Committee shall be as set out in Schedule 2 (*Governance Arrangements*); and the relevant Joint Committee Terms of Reference.

8. GOVERNANCE

8.1 Overall strategic oversight of partnership working between the Partners shall be as set out in Schedule 2 (*Governance Arrangements*).

8.2 Each Partner has internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

8.3 The Governance Arrangements shall set out how the Partners shall provide overall oversight and approval of Individual Schemes and variations to those Individual Schemes.

8.4 Each Scheme Specification shall confirm the Governance Arrangements in respect of the Individual Scheme and how that Individual Scheme is reported to each partner.

9. POOLED FUNDS, NON-POOLED FUNDS AND RISK SHARING

9.1 The Partners may establish Pooled Funds, Non-Pooled Funds and agree Risk Sharing in accordance with Schedule 4 (*Financial Arrangements*).

10. REVIEW

10.1 Save where the Partners agree alternative arrangements (including alternative frequencies) the Partners shall undertake an Annual Review of the operation of this Agreement, any Pooled Fund and Non-Pooled Fund and the provision of the Services within three (3) months of the end of each Financial Year.

10.2 Annual Reviews shall be conducted in good faith.

11. COMPLAINTS

11.1 Complaints will be managed by the specialised commissioning team hosted by NHSE England in line with the agreed complaints process.

11.2 A report summarising complaints, actions and lessons learnt will be provided to the East and West Board annually.

12. FINANCES

12.1 The financial arrangements shall be as agreed between the Partners in the relevant Scheme Specification and Schedule 4 (*Financial Arrangements*).

12.2 Unless expressly provided otherwise in this Agreement or otherwise agreed in advance in writing by the Partners, each Partner shall bear its own costs as they are incurred.

13. VARIATION

13.1 The Partners acknowledge that the scope of the Collaboration Arrangements may be reviewed and amended from time to time.

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

13.3 No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Partners.

13.4 Where the Partners agree that there will be:

13.4.1 a new Pooled Fund;

13.4.2 a new Individual Scheme; or

13.4.3 an amendment to a current Individual Scheme,

the Partners shall agree the new or amended Individual Scheme in accordance with the Governance Arrangements and, in respect of amendments, the Scheme Specification. Each new or amended Individual Scheme must be signed by each of the Partners. A request to vary an Individual Scheme, which may include (without limitation) a change in the level of Financial Contributions or other matters set out in the relevant Scheme Specification, may be made by any Partner but will require agreement from all the Partners. The notice period for any variation unless otherwise agreed by the Partners shall be three (3) months or in line with the notice period for variations within the associated Service Contract(s), whichever is the shortest.

13.5 Partners may propose additional schemes to be added to this agreement via the Joint Committees.

13.6 The following approach shall, unless otherwise agreed, be followed by the Partners:

13.6.1 on receipt of a request from one Partner to vary the Agreement including (without limitation) the introduction of a new Individual Scheme or amendments to an existing Individual Scheme, the Partners will first undertake an impact assessment and identify the likely impact of the variation including those Individual Schemes and Service Contracts likely to be affected;

13.6.2 the Partners will agree any action to be taken because of the proposed variation. This shall include consideration of:

13.5.2.1 governance and decision-making arrangements;

13.5.2.2 oversight and assurance arrangements;

13.5.2.3 contracting arrangements; and/or

13.5.2.4 whether the proposed variation could have an impact on a Commissioning Team and/or any Staff;

13.6.3 wherever possible agreement will be reached to reduce the level of funding in the Service Contract(s) in line with any reduction in budget; and

13.6.4 should this not be possible, and one Partner is left financially disadvantaged because of the proposed variation, then the financial risk will, unless otherwise agreed, be apportioned according to the financial risk share arrangement detailed in Schedule 4.

14. DATA PROTECTION

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

14.2 Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a need-to-know basis. If any Partner:

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

14.2.2 becomes aware of any security breach,

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

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

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

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

14.6 The Partners will share information to enable joint service planning, commissioning, and financial management subject to the requirements of

Law, including the Data Protection Legislation in respect of any Personal Data.

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

14.8 Schedule 5 *(Further Information Governance and Sharing Provisions)* makes further provision about information sharing and information governance.

15. IT INTER-OPERABILITY

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

15.2 The Partners will each use reasonable endeavours to help develop initiatives to further this aim.

16. FURTHER ARRANGEMENTS

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

17. FREEDOM OF INFORMATION

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

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

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

17.2.2 each Partner shall consult the other Partners as relevant regarding the possible application of exemptions in relation to the FOIA or EIA Information requested; and

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

17.3 The commissioning team will respond to all FOIA requests on behalf of Partners as part of the administrative responsibility set out in Schedule 6 (Commissioning Team Agreement and Standard Operating Framework).

18. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY

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

18.2 Each ICB must maintain a register of interests in respect of all persons involved in decisions concerning the Joint Working Arrangements. This register must be publicly available. For the purposes of this clause, an ICB may rely on an existing register of interests rather than creating a further register.

19. CONFIDENTIALITY

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

19.2 Subject to Clause 19.3, the receiving Partner agrees:

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

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

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

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

19.3.1 in connection with any Dispute Resolution Procedure;

19.3.2 to comply with the Law;

19.3.3 to any appropriate Regulatory or Supervisory Body;

19.3.4 to its Staff, who in respect of that Confidential Information will be under a duty no less onerous than the Receiving Partner's duty under Clause 19.2;

19.3.5 to NHS bodies for the purposes of carrying out their functions; and

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

19.4 The obligations in Clause 19 will not apply to any Confidential Information which:

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

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

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

19.5 This Clause 19 does not prevent NHS England making use of or disclosing any Confidential Information disclosed by an ICB where necessary for the purposes of exercising its functions in relation to that ICB.

19.6 This Clause 19 will survive the termination of this Agreement for any reason for a period of five (5) years.

19.7 This Clause 19 will not limit the application of the Public Interest Disclosure Act 1998 in any way whatsoever.

20. LIABILITIES

20.1 Subject to Clause 20.2, and 20.3, if a Partner ("First Partner") incurs a Loss arising out of or in connection with this Agreement (including a Loss arising under an Individual Scheme) as a consequence of any act or omission of another Partner ("Other Partner") which constitutes negligence, fraud or a breach of contract in relation to this Agreement then the Other Partner shall be liable to the First Partner for that Loss.

20.2 Clause 20.1 shall only apply to the extent that the acts or omissions of the Other Partner contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Partner acting in accordance with the instructions or requests of the First Partner. Clause 20.1 shall not apply in respect of Loss where an alternative arrangement has been agreed by the Partners and set out in the relevant Scheme Specification.

20.3 If any third party makes a Claim or intimates an intention to make a Claim against any Partner, which may reasonably be considered as likely to give rise to liability under this Clause 20, the Partner that may have a Claim against the Other Partner will:

20.3.1 as soon as reasonably practicable give written notice of that matter to the Other Partner specifying in reasonable detail the nature of the relevant Claim;

20.3.2 not make any admission of liability, agreement, or compromise in relation to the relevant Claim without the prior written consent of the Other Partner (such consent not to be unreasonably conditioned, withheld or delayed); and

20.3.3 give the Other Partner and its professional advisers reasonable access to its premises and Staff and to any relevant assets, accounts, documents and records within its power or control so as to enable the Other Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant Claim.

20.4 Each Partner shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a Claim against the other pursuant to this Agreement.

20.5 Unless expressly agreed otherwise, nothing in this Agreement shall affect:

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

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

20.6 Each ICB must:

20.6.1 comply with any requirements set out in the Delegation Agreement in respect of Claims and any policy issued by NHS England from time to time in relation to the conduct of or avoidance of Claims or the pro-active management of Claims;

20.6.2 if it receives any correspondence, issue of proceedings, claim document or other document concerning any Claim or potential Claim, immediately notify the other Partners and send each relevant Partner all copies of such correspondence; and

20.6.3 co-operate fully with each relevant Partner in relation to such Claim and the conduct of such Claim.

21. DISPUTE RESOLUTION

21.1 Where any dispute arises between the ICBs in connection with this Agreement, the Partners must use their best endeavours to resolve that dispute.

21.2 Where any dispute is not resolved under Clause 21.1 on an informal basis, any Authorised Officer may convene a special meeting of the Partners to attempt to resolve the dispute.

22. BREACHES OF THE AGREEMENT

22.1 If any Partner ("Relevant Partner") fails to meet any of its obligations under this Agreement, the other Partners (acting jointly) may by notice require the Relevant Partner to take such reasonable action within a reasonable timescale as the other Partners may specify to rectify such failure. Should the Relevant Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 21 (*Dispute Resolution*).

22.2 Without prejudice to Clause 22.1, if any Partner does not comply with the terms of this Agreement (including if any Partner exceeds its authority under this Agreement), the other Partners may at their discretion agree to:

22.2.1 waive their rights in relation to such non-compliance;

22.2.2 ratify any decision;

22.2.3 terminate this Agreement in accordance with Clause 23 *(Termination and Default)* below; or

22.2.4 exercise the Dispute Resolution Procedure in accordance with Clause 21 *(Dispute Resolution).*

23. TERMINATION AND DEFAULT

23.1 If an ICB wishes to end its participation in this Agreement, the relevant ICB must provide at least six (6) months' notice to the other Partners of its intention to end its participation in this Agreement and must have given prior notification to NHS England. Such notification shall only take effect from the end of 31 March in any calendar year and shall only take effect where alternative arrangements for the provision of the Delegated Services and effective exercise of the Delegated Functions are in place for the period immediately following termination.

23.2 Each Individual Scheme may be terminated in accordance with the terms set out in the relevant Scheme Specification provided that each Partner is assured that the relevant Services will continue to be appropriately commissioned.

23.3 The ICBs will work together to ensure that there are suitable alternative arrangements in place in relation to the Services.

24. CONSEQUENCES OF TERMINATION

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

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

24.1.2 where there are Commissioning Team arrangements in place the Partners shall discuss and agree arrangements for the Staff and any financial arrangements;

24.1.3 where a Partner has entered a Service Contract in exercise of the Functions of any other Partner which continues after the termination of this Agreement, all Partners shall continue to provide necessary funding in accordance with the agreed contribution for that Service prior to termination and will enter all appropriate legal documentation required in respect of this;

24.1.4 where there are Lead Commissioning Arrangements in place, the Lead Partner shall make reasonable endeavours to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place the Lead Partner in breach of the Service Contract) where the other Partner requests the same in writing provided that the Lead Partner shall not be required to make any payments to a Service provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment;

24.1.5 where there are Joint Commissioning Arrangements in place, the Partners shall co-operate with each other as reasonably necessary to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place any Partner in breach of the Service Contract) where a Partner requests the same in writing provided that no Partner shall be

required to make any payments to a Service provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment;

24.1.6 where a Service Contract held by a Lead Partner relates all or partially to services which relate to the other Partner's Functions and provided that the Service Contract allows, the other Partner may request that the Lead Partner assigns the Service Contract in whole or part upon the same terms as the original contract; and

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

24.2 The provisions of Clauses 14 (*Data Protection*), 1717 (*Freedom of Information*), 19 (*Confidentiality*), 20 (*Liabilities*) and 24 (*Consequences of Termination*) shall survive termination or expiry of this Agreement.

25. PUBLICITY

25.1 The Partners shall use reasonable endeavours to consult one another before making any public announcements concerning the subject matter of this Agreement, the Joint Working Arrangements or any Services provided under the Joint Working Arrangements.

26. EXCLUSION OF PARTNERSHIP OR AGENCY

26.1 Nothing in this Agreement shall create or be deemed to create a legal partnership under the Partnership Act 1890 or the relationship of employer and employee between the Partners.

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

27. THIRD PARTY RIGHTS

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

28. NOTICES

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

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

29. ASSIGNMENT AND SUBCONTRACTING

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

30. SEVERABILITY

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

31. WAIVER

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

32. STATUS

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

33. ENTIRE AGREEMENT

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

34. GOVERNING LAW AND JURISDICTION

34.1 Subject to the provisions of Clause 21 (*Dispute Resolution*) and Clause 32 (*Status*), this Agreement shall be governed by and construed in accordance with English Law, and the Partners irrevocably agree that the courts of England shall have exclusive jurisdiction to settle any dispute or claim that arises out of or in connection with this Agreement.

35. FAIR DEALINGS

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

36. COUNTERPARTS

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

This Agreement has been entered into on the Commencement Date

SIGNED by John Turner .....

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

.....

(Date)

SIGNED by Amanda Sullivan .....

for and on behalf of NHS Nottingham & Nottinghamshire Integrated Care Board (Signature)

.....

(Date)

SIGNED by Dr Caroline Trevithick .....

for and on behalf of NHS Leicester, Leicestershire & Rutland Integrated Care Board (Signature)

.....

(Date)

SIGNED by Toby Sanders .....

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

.....

(Date)

SIGNED by Chris Clayton .....

for and on behalf of NHS Derby & Derbyshire Integrated Care Board (Signature)

.....

(Date)

SIGNED by Philip Johns .....

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

.....

(Date)

SIGNED by Mark Axcell .....

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

.....

(Date)

SIGNED by Simon Trickett .....

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

.....

(Date)

SIGNED by David Melbourne .....

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

.....

(Date)

SIGNED by Peter Axon .....

for and on behalf of NHS Staffordshire & Stoke-on-Trent Integrated Care Board (Signature)

.....

(Date)

SIGNED by Simon Whitehouse .....

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

.....

(Date)

SIGNED by Roz Lindridge .....

For and on behalf of NHS England (Signature)

.....

(Date

SCHEDULE 1: DEFINITIONS AND INTERPRETATIONS

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

“Agreement"	means this agreement between the Partners comprising these terms and conditions together with all schedules attached to it;
“Aligned Commissioning Arrangements”	means the arrangements by which the Partners agree to commission a Service in a co-ordinated and collaborative manner. For the avoidance of doubt, an aligned commissioning arrangement does not involve the delegation of any functions between ICBs;
“Annual Review”	means the annual review of the arrangements under this Agreement by the Partners;
“Area”	means the geographical area covered by the ICBs;
"Authorised Officer"	the individual(s) appointed as Authorised Officer in accordance with the agreed Terms of Reference;
“Claim”	means for or in relation to the Commissioning Functions (a) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal, or the Secretary of State, any governmental, regulatory, or similar body, or any department, board or agency or (b) any dispute with, or any investigation, inquiry or enforcement proceedings by any governmental, regulatory or similar body or agency;
“Clinical Commissioning Policies”	a nationally determined clinical policy sets out the commissioning position on a particular clinical treatment issue and defines accessibility (including a not for routine commissioning position) of a medicine, medical device, diagnostic technique, surgical procedure, or intervention for patients with a condition requiring a specialised service;
“Clinical Reference Groups”	means a group consisting of clinicians, commissioners, public health experts, patient and public voice representatives and professional associations, which offers specific knowledge and expertise on the best ways that Specialised Services should be provided;
“Collaborative Commissioning Agreement”	means an agreement under which NHS Commissioners set out collaboration arrangements in respect of commissioning Specialised Services Contracts;
"Commencement Date"	[means 1 April 2024];
"Commissioning Functions"	the respective statutory functions of the Partners in arranging for the provision of services as part of the health service;
“Commissioning Team”	means a staffing arrangement for commissioning agreed Services through an integrated team structure. This can be either set up using: . Lead Commissioning (one Partner hosts the Unit as Lead and all functions are delegated to that Partner); or . Joint Commissioning or Aligned Commissioning (one Partner may host but no functions are delegated). The Partners will need to agree whether decisions are taken via a Joint Commissioning

arrangement such as a Joint Committee or whether each Partner is required to take decisions;

"Confidential Information"	means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement or Joint Working Arrangements made pursuant to it and: i. which comprises Personal Data or which relates to any patient or his treatment or medical history; ii. the release of which is likely to prejudice the commercial interests of a Partner; or iii. which is a trade secret;
"Contracting Standard Operating Procedure"	means any contracting standard operating procedure produced by NHS England in respect of the Delegated Specialised Services;
"Data Controller"	shall have the same meaning as set out in the Data Protection Legislation;
"Data Processor"	shall have the same meaning as set out in the Data Protection Legislation;
"Data Sharing Agreement"	means any data sharing agreement entered in accordance with Schedule 5 (*Further Information Governance and Sharing Provisions*);
"Data Guidance"	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement regarding information governance, confidentiality, privacy, or compliance with Data Protection Legislation to the extent published and publicly available or their existence or contents have been notified to the ICB by NHS England and/or any relevant Regulatory or Supervisory Body. This includes but is not limited to guidance issued by NHS Digital, the National Data Guardian for Health & Care, the Department of Health and Social Care, NHS England, the Health Research Authority, the UK Health Security Agency, and the Information Commissioner;
"Data Protection Legislation"	means the UK General Data Protection Regulation, the Data Protection Act 2018, the Regulation of Investigatory Powers Act 2000, the Telecommunications (Lawful Business Practice) (Interception of Communications) Regulations 2000 (SI 2000/2699), the Privacy and Electronic Communications (EC Directive) Regulations 2003 (SI 2426/2003), the common law duty of confidentiality and all applicable laws and regulations relating to the processing of Personal Data and privacy, including where applicable the guidance and codes of practice issued by the Information Commissioner;
"Data Protection Officer"	shall have the same meaning as set out in the Data Protection Legislation;
"Data Security and Protection Toolkit"	means the toolkit at: https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/data-security-and-protection-toolkit or as amended or replaced from time to time
"**Delegated Commissioning Group**" **"DCG"**	means the advisory forum in respect of Delegated Services set up by NHS England currently known as the Delegated Commissioning Group for Specialised Services;

“Delegation Agreement(s)”	means the Delegation Agreements under which NHS England delegate specific NHS England Specialised Services Commissioning Functions to each ICB;
“Delegated Functions”	means the Specialised Services Commissioning Functions of NHS England delegated to each ICB under a Delegation Agreement;
“Delegated Services”	means those Specialised Services commissioned in exercise of the Delegated Functions;
"Dispute Resolution Procedure"	the procedure set out in Clause 21 (*Dispute Resolution*);
“EIR”	means the Environmental Information Regulations 2004;
“Finance Guidance”	guidance, rules and operating procedures produced by NHS England that relate to these Joint Working Arrangements, including but not limited to the following: • Commissioning Change Management Business Rules; • Contracting Standard Operating Procedure; • Cashflow Standard Operating Procedure; • Finance and Accounting Standard Operating Procedure; • Service Level Framework Guidance;
“Flexibilities”	Mean the flexibilities that the Partners may use to work in a co-ordinated manner as set out at Clause 3 (*Scope of the Arrangements*);
“Financial Contribution”	means the financial contributions agreed by each Partner in respect of an Individual Scheme in any Financial Year;
“Financial Year”	means each financial year running from 1 April in any year to 31 March in the following calendar year;
"FOIA"	the Freedom of Information Act 2000 and any subordinate legislation made under it from time to time, together with any guidance or codes of practice issued by the Information Commissioner or relevant government department concerning this legislation;
"FOIA or EIR Information"	has the meaning given under section 84 of FOIA or the meaning given for “environmental information” under the EIR as applicable;
“Good Practice”	means using standards, practices, methods and procedures conforming to the law, reflecting up-to-date published evidence and exercising that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced commissioner;
“Governance Arrangements”	means the governance arrangements in respect of the Arrangements agreed by the Partners and as set out in Schedule 2 (*Governance Arrangements*);
“Guidance”	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the Partners have a duty to have regard (and whether specifically mentioned in this Agreement or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified by any relevant Regulatory or Supervisory Body;
“High-Cost Drugs”	means medicines not reimbursed though national prices and identified on the NHS England high-cost drugs list;

"ICB Reserved Functions"	Where there is any delegation of an ICB's Commissioning Functions or further delegation of Delegated Functions, those functions that remain reserved to each ICB;
"Indemnity Arrangement"	means either: (i) a policy of insurance; (ii) an arrangement made for the purposes of indemnifying a person or organisation; or (iii) a combination of (i) and (ii);
"Individual Scheme"	means an arrangement in relation to how the ICBs will work together using one or more of the Flexibilities which has been agreed by the Partners to be included within this Agreement as part of the Joint Working Arrangements;
"Joint Committee"	means the joint committee(s) established by the partners that perform functions under this Agreement on the terms set out in their Terms of Reference;
"Joint Functions"	any Functions that are delegated to a Joint Committee;
"Joint Commissioning"	means Partners agreeing to jointly exercise agreed Commissioning Functions on behalf of each other in exercise of the functions of each Partner part of that Individual Scheme. This may, for example, be through agreeing to enter into the same contract or by use of a Joint Committee;
"Joint Working Arrangements"	means the Flexibilities that the Partners have agreed to use to work in a co-ordinated manner which, at the Commencement Date, are as set out in Clause 3;
"Law"	means: i. any statute or proclamation or any delegated or subordinate legislation; i. any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and i. any judgment of a relevant court of law which is a binding precedent in England;
"Lead Commissioning Arrangements"	means the arrangements by which one Partner commissions Services in relation to an Individual Scheme on behalf of another Partner or Partners in exercise of the Commissioning Functions of the ICB Partners;
"Lead Partner"	means the Partner responsible for commissioning under a Lead Commissioning Arrangement;
"Loss"	means all damages, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services) proceedings, demands and charges whether arising under statute, contract or common law;
"Managing Conflicts of Interest in the NHS"	means the NHS publication by that name available at: https://www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-guidance-for-staff-and-organisations/ or such publication that amends or replaces that publication;

"Mandated Guidance"	means any protocol, policy, guidance, guidelines, framework or manual relating to the exercise of Delegated Functions and issued by NHS England from time to time as mandatory;
"National Standards"	means the service standards for each Specialised Service, as set by NHS England and included in Clinical Commissioning Policies or National Specifications;
"National Specifications"	the service specifications published by NHS England in respect of Specialised Services;
"Need to Know"	has the meaning set out in Schedule 5 *(Further Information Governance and Sharing Provisions)*;
"NHS Act"	the National Health Service Act 2006;
"NHS England Functions"	NHS England's Commissioning Functions exercisable under or by virtue of the NHS Act;
"NHS England Reserved Functions"	those aspects of the Specialised Commissioning Functions for which NHS England retains commissioning responsibility;
"Non-Personal Data"	means data which is not Personal Data;
"Non-Pooled Funds"	means the budget detailing the financial contributions of the Partners which are not included in a Pooled Fund in respect of a particular Service as set out in the relevant Scheme Specification;
"Operational Days"	means a day other than a Saturday, Sunday, Christmas Day, Good Friday or a bank holiday in England;
"Partners"	means the parties to this Agreement;
"Personal Data"	has the meaning set out in the Data Protection Legislation;
"Pooled Funds"	means any pooled fund established and maintained by the Partners as a pooled fund;
"Population"	means the population for which an ICB or all the ICBs have the responsibility for commissioning health services;
"Provider Collaborative"	means a group of Providers who have agreed to work together to improve the care pathway for one or more Services;
"Provider Collaborative Arrangements"	means the arrangements entered in respect of a Provider Collaborative;
"Provider Collaborative Guidance"	means any guidance published by NHS England in respect of Provider Collaboratives;
"Regional Quality Group"	means a group set up to act as a strategic forum at which regional partners from across health and social care can share, identify, and mitigate wider regional quality risks and concerns as well as share learning so that quality improvement and best practice can be replicated;
"Regulatory or Supervisory Body"	means any statutory or other body having authority to issue guidance, standards, or recommendations with which the relevant Party and/or Staff must comply or to which it or they must have regard, including: i. CQC;

ii. NHS England;

iii. the Department of Health and Social Care;

iv. NICE;

v. Healthwatch England and Local Healthwatch;

vi. the General Medical Council;

vii. the General Dental Council;

viii. the General Optical Council;

ix. the General Pharmaceutical Council;

x. the Healthcare Safety Investigation Branch; and

xi. the Information Commissioner;

"Relevant Information"	means the Personal Data and Non-Personal Data processed under this Agreement, and includes, where appropriate, "confidential patient information" (as defined under section 251 of the NHS Act), and "patient confidential information" as defined in the 2013 Report, The Information Governance Review – "*To Share or Not to Share?"*);
"Reserved Functions"	means NHS England Reserved Functions or ICB Reserved Functions;
"**Relevant Clinical Networks"**	means those clinical networks identified by NHS England as required to support the commissioning of Specialised Services for the Population;
"Retained Services"	means those Specialised Services for which NHS England shall retain commissioning responsibility, as set out the Delegation Agreement;
"Risk Sharing"	means an agreed arrangement for risk and benefit sharing between the Partners;
"Scheme Specification"	means a specification setting out the Joint Working Arrangements in respect of an Individual Scheme agreed by the Partners to be commissioned under this Agreement;
"Services"	means such health services as agreed from time to time by the Partners as commissioned under the Joint Working Arrangements and more specifically defined in each Scheme Specification;
"Service Contract"	means an agreement entered into by one or more of the Partners in exercise of its obligations under this Agreement to secure the provision of Services in accordance with the relevant Individual Scheme
"Single Point of Contact"	the member of Staff appointed by each relevant Partner in accordance with Paragraph 13 of Schedule 5 *(Further Information Governance and Sharing Provisions)*
"Special Category Personal Data"	has the meaning set out in the Data Protection Legislation;
"Specialised Commissioning Budget"	means the budget identified by NHS England in respect of each ICB for the purpose of exercising the Delegated Functions;

"Specialised Commissioning Functions"	means the statutory functions conferred on NHS England under Section 3B of the NHS Act 2006 and Regulation 11 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996 (as amended or replaced);
"Specified Purpose"	means the purpose for which the Relevant Information is shared and processed to facilitate the exercise of the Joint Working Arrangements as specified in Schedule 5 *(Further Information Governance and Sharing Provisions)* to this Agreement;
"Specialised Services"	means the services commissioned in exercise of the Specialised Commissioning Functions;
"Specialised Services Contract"	means a contract for the provision of Specialised Services entered in the exercise of the Specialised Commissioning Functions;
"Specialised Services Provider"	means a provider party to a Specialised Services Contract;
"Staff"	means the Partners' employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of any Partner (whether the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors' and their sub-contractors' personnel;
"Standard Operating Framework"	means the agreement(s) that sets out the arrangements for a Commissioning Team;
"Terms of Reference"	means the Terms of Reference for the Joint Committee agreed between the Partners at the first meeting of the Joint Committee;
"Triple Aim"	means the duty on each of the Partners in making decisions about the exercise of their functions, to have regard to all likely effects of the decision in relation to: i. the health and well-being of the people of England; ii. the quality of services provided to individuals by the NHS; iii. efficiency and sustainability in relation to the use of resources by the NHS;
"Underspend"	means any expenditure from a Pooled Fund or Non-Pooled Fund in a Financial Year which is less than the value of the agreed contributions by the Partners for that Financial Year;
"UK GDPR"	means Regulation (EU) 2016/679 of the European Parliament and of the Council of 27th April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018.

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

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

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

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

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

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

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

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

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

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

SCHEDULE 2: GOVERNANCE ARRANGEMENTS

1. Joint Committees

1.1. The overall oversight and governance arrangements for these collaborative working arrangements will be discharged through the Joint Committees established by the ICBs through Joint Working Agreements between NHS Lincolnshire Integrated Care Board, NHS Nottingham and Nottinghamshire Integrated Care Board, NHS Leicester, Leicestershire and Rutland Integrated Care Board, NHS Northamptonshire Integrated Care Board and NHS Derby and Derbyshire Integrated Care Board (the "East Midlands ICBs") and NHS Birmingham and Solihull Integrated Care Board, NHS Black Country Integrated Care Board, NHS Coventry and Warwickshire Integrated Care Board, NHS Herefordshire and Worcestershire Integrated Care Board, NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire and Stoke-on-Trent Integrated Care Board (the "West Midlands ICBs")

1.2. The Terms of Reference and other detailed arrangements that support the operation of the Joint Committees are detailed in the Joint Working Agreements between the East and West ICBs. They set out that the two Joint Committees will have delegated authority on behalf of the East and West ICBs respectively to discharge the functions delegated to the ICBs by NHS England in respect of Specialised Services, including establishing appropriate subsidiary arrangements to enable effective decision-making and detailed oversight of performance, finance, and quality.

1.3. In recognition that effective collaboration may require aligned decisions from all the partners, the Joint Committees may consider meeting 'in common' where this is appropriate and will ensure that decisions by either the East or West Joint Committee that impact on the other are made having taken relevant views from the other committee into account.

1.4. The NHS England regional team will continue to work jointly with the Joint Committees on the commissioning of retained specialised services. This will include, where appropriate, discharging its authority (through accountable directors) in consultation with the Joint Committees.

1.5. The subsidiary arrangements established by the Joint Committees will include appropriate schemes of reservation and delegation in place to enable Sub-Groups of the Joint Committees and/or members of staff employed by Joint Commissioning Team to have the authority to make decisions. These arrangements will be developed in collaboration with NHS England to support effective working on both the delegated and retained services.

2. Joint Subgroups

2.1. There will be three joint subgroups established by the partners to support these arrangements, these being:

- **Midlands Acute Specialised Commissioning Group (MASCG)**
- **Specialised Commissioning Quality Group**
- **Finance and Contracting Group**

2.2. Subsidiary arrangements established by the Joint Committees will include providing delegated authority to **Midlands Acute Specialised Commissioning Group (MASCG)** a Joint Sub-Group established by all the partners to make decisions on both the delegated and retained services.

2.3. The role of MASCG will be to support the partners and the Joint Committees in ensuring that the delivery of the delegated and retained services is effective, efficient, and economical and in line with each partner's statutory responsibilities.

2.4. MASCG will report and make recommendations to the Joint Committees in respect of delegated services and to Midlands Commissioning Group in respect of the retained services and will always operate in accordance with its agreed terms of reference (which are set out in Appendix 1 of this schedule) and the relevant schemes of reservation and delegation and standing financial instructions for delegated and retained services.

2.5. Each of the partners will appoint a member of MASCG who is authorised to act as part of the group and participate in collective decision making on behalf of their organisation. MASCG will also ensure that its decisions are taken with the advice of suitable subject matter experts.

2.6. **Specialised Commissioning Quality Group –** This group, chaired by the Regional Medical Director for Commissioning (RMDC) will provide a forum to share and discuss potential and known issues which impact on the quality and safety of Acute Specialised Commissioned services in the Midlands region and agree any remedial action.

2.7. The purpose of the Specialised Commissioning Quality Group is to provide a forum for routinely and systematically bringing together partners from across ICSs and the region to share insight and intelligence in relation to quality concerns, to identify opportunities for improvement and to develop regional responses as required. The focus of the discussions will be on intelligence, learning, issues and risks that are recurrent and/ or have an impact wider than individual ICSs.

2.9 **Finance and Contracting Subgroup** – will have responsibility to oversee the management of the pooled fund on behalf of the Joint Committees.

2.10 The purpose of the Finance and Contracting Subgroup is to provide robust joint financial management of the pooled fund on behalf of the ICBs in line with the terms set out in schedule 4 of this agreement.

Subgroups reporting to East and West Joint Committees

3. Clinical Governance

3.1. The ICBs will access the clinical, pharmaceutical, and quality governance functions provided by the Midlands Commissioning Multidisciplinary Team via the

Commissioning Team Arrangements and Standard Operating Framework.

3.2. Clinical engagement and leadership will be secured at multiple tiers across the Midlands region and will draw upon established clinical networks including those formally commissioned plus the informal networks that have been recognised over time.

3.3. The Specialised Services Operational Delivery Networks (ODNs) will continue to be formally commissioned by NHS England. NHS England will retain the financial responsibility for the ODNs and will continue to play a key role in supporting understanding of clinical quality for the relevant services.

3.4. At a senior clinical level, the Collaborative Clinical Executive Forum (CCEF), a regional forum of Acute Provider and ICB Chief Medical Officers (CMOs), will continue to meet regularly and engage with the Midlands Commissioning Team. Advice offered via that forum will feed into the decision -making process via the Midlands Acute Specialised Commissioning Group (MASCG) and into the Joint Committees.

3.5. The Commissiong Team will retain Medical Director, Pharmacy and Nursing roles which will provide a vital conduit to local systems and the national clinical leadership architecture.

3.6. Governance and decision-making for high-cost drugs assurance will be via Joint Committees and their sub-groups, with links to the Regional Pharmacy Leadership Board. The pharmacy team for High Costs Drugs will work across ICBs and NHS England informed by other senior pharmacists across the region e.g., HCD pharmacists, regional cancer pharmacists,

3.7. High-cost tariff excluded drugs will continue to be reimbursed through a national process by NHS England irrespective of whether they are used for delegated services, meaning that ICBs will not bear the financial risk of new specialised drugs growth.

4. Quality Governance

4.1. Key quality concerns requiring escalation relating to the Joint Services will be reported monthly to the Joint Committees by the Specialised Commissioning Quality Group. Furthermore, key quality concerns for specialised services will continue to be reported to and discussed at the NHSE led Regional Quality Group, of which all ICBs are members. These groups will ensure key quality concerns are fed back into systems to inform conversations at a local level.

4.2. Key quality concerns involving specialised services will also be reported into Midlands Acute Specialised Commissioning Group (MASCG) of which all 11 Midlands ICBs are members and have representation. Specialised Commissioning Quality Group will provide a forum for delegated decision making, including on quality matters.

4.3. To be proactive on identification of areas for quality improvement, a Quality Surveillance and Improvement Programme (QSIP) has been established to support implementation of the NHSE Midlands Acute Specialised Commissioning Quality Surveillance & Improvement Framework (QSIF). The QSIP aims to provide strategic direction and support implementation of the Quality Surveillance and Improvement Framework QSIF and will agree priorities for the Programme in addition to evaluating risks related to the Programme and to devise and implement mitigations and remedial action. The QSIF involves triangulating intelligence and data from several sources (e.g., CQC reports, specialised services dashboards, national audit etc) to monitor the

quality of each service. This work is overseen by the QSIP Programme Board, has ICB representation, is chaired by the RMDC and reports to MASCG.

4.4. The Joint Committees will also agree a comprehensive Quality Assurance Framework which will provide a high-level description of the proposed overarching governance arrangements including for quality assurance in the Midlands region in terms of how decisions are made; outline reporting flows; where assurances will be sought, and the structures put in place to ensure that NHSE and ICB's act within their powers and discharge their responsibilities correctly and appropriately.

5. Financial Governance

5.1 The Financial governance arrangements in Schedule 4 shall apply to the Collaborative Arrangements.

5.7 **Risk Management Arrangements** - In line with their overall role to provide strategic decision-making, leadership, and oversight for the joint services the Joint Committee will establish a monitoring and management in relation to risk and issue management and escalation, and co-ordinating the approach to intervention with providers where there are quality or contractual issues. This will include feeding back to individual ICBs for consideration of any impact on their own risk management arrangements.

5.8 A formal risk register will be maintained by the Midlands Commissioning Team and reported monthly through the Midlands Acute Specialised Commissioning Group to ensure ICBs are aware of any risks they may impact their systems.

6. Assurance arrangements

6.1. The Joint Committees will be responsible for ensuring that the ICBs are able to meet their obligations under the NHSE Oversight and Assurance Framework in relation to the delegation of specialised services which, requires that the ICBs must at all times operate in accordance with:

(a) the Oversight and Assurance Framework published by NHS England;

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

(c) any other relevant NHS oversight and assurance guidance;

collectively known as the "Assurance Processes".

And that the ICBs must:

(a) Develop and operate in accordance with mutually agreed ways of working in line with the Assurance Processes.

(b) Oversee the provision of Delegated Services and the outcomes being delivered for their patients and Populations in accordance with the Assurance Processes.

(c) Assure Providers are meeting, or have an improvement plan in place to meet, National Standards.

(d) Provide any information and comply with specific actions in relation to the Delegated Specialised Services, as required by NHS England,

including metrics and detailed reporting in accordance with the Terms of Reference.

Appendix 1 – MASCG Terms of Reference

Document name:		Midlands Acute Specialised Commissioning (MASC) Group/ Terms of Reference	
Senior Responsible Owner (SRO):		Alison Kemp	
Lead:		Jon Currington	
Author:		Mel Harris, Peter McKenzie	
Version	1.5	**Date:**	[Publish Date]

Document management

Revision history

Version	Date	Summary of changes
0.1	28/02/23	Initial template
0.2	08/03/23	Incorporating JC/MD edits
1.0	02/08/23	Updated by JC to include financial limits as requested by Joint Committees and non-material amendments for clarity and consistency.
1.1	30/01/24	Amendments to align with ICB Collaboration Agreement for 2024/25
1.2	02/02/24	JM review and update
1.3	05/02/24	JM review and Update
1.4	06/02/24	PMcK review and update including JC Feedback
1.5	21/02/24	Version for approval in Collaboration Agreement

Approved by

This document must be approved by the following people:

Name	Signature	Title	Date	Version
Matt Day		Regional Director Specialised Commissioning and Health and Justice		0.2
Formal Midlands Acute Specialised Commissioning Group	Approved		17/03/23	0.2
Delegation Governance Working Group				0.2
East Midlands Joint Committee	Approved		20/06/23	0.3
West Midlands Joint Committee	Approved		14/07/23	0.3
Midlands Commissioning Group				0.3

Related documents

Title	Owner	Location
ICB Collaboration Agreement for Specialised Services	NHSE & 11 Midlands ICBs	
East Midlands Joint Committee Terms of Reference	NHSE & 5 EM ICBs	
West Midlands Joint Committee Terms of Reference	NHSE & 6 WM ICBs	

Document control

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Midlands Acute Specialised Commissioning Group (MASCG) Terms of Reference 2024/25	
Introduction and purpose	From April 2024, NHS England delegated responsibility to the eleven Integrated Care Boards ("the ICBs") in the Midlands region for commissioning 59 Prescribed Specialised Services (the "delegated services"). To discharge these duties the ICBs and NHS England have developed a collaboration agreement that sets out that the individual ICBs will delegate responsibilities to the existing East and West Joint Committees (JC) established under the Joint Working Agreements between the ICBs. The two JCs are defined as Tier I Bodies and their responsibilities for the delegated services are set out in their Terms of Reference. NHS England will continue to be responsible for other Prescribed Specialised services, including 29 services designated as suitable but not yet ready for delegation to the ICBs (the "retained services") and will seek input from the ICBs into the commissioning of Retained Specialised Services. NHS England will continue to have budgetary responsibility and holds accountability and responsibility for high-cost drugs within specialised services. NHSE and ICBs will collaborate in the commissioning of high-cost drugs via joint working arrangements. The Collaboration Agreement sets out that the ICBs and NHSE will establish the Midlands Acute Specialised Commissioning Group (MASCG) as a Joint Sub-group to support the JCs and NHSE in the effective and efficient commissioning of both the delegated and retained services. MASCG will have delegated decision-making authority from both JCs and NHS England and will provide joint oversight for the commissioning of all Prescribed Acute Specialised Services for the population of the Midlands.
The Terms of Reference	These Terms of Reference are intended to support effective collaboration between NHS England and ICBs acting through MASCG. They set out the roles, responsibilities, membership, decision-making powers, and reporting arrangements of the MASCG in accordance with the Collaboration Agreement. The MASCG will operate under the limitations of the delegated authority given to it by the East and West Joint Committees (for the delegated services) and NHS England Standing Financial Instructions (SFI) (for the retained service) . This will include authority to make decisions of a value up to £2.5 Million for contract variations and extensions for directly commissioned healthcare services and up to £2.5 million for clinical

	and non-clinical business cases. Values above this will be referred upwards to the JCs and/or authorised decision makers in NHS England as appropriate.
Role of the Group	The role of the MASCG is to support the JCs and NHS England in discharging their duties with respect to prescribed specialised services safely, effectively, efficiently and economically. The MASCG will achieve this through: • Determining the appropriate structure of the MASCG; ▪ Making decisions in relation to the planning and commissioning of delegated and retained specialised services and working collaboratively on any associated commissioning or statutory functions, for the population within the scope of the agreed authority for the group; ▪ Making recommendations to the Joint Committees and NHS England as appropriate in relation to decisions required for delegated and retained specialised services that fall outside the scope of the agreed authority for the group; ▪ Making recommendations on the population-based financial allocation and financial plans for delegated and retained Specialised Services to the Joint Committees and NHS England as appropriate; ▪ Oversight and assurance of all specialised services, either directly or through Tier 3 sub-groups, in relation to quality, operational and financial performance, including co-ordinating risk and issue management and escalation, and developing the approach to intervention with specialised services providers where there are quality or contractual issues and escalating these issues to the Joint Committees and NHS England when required; ▪ Identifying and setting strategic priorities and undertaking ongoing assessment and review of joint specialised services within the remit of the Group and consistent with national, regional and ICS plans, including tackling unequal outcomes and access; ▪ Supporting the development of partnership and integration arrangements with other health and care bodies in relation to all specilaised services including Provider Collaboratives and the Cancer Alliances, and working closely across regional footprints, where there are cross-border patient flows to providers; ▪ Engaging effectively with stakeholders, including patients and the public, and involving them in decision-making; ▪ Obtaining appropriate clinical advice and leadership, including through Clinical Reference Groups and relevant Clinical Networks;

	▪ Linking in with the NHS England National team in order to implement policies, initiatives and service specifications; ▪ Supporting longer-term planning for both delegated and retained services; and ▪ Discussing any matter which any member of the Group believes to be of such importance that it should be brought to the attention of the Group. The Group must adhere to these Terms of Reference but may otherwise regulate its own procedures.
Accountability and reporting	The MASCG is a joint sub-group, established in line with the Collaboration Agreement between the eleven Midlands ICBs and NHS England and is formally accountable to the JCs for delegated services and to the NHS England Midlands Commissioning Group (MCG) for retained services. It will report to the Joint Committees and the MCG after each meeting and make recommendations and escalate issues when required.
Membership	The core membership of the MASCG will comprise one representative of each of the eleven ICBs, nominated by the respective Chief Executive Officer with authority to participate in the collective decision-making of the Group on behalf of their organisation and the Regional Director of Specialised Commissioning, NHS England Midlands. A named substitute may be nominated to attend if a core member of the MASCG is unavailable or unable to attend or because they are conflicted. Core members must ensure that their substitute is fully authorised to act on their behalf. The MASCG will be supported by the NHS England Midlands Acute Specialised Commissioning (MASC) Team including: • Chief Medical Officer for Commissioning • Head of Acute Specialised Commissioning • Deputy Director of Nursing and Quality • Heads of Finance • Regional Pharmacy Lead • Consultants in Public Health • Head of Business Intelligence • Head of Planning • Acute Commissioning Leads Subject matter experts will also support the MASCG from core ICB functions including the offices of the Chief Medical Officers, Chief Nursing Officers and Chief Finance Officers. During 2024/25 (until transfer of staff) this will include nominated ICB Quality and Finance leads on behalf of all the ICBs of the West (6) and the East (5) whose role will be to provide a liaison between MASCG and the Finance and

	Quality sub-groups established to support Joint Commissioning arrangements. The ICBs will agree who will attend the Group, which Include members of the Clinical Collaboration Forum from these functions, and they will be invited on a standing basis. Individuals or representatives of other organisations that may be invited to observe proceedings and contribute to the MASC Group's work at the discretion of the Chair. A list of the members will be made available.
Chair	MASCG will be co-chaired by the Regional Director, Specialised Commissioning, NHS England Midlands and an ICB representative elected from the core membership. The co-chairs will arrange cover in their absence.
Meetings	MASCG shall meet monthly with arrangements to meet face-to-face and virtually. At its first meeting (and at the first meeting following each subsequent anniversary of that meeting) the MASCG shall prepare a of meetings and work programme for the forthcoming year.
Quorum	The MASCG shall be quorate if the Chair, or their nominated deputy is present together with representation from the ICBs from the Joint Committee that any decisions on the agenda relate to. In urgent circumstances, consideration will be given by the Chair to make decisions which significantly impact an ICB or ICBs not present subject to confirmation of support of the relevant ICB or ICBs outside of the meeting. These situations, together with the outcome will be formally recorded in the minutes.
Decisions and voting arrangements	The decision-making arrangements for the Group will be in line with the delegated authority provided to it by the Joint Committees and NHS England. Items for decision will clearly indicate the source of the authority for the decision which will determine which members will be eligible to participate in the decision-making for that item: - • For items on behalf of the East Midlands Joint Committee this will be the core representatives from Derby and Derbyshire, Leicester, Leicestershire and Rutland, Lincolnshire, Nottingham and Nottinghamshire and Northamptonshire ICBs; • For items on behalf of the West Midlands Joint Committee this will be the Core representatives from Birmingham and Solihull, Black Country, Coventry and Warwickshire, Herefordshire and Worcestershire, Shropshire Telford and Wrekin and Staffordshire and Stoke-on-Trent ICBs;

	• For items on behalf of NHS England this will be the Regional Director Specialised Commissioning and Health and Justice in consultation with the other core members. Items for decision that impact more than one group of eligible members will be decided by all those eligible members. MASCG shall aim to make decisions by consensus of the eligible core membership wherever possible. Where this is not possible the Chair will check whether all the information is available to make a decision or if there are alternative options that may offer an acceptable solution. The core members must ensure that matters requiring a decision are anticipated, and that sufficient time is allowed prior to Group meetings for discussions and negotiations internally and between ICBs and other partners to take place. Where possible papers will be co-developed and jointly sponsored by NHS England and the ICBs. At the discretion of the Chair, where it is not possible to make a decision at the meeting decisions may be deferred to the next meeting or, with appropriate consultation with eligible core members, to take a decision outside of the meeting. Where it has not been possible, despite the best efforts of the core membership, to come to a consensus decision the Chair may decide that a decision may be escalated to the relevant Joint Committee or MCG as appropriate, supported by detail of the issues raised and further steps taken.
Conduct and conflicts of interest	Members of the MASCG will be expected to act consistently with existing statutory guidance, NHS Standards of Business Conduct, Nolan Principles and relevant organisational policies. Where any core member of the MASCG or the MASC Team or observer has an actual or potential conflict of interest in relation to any matter under consideration by the MASC Group, that individual must declare that interest and take appropriate action to manage the conflict, which could include not participating in the discussion or voting at meetings (or parts of meetings) in which the relevant matter is discussed. The Chair will be responsible for making final decisions on the appropriate management of conflicts of interest.
Confidentiality of proceedings	All members in attendance at a MASCG are required to give due consideration to the possibility that the material presented to the meeting, and the content of any discussions, may be confidential or commercially sensitive, and to not disclose information or the content of deliberations outside of the meeting's membership, without the prior agreement of the MASCG.
Publication of notices, minutes and papers	The MASC Multi-Disciplinary Team of NHS England shall provide sufficient resources, administration and secretarial support for the proper organisation and functioning of the Group.

	The co-chair(s) (or in the absence of the co-chairs, the person covering for them) shall see that notice of meetings of the MASCG, together with an agenda listing the business to be conducted and supporting documentation, is issued one week, (seven calendar days), prior to the date of the meeting. The proceedings and decisions taken by the MASCG shall be recorded in minutes, and those minutes circulated in draft form having been reviewed by the person who presided at the meeting within two weeks of the date of the meeting. The MASCG shall approve those minutes at its next meeting.
Review of the Terms of Reference	These Terms of Reference will be in place for the 2024/25 transitional year only. Updated Terms of Reference will be in place to reflect post April 2025 arrangements.

SCHEDULE 3: INDIVIDUAL SCHEMES

Part 1– East Midlands scheme

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1 OVERVIEW OF THE EAST MIDLANDS SCHEME FOR DELEGATED SPECIALISED SERVICES IN 2024/25

1.1 This scheme sets out the arrangements through which the Partners will work together to commission the 59 specialised services delegated to the East Midlands Integrated Care Boards (ICBs) by NHS England on 1st April 2024.

1.2 The Partners' aims are:

(a) to maximise the benefits to patients of integrating the Delegated Functions with the ICBs' Commissioning Functions through designing and commissioning the Specialised Services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim.

2 SERVICES AND FUNCTIONS

2.1 NHS England has delegated the statutory function for the commissioning of the 59 delegated specialised services to the ICBs. The key powers and duties that the ICBs will be required to carry out in exercise of the delegated functions being, in summary:

(a) decisions in relation to the commissioning and management of the delegated services;

(b) planning delegated services for the population, including carrying out needs assessments;

(c) undertaking reviews of delegated services in respect of the population;

(d) supporting the management of the specialised commissioning budget for delegated services;

(e) co-ordinating a common approach to the commissioning and delivery of delegated services with other health and social care bodies in respect of the population where appropriate; and

(f) such other ancillary activities that are necessary to exercise the specialised commissioning functions.

2.2 A list of the delegated services included within the scheme are detailed within schedule 2 of the Delegation Agreement

2.3 The services are being provided to the populations within the East Midlands ICBs geographical footprints.

3 PARTNERS

3.1 The partners of this scheme are NHS England, Lincolnshire ICB, Nottingham & Nottinghamshire ICB, Leicester, Leicestershire & Rutland ICB, Northamptonshire ICB, Derby & Derbyshire ICB.

4 THE ARRANGEMENTS

4.1 The Scheme will be overseen by the East Midlands Joint Committee established via a Joint Working Agreement between the ICBs whose role shall be to carry out the strategic decision-making, leadership and oversight functions relating to the commissioning of specified delegated specialised services as agreed by the partners and outlined in Schedule 2 of the ICB Collaboration Agreement.

4.2 Administrative and management functions will be provided to the multi-ICB by the Multidisciplinary Team, hosted in 2024-2025 by NHS England. Details of which are set out in an Commissioning Team Agreement and Standard Operating Framework between all parties.

4.3 Details of the financial arrangements relating to this scheme are contained with Schedule 4 of the ICB Collaboration Agreement.

5 GOVERNANCE ARRANGEMENTS

5.1 The scheme shall be governed by the East Midlands Joint Committee, as set out in Schedule 2 of the ICB Collaboration Agreement.

5.2 The terms of reference of the Joint Committee are set out in the Joint Working Agreement between the ICBs.

6 COMMISSIONING, CONTRACTING, ACCESS

6.1 Commissioning Arrangements

Delegated services will be commissioned from providers on behalf of the ICBs by the Commissioning Team in line with legislative requirements and the NHS planning guidance 2024/25.

6.2 Contracting Arrangements

The list of contracts which are in place across the Midlands in 2023/24 for services due to be delegated in April 24 are contained in Appendix 1. These include;

- 26 x Main NHS Provider contracts
- 2 x Section 75 contracts (in collaboration with Northants & Lincs Local Authorities for HIV)

The scheme will be administered by the Commissioning Team, where;

- Each Midlands provider will have a contract for specialised services where NHSE is the co-ordinating commissioner and a separate contract for core ICB services where the ICB is the co-ordinating commissioner.
- On the specialised services contracts the ICBs will either be associate commissioners or receive service responsibilities via GC12.

6.2.1 The contracting arrangement for the scheme will be as follows:

- The scheme will encompass all existing contracts.
- The contracts will be agreed in line with the National Contracting SOP and the ICB Collaboration Agreement.

- The contracts will be funded in line with the pooled budget arrangements detailed in Schedule 4 of the ICB Collaboration Agreement.

- The contracts will be managed on behalf of the Midlands multi-ICB, by the Commissioning Team.

6.3 **Access**
The scheme will apply to all delegated specialised services provided via contracts with providers.

7. HIGH-COST DRUGS

7.1 All identified service lines that are delegated include any activities within these areas including High-Cost drugs and support through the networks. Financial responsibility for HCD and networks remains within NHSE, and responsibility will be managed through collaboration and appropriate decision making.

8. FINANCIAL GOVERNANCE ARRANGEMENTS

8.1. The financial governance arrangements are set out in Schedule 4 of the ICB Collaboration Agreement.

9. NON FINANCIAL RESOURCES

9.1. The non-financial resources required to deliver scheme will be provided by NHSE in accordance with Schedule 6 of the ICB Collaboration Agreement.

10. STAFF

10.1. The commissioning team responsible for the operational delivery of specialised commissioning for delegated services will be hosted by NHS England in 2024/25.

10.2. The arrangement through which the commissioning team will provide this support to the ICBs is set out Schedule 6 of the ICB Collaboration Agreement.

11. ASSURANCE AND MONITORING

11.1. The arrangements in relation to assurance and monitoring in relation to this scheme are contained Schedule 4 of the ICB Collaboration Agreement.

12. AUTHORISED OFFICERS

12.1. The authorised officers for this scheme are as follows:

Partner	**Name of Authorised Officer – Tier 1**
Lincolnshire ICB	John Turner
Nottingham & Nottinghamshire ICB	Amanda Sullivan
Leicester, Leicestershire & Rutland ICB	Dr Caroline Trevithick
Northamptonshire ICB	Toby Sanders
Derby & Derbyshire ICB	Dr Chris Clayton

Partner	Name of Authorised Officer – Tier 1
NHS England	Roz Lindridge

13. INTERNAL APPROVALS

13.1. The levels of authority relating to this scheme are described within Schedule 4 of the ICB Collaboration Agreement.

14. REGULATORY REQUIREMENTS

14.1. Details in relation to regulatory requirements in relation to this scheme are contained within the delegation agreement and will be fulfilled on behalf of the ICBs by the Commissioning Team.

15. COMPLAINTS

15.1. Complaints will be managed by the specialised commissioning team hosted by NHSE England in line with the agreed complaints process.

15.2. A report summarising complaints, actions and lessons learnt will be provided to the East and West Board annually.

Part 2 – West Midlands scheme

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1 OVERVIEW OF THE WEST MIDLANDS SCHEME FOR DELEGATED SPECIALISED SERVICES IN 2024/25

1.1 This scheme sets out the arrangements through which the Partners will work together to commission the 59 specialised services delegated to the West Midlands Integrated Care Boards (ICBs) by NHS England on 1st April 2024.

1.2 The Partners' aims are:

(a) to maximise the benefits to patients of integrating the Delegated Functions with the ICBs' Commissioning Functions through designing and commissioning the Specialised Services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim.

2 SERVICES AND FUNCTIONS

2.1 NHS England delegates to the ICBs the statutory function for the commissioning of the 59 delegated specialised services. The key powers and duties that the ICBs will be required to carry out in exercise of the delegated functions being, in summary:

(a) decisions in relation to the commissioning and management of the delegated services;

(b) planning delegated services for the population, including carrying out needs assessments;

(c) undertaking reviews of delegated services in respect of the population;

(d) supporting the management of the specialised commissioning budget for delegated services;

(e) co-ordinating a common approach to the commissioning and delivery of delegated services with other health and social care bodies in respect of the population where appropriate; and

(f) such other ancillary activities that are necessary to exercise the specialised commissioning functions.

2.2 A list of the delegated services included within the scheme are detailed within schedule 2 of the Delegation Agreement

2.3 The services are being provided to the populations within the West Midlands ICBs geographical footprints.

2.4 There are currently no planned changes to the services in 2024/25.

3 PARTNERS

3.1 The partners to this scheme are as recorded in the main Collaboration Agreement.

3.2 The partners of this scheme are NHS England, The Black Country ICB, Staffordshire & Stoke ICB, Shropshire Telford & Wrekin ICB, Coventry and Warwickshire ICB, Herefordshire & Worcestershire ICB and Birmingham & Solihull ICB.

4 THE ARRANGEMENTS

4.1 The Scheme will be overseen by the West Midlands Joint Committee established via a Joint Working Agreement between the ICBs whose role shall be to carry out the strategic decision-making, leadership and oversight functions relating to the commissioning of specified delegated specialised services as agreed by the partners and outlined in Schedule 2 of the ICB Collaboration Agreement.

4.2 Administrative and management functions will be provided to the multi-ICB by the Multidisciplinary Team, hosted in 2024-2025 by NHS England. Details of which are set out in a Commissioning Team Agreement and Standard Operating Framework between all parties.

4.3 Details of the financial arrangements relating to this scheme are contained with Schedule 4 of the ICB Collaboration Agreement.

5 GOVERNANCE ARRANGEMENTS

5.1 The scheme shall be governed by the West Midlands Joint Committee as set out in Schedule 2 of the ICB Collaboration Agreement.

5.2 The terms of reference of the Joint Committee are contained within the Joint Working Agreement between the ICBs.

6 COMMISSIONING, CONTRACTING, ACCESS

6.1 Commissioning Arrangements

Delegated services will be commissioned from providers on behalf of the ICBs by the Commissioning Team in line with legislative requirements and the NHS planning guidance 2024/25.

6.2 Contracting Arrangements

The list of contracts which are in place across the Midlands in 2023/24 for services due to be delegated in April 24 are contained in Appendix 1. These include;

- 26 x Main NHS Provider contracts

The scheme will be administered by the Commissioning Team, where;

- Each Midlands provider will have a contract for specialised services where NHSE is the co-ordinating commissioner and a separate contract for core ICB services where the ICB is the co-ordinating commissioner.
- On the specialised services contracts the ICBs will either be associate commissioners or receive service responsibilities via GC12.

The contracting arrangement for the scheme will be as follows:

- The scheme will encompass all existing contracts.

- The contracts will be agreed in line with the National Contracting SOP and the ICB Collaboration Agreement.
- The contracts will be funded in line with the pooled budget arrangements detailed in Schedule 4 of the ICB Collaboration Agreement.
- The contracts will be managed on behalf of the Midlands multi-ICB, by the Commissioning Team.

6.3 **Access**
The scheme will apply to all delegated specialised services provided via contracts with providers.

7 HIGH-COST DRUGS

7.1 All identified service lines that are delegated include any activities within these areas including High-Cost drugs and support through the networks. Financial responsibility for HCD and networks remains within NHSE, and responsibility will be managed through collaboration and appropriate decision making.

8 FINANCIAL GOVERNANCE ARRANGEMENTS

8.1 The financial governance arrangements are set out in Schedule 4 of the ICB Collaboration Agreement.

9 NON FINANCIAL RESOURCES

9.1 The non-financial resources required to deliver scheme will be provided by NHSE in accordance with Schedule 6 of the ICB Collaboration Agreement.

10 STAFF

10.1 The commissioning team responsible for the operational delivery of specialised commissioning for delegated services will be hosted by NHS England in 2024/25.

10.2 The arrangement through which the commissioning team will provide this support to the ICBs is set out in Schedule 6 of the ICB Collaboration Agreement.

11 ASSURANCE AND MONITORING

11.1 The arrangements in relation to assurance and monitoring in relation to this scheme are contained Schedule 4 of the ICB Collaboration Agreement.

12 AUTHORISED OFFICERS

12.1 The authorised officers for this scheme are as follows:

Partner	**Name of Authorised Officer – Tier 1**
Coventry & Warwickshire ICB	Philip Johns
The Black Country ICB	Mark Axcell
Herefordshire & Worcestershire ICB	Simon Trickett
Birmingham & Solihull ICB	David Melbourne

Partner	Name of Authorised Officer – Tier 1
Staffordshire and Stoke on Trent ICB	Peter Axon
Shropshire Telford and Wrekin ICB	Simon Whitehouse
NHS England	Roz Lindridge

13 INTERNAL APPROVALS

13.1 The levels of authority relating to this scheme are described within Schedule 4 of the ICB Collaboration Agreement.

14 REGULATORY REQUIREMENTS

14.1 Details in relation to regulatory requirements in relation to this scheme are contained within the delegation agreement and will be fulfilled on behalf of the ICBs by the Commissioning Team.

15 COMPLAINTS

15.1 Complaints will be managed by the specialised commissioning team hosted by NHSE England in line with the agreed complaints process.

15.2 A report summarising complaints, actions and lessons learnt will be provided to the East and West Board annually.

Part 3– Retained Services Scheme

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1 OVERVIEW OF THE SCHEME FOR RETAINED SPECIALISED SERVICES IN 2024/25

1.1 This scheme sets out the arrangements through which the Partners will work together to commission the specialised services for which responsibility is being retained by NHS England in 2024/25 but identified as suitable for future delegation to Integrated Care Boards (ICBs) in the future.

1.2 The Partners' aims are:

(a) to maximise the benefits to patients by working collaboratively on the Retained Functions in preparation for future delegation and integration with the ICBs' Commissioning Functions through designing and commissioning the Specialised Services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim.

2 SERVICES AND FUNCTIONS

2.1 NHS England has identified that the statutory function for the commissioning of the specialised services is suitable for future delegation to the ICBs. Whilst this responsibility is being retained by NHS England for 2024/25 it will involve the ICBs in the of these functions being, in summary:

(a) decisions in relation to the commissioning and management of the services;

(b) planning for the services for the population, including carrying out needs assessments;

(c) undertaking reviews of services in respect of the population;

(d) supporting the management of the specialised commissioning budget for the services;

(e) co-ordinating a common approach to the commissioning and delivery of the services with other health and social care bodies in respect of the population where appropriate; and

2.2 A list of the services included within the scheme are detailed within Appendix 2 of this Schedule.

2.3 The services are being provided to the populations within the Midlands ICBs geographical footprints.

3 PARTNERS

3.1 The partners for joint working within this scheme are NHS England, Birmingham and Solihull ICB, Black Country ICB, Coventry and Warwickshire ICB, Herefordshire and Worcestershire ICB, Shropshire, Telford and Wrekin ICB, Staffordshire and Stoke-on-Trent ICB, Lincolnshire ICB, Nottingham & Nottinghamshire ICB, Leicester, Leicestershire & Rutland ICB, Northamptonshire ICB, Derby & Derbyshire ICB

4 THE ARRANGEMENTS

4.1 NHS England will retain responsibility for the delivery of the functions covered by this scheme, working with the ICBs through appropriate consultation with and reporting to the East Midlands Joint Committee and the West Midlands Joint Committee established via a Joint Working Agreements between the ICBs.

4.2 Administrative and management functions will be provided to deliver the scheme by the multi-disciplinary commissioning team, hosted in 2024-2025 by NHS England. Details of which are set out in a commissioning team agreement between all parties.

4.3 Financial arrangements for this scheme will follow NHS England's budgetary and financial arrangements.

5 GOVERNANCE ARRANGEMENTS

5.1 NHS England will continue to hold responsibility for the delivery of the functions covered by the scheme.

5.2 Decision making will be in line with NHS England's Scheme of Reservation and Delegation subject to decisions being taken in consultation with the ICBs and the Joint Committees where appropriate.

5.3 The exercise of NHS England functions in consultation with the Joint Committees will be achieved by NHS England Officers with appropriate delegated authority attending meetings of the East Midlands Joint Committee and West Midlands Joint Committee when exercising that authority.

5.4 NHS England will report on the delivery of the functions under this scheme to the East Midlands and West Midlands Joint Committees.

6 COMMISSIONING, CONTRACTING, ACCESS

6.1 Commissioning Arrangements

6.1.1 Services will be commissioned from providers by the Commissioning Team in line with legislative requirements and the NHS planning guidance 2024/25.

6.2 Contracting Arrangements

6.2.1 The scheme will be administered by the Commissioning Team.

6.2.2 The contracting arrangement for the scheme will be as follows:

- The scheme will encompass all existing contracts.
- The contracts will be agreed in line with the National Contracting SOP and the ICB Collaboration Agreement.
- The contracts will be funded by NHS England.
- The contracts will be managed by the Commissioning Team.

6.3 Access

The scheme will apply to all delegated specialised services provided via contracts with providers.

7 HIGH-COST DRUGS

7.1 All identified service lines that are delegated include any activities within these areas including High-Cost drugs and support through the networks. Financial responsibility for HCD and networks remains within NHSE, and responsibility will be managed through collaboration and appropriate decision making.

8 FINANCIAL GOVERNANCE ARRANGEMENTS

8.1 The financial governance arrangements will be in line with NHS England's Scheme of Reservation and Delegation and Standing Financial Instructions.

9 NON-FINANCIAL RESOURCES

9.1 The non-financial resources required to deliver scheme will be provided by NHSE in accordance with Schedule 6 of the ICB Collaboration Agreement.

10 STAFF

10.1 The commissioning team responsible for the operational delivery of specialised commissioning for the services will be retained by NHS England.

11 ASSURANCE AND MONITORING

11.1 NHS England's requirements in relation to Assurance and Monitoring will apply to this scheme.

12 INTERNAL APPROVALS

12.1 The levels of authority relating to this scheme will follow NHS England's Scheme of Reservation and Delegation and Standing Financial Instructions

13 REGULATORY REQUIREMENTS

13.1 NHS England will retain responsibility for fulfilling the regulatory requirements in relation to this scheme.

14 COMPLAINTS

14.1 Complaints will be managed by the specialised commissioning team within NHSE England in line with the agreed complaints process.

APPENDIX 1 – LIST OF CONTRACTS HELD WITH PROVIDERS IN 2023/24

Standard Contracts

BIRMINGHAM COMMUNITY HEALTHCARE NHS FOUNDATION TRUST
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST
DERBYSHIRE COMMUNITY HEALTH SERVICES FOUNDATION TRUST
CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST
GEORGE ELIOT HOSPITAL NHS TRUST
KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST
MIDLANDS PARTNERSHIP NHS FOUNDATION TRUST
NORTHAMPTON GENERAL HOSPITAL NHS TRUST
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST
SHREWSBURY AND TELFORD HOSPITAL NHS TRUST
THE DUDLEY GROUP NHS FOUNDATION TRUST
THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST
THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST
THE ROYAL WOLVERHAMPTON NHS TRUST
THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST
UNITED LINCOLNSHIRE HOSPITALS NHS TRUST
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST
UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST
WALSALL HEALTHCARE NHS TRUST
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST
WYE VALLEY NHS TRUST

Section 75 Contracts

LINCOLNSHIRE COMMUNITY HEALTH SERVICES NHS TRUST
NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST

APPENDIX 2 RELEVANT SERVICES

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
4	Adult specialist respiratory services	29E	Management of central airway obstruction
		29V	Complex home ventilation
15	Adult specialist renal services	11T	Renal transplantation
29	Haematopoietic stem cell transplantation services (adults and children)	02Z	Blood and marrow transplantation services
		ECP	Extracorporeal photopheresis service
45	Cystic fibrosis services (adults and children)	10Z	Cystic fibrosis services
55	Gender dysphoria services (children and adolescents)	22A	Gender identity development service for children and adolescents
56	Gender dysphoria services (adults)	22Z	Gender identity services
		42A	Gender dysphoria: genital surgery (trans feminine)
		42B	Gender dysphoria - genital surgery (trans masculine)
		42C	Gender dysphoria: chest surgery (trans masculine)
		42D	Gender dysphoria - non-surgical services
		42E	Gender dysphoria: other surgical services
58	Specialist adult gynaecological surgery and urinary surgery services for females	04K	Specialised services for women with complications of mesh inserted for urinary incontinence and vaginal prolapse (16 years and above)
		04L	Reconstructive surgery and congenital anomalies of the female genital tract
65	Specialist services for adults with infectious diseases	18T	Tropical Disease
82	Paediatric and perinatal post mortem services	F23	Paediatric and perinatal post mortem services
87	Positron emission tomography-computed tomography services (adults and children)	01P	Positron emission tomography- computed tomography services (PETCT)
89	Primary malignant bone tumours service (adults and adolescents)	01O	Primary malignant bone tumours service (adults and adolescents)
101	Severe intestinal failure service (adults)	12Z	Severe intestinal failure service
103A	Specialist adult haematology services	03C	Castleman disease
105	Specialist cancer services (adults)	01L	Soft tissue sarcoma
		01X	Penile cancer
111	Clinical genomic services (adults and children)	20G	Genomic laboratory testing services
		20H	Pre-Implantation genetic diagnosis and associated in-vitro fertilisation services
		20Z	Specialist clinical genomics services
		MOL	Molecular diagnostic service
114	Specialist haemoglobinopathy services (adults and children)	38S (DPC)	Sickle cell anaemia -direct patient care
		38T (DPC)	Thalassemia - direct patient care
		38X (HCC)	Haemoglobinopathies coordinating centres (HCCs)
		38X (SHT)	Specialist Haemoglobinopathies Teams (SHTs)
115	Specialist immunology services for adults with deficient immune systems	16X	Specialist immunology services for adults with deficient immune systems
115A	Specialist immunology services for children with deficient immune systems	16Y	Specialist immunology services for children with deficient immune systems
134	Specialist services to support patients	05C	Specialist augmentative and alternative

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

SCHEDULE 4: FINANCIAL ARRANGEMENTS

PART A: POOLED FUND MANAGEMENT

1 ESTABLISHMENT OF A POOLED FUND

1.1 The ICBs have agreed to establish and maintain a mutual agreement pooled fund arrangement for in-year financial management of Schemes 1 and 2 of Schedule 3 of this agreement, with a defined contribution based on the allocation received will be transferred to the Host ICB, (Birmingham & Solihull ICB) on behalf of the Midlands.

The monies held in a Pooled Fund may only be expended on the following:

- the Contract Price;
- Third Party Costs where these are set out in the relevant Scheme Specification or as otherwise agreed in advance in writing in accordance with the relevant Scheme Specification;
- Approved expenditure as set out in the relevant Scheme Specification or as otherwise agreed in advance in accordance with the relevant Scheme Specification.
(collectively known as "Permitted Expenditure")

1.2 The Pooled Fund is explicitly for the management of in year expenditure against specialised services contractual commitments. This includes all contractual commitments for the population of Midlands ICBs including any out of Region contractual arrangements.

1.3 The Pooled Fund is not intended to be the route for recurrent commissioning decisions for specialised services. Such decisions would be made through the governance structure established in East and West Midlands.

1.4 The Partners may only depart from the definition of Permitted Expenditure or exceed Pooled Fund budget with the express written agreement of each relevant Partner and in line with approved delegations.

1.5 Birmingham & Solihull ICB on behalf of the Midlands shall be the Partner responsible for:

- Holding all monies contributed to the Pooled Fund on behalf of itself and the other Partners;
- Providing the financial administrative systems for the Pooled Fund; and
- The manager of the Pooled Fund (“Pooled Fund Manager”) will be the Director Specialised Commissioning of Finance
- Ensuring that the Pooled Fund Manager complies with its obligations under this Agreement.

2. RISK EXPOSURE

2.1. ICB population-based allocations have been developed on the basis of current contractual commitments as demonstrated in the document “ICB Baseline Development”.

2.2. All ICB 2024/25 opening baselines have been updated for 2023/24 variable activity levels and precommitments.

2.3. All ICB 2024/25 opening baselines are in recurrent financial balance and there is no risk exposure from opening contract baselines for 2024/25.

2.4. The specialised services contract is operated on a block basis and there is no financial exposure to activity variance through the block contract.

2.5. Elective activity is managed through the Elective Recovery Fund which will be managed on the same basis as 2023/24 with contract values and allocations being adjusted for activity variances. There will be no financial risk associated with the application of ERF. There are a small number of variable services (linked to Best Practice Tariffs) within the contract, these being:

- Chemotherapy
- Diagnostic Imaging
- Nuclear Medicine
- PRT-CT
- Molecular Radiotherapy
- Renal Transplant

2.6. These services are paid on a cost per case basis. Opening baselines for variable services will be based on 2023/24 outturn with growth applied based on historic activity.

2.7. There remains risk at an ICB and regional level of variance against contract and budget for these services.

2.8. ICBs hold contracts with providers outside the geographical boundary of the Midlands. It is expected that there will be consistency between planning assumptions and contractual growth across regions, but there is a risk that differential application of growth by other NHS England regions will impact on partners to this agreement.

2.9. A contingency of 0.5% will be held to manage in year financial risk to mitigate the impact of variable service financial risks and consequences of cross regional contractual commitments.

2.10. The use of a Pooled Fund will mitigate in year fluctuation at ICB level for variable services within delegated specialised services.

3. POOLED FUND MANAGEMENT

3.1. The Pooled Fund Manager for Pooled Fund shall have the following duties and responsibilities:

- The day-to-day operation and management of the Pooled Fund,
- Ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this Agreement and the relevant Scheme Specification,
- Maintaining an overview of all joint financial issues affecting the Partners in relation to the Services and the Pooled Fund,
- Ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund,
- Reporting to the relevant governance group as required by this Agreement,
- ensuring action is taken to manage any projected under or overspends relating to the Pooled Fund in accordance with this Agreement, and
- preparing and submitting reports as required by the relevant Scheme Specification.

3.2. The Partners may agree to the virement of funds between Pooled Funds or amending the allocation of the Pooled Fund between Individual Schemes.

4. FINANCIAL CONTRIBUTIONS

4.1. The pooled fund shall initially operate for the financial year 2024/25. Should the scheme be continued into future years, the Financial Contribution to any Pooled Fund for each subsequent Financial Year of operation shall be subject to review by the Partners.

4.2. Unless otherwise agreed, no provision of this Agreement shall preclude the Partners from making additional contributions to a Pooled Fund from time to time by mutual agreement. Any such additional contributions of Non-Recurrent Payments shall be explicitly recorded in the budget statement as a separate item.

4.3. ICBs will pay contributions to the Pooled Fund for Specialised Services to the identified Host ICB.

4.4. Contributions will be the equivalent of the allocation for delegated specialised services or an amount specified by the payments schedule calculated by the specialised commissioning team.

Table of contributions to be added once final 2024/25 allocations have been confirmed.

Partner	Name of CFO	Contribution to the Fund
Coventry & Warwickshire ICB		
The Black Country ICB		
Herefordshire & Worcestershire ICB		
Birmingham & Solihull ICB		
Staffordshire and Stoke on Trent ICB		
Shropshire Telford and Wrekin ICB		
Lincolnshire ICB		
Nottingham & Nottinghamshire ICB		
Leicester, Leicestershire & Rutland ICB		
Northamptonshire ICB		
Derby & Derbyshire ICB		

5. RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPEND

5.1. The Host Partner for the relevant Pooled Fund shall, through the Specialised Commissioning Team Fund Manager, manage expenditure from a Pooled Fund within the Financial Contributions and shall use reasonable endeavours to ensure that the expenditure is limited to Permitted Expenditure.

5.2. The Host Partner shall not be in breach of its obligations under this Agreement if an Overspend occurs provided that it has used reasonable endeavours to ensure that the only expenditure from a Pooled Fund has been incurred and it has informed the Partners of any variance.

5.3. In the event that the Pooled Fund Manager identifies an actual or projected Overspend the Pooled Fund Manager must ensure that the Partners are informed as soon as reasonably possible.

5.4. If expenditure from the Pooled Fund in any Financial Year is less than the aggregate value of the Financial Contributions made for that Financial Year, financial resources will be returned to the Partners proportionate to the contributions to the Pooled Fund. Arrangements shall be subject to the Law and the Standing Orders and Standing Financial Instructions of the Partners.

5.5. Any unmitigated net variance will need to be recognised in the Agreement of Balances exercise completed as part of the month 09 financial reporting process.

5.6. Residual variances (under or overspend), after mitigations and application of contingency, will be allocated to ICBs proportionately to contributions to the Pooled Fund.

6. CAPITAL EXPENDITURE

6.1. Pooled Funds shall not be applied towards any one-off expenditure on goods or services, which will provide continuing benefit and would historically have been funded from the capital budgets of one of the Partners. If a need for capital expenditure is identified this must be agreed by the Partners.

7. POOLED FUND FINANCIAL GOVERNANCE

7.1. The partners in the Pooled Fund shall make monthly payments of one twelfth of the Pooled Fund contributions by the 5th of the month.

7.2. The Specialised Commissioning Team will manage specialised services through the host ledger managing financial risk across all Partner ICBs.

7.3. All contractual payments including variable adjustments will be managed by the Specialised Commissioning Team through the single joint Specialised Commissioning contract in line with the Contracting Standard Operating Procedure.

7.4. In year financial management will be undertaken at a multi ICB level across eleven ICBs in the Midlands region, mitigating the risk of variation between systems.

7.5. Regional financial variances (under or overspend) would be mitigated through the application of local financial management and the use of the contingency held by the Host, as agreed by partners, to minimise exposure to financial fluctuation.

7.6. Residual variances (under or overspend), after mitigations and application of contingency, will be allocated to ICBs proportionately to contributions to the Pooled Fund.

8. POOLED FUND FINANCIAL REPORTING AND ASSURANCE

8.1. The Joint finance subgroup will have responsibility to oversee the management of the pooled fund on behalf of the Joint Committees.

8.2. ICB level in year financial reporting will show contributions to the pool in the ICB position thereby demonstrating a break-even position for specialised commissioning on monthly financial reports.

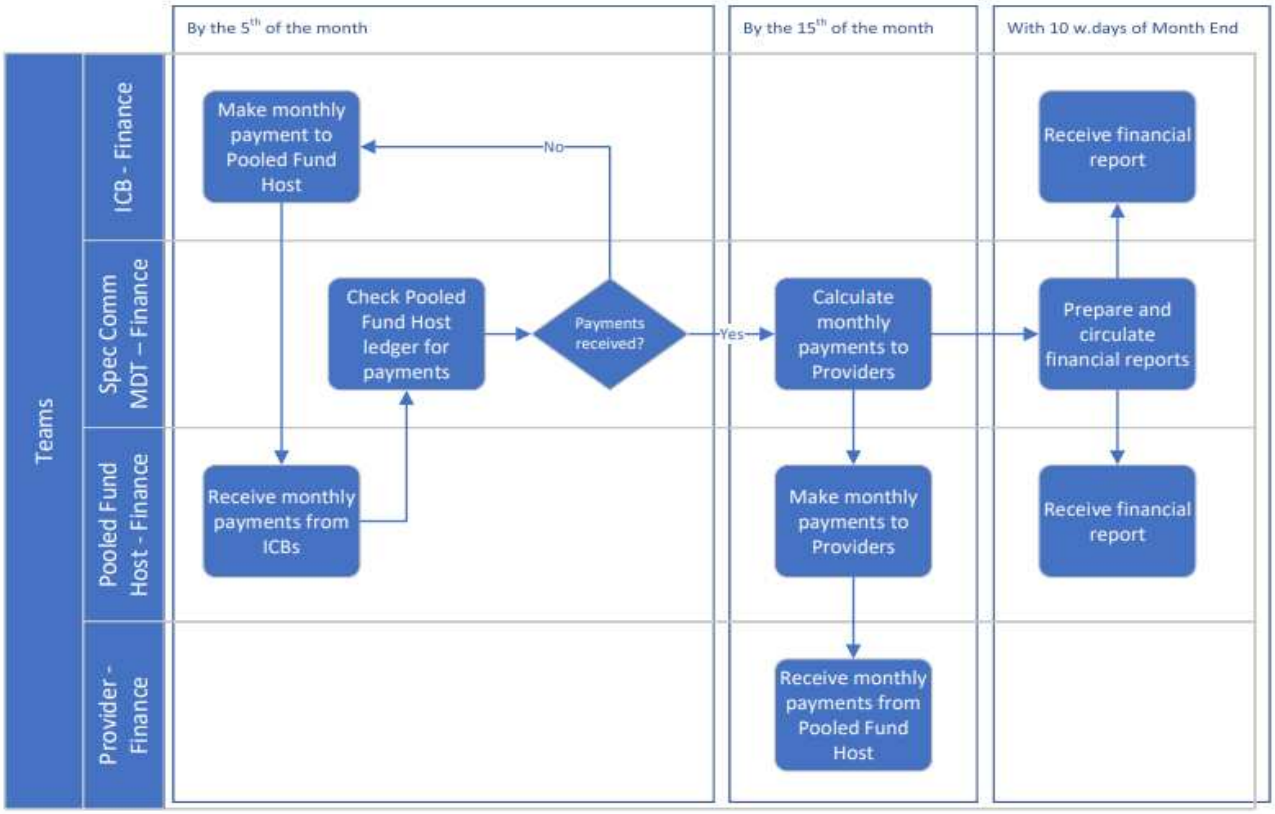
8.3. Performance reporting will be developed at an ICB and multi ICB level to enable local intelligence on performance in delegated specialised services.

8.4. The Specialised Commissioning Team on behalf of the Host will prepare quarterly memorandum finance reports at individual ICB level to ensure all ICBs have full sight of the overall actual performance of specialised commissioning and indicative ICB level performance.

8.5. Year-end reporting will be prepared in line with nationally produced annual accounts timetables recognising any locally agreed requirements.

8.6. As part of the year end process the Specialised Commissioning Team will prepare reconciliation journals to update individual ICB ledgers with detailed Provider level expenditure in line with Pooled Fund contributions.

8.7. Financial Flow arrangements are illustrated below



PART B: OTHER FINANCIAL ARRANGEMENTS

9. BUDGETARY DELEGATION

9.1. Commissioning decisions will be made in line with the Arrangements agreed by the East/West Midlands Joint Commissioning Committee which has Delegated Authority to set approval limits in line with those arrangements. Initial approval limits, subject to the agreement of the Joint Committees are set out in Annex 1 to this schedule.

9.2. ICBs have agreed to delegate budgetary responsibility to the specialised commissioning team for the processing and delivery of specialised services transactions. These delegations are to facilitate the delivery of contract signature, purchase orders and non-purchase order invoices and budgetary virement and are set out in Annex 2 to this schedule.

9.3. For 2024/25, the specialised commissioning team will be employed by NHS England on behalf of the partner ICBs. From 2025/26 the specialised commissioning team will be employed by the Host ICB.

10. AUDIT ARRANGEMENTS

10.1. Transactions through ICB ledgers will be subject to audit through existing internal audit arrangements. It will be the responsibility of ICBs to ensure that this appropriately referenced in the 2024/25 audit plan.

10.2. In 2024/25 Specialised Commissioning Team responsible for the management of specialised commissioning resources will continue to be employed by NHS England but will access the ledger of the Host ICB to process transactions for specialised services.

10.3. In 2024/25 the Host ICB will commission a specific review of the financial control, governance and assurance of the Specialised Commissioning Team delivered service to provide assurance to ICBs that the controls in place for specialised services are robust.

11. FINANCIAL MANAGEMENT

11.1. Financial transactions for the 59 delegated specialised services will be processed through the Oracle ISFE ledger system of the Host ICB. Specialised Commissioning team will have appropriate access to ICB ledgers enabled.

11.2. Financial monitoring reports will be produced by the NHSE hosted Specialised Commissioning Team on behalf of the ICBs. The team, for 2024/25, will provide financial support to ICBs for delegated services and NHSE for retained and highly specialised services.

11.3. Financial reports will be prepared monthly within ten working days of the end of the month. Forecast outturn positions will be included in the monitoring reports from quarter 2.

11.4. Monthly budget reporting with variance analysis and forecasting will be provided the Joint Finance Subgroup, Host ICB, and Partner ICBs including:

- ICB reporting based on pool contribution,
- Overall pool financial performance report to be shared with all ICBs,
- Management and review of reserves and investments.

Annex 1 to Schedule 4

Commissioning Decisions Budgetary Delegation Schedule

Description of Delegation (All Delegations are Annual Values)	**Delegated Limits**		
	Director of Specialised Commissioning	**MASCG**	**Joint Committees**
Approval of extensions to contracts and contract variations	N/a	Up to £2.5m	Above £2.5m
Approval of business cases for investment for **existing services** within **existing budget envelope**	Unlimited		
Approval of business cases for investment for **existing services** with **additional investment**	Up to £1m	Up to £2.5m	Above £2.5m
Approval of business cases for investment for **existing services** with **new investment**	Up to £1m	Up to £2.5m	Above £2.5m

Annex 2 to Schedule 4

Operational Budgetary Delegation Schedule

Contract award, signature and variation		
Description of delegation: Approval of contract award reports, providing requirements for competitive tendering have been met. Signature of contracts and contract variations, within the approved budget.		
Delegated Limit Limits are annual values	Up to £2m	Unlimited
Approvers and/or restrictions No variation can be granted to a contract awarded under the PCR threshold where the value of the variation results in the contract value exceeding the PCR threshold.	Commissioning Lead – Acute Specialised Commissioning (Contracting)	Director of Specialised Commissioning Director of Commissioning Finance (specialised commissioning).

Purchase Requisitions, invoices and non POs			
Description of delegation: Approval of purchase requisitions, purchase credit notes, invoices and non-purchase order invoices. Approval of contract payments to NHS providers.			
Delegated Limit	Up to £50k	Up to £2m or 1/12 of contract value for NHS Providers	Over £2m
Approvers and/or restrictions Expenditure must be covered by a relevant budget. Purchase orders should be raised for all nonhealthcare goods and services and the non-purchase order route should only be used in exceptional circumstances.	Specialised commissioning: Contract Managers or Budget Holders	Director of Specialised Commissioning Director of Commissioning Finance (specialised)	Director of Specialised Commissioning **or** Director of Commissioning Finance (Specialised) **And** Pooled Fund Host CFO

Budget Virements			
Description of delegation: Approval of budget virements/movements within approved revenue and capital budgets.			
Delegated Limit	Up to £50k	Up to £2m	Over £2m
Approvers and/or restrictions Expenditure must be covered by a relevant budget.	Specialised commissioning Contract Managers or Budget Holders	Director of Specialised Commissioning	MASCG

Purchase orders should be raised for all nonhealthcare goods and services and the non-purchase order route should only be used in exceptional circumstances.		Director of Commissioning Finance (specialised)	

SCHEDULE 5: FURTHER INFORMATION GOVERNANCE AND SHARING PROVISIONS

PART 1

1. Introduction

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

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

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

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

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

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

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

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

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

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

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

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

2. Purpose

2.1. The Specified Purpose of the data sharing is to facilitate the exercise of the Joint Working Arrangements.

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

3. Benefits of information sharing

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

4. Lawful basis for sharing

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

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

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

5. Restrictions on use of the Shared Information

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

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

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

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

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

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

6. Ensuring fairness to the Data Subject

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

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

6.1.2. amendment of respective privacy notices and policies to reflect the processing of data carried out further to this Agreement, including covering the requirements of articles 13 and 14 UK GDPR and providing these (or making them available to) Data Subjects;

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

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

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

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

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

7. Governance: Staff

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

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

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

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

7.5. The Partners shall ensure that:

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

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

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

8. Governance: Protection of Personal Data

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

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

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

8.4. If any Partner becomes aware of:

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

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

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

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

8.5.1. in accordance with the terms of this Agreement and otherwise (to the extent that it acts as a Data Processor for the purposes of Article 27-28 GDPR) only

in accordance with written instructions from the originating Data Controller in respect of its Relevant Information;

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

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

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

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

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

8.7. Each Partner shall:

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

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

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

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

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

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

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

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

9. Governance: Transmission of Information between the Partners

9.1. This paragraph supplements paragraph 8 of this Schedule.

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

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

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

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

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

10. Governance: Quality of Information

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

11. Governance: Retention and Disposal of Shared Information

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

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

11.3. If a Partner is required by any Law, regulation, or government or regulatory body to retain any documents or materials that it would otherwise be required to return or destroy

in accordance with this Schedule, it shall notify the other Partners in writing of that retention, giving details of the documents or materials that it must retain.

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

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

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

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

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

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

12. Governance: Complaints and Access to Personal Data

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

12.2. Complaints about information sharing shall be reported to each Partner. Complaints about information sharing shall be routed through each Partner's own complaints procedure unless otherwise provided for in the Joint Working.

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

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

13. Governance: Single Points of Contact

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

14. Monitoring and review

14.1. The Partners shall monitor and review on an ongoing basis the sharing of Relevant Information to ensure compliance with Data Protection Legislation and best practice.

Specific monitoring requirements must be set out in the relevant Data Sharing Agreement.

SCHEDULE 6: COMMISSIONING TEAM AGREEMENT and STANDARD OPERATING FRAMEWORK

COVERED UNDER A SEPARATE AGREEMENT - COMMISIONING TEAM AGREEMENT AND OPERATING FRAMEWORK

Midlands Acute Specialised Commissioning (MASC)

Commissioning Team Agreement and Standard Operating Framework for 2024/25

Contents:

1. Introduction

This agreement sets out the purpose and role of the Midlands Acute Specialised Commissioning (MASC) Multidisciplinary Team, how it will operate and how it will be governed from 1st April 2024 to 31st March 2025.

This Commissioning Team Agreement and Standard Operating Framework should be read in conjunction with:

- Overarching governance documents
  - Delegation Agreement
  - Memorandum of Understanding and Collaboration Agreement
- Key documents produced as part of the above Agreements including,
  - Cash Flow SOP
  - Contracting SOP
  - Financial Risk Share and Pooling Arrangement
  - Quality Assurance Framework
    and other key operating instructions
- National guidance relating to the roles and responsibilities of NHS England in relation to specialised services.

This agreement will commence on 1st April 2024 for one year only. The year will operate as a transition for some defined functions with NHSE remaining the employing organisation.

The Multidisciplinary Team will support the following organisations in the commissioning of delegated services:

- NHS Lincolnshire ICB
- NHS Derbyshire ICB
- NHS Nottingham and Nottinghamshire ICB
- NHS Leicester, Leicestershire, and Rutland ICB
- NHS Northamptonshire ICB

Known as the East Midlands Multi-ICB.

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

Known as the West Midlands Multi-ICB.

And the following organisation in the commissioning of retained specialised services and financial and governance responsibility High Cost Drugs and clinical networks:

- NHS England

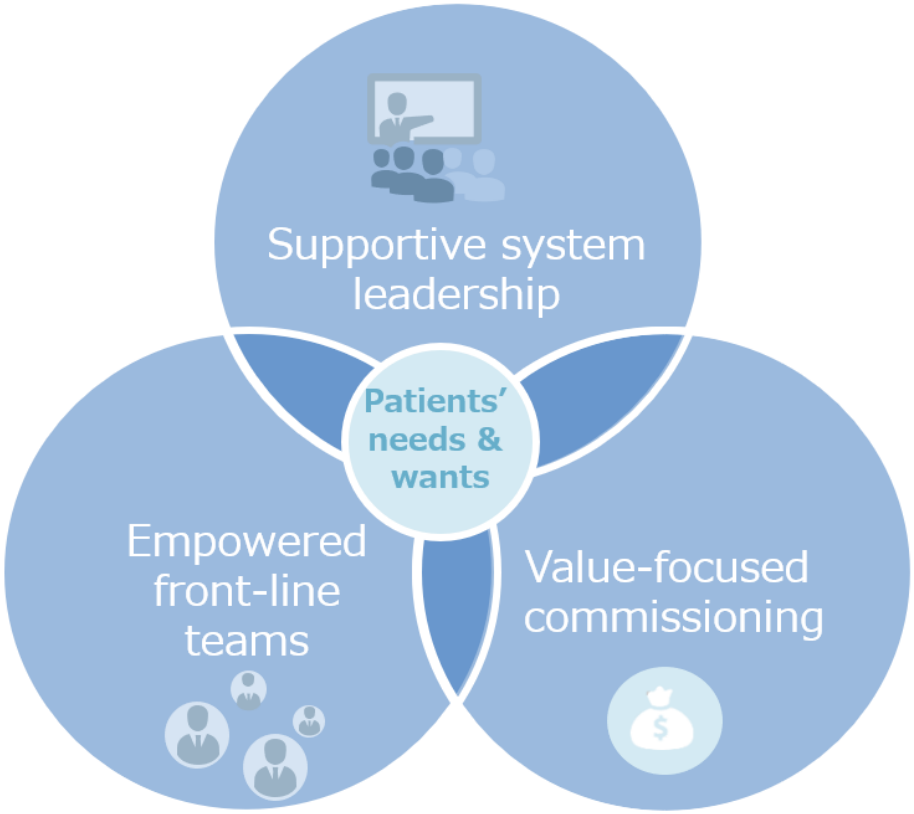
The team will be responsible for commissioning, financial and clinical and quality management of the 59 delegated specialised services on behalf of the East and West Midlands Joint Committees and the retained services on behalf of NHSE in collaboration with the ICBs.

2. Values and Principles

The Multidisciplinary Team will work to support the following:

- **Programmes of Care**:
  Specialist services – which are low volume and high cost – that must be in place and able to meet the needs of patients and families at the right time and in the right way, aligned to national specifications.
- **Patient Pathways**:
  Delegation enables improved working between commissioners and across networks to ensure the best value for patients moving through services.
- **Providers and Partners**:
  That fewer, better relationships create improvements in delivery and new models support this (provider collaboratives)
- **Population Outcomes**:
  That systems can articulate the benefit to their patients of working across all services from prevention through to highly specialist intervention.

The principles of a successful model are set out below:



The Multidisciplinary Team will work coherently and consistently and will champion specialised care on behalf of the 12 commissioning partners. They will work as a part of a network of partners, enabling staff to deliver across complex geographies and as part of multi-layered systems and local collaboration.

3. Key Terms

The following are key terms and abbreviations to support navigation through specialised commissioning and specialised services:

MASC	Midlands Acute Specialised Commissioning
MDT	Multi-Disciplinary Team: The collaboration between specialist components of the MASC that provide the single support offer – Commissioning (inc. Contracting), Pharmacy, Finance, Nursing & Quality, Business Intelligence & Analytics and Regional Communications and Engagement. Complaints will be dealt with by the relevant functional teams.
MASCG	Midlands Acute Specialised Commissioning Group, the Tier 2 sub-group of the East and West Midlands Joint Committees, representing all 12 partners
EMJC/WMJC	East Midlands/West Midlands Joint Committee, the Tier 1 governance structure for the East/West Midlands multi-ICB.
DELEGATED SERVICES	The 59 Specialised Services being delegated from NHSE to Midlands ICB on 1st April 2024
RETAINED SERVICES	The remaining Specialised Services not being delegated on 1st April 2024 which will be retained by NHSE.
POC	Programmes of Care which operate on a Pan-Midlands footprint and to individual contracts (27 NHS and 3 IS) at a system level including; • Blood and Infection • Cancer • Internal Medicine • Trauma; and • Women and Children
DCG	Delegated Commissioning Group for national decisions applied to delegated services including updates to specification. The Regional Director of Specialised Commissioning will represent the ICBs on the Group
NCG	National Commissioning Group for Non-Delegated Services. The Regional Director of Specialised Commissioning will represent NHSE Midlands on the Group
ODN(s)	Operational Delivery Network(s) for Specialised Services
HCDs	High-Cost Drugs

4. Key elements

The following are key elements relating to the operation of the Multidisciplinary Team in 2024/25:

- The Multidisciplinary Team will support the delivery of delegated and retained services. The team will not be split, in terms of time aligned to these, but will be driven by needs as agreed through the MASCG. The 59 delegated services are the predominant areas of focus for the team based on the work plan.

- Corporate support will be provided by NHSE as the host organisation including estates, IT, legal support, HR and business administration.

- The Multidisciplinary Team will link with NHSE Regional and National directorates regarding risk management where this is appropriate.

- Although the responsibility for commissioning of the 59 specialised services is delegated to the Midlands ICBs on 1st April 2024, accountability remains with NHSE. This will be managed by the NHSE Midlands regional team through an Oversight and Assurance Framework informed by subject matter expertise provided by the Multidisciplinary Team and wider regional commissioning integration team.

- The team will work to ensure consistency of communication through the established governance model, recognising the different populations and system issues in the East and West Midlands. The team will remain pan-Midlands in structure.

5. Administrative & Management Services

5.1 Purpose, Roles, Responsibilities and Functions

The Multidisciplinary Team recognises the robust governance required to operate on behalf of 12 organisations and to ensure that conflicts of interest are well managed.

The Multidisciplinary Team represents specialist knowledge in relation to Acute Specialised Services. However, the team will also be working with expert commissioning partners across 11 ICBs to deliver pathway improvements and maximise value in systems and with provider partners.

The Multidisciplinary Team will ensure the day-to-day management and monitoring of Specialised Acute and Pharmacy services provided across the Midlands. This requires ongoing integrated working through the links with the Acute Providers either directly with corporate and clinical teams or via Operational Delivery Networks (ODNs).

The Multidisciplinary Team will report on performance, progress on transformation priorities, and make recommendations for improvement through the Tier 1 and 2 governance groups and through NHSE governance frameworks, aligned to an agreed work programme. The Multidisciplinary Team will manage operational, financial, and quality risks in line with agreed escalation routes in line with this collaborative approach.

The Multidisciplinary team will carry out all duties in relation to the commissioning of delegated services liaising through the East and West Boards and their subgroups. The team details are below but in summary are made up of

Supporting Retained NHSE Functions and Delegated ICB Functions	
Function	Number (includes those who have a wider portfolio beyond specialised services)
Finance	17 WTE
Commissioning & Pharmacy	41 WTE
Quality	8 WTE
Commissioning Support	5 WTE

A list of key contacts is provided below

Core Functions	Lead Officer	Contact details
Commissioning & contracting	Alison Kemp Jon Currington	Alison.kemp1@nhs.net Jon.currington@nhs.net
Pharmacy	Susanna Allen	susanna.allen@nhs.net
Finance	Jon Cooke/ Pete Davies	Jon.cooke1@nhs.net Peter.davies4@nhs.net
Clinical & Quality	Dr Colette Marshall Dr Mel McFeeters	colette.marshall6@nhs.net melanie.mcfeeters@nhs.net
Business Intelligence & Analytics	Simon Collings	Simon.collings@nhs.net
Regional Comms Team	Claire Deeley	claire.deeley@nhs.net
Specialised Networks (ODMs)	Kieren Caldwell	Kieren.caldwell@nhs.net

5.2 Specialised Commissioning & Contracting Team

The Commissioning & Contracting Team is responsible for commissioning prescribed acute specialised services as described in the Manual of Prescribed Services, in line with national service specifications and policies, on behalf of ICBs for delegated services and NHSE for retained services.
The team discharges its responsibilities through a structure of five Clinical Programmes of Care (PoC) which operate on a pan-Midlands footprint and to individual contracts (27 NHS and three Independent Sector (IS) providers) at a system level.

The five PoC are:

- Blood and Infection;
- Cancer;
- Internal Medicine;
- Trauma; and
- Women and Children.

Each PoC is headed by a Commissioning Lead from a clinical, finance or management background with specific expertise in their PoC area. Each of the PoC Leads has a lead responsibility for named ICBs, although at present the role is largely nominal based on the individual contracts their team is responsible for (Appendix 1). The Commissioning Lead for Blood and Infection also has lead responsibility for Contracting across the Midlands.

The Head of Acute Specialised Services oversees all these functions and reports directly to the Director of Specialised Commissioning.

The core functions the team deliver on behalf of ICB partners include:

- Co-ordinating commissioner for the 59 delegated services;
- Contract negotiation and Contract Relationship Management with Midlands Acute Providers;
- Oversight of transformation portfolio focused on improving health outcomes & reducing inequalities.
- Single point of contact for all acute specialised services for Specialised Networks, provider clinicians and management teams and ICB teams; and
- Oversight and assurance of all acute specialised services.

Working with:

- ICB teams;
- Other regional NHS England functions as part of a single Multi-Disciplinary Team (MDT) (e.g. pharmacy, medical, nursing, finance, business intelligence, communications etc.);
- Regional and National NHS England Teams including clinical reference groups;
- Clinical and corporate teams at NHS trusts and other service providers; and
- Cancer Alliances and Specialised Networks

Complaints

All complaints received (on average circa 5-7 per annum across all Specialised services inc retained services) are managed by the Head of Services with input from subject matter experts with clinical and quality review. Complaints will continue to be managed in this way for ICB and NHSE during 24/25.

The team carries out similar functions on behalf of NHS England for the 90 retained services.

The team consists of

Supporting Retained NHSE Functions and Delegated ICB Functions		
Role	**Grade**	**WTE**
Director of Specialised and Collaborative Commissioning	ESM1	*
Senior Programme Director – Specialised Clinical Networks	Band 9	*
Head of Acute Specialised Commissioning	Band 8D	1.00
Commissioning Lead – Acute Services	Band 8C	5.00
Senior Commissioning Manager	Band 8B	6.00
Programme Manager – specialised commissioning	Band 8B	1.00
Senior Neurorehabilitation Case Manager	Band 8B	1.00
Commissioning Manager	Band 8A	3.00
Neurorehabilitation Case Manager	Band 8A	3.00
Contract Manager	Band 7	2.00
Commissioning Officer	Band 6	2.00
Project co-ordinator	Band 6	1.00
Commissioning Support Officer	Band 5	2.00
Business Support Assistant	Band 4	1.00
	Total	**30.00**

*Denotes these posts have wider portfolio responsibilities than for acute specialised services alone.

5.3 Specialised Pharmacy Team

The role of the Specialised Commissioning Pharmacy team is to support clinical and pharmacy colleagues in Trusts, across regions and nationally in optimising the use of medicines, ensuring that high-cost drugs are introduced efficiently and used consistently in line with national clinical commissioning policy. The team work to improve uptake and access to new High-Cost Drugs (HCDs), ensuring that high-cost medicines are prescribed and delivered in the safest, most cost-effective manner. A contact list for the Pharmacy team including which Trusts they support can be found in Appendix 2.

Responsibilities are discharged in line with national service specifications and clinical commissioning policies with responsibility and accountability for the high-cost drugs budget being with NHS England in 2024/25. The team will collaborate with ICBs via the joint working arrangements to optimise the commissioning of high cost drugs.
The core functions of the Pharmacy team to deliver on behalf of the ICBs for delegated service and NHSE retained services are as follows:

- Medicines prescribed/ dispensed in a manner that provides value for money.
- Consistency of application of prescribing policies for HCDs.
- Optimised value for money re medicines and procurement and use.
- Specialised care provided closer to home with improved quality of life for patients with longer term conditions.
- Strategic view of medicines related issues.
- Efficient use of resources

Working with:

- Acute Trusts and Providers
- Regional ICB and Trust Pharmacy Leads
- Colleagues within Commissioning Team MDT
- NHSE National and Regional teams

The team consists of

Supporting Retained NHSE Functions and Delegated ICB Functions		
Role	**Grade**	**WTE**
Director of Specialised & Collaborative Commissioning	ESM1	*
Head of Pharmacy Commissioning (Midlands)	Band 8D	1.00
Senior Pharmacy Lead – Midlands	Band 8C	1.00
Pharmacy Programme Manager	Band 8B	3.00
Pharmacy Analyst (Midlands)	Band 7	2.00
	Total	**7.00**

*Denotes these posts have wider portfolio responsibilities than for acute specialised services alone.

5.4 Specialised Finance Team

The Commissioning Finance Team is responsible for working in partnership with all elements of the commissioning directorate to support ICB delegated acute services and NHSE retained services.

The team has wider responsibilities across Acute Specialised Commissioning, Specialised Mental Health and Learning Disabilities, Offender Personality Disorder Service and Health and Justice commissioning portfolios.

The core finance functions are as follows:

- Financial Planning
    - Lead on national allocations processes for all commissioned services – both delegated and non-delegated for 2024/25, ensuring all adjustments are validated and attributed to system population level.
    - Ensure planning methodologies (eg ERF, Needs Based Proposals) are checked and challenged through national finance forums nationally and communicated locally.
    - Support local planning arrangements and engagement both internally and with ICBs to support contract management (in compliance with SOP), negotiation and risk provision.
- Payments
    - Lead all payments to NHS and non-NHS providers in compliance with Standard Financial Instructions/Standing Orders and the agreed Scheme of Delegation. This includes the submission of the monthly payment file and working with Corporate Finance functions to deliver compliance.
- Payment System Engagement
    - Engage at a national level of payment system reform and application. It is the local expertise on the application of Payment Systems and will provide expert advice to Provider business cases and service development proposals.
- Cash Management
    - Co-ordination of all cash requirements for Delegated and Retained Specialised Services
- Budget Management
    - Ensure budgets fully reflect planning assumptions and are phased appropriately in accordance with Best Financial Management Practice for all services including delegated.
- Financial Reporting
    - Maintain robust ledger accounting in accordance with agreed timetables to comply with local and national guidelines to ensure assurance over the accuracy of ledger reporting and finance information for both reporting groups both nationally, regionally and at ICB level.
    - Ensure internal controls for processes are resilient and audit compliant and in accordance with SFIs.
- Investments
    - Provision of expert technical advice to ensure all service proposals are reviewed and approved in accordance with due processes.
- Provision of support to internal and external meetings across MDT Commissioning, Nationally and regionally across all commissioned services.
- Support of ongoing development to Delegation process and workstreams nationally on behalf of Midlands region.

The core functions the team deliver on behalf of partners is as follows:

Financial Management, Financial Planning, Financial Reporting, Audit Compliance, National, System and Provider level engagement

Working with:

- ICB Specialist Networks
- NHS trusts and other service providers
- National and Regional NHS England directorates

The Midlands Specialised Commissioning portfolio consists of Acute and Mental Health services along with management of the associated high-cost drugs and devices allocations and Operational Deliver Networks (ODN) budgets.

The population-based split of allocations relating to service budgets has been adopted in 2023/24 reporting. This will be expanded further in 2024/25 to cover the total allocations including any reserves and contingency.

The Finance team for Specialised Services consists of:

Supporting Retained NHSE Functions and Delegated ICB Functions		
Role	Grade	WTE
Director of Commissioning Finance	ESM 1	*
Deputy Director of Finance Specialised Commissioning	Band 9	1.0
Assistant Director of Finance	Band 8D	2.0
Assistant head of Finance	Band 8C	2.0
Senior Finance Manager	Band 8B	2.0
Finance Manager	Band 8A	3.0
Finance Officer	Band 7	1.0
Finance Support	Band 5	2.0
Finance Support	Band 4	1.0
Finance Assistant	Band 2	2.0
	Total	**16.0**

* Denotes these posts have wider portfolio responsibilities than for acute specialised services alone.

The finance team is responsible for all Specialised Commissioning finance including non-acute and retained services.

5.5 Specialised Services Clinical and Quality Team

The Clinical and Quality team are responsible for managing quality in relation to all specialised services in line with the national Quality Framework for Specialised Services 2024/25, on behalf of ICBs for delegated services and NHSE for retained services.
They operate in accordance with the Midlands Quality Assurance Framework, the National Quality Board's (NQB) National Guidance on Quality Risk Response and Escalation in Integrated Care Systems (NQB 2022) and 'A Shared Commitment to Quality' (NQB 2020) and align to the following agreed principles:

- Integration with NHSE/ICB regional governance
- Clear lines of accountability and escalation for each stage of the quality assurance process
- Share intelligence in an open, timely way.
- Proactively monitor and follow up on early warning signs.
- Agree responsibilities, accountabilities, and governance routes, taking a system-led approach where possible, at all stages of the process.
- Monitor and mitigate future risks.
- Commitment to drive quality improvement through ongoing learning and development.

The core functions the quality team deliver to support delivery of the statutory quality duties are as follows:

- Reviewing the data on the quality of acute specialised services e.g. Specialised Services Dashboards, and triangulation with wider data sources and metrics.
- Identification & management of quality risks using agreed governance and escalation mechanisms.
- SME input into the incident oversight process in line with PSIRF and the management of complaints.
- Provision of clinical and professional advice and support for commissioning managers and clinical and quality teams.
- Support quality improvement & transformation, reduce unwarranted variation, including national & regional programmes, Midlands Quality Surveillance & Improvement Framework.

Working with:

- Formal Operational Delivery Networks (ODNs) & Informal Clinical Networks
- Regional and national teams - Commissioners, national quality group for specialised services, Clinical Reference Groups (CRGs), System Teams, Subject Matter Experts (SMEs), ASC pharmacy team
- ICB Quality Teams, Provider Trusts

The Specialised Services Clinical and Quality team consists of

Supporting Retained NHSE Functions and Delegated ICB Functions		
Role	**Grade**	**WTE**
Regional Medical Director - Commissioning	ESM1	*
Deputy Director of Nursing & Quality	Band 9	*
Assistant Director of Nursing & Quality: Acute SC	Band 8D	1.00
Head of Clinical Quality Reviews: Specialised Commissioning	Band 8C	1.00
Head of Quality: Acute Specialised Commissioning	Band 8C	1.00
Senior Quality Officer	Band 7	1.00
Quality Officer	Band 6	2.00
	Total	**6.00**

*Denotes these posts have wider portfolio responsibilities than for acute specialised services alone.

5.6 Business Intelligence & Analytics Team

The Commissioning Business Intelligence & Analytics functions provide analytical support across the commissioning portfolio. The team is led by NHSE employed BI and Analytics staff with most of the team's analytical capacity and capability being supplied by Arden and GEM CSU through a nationally held and agreed contract. This contract will remain in place for 2024/25 and will be reviewed during that time in collaboration with NHSE regional commissioning team and the ICBs. The core functions are as follows:

- Act in with accordance and the delivery of the NHS Long Term Plan specifically pertaining to Specialised and Direct Commissioning within NHSE Midlands Region;
- Support commissioning through the development of insight-based analytics including planning, performance, assurance, and oversight of regional delivery against annual Operational Planning.

- Provide population health-based analysis to deliver improved outcomes for patients and ensure wider management of pathways of care.
- Deliver a high-quality integrated commissioning BI function which is reflective of, and responsive to the needs of delegated and retained commissioning teams within the Midlands.
- Support the NHSE national team in identifying and delivering data and analytics strategic priorities in preparation for delegation of specialised services, reflective of regional priorities in the Midlands.
- Collaborate effectively in creating an efficient workforce model to deliver a BI service that is responsive to changing needs.

The core functions the team deliver on behalf of partners is as follows:

- Performance and assurance for commissioning programmes
- Data Quality
- AIVs and Challenges
- Planning and Priority Setting
- Demand and Capacity

Working with:

- ICBs
- Specialist Networks
- External Data Providers i.e. Academic Health Science Provision
- NHS trusts and other service providers
- Department of Health and Social Care
- National NHS England directorates

The team consists of

Supporting Retained NHSE Functions and Delegated ICB Functions		
Role	**Grade**	**WTE**
Head of Planning and Decision Support	Band 9	*
Head of Data and Information	Band 8D	*
Senior Planning Manager	Band 8B	*
	Total	*

*Denotes these posts have wider portfolio responsibilities than for acute specialised services alone.

5.7 Specialised Networks

The core functions include:

- Lead major programmes (i.e. currently paediatric sustainability and neonatal cot configuration) which include specialised networks.
- Oversight of programme delivery across 24 networks
- Risk management and operational delivery/transactional change success via network work programmes
- Engagement with key stakeholders is effective, timely and useful.
- Improving network board functionality.

The team consists of

Supporting Retained NHSE Functions and Delegated ICB Functions

Role	Grade	WTE
Senior Programme Manager – Integrated Commissioning	Band 9	*

*Denotes these posts have wider portfolio responsibilities than for acute specialised services alone.

The role of the Programme Director is to:

- Develop and deliver the strategy for acute specialised networks.
- Provide subject matter leadership to network leadership teams which are imbedded in provider organisations.
- Oversee the collaborative development of network work programmes.
- Lead the Collaborative Clinical Executive Forum, securing regional clinical engagement into the key strategic decisions made by the Acute Specialised Commissioning Team.
- Support the development of Acute Provider Collaboratives including, but not limited to EMAP and WMAP.
- Develop systems for clinical quality assurance and responsiveness when it involves specialised clinical networks.

5.8 Regional Communications and Engagement Team

The role of the Regional Communications and Engagement team is to:

- Develop communications strategies and plans around individual services – new services, changes to services or closures of services – working together with specialised operating teams, relevant ICB and provider/s.
- Engage with stakeholders and patient groups around these services.
- Brief relevant ICB and NHS colleagues
- Hold regular meetings with ICBs and providers as well as having mechanisms for cascading news and materials from national teams.
- Promote the work of specialised services within ICBs and NHS England through internal mechanisms.
- Manage any media queries, liaising with specialised team and provider and gaining approval from ICB communications.
- Develop any proactive activity such as media releases, social media, or stakeholder materials with approval from ICB communications teams.
- Share newsletters and regional updates with system ICB communications leads.
- Update and maintain regional NHSE web pages for any information relevant to specialised services.
- ICB & NHSE responsibilities in relation to the duty to consult with patients and the public under section 13Q can be found in Appendix 3

The core functions the team deliver on behalf of partners is as follows:

- Handling of Media queries
- Development of materials such as press releases, social media, and stakeholder briefings.
- Development of internal news stories
- Advice on stakeholder and patient engagement
- Managing stakeholder and patient consultations

Working with:

- ICBs
- Specialised Networks
- NHS trusts and other service providers
- NHS England national and regional directorates

The team consists of

Supporting Retained NHSE Functions and Delegated ICB Functions		
Role	**Grade**	**WTE**
Regional Communications and Engagement Lead	Band 8C	1.0*
Communications Manager	Band 7	0.8*
	Total	**2.00***

*Denotes these posts have wider portfolio responsibilities than for acute specialised services alone.

6. Costs and Liabilities

6.1 Costs

During the 2024/25 transitional year where NHS England will continue to employ all staff and functions that support the 59 delegated services.
The costs associated with the provision of the Administrative and Management Services set out in section 5 by the Specialised Services Multi-disciplinary team shall not be included within the Delegated Funds allocated or transferred to the ICBs for 1st April 2024 to 31st March 2025 and that NHS England shall meet those costs.

6.2 Liabilities

NHS England shall be liable for any losses arising out of negligent acts or omissions in respect of the provision of Administrative and Management Services except where such losses arise as a result of action taken in accordance with instruction from any ICB or a failure of an ICB to provide on request appropriate instruction.

NHS England will meet the liabilities as a result of:

- Death or personal injury caused by its negligence.
- Fraud
- Fraudulent misrepresentation

7. Learning and Development

7.1 MaST training and professional development

The costs associated with the provision of agreed ongoing learning and development including mandatory (MaST) training for the Specialised Services Multidisciplinary team will be met by NHSE.

100% compliance is required by all staff for the MaST training detailed below:

Equality, Diversity and Inclusion

As part of the system leadership arrangements for the NHS, we recognise the importance of becoming a role model for the rest of the NHS in respect of issues relating to equality, diversity, and inclusion in the workplace.

Fraud Awareness
This course focuses on providing you with awareness of the key aspects of fraud and corruption in the NHS and help you know your responsibilities to combat it.

Data Security Awareness
This course focuses on the importance of data security in health and social care. It will help you understand how to comply with the law, define potential threats and how to identify and avoid breaches.

Health and Safety
This course focuses on health and safety in the workplace. You will gain an understanding for responsibilities under Health and Safety Law, different types of safety signage, basic fire safety principle, basic moving, and handling techniques and why incident reporting is so important.

Safeguarding Children & Adults at Risk of Harm or Abuse
This course introduces safeguarding children and adults at risk of harm or abuse. It focuses on safeguarding in the NHS, data sharing, domestic abuse, and associated legislation as well as what you can do when raising a concern.

Records Management
This course introduces you on the importance of records management, legal and contractual requirements, and guidance on how to keep information secure.

Patient Safety
This course introduces patient safety for all NHS staff. It focuses on the essentials for creating patient safety and helps recognise that the NHS is a system of essential and interconnected parts; a team with a common goal.

7.2 Dynamic Conversations

NHSE will meet all costs and requirements of ensuing all members of the Specialised Services Multi-disciplinary team have regular performance and development through regular Dynamic Conversations.

Dynamic Conversations are an opportunity for both line managers and team members to have meaningful, fluid, and organic 1:1s. Dynamic Conversations put wellbeing at the forefront of initial conversations and will help to support colleagues through change.

NHSE will ensure that monthly 1:1s with line managers are regularly scheduled.

8. Escalations, FoI & Incident Management

8.1 Freedom of Information and Parliamentary Requests

All Freedom of Information and Parliamentary Requests relating to Delegated Services should be forwarded to the Multi-Disciplinary Team will ensure the appropriate handling, management, and response, ensuring where appropriate that ICBs are informed and engaged. The team will also ensure they provide reasonable support to ICBs in responding to freedom of information and parliamentary correspondence as required.

8.2 Incident Response and Management

The Multi-Disciplinary Team shall provide such reasonable support as required by an ICB in relation to local incident management for Delegated Specialised Services.

8.3 Provider Selection and Procurement

The Multi-Disciplinary Team shall act on instructions from the ICBs in relation to provider selection and procurement processes for the Delegated Specialised Services.

8.4 Escalations

If an ICB has cause to raise concerns regarding the performance, actions or conduct of a member of the Multi-Disciplinary Team the ICB will in the first instance contact by email the Director of Specialised & Collaborative Commissioning, who will where possible provide an acknowledgement within 7 days of receipt.

The Director of Specialised & Collaborative Commissioning will provide the ICB with feedback and action taken with 30 days.

If for any reason the ICB is unhappy with the response the concerns can be escalated to the NHS England Regional Director of Commissioning

9 Confidential information

The ICBs and NHSE shall always use its best endeavours to keep confidential and ensure that its employees and agents keep confidential any information in relation to the business and affairs of another Partner.

If the information referred to herein is subject to a freedom of information (FOI) or other request to share the data, then NHS England will be responsible for the fulfilment of the request, but will seek views from the ICBs before undertaking this in accordance with the Freedom of Information Code of Practice issued by the Cabinet Office under section 45 of the Freedom of Information Act 2000.

The ICBs and NHSE will not make any press announcements about this Agreement or publicise this Agreement or any of the terms in any way. The ICBs and NHSE shall ensure that any such information disclosed is solely for the purpose of performing its obligations under this Agreement.

10 Finance

10.1 Scope

Schedule 4 of the ICB Collaboration Agreement provides detail of the approach to risk sharing and other financial arrangements, this section specifies how the Specialised Commissioning Finance Team within the Multidisciplinary Team will operate on behalf on the ICBs during 2024-25.

10.2 Multidisciplinary Team – Specialised Commissioning Finance Team

The role, functions and staffing model of the Specialised Commissioning Finance Team within the Multidisciplinary Teams is described in section 5.4 above. The team will aim to work on behalf of and in partnership with ICBs on financial planning and allocations, contract finance, financial management including risk management, financial reporting, financial control and cash management.

The team will also support NHSE Midlands on retained services and work with the National Finance Team to support future delegations. The team will continue to work across Midlands ICBs to ensure the maintenance of an efficient and effective service across both delegated and retained specialised services.

The Specialised Commissioning Finance Team will support other functions within the Multidisciplinary Team covering planning, service reviews and provider performance issues. For 2024/25, work with ICB and providers will be enhanced to extend existing arrangements covering contract arrangements, financial reporting, and risk management, building on the current finance, contracts and operational steering groups.

10.3 Multidisciplinary Team – Discretion relating to finances.

The issues of scope and limitations to decision making are addressed specifically in schedule 4 of the Collaboration Agreement

Historic investment decisions have been reviewed to ensure that the suggested limits would be operationally appropriate in respect of:

- The approval limits across systems and by MASCG
- Contract Awards
- Purchase Requisitions, Invoices and Non-Purchase Orders
- Budget virements

10.4 Multidisciplinary Team – Making payments in accordance with contracts.

The arrangements for making payments in accordance with contracts has been outlined as part of the delegation arrangements in the Cashflow SOP. NHS England will engage with ICBs to share contract payment schedules for NHS and Non-NHS providers linked to Contracting SOP.

The team will also be responsible for:

- Engagement to ensure supplier payment information is current and inclusive.
- Production of timetable for monthly activities shared and aligned with ICB officers.
- Operation of Financial Limits agreed in line with SFI's by ICB CFOs.
- Specific arrangements for monthly sign reporting sign offs and contract adjustments.
- Detail of ERF adjustments.

10.5 Multidisciplinary Team – Expectation in relation to financial reporting

The development and engagement between Specialised Commissioning Finance Team and ICBs in respect of Financial Reporting will be conducted through the East and West Midlands Joint Committees' formal Finance Sub-Group. This will include;

- Allocations for 59 delegated specialised services would be made to the eleven ICBs in the Midlands.
- ICBs would transfer allocations for the commissioning of these specialised services to the identified host ICB.
- The Specialised Commissioning Finance Team would manage specialised services through the host ledger managing financial risk across all eleven ICBs.
- All contractual payments would be managed by the Multidisciplinary Team through the single joint Specialised Commissioning contract (see Contracting SOP).
- In-year financial management would be undertaken at a multi-ICB level, mitigating the risk of variation between systems.

- Regional financial variances (under or overspend) would be mitigated through a contingency held by the host to minimise exposure to financial fluctuation as part of the risk sharing agreement.
- ICB level in-year financial reporting would show contributions to the pool in the ICB position thereby demonstrating a break-even position for specialised commissioning on monthly financial reports.
- Performance reporting would be developed at an ICB and multi ICB level to enable local intelligence on performance in these services.
- The Specialised Commissioning Finance Team would prepare finance reports at organisational level to ensure all ICBs have full sight of the overall actual performance of specialised commissioning and indicative ICB level performance.
- Residual variances after mitigations would be allocated to ICBs based on contributions to the pool.
- Adjustments will be made to timescales agreed through the Finance sub-group.

10.6 Multidisciplinary Team – Dispute process in relation to activities undertaken.

In the event of a dispute relating to finance or the activities undertaken by the Specialised Commissioning Finance Team, the following escalation routes will apply;

- Address with NHS England Senior Finance Leads through to Director of Commissioning Finance
- Escalation to Finance Subgroup
- Further escalation to Joint Committees

10.7 Multidisciplinary Team – Access to ledgers

ICB CFOs will be required to approve access to ICB ledger to assure internal controls and processes. In addition, validation of ledger codes for specialised services, together with confirmation of supplier codes prior to the commencement of 2024/25 on each of the ICB ledgers will be required.

Appendix 1 – Contract Leads for NHSE Specialised Contracts

Area	ICB	Provider	Provider Acronym	Provider Code	Contract Lead	Escalation lead
East	Derby and Derbyshire	University Hospitals of Derby and Burton	UHDB	RTG	Nick Hey	Nick Hey
East	Derby and Derbyshire	Chesterfield Royal Hospital NHS Trust	CRH	RFS	Nick Hey	Nick Hey
East	Leicester, Leicestershire and Rutland	University Hospitals of Leicester NHS Trust	UHL	RWE	Steph deCelis	Dom Tolley
East	Lincolnshire	United Lincolnshire Hospitals NHS Trust	ULHT	RWD	Nick Hey	Nick Hey
East	Lincolnshire	Lincolnshire Community Health Service NHS Trust	LCHS	RP7	Dawn Newman	Nick Hey
East	Northamptonshire	Kettering General Hospital NHS Trust	KGH	RNQ	Steph deCelis	Dom Tolley
East	Northamptonshire	Northamptonshire General Hospital Trust	NGH	RNS	Steph deCelis	Dom Tolley
East	Nottingham and Nottinghamshire	Nottingham University Hospitals NHS Trust	NUH	RX1	Nick Hey	Nick Hey
East	Nottingham and Nottinghamshire	Sherwood Forest Hospitals NHS Trust	SFHT	RK5	Dawn Newman	Nick Hey
West	Birmingham and Solihull	Birmingham Community Healthcare NHS Trust	BCHC	RYW	Nikita Panesar	Leila Marchant
West	Birmingham and Solihull	Birmingham Women's and Childrens Hospital NHS Foundation Trust	BWCH	RQ3	Sarah Simkins	Sumana Bassinder
West	Birmingham and Solihull	Royal Orthopaedic Hospital NHS Foundation Trust	ROH	RRJ	Leila Marchant	Sumana Bassinder
West	Birmingham and Solihull	Sandwell and West Birmingham Hospitals NHS Trust	SWBH	RXK	Leila Marchant	Sumana Bassinder
West	Birmingham and Solihull	University Hospital Birmingham NHS Foundation Trust	UHB	RRK	Leila Marchant	Sumana Bassinder
West	Coventry and Warwickshire	University Hospitals Coventry and Warwick NHS Trust	UHCW	RKB	Emma Partridge	Laura Morris
West	Coventry and Warwickshire	South Warwickshire Foundation Trust	SWFT	RJC	Jasmeet Najran	Emma Partridge
West	Coventry and Warwickshire	George Eliot Hospital NHS Trust	GEH	RLT	Jasmeet Najran	Emma Partridge
West	Coventry and Warwickshire	Coventry and Warwickshire Partnership Trust	CWPT	RYG	Maria Muro	Emma Partridge
West	Herefordshire and Worcestershire	Worcestershire Acute Hospitals NHS Trust	WAHT	RWP	Nick Hey	Nick Hey
West	Herefordshire and Worcestershire	Wye Valley NHS Trust	WVT	RLQ	Maria Muro	Emma Partridge
West	Shropshire, Telford and Wrekin	Shrewsbury and Telford Hospitals NHS Trust	SATH	RXW	Jasmeet Najran	Emma Partridge
West	Shropshire, Telford and Wrekin	Robert Jones Agnes Hunt Foundation Trust	RJAH	RL1	Jasmeet Najran	Emma Partridge
West	Staffordshire and Stoke on Trent	University Hospital of North Midlands NHS Trust	UHNM	RJE	Emma Partridge	Laura Morris
West	Staffordshire and Stoke on Trent	Midland Partnership	MPFT	RRE	Maria Muro	Emma Partridge
West	The Black Country	The Dudley Group of Hospitals NHS Foundation Trust	DGOH	RNA	Nikita Panesar	Leila Marchant
West	The Black Country	The Royal Wolverhampton NHS Trust	RWHT	RL4	Leila Marchant	Sumana Bassinder
West	The Black Country	Walsall Healthcare NHS Trust	WHT	RBK	Leila Marchant	Sumana Bassinder

Appendix 2 – Specialised Pharmacy Contacts

ICB	Provider	Pharmacist Lead	Pharmacy Analyst Lead
Birmingham and Solihull	University Hospitals Birmingham NHS Foundation Trust	Susanna Allen	Jeetender Dhap
Birmingham and Solihull	Birmingham Women's and Children's Hospital NHS Foundation Trust	Susanna Allen	Emma Shannon
Birmingham and Solihull	Royal Orthopaedic Hospital NHS Foundation Trust	Anand Mistry	Jeetender Dhap
The Black Country	Royal Wolverhampton Hospitals NHS Trust	Anand Mistry	Jeetender Dhap
The Black Country	The Dudley Group of Hospitals NHS Foundation Trust	Dhiren Bharkhada	Emma Shannon
The Black Country	Walsall Healthcare NHS Trust	Anand Mistry	Jeetender Dhap
The Black Country	Sandwell and West Birmingham Hospitals NHS Trust	Anand Mistry	Jeetender Dhap
Coventry and Warwickshire	University Hospitals Coventry and Warwickshire NHS Trust	Anand Mistry	Jeetender Dhap
Coventry and Warwickshire	South Warwickshire NHS Foundation Trust	Dhiren Bharkhada	Jeetender Dhap
Coventry and Warwickshire	George Eliot Hospital NHS Trust	Dhiren Bharkhada	Jeetender Dhap
Coventry and Warwickshire	Coventry and Warwickshire NHS Partnership Trust	Anand Mistry	Emma Shannon
Herefordshire and Worcestershire	Worcestershire Acute Hospital NHS Trust	Anand Mistry	Emma Shannon
Herefordshire and Worcestershire	Wye Valley NHS Trust	Anand Mistry	Jeetender Dhap
Shropshire, Telford and Wrekin	Shrewsbury and Telford Hospitals NHS Trust	Dhiren Bharkhada	Emma Shannon
Shropshire, Telford and Wrekin	Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Trust	Anand Mistry	Emma Shannon
Staffordshire and Stoke-on-Trent	University Hospitals North Midlands NHS Trust	Dhiren Bharkhada	Jeetender Dhap
Staffordshire and Stoke-on-Trent	Midlands Partnership Foundation Trust	Anand Mistry	Emma Shannon
Derbyshire	Chesterfield Royal Hospital NHS Foundation Trust	Anand Mistry	Emma Shannon
Derbyshire	University Hospitals Derby and Burton	Dhiren Bharkhada	Jeetender Dhap
Nottinghamshire	Nottingham University Hospitals NHS Trust	Susanna Allen	Emma Shannon
Nottinghamshire	Nottingham Treatment Centre	Dhiren Bharkhada	Jeetender Dhap
Nottinghamshire	Sherwood Forest Hospitals NHS Foundation Trust	Dhiren Bharkhada	Jeetender Dhap
Lincolnshire	Lincolnshire Community Health Services NHS Trust	Anand Mistry	Emma Shannon
Lincolnshire	United Lincolnshire Hospitals NHS Trust	Anand Mistry	Emma Shannon
Leicester, Leicestershire and Rutland	University Hospitals Leicester	Dhiren Bharkhada	Jeetender Dhap
Northamptonshire	Kettering General Hospital NHS Foundation Trust	Dhiren Bharkhada	Jeetender Dhap
Northamptonshire	Northampton General Hospital NHS Trust	Dhiren Bharkhada	Emma Shannon
Northamptonshire	Northamptonshire Healthcare NHS Foundation Trust	Anand Mistry	Jeetender Dhap

Appendix 3: Fulfilling statutory duties (13Q) & Communications & Engagement

Introduction

The delegation of 59 specialised services to ICBs will mean some changes in the way communications and engagement are handled. This document aims to clarify the roles and responsibilities after delegation of this initial groups of 59 services in April and before planned transfer of staff in April 2025.

General principles

Each ICB will be responsible for communications and engagement for the 59 delegated specialised services within its own system.

In this transitional year, the existing commissioning communications team of Communications and Engagement Lead and Communications Manager will continue to manage activity for the 59 delegated services, working with the existing operating teams, and reporting to the relevant ICB or ICBs.

The regional NHS Midlands media team will retain responsibility for matters where there is a risk to NHS reputation – for instance if the impact is significant or wider than one joint committee (East and West).

Full details of specialised services contacts in comms and engagement and in the operational teams will be shared.

Reactive media enquiries

Media enquiries will be flagged to communications team and with ICB and specialised operating team. Providers may be liaised with, and ICB communications will be kept informed by NHSE communications team. The ICB/s will approve the final planned response (they may choose to deliver the response if they wish).

Proactive activity

National activity will be cascaded via the NHS Midlands communications team to all ICBs individually – for instance new treatments.

Individual activity around services will be undertaken by the NHSE communications team working with the operational team and provider and reporting into ICB communications teams.

Healthwatch and engagement

Responsibility for engagement with Healthwatch groups and other system-wide stakeholders will be treated as follows:

- Individual services at trusts will be carried out by providers with approvals from ICBs – for instance location changes; changes in service levels
- Region-wide services (e.g. renal services; paediatric reviews) will be carried out by NHSE communications with prior approval from ICBs

NHS England in the Midlands will include region-wide news regarding access to services, investment, healthcare trends etc in updates to MPs, DsPH etc but ICBs will be informed and involved in each instance.

Patient and stakeholder engagement to fulfil statutory duties (13Q)

NHS England will be responsible for ensuring statutory duties are met.

NHSE communications team will liaise with specialised operating team and providers to ensure that engagement and consultation activity is being undertaken whenever necessary.

NHSE communications team will report to ICB communications and to the NHS England national team as part of the six monthly reporting duties.

HOSC

Specialised operating teams are sometimes required to liaise with HOSCs.

If this arises in the period to April 2025, ICB communications teams will be informed and involved.

Service Profile Pack Shropshire, Telford & Wrekin ICB

Midlands Specialised Delegation Programme

Date of issue: MAR 2024

Introduction

This service profile pack contains essential high-level information regarding the 59 specialised services being delegated to your ICB on the 1st April 2024. It has been co-designed by ICB and NHSE representatives from the Clinical & Quality workstream of the Midlands Specialised Delegation Programme and provides some examples of the clinical case for change and how delegation will better support better services for patients. It includes information about the services that are being delegated, where they are being provided, the volume of current activity and the planning priorities for 2024/25.

A suite of service profiles containing details of clinical outcomes, patient safety concerns and workforce challenges will be available at the time of delegation. The service profile for Vascular Services is included as an example.

Dr Colette Marshall
Regional Medical Director of Commissioning, NHS England

Dr Clara Day
Chief Medical Officer, BSOL ICB

Sally Roberts
Chief Nursing Officer, Black Country ICB

Dr Nil Sanganee
Chief Medical Officer, LLR ICB

Kay Darby
Chief Nursing Officer, LLR ICB

Contents

1. Case for Change

Why delegate specialised services?

What should this mean for our patients, populations and their communities?

ICBs and providers to have **freedom to design services and to innovate** in meeting the national standards where they take on delegated or joint commissioning responsibility

ICBs and providers able to **pool specialised budget and non-specialised budgets** to best meet the needs of their population, tackle health inequalities and to join up care pathways for their patients

ICBs and providers able to use world class assets of specialised services to **better support their communities closer to home** (e.g. designing local public health initiatives, greater diagnostics and screening)

Quality of patient care

Patients will receive more **joined up care** – better communication and sharing of information between professionals and services.

More of a **holistic, multi-disciplinary approach** to care. A range of professionals can be involved in planning a patient's care.

Increase focus and investment on **prevention**.

Patients will receive the **right care at the right time in the right place**.

Better **step-down care** to support patients who are ready to leave specialised care.

Equity of access

Population based budgets means decisions on spend are based on the **needs of a local population** – the demographics, health behaviours etc rather than on activity in hospitals.

Specialised clinical expertise will have a role in managing population health and to **challenge underlying drivers of health inequalities**.

Providers and professionals working collaboratively, free from organisational constraints and commissioning boundaries, will help improve **quality of care and tackle unwarranted variation**.

Opportunity to **level up access across the country**

Value

Investment in preventative care could **reduce demand** for specialised services.

Providers and professionals can **better manage patient demand**, even when one part of the system becomes stretched. Patients can be re-directed or transferred so they have faster and better access to treatment

A whole system approach creates opportunities **to protect and build 'workforce resilience'**, as shown during the pandemic.

Pooled/delegated budgets allow **underspends to be shared or reinvested** and avoids commissioning pressures on any one organisation.

- Accessible care
- Tailored care
- Seamless care
- Effective care
- Preventative care

Case study examples of benefits are included in Appendix A.

2.Contracted Delegated Services by Provider

Contracts Overview

- The contract portfolio for Specialised Services in the Midlands in 2023/24 includes
  - 27 Main NHS Provider Contracts
  - 2 NHS Standalone Service Contracts
  - 4 Standalone Independent sector Contracts
- These contracts are currently managed for NHS England by the Midlands Acute Specialised Commissioning (MASC) Team
- Following the delegation of the 59 Specialised Services in April 2024, the MASC Team will continue to manage these contracts on behalf of the 11 ICBs for delegated services and on behalf on NHSE for retained services.

- **The next slide contains a list of which delegated specialised services are provided by Trusts within the Shropshire, Telford & Wrekin system.**

- **Further details including the following contact details is available in Appendix 1.1;**
  - Commissioning Lead
  - Contract Manager
  - Quality Lead
  - Finance Lead

Specialised Services provided by Trust in Shropshire, Telford & Wrekin ICS

Shrewsbury & Telford Hospitals
Adult specialist cardiac services
Adult specialist endocrinology services
Adult specialist renal services
Adult specialist vascular services
Bone conduction hearing implant services (adults and children)
Fetal medicine services (adults and children)
Specialist palliative care services for children and young adults
Radiotherapy services (adults and children)
Specialist cancer services (adults)
Specialist cancer services for children and young adults
Specialist colorectal surgery services (adults)
Specialist endocrinology services for children
Specialist gastroenterology, hepatology and nutritional support services for children
Specialist haematology services for children
Neonatal critical care services
Specialist ophthalmology services for children
Specialist respiratory services for children
Adult Critical Care

Robert Jones & Agnes Hunt
Adult specialist orthopaedic services
Complex spinal surgery services (adults and children)
Specialist gynaecology services for children
Specialist neuroscience services for children
Specialist orthopaedic services for children
Specialist rheumatology services for children
Adult Critical Care

3. Activity Data by ICB

Activity Overview

- Specialised Services are delivered to Midlands' patients at Trusts across the Midlands. In addition, some Midlands patients access Specialised Services in Trust outside of the Midlands region.

- Midlands' providers treat patients from the Midlands but also patients from other regions.

- The following slide (Slide 11) gives an overview of these activity flows for patients and providers in the Shropshire, Telford & Wrekin system for Month 1 to 9 of 2023

- Slide 12 aggregates the same information at a regional level and gives an overview of activity flows for patients and providers in the Midlands region for comparison.

Example

NPoC (National Programme of Care (NPoC) Category and Clinical Reference Group (CRG)	Intra Activity	Imported Activity	Exported Activity	Total Activity by Providers in Mid ICB	Total Activity for Patients from Mid ICB	Grand Total
A06 - RENAL SERVICES	39,361	321	2,060	39,682	41,421	41,742

- **Further detail, including a drill-down to individual provider. is available in Appendix 2.1.**

Total Activities for QOC: NHS Shropshire, Telford & Wrekin ICB

Activity Period: M01-M09 2023/24 (Apr 2023 – Dec 2023)

NPoC (National Programme of Care (NPoC) Category and Clinical Reference Group (CRG)	Intra Activity	Imported Activity	Exported Activity	Total Activity by Providers in Mid ICB	Total Activity for Patients from Mid ICB	Grand Total
A06 - RENAL SERVICES	39,361	321	2,060	39,682	41,421	41,742
B03 - SPECIALISED CANCER SURGERY	31,433	198	7,252	31,631	38,685	38,883
B05 - CHILDREN AND YOUNG ADULT CANCER SERVICES	464	0	6,770	464	7,234	7,234
A05 - CARDIOTHORACIC SERVICES	51	-	5,971	-	6,022	6,022
E03 - PAEDIATRIC MEDICINE	1,720	19	4,012	1,739	5,732	5,751
D04 - NEUROSCIENCES	0	-	4,008	-	4,008	4,008
E06 - METABOLIC DISORDERS	0	-	3,822	-	3,822	3,822
E02 - SPECIALISED SURGERY IN CHILDREN	539	29	2,124	568	2,663	2,692
F03 - HIV	0	-	2,138	-	2,138	2,138
D10 - SPECIALISED ORTHOPAEDIC SERVICES	1,243	637	19	1,880	1,262	1,899
E05 - CONGENITAL HEART SERVICES	289	3	1,341	292	1,630	1,633
A04 - VASCULAR DISEASE	1,338	20	134	1,358	1,472	1,492
D06 - SPECIALISED EAR AND OPHTHALMOLOGY SERVICES	193	18	1,207	211	1,400	1,418
E08 - NEONATAL CRITICAL CARE	-	-	1,203	-	-	1,203
B02 - CHEMOTHERAPY	0	0	1,160	0	1,160	1,160
A03 - SPECIALISED ENDOCRINOLOGY	752	13	374	765	1,126	1,139
A02 - HEPATOBILIARY AND PANCREAS	-	-	1,099	-	-	1,099
E04 - PAEDIATRIC NEUROSCIENCES	0	-	838	-	838	838
B01 - RADIOTHERAPY	-	-	835	-	-	835
D01 - REHABILITATION AND DISABILITY	-	-	622	-	-	622
E07 - PAEDIATRIC INTENSIVE CARE	-	-	444	-	-	444
A01 - SPECIALISED RESPIRATORY	0	-	323	-	323	323
D02 - MAJOR TRAUMA	-	-	179	-	-	179
D07 - SPECIALISED PAIN	-	-	168	-	-	168
F06 - SPECIALISED IMMUNOLOGY AND ALLERGY SERVICES / E03 - PAEDIATRIC MEDICINE	0	-	133	-	133	133
A09 - SPECIALISED RHEUMATOLOGY	-	-	132	-	-	132
D03 - SPINAL SERVICES	77	6	28	83	105	111
A08 - SPECIALISED DERMATOLOGY	-	-	81	-	-	81
E09 - SPECIALISED WOMENS SERVICES	7	-	5	-	12	12
A07 - SPECIALISED COLORECTAL SERVICES	2	-	5	-	7	7
F04 - INFECTIOUS DISEASES	0	0	1	0	1	1
Unknown	6	-	62	-	68	68
Grand Total	**77,475**	**1,264**	**48,549**	**78,739**	**126,024**	**127,288**

Total Activities for Midlands Region

Activity Period: M01-M09 2023/24 (Apr 2023 – Dec 2023)

	A	B	C	A+B	A+C	A+B+C
NPoC (National Programme of Care (NPoC) Category and Clinical Reference Group (CRG)	Intra Activity	Imported Activity	Exported Activity	Total Activity by Providers in Mid ICB	Total Activity for Patients from Mid ICB	Grand Total
A06 - RENAL SERVICES	761,379	38,806	37,405	800,185	798,783	**837,589**
B03 - SPECIALISED CANCER SURGERY	723,206	8,546	74,570	731,752	797,776	**806,322**
B05 - CHILDREN AND YOUNG ADULT CANCER SERVICES	332,751	343	2,546	333,094	335,297	**335,640**
A05 - CARDIOTHORACIC SERVICES	225,064	8,465	18,289	233,529	243,353	**251,818**
B02 - CHEMOTHERAPY	190,405	17,030	27,686	207,435	218,091	**235,121**
B01 - RADIOTHERAPY	173,641	3,242	31,152	176,883	204,793	**208,035**
E03 - PAEDIATRIC MEDICINE	156,469	7,358	9,089	163,827	165,558	**172,916**
E06 - METABOLIC DISORDERS	154,286	3,165	401	157,451	154,687	**157,852**
D04 - NEUROSCIENCES	99,651	4,807	26,781	104,458	126,432	**131,239**
E02 - SPECIALISED SURGERY IN CHILDREN	103,670	2,598	11,090	106,268	114,760	**117,358**
E08 - NEONATAL CRITICAL CARE	105,630	1,225	9,172	106,855	114,802	**116,027**
D06 - SPECIALISED EAR AND OPHTHALMOLOGY SERVICES	92,348	1,555	5,811	93,903	98,159	**99,714**
D01 - REHABILITATION AND DISABILITY	45,596	1,068	2,513	46,664	48,109	**49,177**
A02 - HEPATOBILIARY AND PANCREAS	31,850	3,463	4,058	35,313	35,908	**39,371**
E05 - CONGENITAL HEART SERVICES	31,235	917	3,217	32,152	34,452	**35,369**
E04 - PAEDIATRIC NEUROSCIENCES	25,760	425	4,088	26,185	29,848	**30,273**
F03 - HIV	25,665	488	1,529	26,153	27,194	**27,683**
A09 - SPECIALISED RHEUMATOLOGY	23,300	79	2,256	23,379	25,556	**25,635**
A04 - VASCULAR DISEASE	20,593	516	2,420	21,109	23,013	**23,529**
A01 - SPECIALISED RESPIRATORY	15,767	90	4,701	15,857	20,468	**20,558**
A03 - SPECIALISED ENDOCRINOLOGY	17,142	563	2,381	17,705	19,523	**20,086**
E07 - PAEDIATRIC INTENSIVE CARE	13,978	221	2,659	14,199	16,637	**16,858**
D02 - MAJOR TRAUMA	5,499	516	201	6,015	5,700	**6,216**
D03 - SPINAL SERVICES	4,113	296	549	4,409	4,662	**4,958**
A08 - SPECIALISED DERMATOLOGY	3,594	14	1,074	3,608	4,668	**4,682**
F06 - SPECIALISED IMMUNOLOGY AND ALLERGY SERVICES / E03 - PAEDIATRIC MEDICINE	2,640	74	804	2,714	3,444	**3,518**
E09 - SPECIALISED WOMENS SERVICES	2,661	10	117	2,671	2,778	**2,788**
D10 - SPECIALISED ORTHOPAEDIC SERVICES	2,081	460	66	2,541	2,147	**2,607**
F04 - INFECTIOUS DISEASES	120	-	2,202	120	2,322	**2,322**
D07 - SPECIALISED PAIN	812	3	901	815	1,713	**1,716**
A07 - SPECIALISED COLORECTAL SERVICES	970	7	135	977	1,105	**1,112**
Unknown	3,956	93	1,035	4,049	4,991	**5,084**
Grand Total	**3,395,830**	**106,444**	**290,897**	**3,502,273**	**3,686,727**	**3,793,170**

4. Quality Dashboard Overview

Quality Dashboard Overview

The following slides provide the following information on delegated specialised services

- How many units in the Midlands are delivering the service?
- Is the service required to submit data to the Specialised Services Quality Dashboard? (see next slide for definition on an SSQD)
- Is the service supported by an Operational Delivery Network (ODN) or other Clinical Network?
- Is the team aware of any Serious Incidents (Sis) relating to the service?
- Is the team aware of any complaints relating to the service?
- Is the team aware of any CQC reports relating to the service?
- Is the team aware of any other intelligence relating to the service?

Example

Priority	Service	Units	Has SSQD Y/N	Has Network Y/N	Any SIs reported April 2022-present Y/N	Any complaints reported 2021-present Y/N	CQC Reports Y/N	Any other intelligence available on quality of care e.g. Peer Review Visits, national audits, GIRFT reports
1	ACC	61	Y	Y	Y	N	1 UHB	Network Peer Reviews, GIRFT
		There are 61 sites in the Midlands delivering ACC (Adult Critical Care)	There are SSQDs relating to ACC	There is a Network for ACC	There are SIs relating to ACC	There are no complaints relating to ACC	There is a CQC report relating to ACC at UHB	There network peer reviews and a GIRFT report relating to ACC

Specialised Services Quality Dashboard (SSQD)

- SSQDs are designed to provide assurance on the quality of care by collecting information about outcomes from healthcare providers. SSQDs are a key tool in monitoring the quality of services, enabling comparison between service providers and supporting improvements over time in the outcomes of services commissioned by NHS England.

- For each SSQD, there is a list of agreed measures for which data is to be collected. Healthcare providers, including NHS Trusts, NHS Foundation Trusts and independent providers, submit data for each of the agreed measures.

- Each SSQD is ‘refreshed’ with up-to-date outcomes submitted from national data sources, and where necessary healthcare providers, on a quarterly basis. The information provided by the SSQDs is used by NHS England specialised services commissioners to understand the quality and outcomes of services and reasons for excellent performance. Healthcare providers can use the information to provide an overview of service quality compared with other providers of the same service.

Quality Overview Dashboard (1 of 4)

Priority	Service	Total No. of Units in Midlands	Has SSQD Y/N	Has Network Y/N	Any SIs reported April 2022-present Y/N	Any complaints reported 2021-present Y/N	CQC Reports Y/N	Any other intelligence available on quality of care e.g. Peer Review Visits, national audits, GIRFT reports
1	ACC	61	Y	Y	Y	N	1 UHB	Network Peer Reviews, GIRFT
2	Cancer- Chemotherapy	43	Y	Y	Y	N	N	GIRFT
3	Cirrhosis of the liver	36	Y	Y	N	N	N	N
4	Neonatal Care	25	Y	Y	Y	N	N	Network Peer Reviews
5	Cardiology: implantable cardioverter defibrillator (ICD)	17	Y	Y	Y	N	N	National Audit
6	Cardiology: primary percutaneous coronary intervention (PPCI) (Adult)	11	Y	Y	N	N	N	National audit, GIRFT
7	Cardiac MRI	11	Y	Y	N	N	N	National audit, GIRFT
8	In centre haemodialysis: main & satellite units	11	Y	Y	Y	N	N	N
9	Cardiac surgery (Adults)	10	Y	Y	Y	N	N	National Audit, GIRFT
10	Haemophilia (All ages)	10	Y	Y	N	N	N	National Audits
11	Fetal medicine – (West Mids has AIP & Fetal Med)	9	Y	Y	N	N	N	National Audits
12	Cancer: anal	8	Y	Y	N	N	N	National Audits, GIRFT
13	Specialised kidney, bladder, & prostate cancer services	8	Y	Y	Y	N	N	GIRFT
14	Cardiac: electrophysiology & ablation services	7	Y	Y	N	N	N	National Audits, GIRFT
15	Thoracic surgery (adults)	6	Y	Y		N	N	N
16	Hepatobiliary & pancreas (Adult)	6	Y	Y	N	N	N	N
17	Cancer: pancreatic (Adult)	5	Y	Y	N	N	N	N
18	Cancer: malignant mesothelioma (Adult)	4	Y	Y	N	N	N	N
19	Level 3 - Paediatric Critical Care	4	Y	Y	N	N	Y	GIRFT
20	Adult congenital heart disease (ACHD)	2	Y	Y	N	N	N	National Audits, GIRFT(Cardiology)
21	Stereotactic radiosurgery & stereotactic radiotherapy (Intracranial) (All ages)	2	Y	Y	N	N	N	N
22	Testicular cancer	2	Y	Y	N	N	N	GIRFT

Quality Overview Dashboard (2 of 4)

Priority	Service	Total No. of Units in Midlands	Has SSQD Y/N	Has Network Y/N	Any SIs reported April 2022-present Y/N	Any complaints reported 2021-present Y/N	CQC Reports Y/N	Any other intelligence available on quality of care e.g. Peer Review Visits, national audits, GIRFT reports
23	Cancer: Clinical chemotherapy	28	N	Y	N	N	N	N
24	Cancer: chemotherapy ITC	18	N	Y	N	N	N	N
25	Cancer chemotherapy Higher Intensity	14	N	Y	N	N	N	N
26	Renal – assessment & prep for renal replacement therapy	10	N	Y	N	N	N	N
27	Haemodialysis to treat established renal failure	10	N	Y	N	N	N	N
28	Peritoneal dialysis to treat established renal failure	10	N	Y	N	N	N	N
29	Renal dialysis – intermittent haemodialysis & plasma exchange to treat acute kidney injury	10	N	Y	N	N	N	N
30	Level 2 - Paediatric Critical Care	8	N	Y	N	N	I KGH	N
31	Complex spinal surgery (All ages)	8	N	Y	N	N	N	N
32	Paed surgery: surgery (and surgical pathology, anaesthesia & pain)	7	N	Y	N	N	N	N
33	Colorectal: transanal endoscopic microsurgery (TEMS)	7	N	Y	N	N	N	N
34	Specialised HIV services (Adults)	7	N	Y	N	N	N	N
35	Specialised cancer surgery: non-surgical	6	N	Y	N	N	N	N
36	Paed medicine: respiratory	5	N	Y	Y	N	N	N
37	Neurosciences: specialised neurology (Adults)	5	N	Y	N	N	N	N
38	Cardiology: inherited cardiac services (All ages)	5	N	Y	N	N	N	N
39	Neurosurgery: Adults	4	N	Y	Y	N	N	N
40	Brain & other rare CNS tumours	4	N	Y	N	N	N	N
41	Major trauma (Adult)	4	N	Y	Y	N		Network Peer Reviews
42	Specialised services for haemoglobinopathy (All ages): haemoglobinopathies coordinating care centres	3	N	Y	N	N	N	N
43	Major trauma (children)	2	N	Y	Y	N	N	Network Peer Reviews
44	Paed surgery: chronic pain	2	N	Y	N	N	N	

Quality Overview Dashboard (3 of 4)

Priority	Service	Total No. of Units in Midlands	Has SSQD Y/N	Has Network Y/N	Any SIs reported April 2022-present Y/N	Any complaints reported 2021-present Y/N	CQC Reports Y/N	Any other intelligence available on quality of care e.g. Peer Review Visits, national audits, GIRFT reports
45	Specialised immunology (All ages)	13	Y	N	N	N	N	National Audits, GIRFT
46	Vascular disease: arterial	11	Y	N	Y	N	N	National Audits, GIRFT
47	Specialised rheumatology services (Adult)	10	Y	N	N	N	N	GIRFT
48	Haemophilia (All ages)	10	Y	N	N	N	N	National Audits
49	Implantable hearing aids for microtia, bone anchored hearing aids….	7	Y	N	N	N	N	N
50	Paed medicine: rheumatology	7	Y	N	N	N	N	N
51	Specialised complex surgery for urinary incontinence and vaginal prolapse (16yrs & above)	7	N	N	N	N	N	N
52	Colorectal: faecal incontinence (Adult)	6	Y	N	N	N	N	N
53	Interstitial lung disease	6	Y	N	N	N	N	QSIP self-assessment pilot
54	Intestinal failure (Adult)	6	Y	N	N	N	N	N
55	Specialised endocrinology services (Adult)	6	Y	N	N	N	N	N
56	Cystic fibrosis (children)	5	Y	N	N	N	N	N
57	Cystic fibrosis (Adult)	4	Y	N	N	N	N	N
58	Complex disability equipment: prosthetic specialised services (all ages) with limb loss	3	Y	N	N	N	N	N
59	Positron emission tomography – computed tomography (PET CT) (All ages)	3	Y	N	N	N	N	N
60	Cleft lip and/or palate	3	Y	N	N	N	N	N
61	Complex gynae: congenital gynae anomalies (Children 13yrs & above and adults)	4	Y	N	N	N	N	N
62	Fetal medicine (East Midlands don't have network)	3	Y	N	N	N	N	N
63	Specialised resp services (Adult): severe asthma	3	Y	N	N	N	N	N
64	Metabolic disorders (Children)	3	Y	N	N	N	N	N
65	Metabolic disorders (Adult)	1	Y	N	N	N	N	N
66	Adult highly specialist pain management services	1	Y	N	N	N	N	N
67	Spinal cord injuries	1	Y	N	N	N	N	N
68	Complex gynae/female urology: genito-urinary tract fistulae (Girls & women aged 16yrs & above)	1	Y	N	N	N	N	N

Quality Overview Dashboard (4 of 4)

Priority	Service	Total No. of Units in Midlands	Has SSQD Y/N	Has Network Y/N	Any SIs reported April 2022-present Y/N	Any complaints reported 2021-present Y/N	CQC Reports Y/N	Any other intelligence available on quality of care e.g. Peer Review Visits, national audits, GIRFT reports
69	Specialised HIV (Adults)	19	N	N	N	N	N	N
70	Specialised ophthalmology (Paeds)	10	N	N	N	N	N	N
71	Colorectal: transanal endoscopic microsurgery (TEMS) (Adult)	7	N	N	N	N	N	N
72	Paed medicine: gastro, hepatology & nutrition	7	N	N	N	N	N	N
73	Paed medicine: endocrinology & diabetes	6	N	N	N	N	N	N
74	Colorectal: complex IBD (Adults)	6	N	N	N	N	N	N
75	Specialised rehabilitation services for patients with highly complex needs (All ages)	6	N	N	N	N	N	N
76	Specialised allergy services (All ages)	6	N	N	N	N	N	N
77	Specialised dermatology services (All ages)	6	N	N	N	N	N	N
78	Neurosciences: specialised neurology (Adults)	5	N	N	N	N	N	N
79	Paed medicine: respiratory	5	N	N	N	N	N	N
80	Specialised ophthalmology (Adult)	5	N	N	N	N	N	N
81	Specialised orthopaedics (Adult)	5	N	N	N	N	N	N
82	Colorectal: distal sacrectomy (Adult)	4	N	N	N	N	N	N
83	Complex gynae – severe endometriosis	4	N	N	N	N	N	N
84	Paed medicine: haematology	4	N	N	N	N	N	N
85	Specialised ear surgery: cochlear implants	3	N	N	N	N	N	N
86	Complex disability equipment: communication aids	2	N	N	N	N	N	N
87	Metabolic disorders (lab services)	2	N	N	N	N	N	N
88	Environmental control equipment for patients with complex disability (All ages)	2	N	N	N	N	N	N
89	Paed medicine: renal	2	N	N	N	N	N	N
90	Paed medicine: specialised allergy services	2	N	N	N	N	N	N
91	Paed neuroscience: neurology	2	N	N	N	N	N	N
92	Paed medicine: immunology & infectious diseases	1	N	N	N	N	N	N

5. Quality Service Profile
Specialised Vascular (Arterial) Services

(Included as an example of profiles to follow)

Overview of the Quality Service Profiles

The following slides provide an example of the level of information held for each delegated specialised service. This Quality Service Profile for Vascular Services is provided as an example. The full suite of Quality Service Profiles is being prepared to be handed over at the point of delegation.

The following information is included in the Quality Service Profiles

- Which Midlands providers are delivering the service?
- What are the contact values and activity levels used for contract monitoring?
- What site are delivering the service?
- What local intelligence does the commissioning team hold about the service?
- What patient safety information does the quality team hold about the service?
- What information on clinical outcomes does the quality team hold about the service?
- What information on workforce and sustainability does the quality team hold about the service?

Further information in relation to Vascular Services is included in appendices 5.1-5.3.

Specialised Vascular (Arterial) Services - Overview

Eleven (5 East & 6 West) Midlands Providers (Based on 2022/23 and all Points Of Delivery). Values based on SLAM.

			Contract Monitoring Actual Price	Contract Monitoring Actual Activity
Grand Total			£19,530,304	27,310
RJE : UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£2,236,112	4,243
RKB : UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£1,470,165	942
RNA : THE DUDLEY GROUP NHS FOUNDATION TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£89,878	657
RNS : NORTHAMPTON GENERAL HOSPITAL NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£883,025	2,045
RR1 : HEART OF ENGLAND NHS FOUNDATION TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£5,956,526	2,033
RRK : UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£510,404	819
RTG : UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£1,339,425	1,324
RWD : UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£1,271,398	3,552
RWE : UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£1,526,080	4,834
RWP : WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£860,810	827
RX1 : NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£2,681,339	4,047
RXW : THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£705,142	1,987

The 11 Arterial Centres in the Midlands have no, one or more spokes as listed below
(information based on Trust returns to the National Vascular Registry (NVR)):

	Arterial centre (Hub)	Associated Centre (Spoke)
East Midlands	Nottingham University Hospital (Nottingham City Hospital)	Kings Mill (Mansfield)
	University Hospitals Leicester (Glenfield)	
	University Hospitals of Derby and Burton (Royal Derby Hospital)	Chesterfield Royal Hospital
	Northampton General Hospital	Kettering General Hospital
	United Lincolnshire Hospitals (Pilgrim Hospital Boston)	ULHT Lincoln County Hospital
West Midlands	University Hospitals North Midlands (Royal Stoke)	County Hospital Stafford, Leighton Hospital Crewe;
	Shrewsbury & Telford Hospitals (Royal Shrewsbury Hospital)	Princess Royal Telford;
	Dudley Group Hospitals (Russell's Hall)	New Cross Wolverhampton, Manor Hospital Walsall;
	University Hospitals Birmingham (Birmingham Heartlands Hospital)	QE Birmingham, Good Hope Sutton Coldfield, Solihull Hospital, City Hospital Birmingham, Sandwell Hospital
	Worcester Acute Hospitals (Worcester Royal Infirmary);	
	University Hospitals Coventry & Warwickshire (Walsgrave)	George Eliot, Warwick Hospital

Specialised Vascular (Arterial) Services - Overview

The Action on Vascular (AoV) Project Closure Report (2023) using **National Vascular Registry (NVR) data** included a summary of outstanding issues for the Midlands region.

- In 2018, there were 12 vascular Arterial Centres in the Midlands. Following a merger in the **West Midlands**, one centre ceased providing inpatient vascular care – **Queen Elizabeth, Birmingham.** This did not result in a compliant service at **UHB (Heartlands),** with IR staffing and activity levels being low.
- Of the remaining hospitals in West Midlands none is fully compliant. Activity and staffing are low in **SaTH**, activity is low at **Dudley** and **UHCW**, with **Carotid Endartectomy (CEA)** activity low at **UHNM** and finally, **IR** staffing is low at **WAH**.
- There have been no changes in the provider landscape in **East Midlands**. Three hospitals have **acceptable staffing but low activity** - **UHDB (CEA), NUH Abdominal Aortic Aneurysm (AAA)** and **UHL (AAA).** The challenges in **NGH** and **ULHT** have been partially mitigated by the link with **UHL**, but activity and staffing remain low.
- Based on current activity the region could support nine or ten arterial centres (if activity levels in the index procedures fall no further), but current patient flows result in all of the current centres failing to meet minimum activity requirements with the exception of **WAH.**
- Complex aneurysm procedures are currently undertaken at ten centres. Based on current activity the region is unlikely to be able to support more than three centres undertaking this work. Currently only one centre does more than 12 complex procedures per year **(UHB).**

Specialised Vascular (Arterial) Services

The below information is validated data as of 09/01/2024

Patient Safety	
Serious Incidents (consider PSIRF/LFPSE when available)	**Appendix 5.1** Details of two incidents reported between the period of April 2022 – present
Never Events	None identified
CQC Reports	None identified

Workforce & Sustainability	
Workforce/ Recruitment & retention	GIRFT and Vascular Society recommend a minimum of 6 vascular surgeons and 6 Interventional Radiologists providing 24/7 cover in an arterial centre. Recruitment and retention of IR consultants is a challenge nationally and particularly for smaller centres. This can lead to service fragility and challenges in terms of sustainability (see below).
GMC national training survey/ NETS – national education trainees survey	GMC NTS 2023 – no red flags, green flag for regional training in East Midlands (rated significantly better than expected)
Summary of known risks of service/provider organisation	Census data collected in January 2023 as part of the national Action on Vascular Programme highlighted the following: Worcester – low IR staffing (4 consultants) SaTH – 5 surgeons and low IR staffing (3 consultants) UHB – low IR staffing (4 consultants) ULHT – 5 surgeons and low IR staffing (3 consultants) NGH – low IR staffing (3 consultants)
Other Information	None identified

Clinical Outcomes	
Notable examples of high performance / innovation	None identified
Specialised Services Quality Dashboard (SSQD):	**Appendix 5.2** Providers are required to submit; • Quarterly:13 quality indicators • Annually: 3 quality indicators Indicators include activity data for elective and emergency aneurysms, endarterectomy and amputation; as well as morbidity and mortality metrics
Mortality data	Most recent National Vascular Registry report reveals no mortality outliers for the index procedures (aortic aneurysm surgery, carotid endarterectomy, amputation, lower limb revascularisation).
GIRFT	• National rollout of NCIP portal to consultant vascular surgeons is now under way - Getting It Right First Time - GIRFT Published 08 Jan 24 • arterial - Getting It Right First Time - GIRFT
National Audits	• National Vascular Registry State of the Nation report 2023 – HQIP Published: 09 Nov 2023 • Impact of the COVID-19 pandemic on vascular surgery in the UK (NVR) – HQIP Published: 08 Jun 2023
Other information sources (if Applicable)	**Appendix 5.3** Update from NHSE Trauma POC Lead Aug 23, CQUIN - critical limb ischaemia continues. CQUIN08 Revascularisation within 5 Days Objective: Revascularise patients with chronic limb-threatening ischaemia within 5 days, in line with the national standard, to reduce to length of stay, in-hospital mortality rates, readmissions and amputation rates. Target: 45% to 65% Q1 Scores - Specialised Commissioning Incentives Workspace - FutureNHS Collaboration Platform

6. Services currently classified as Enhanced Monitoring or Intensive Support

Overview of the ASC Quality Highlight report

There is an agreed Quality Assurance framework in place to manage risk across the 12 organisations for 2024/25. Clinical and Quality risks are reported when they are at an Intensive Level or an Enhances level surveillance in line with the NQB guidance. During 2023/24 these have been reported to the East and West Joint Committees, which will continue in 2024/25.

There are no services currently at an Intensive Level of surveillance

There are current 3 services that are being delegated that are at an Enhanced level of surveillance. The following slides contain a copy of January's ASC Quality Highlight report. This report is presented to the Midlands Acute Specialised Commissioning Group (MASC) and the East & West Midlands Joint Committees monthly.

The Quality Highlight report details

- Which services which are subject to enhanced monitoring or intensive support
- Any information relating to the issue/concern and its impact
- Any mitigating actions which are being carried out to address the issue/concern
- Any other intelligence received by the quality team that month
- Any learning or best practice to be shared

Acute Specialised Commissioning Highlight Report – West Midlands

Date: 18/01/2024

Key messages

Quality concerns and issues arising in Specialised Services are assessed utilising the NHSE Midlands Quality Assurance Framework and are identified as on Routine, Enhanced or Intensive Surveillance in line with NQB Guidance.

Key Messages					
#	**Concern/Issue** *New or Ongoing and Escalation Level*	**Programme of care /Speciality**	**Organisation & Integrated Care System (ICS)**	**Concern/Issue identified, Description/Impact** *Please include whether this requires **formal escalation** to RQG following discussion at commissioning meetings*	**Proposed mitigation/Action being taken/Key Learning Points**
1	Ongoing – Enhanced Surveillance	Neonatal Services	Dudley Group of Hospitals (DGOH) BLACK COUNTRY ICB	• Baby born at Russell Hall Hospital (RHH) at 30+6 weeks gestation on 30/01/2023. Baby had been treated for suspected necrotising enterocolitis (NEC) conservatively and had progressed to enteral feeds. • On 05/03/2023 the baby deteriorated and transferred to Birmingham Women's & Childrens' Hospital (BWCH) on 06/03/2023 but died on 07/03/2023. Cause of death unascertained at present. • Concerns raised by parents regarding IPC practices • In addition, on 28/09/23 notification received regarding unrelated death where Perinatal Mortality Review had classified as Category D, different management would likely have altered the outcome	• Escalation meeting held 22/03/23 and immediate actions undertaken by the DGOH regarding IPC practices. • A number of IPC assurance visits have been completed by NHSE with ICB. Good progress being made with action plan. • Peer Review Visit undertaken 03/07/23. Full report now signed off and progress with action plan will be monitored. • Serious Incident investigation report received from DGOH and signed off under the SIF process in conjunction with ICB • Results of forensic post-mortem still awaited. • NHSE met to consider information provided by the ODN and wider quality information in relation to the service & following a meeting with the ICB & the trust on 04/10/23, • Quality Improvement Meeting held with trust on 17/11/23. Positive progress noted and a number of supportive actions agreed. Letter sent to trust by CM to confirm these and ongoing monitoring continues. • The ODN will also continue working with the Trust and a neighbouring trust to commence rotation of medical staffing across the units along with other mitigations.

Acute Specialised Commissioning Highlight Report – West Midlands

Date: 18/01/2024

Key Messages					
#	**Concern/Issue** *New or Ongoing and Escalation Level*	**Programme of care /Speciality**	**Organisation & Integrated Care System (ICS)**	**Concern/Issue identified, Description/Impact** *Please include whether this requires **formal escalation** to RQG following discussion at commissioning meetings*	**Proposed mitigation/Action being taken/Key Learning Points**
2	Ongoing – Enhanced Surveillance	Deep Brain Stimulation Service	University Hospitals Birmingham (UHB) BSOL ICB	• Service is currently suspended. External review in 2021 identified a number of actions were required, including review and follow up for several patients, as a pre-condition of consideration of restarting the service. • The findings from the external review have also been the subject of media attention.	•UHB have confirmed completion of the follow up reviews for all but 7 patients, from 3 cohorts who had implantation surgery performed between 1999 and 2016. •Final Report including the outcome from completing all the reviews is being prepared by the Medical Director at UHB but is awaiting review of 3 patients by colleagues who undertook the Independent Review •A T&F Group is undertaking an option appraisal to determine the most appropriate future service model across Midlands.
3	Ongoing – Enhanced Surveillance	Adult Critical Care	University Hospitals Birmingham (UHB) BSOL ICB	• Unannounced CQC focused inspection within Critical Care services at QEH took place in August 2023. Feedback letter on concerns raised around staffing levels, leadership, meds management and equipment sent to trust 29/08/23.	Trust actions plan developed. Assurance oversight in place at the established BSOL ICB System Quality Group meetings which has NHSE representation. Update on progress received from trust at meeting on 1st November. Good progress in a number of areas but further work noted in terms of developing right culture. Further update scheduled end Jan 24.

Acute Specialised Commissioning Highlight Report – West Midlands

INTELLIGENCE SHARING - horizon scanning, trends etc

Neonatal Unit Care
Neonatal care has been agreed as one of the joint NHSE/ICB priority areas and a paper outlining the intentions was previously presented to MASCG and the E & W Joint Commissioning Committees. Linked to the national focus on maternity and the Ockenden review at NUH, as well as in the wake of the Lucy Letby trial, there is significant media attention on neonatal care. Key challenges in neonatal care also include significant staffing challenges in a number of units, plus regional work continues in relation to high neonatal mortality rates. A number of reports have been produced over the last 6 months by N&Q, PH & Commissioning teams based on MBRRACE and local unit data, and action is in progress through the ODNs as well as through each LMNS. Oversight will continue through MASCG, the E & W JCCs as well as through the Regional Perinatal Quality Group which the ICB's also attend.
Work has also begun to develop a combined maternity and neonatal daily Sitrep across the region which will collate the operational position in each unit and system, and also then enable reports to be produced showing trends. The second phase of this work is to agree the key quality outcome metrics for neonatal care that can then be added to the Maternity Heatmap that already exists. An NHSE internal Perinatal Improvement Programme Group has also been established to coordinate actions across all involved directorates which includes specialised commissioners.

University Hospitals Birmingham Neurovascular service:
The MS service in UHB has developed a large backlog of patients requiring treatment with diseasemodifying drugs (approx. 550 patients affected). NHSE has met with the neurology team from UHB to discuss the recovery plan and subsequently has received a written response to some outstanding questions. Progress is slow but recruitment to new positions has commenced which should accelerate progress. NHSE is also in discussion with clinicians regarding starting a formal neurology network regionally. A discussion was also held on 10th January at BSOL SQG in relation to current issues and challenges in the neurology pathway which includes the MS but also the headaches service and potential for a standardised approach to neurosciences using a hub and spoke model. A joint CMO/CEO conversation is planned to discuss opportunities for ICS collaboration to achieve better results for the population and it will then be discussed at a future SQG meeting.

Fetal Medicine Services
There are a number of services in the WM region that have reported capacity issues particularly in the Consultant workforce. Mutual aid conversations continue and is noted on the regional Fragile Services Working Group. Commissioners have also supported a proposal from the Perinatal FM Network to provide a more sustainable model for consultant recruitment

LEARNING AND SHARING - best practice, outcomes

Please share below any examples of positive assurance, good news stories, innovation, lessons learned, best practice, thematic work and intelligence that would be helpful to other regions

N/A

7. Fragile Services

Overview of Fragile Services database

The Fragile Services database is a list of services that the quality or commissioning team is monitoring due to information being received which suggests the service may be subject to some fragility.

This could be as a number of any of the following causes

- Capacity pressures
- Demand pressures
- Workforce issues
- Recruitment and retention issues
- Training and education issues
- Potential lack of provider

The Fragile Service Programme reviews the level of risk and takes appropriate mitigating actions. Whilst some fragile services can be attributed to a specific ICB, some affect whole pathways and have an impact at a regional level.

Fragile Services

The table below contains a count of the number of services across the region that have been bought to the attention of the Fragile Services Programme. These services are across ICB and Specialised Commissioned services as fragile services have the potential to affect the whole pathway.

	ICB specific						Generic	Total
Midlands Region							34	34
East Midlands	LLR	Notts	N'hants	Lincs	Derby		3	92
	21	35	8	15	10			
West Midlands	BSOL	BC	C&W	H&W	SSOT	STW	2	63
	16	8	6	15	4	12		
								189

Fragile Services in delegated Spec Comm services: Shropshire, Telford & Wrekin ICB

Specialty	Site	Reason for fragility	Detail and actions
Adult critical care	SATH	Recruitment and retention of medical and nursing workforce	Issues with estate and consultant workforce. ICB CMO raising at national level.
Paediatric ophthalmology	SATH	Capacity and demand	Lack of consultant workforce. Short to medium term solution with locum in place. Regional workshop held
Fetal medicine	SATH	Recruitment and retention of consultant workforce	All consultants retired in July 2023. Service has a locum in place and mutual aid supplied by Stoke.
Sarcoma services including paediatric	RJAH	Issues with consultant workforce	Service suspended due to issues

Other STW services on the fragility register which may impact on pathways for delegated services are:

- Neurophysiology
- Haematology
- Pharmacy
- Primary care
- Microbiology
- Breast Cancer Screening

8. Deep Dives

Completed Deep Dives

As part of Joint Working on Specialised Services in 2023-24, the Midlands Acute Specialised Commissioning Team conducted a series of deep dives into priority services which were present to the East & West Midlands Joint Committees and the Clinical Collaborative Executive Forum (CCEF).

The following deep dives have been included in the appendices for information.

- **Appendix 8.1**
  Adult Critical Care

- **Appendix 8.2**
  Vascular Services

- **Appendix 8.3**
  Haemoglobinopathy

- **Appendix 8.4**
  Neonatal Services

9. 2024-25 Priorities

Overview of 2024-25 Priorities

As part of the 2024-25 planning round the Specialised Commissioning MDT have engaged with ICB to agree the 2024-25 priority pathways for specialised services in the Midlands.

The 9 priorities approved by ICBs and NHSE at the Midlands Acute Specialised Commissioning Group were as follows

- Neonatal Intensive Care,
- Adult Critical Care,
- Haemoglobinopathy,
- Severe Asthma,
- Oncology Review,
- Acute Aortic Dissection,
- Paediatric Critical Care,
- Multiple Sclerosis,
- Spinal Cord Injury.

Further details of each priority are included in Appendix B.

10. Links

Links

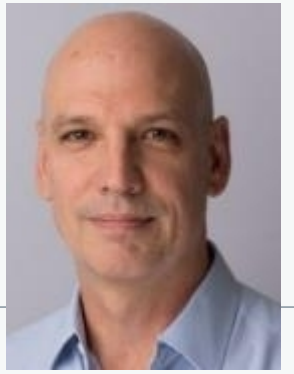
- NHS commissioning » Specialised services (england.nhs.uk)
- NHS England » Prescribed specialised services manual
- NHS commissioning » National Programmes of Care and Clinical Reference Groups (england.nhs.uk)
- NHS England » Service specifications
- NHS England » Commissioner assignment method 2024/25
- Prescribed Specialised Services Tools - NHS Digital
- NHS England » Directly commissioned services reporting requirements
- Integrating specialised services within Integrated Care Systems - FutureNHS Collaboration Platform

Appendix A.
Case for change examples

Example of how ICSs are already making a difference -Virtual e-clinics for kidney disease

- Patients with renal failure in Tower Hamlets now get more time with a specialist consultant thanks to the local ICS redesigning services around the sickest patients.
- Kidney doctors at Barts Health NHS Trust and GPs in the area set up a virtual e-clinic for GPs so they can send questions on kidney patients direct to consultants for a quick reply. The system also flags up patients that might need specialist treatment
- Since it began, waiting times for outpatients have dropped from as much as 15 weeks to just five days for advice, increasing face to face time for consultants and patients for those who most need it.
- The demand for outpatient appointments has reduced to a fifth of previous levels freeing up to time and money for reinvestment in NHS services.
- More integrated commissioning of specialised renal services would make these sorts of innovations easier as –
  - The same people and organisation would be responsible for commissioning both the specialised (eg dialysis) and non specialised (GP led) parts of the patient pathway reducing complexity and bureaucracy
  - Budgets will be pooled which creates more of an incentive to keep patients out of hospital and treat them closer to home
  - Services can be tailored around the needs of local populations helping to address health inequalities
  - Those who do need specialist services such as dialysis will still be able to access them in line with national standards and policies

"We were seeing a lot of patients who gained little from seeing a consultant, and instead are supporting GPs to help these patients. If we think a patient does need extra care then they can get in to see us far more easily, and into the right specialist clinic. Our team can now focus on those on dialysis, or with more severe kidney disease, where specialists can make the biggest difference."



Dr Neil Ashman, who developed the system with local GP Dr Sally Hull

Case for change examples

Current Commissioning Arrangements	Consequences of Current Arrangements
HIV Services Commissioned nationally but Patient care delivered through HIV services via Local Authorities	Service and workforce fragmentation in some areas across England
Mental Health and LDA Services Most Commissioned by CCGs. Only CYP, adult low and medium secure and adult eating disorder services are nationally commissioned.	Specialised MH services are at the end of the pathway focused on inpatient and interventionalist care leaving little incentive for upstream investment by CCGs
Neurology Spec com funds neurology patients only at certain designated centres / in outpatients where the patient has been referred by a consultant. Neurological needs of patients not seen at a centre are met by hospitals funded by CCGs	Discourages development of local provision by CCGs at sites other than neuroscience centres – patients have to travel further. Discourages service evolution, patients not seen in the right places.
Renal Costs of Kidney disease, dialysis and transplantation is funded via Spec com but surgery and most outpatient care is funded by CCGs. Transport is supported by CCGs and makes up 30% of elective transport in the NHS	Funding for renal medicine is complex and discourages upstream investment in prevention and earlier stages of the pathway.

Introduction of ICSs will…

- Enable NHSE and Local Government to collaborate on the commissioning of HIV and sexual health services strengthening pathways with domestic abuse, Sexual Assault Referral Centres and mental health services.
- Help enable a joint approach to support and deliver recommendations from HIV action plan.
- Help to ensure greater integration in the design of services informed by data and insight on the needs of local communities – helping to reduce inequalities.
- Enable local providers of services for mental health and learning disabilities and /or autism to take control of budgets to improve outcomes by managing whole pathways of care.
- Seek to avoid inpatient admissions and provide high quality alternatives to admission.
- Provide an opportunity to improve quality and access to services by moving decisions closer to communities
- Enhance collaboration between partners including across larger geographical footprints
- Make it easier to deliver upstream interventions in primary care around diagnosis and early treatment, to potentially prevent or delay the need for transplants further down the pathway
- Potentially lead to greater investment in home dialysis with financial benefits (from reduction in travel costs) being reinvested elsewhere.
- Support greater focus on prevention and provision of care closer to home.

What do we want to be different in the new model?

	Planning and Governance	Collaborative Delivery	Funding
PRESENT	Prevention, diagnosis, acute treatment, chronic management and specialised services are planned and commissioned by different organisations with plans based on different historic views resulting in misaligned priorities	Some patients have multiple touchpoints across multiple organisations for the same condition which results in limited opportunities to join up care and support innovation and technological advances	Current funding approach provides limited incentives to reduce cost through innovation which can result in specialised budgets outstripping funding available
FUTURE	All organisations across whole patient pathway working under a single planning structure with aligned incentives and plans based on a single forward view of population needs.	Fewer touchpoints which are built around the needs of the patient enabling greater innovation and collaboration and more joined up services across the patient pathway	Care funded on a population basis and with local organisations working together to set and manage budgets incentivised to innovate and save costs, leading to sustainable systems and more focus on the needs of local populations.
EXAMPLE	 Mr Wu, 68yrs Type II Diabetes End stage renal failure Needing dialysis. Can delay the need for dialysis through identification and intervention of his CKD by his GP, thereby improving his quality of life and care experience	 Mrs. Jagathesan, 74yrs Complex cardiac history awaiting a heart procedure, lives far from Cardiac centre. Can attend local hospital for pre-assessment ahead of her surgery, receive follow up care close to home in local or virtual clinics.	 Miss Jones, 19yrs Rare neurological disorder Waiting for multiple diagnostics. Gets co-ordinated diagnostics through a single point of access, reducing outpatient appointments and enabling faster diagnosis and treatment – meaning better patient experience and cost-effective care

Case for change – examples and themes

Current Arrangements	Consequences	Integration Opportunities
Sickle Cell Spec comm funds haematology services. ICBs funds the upstream pathway – from genetic screening, pre-conception care, newborn screening, primary care, urgent and emergency care.	Lack of joined up care meant that significant service quality issues went unchecked for years. Opportunities to support patients through core ICB offerings (e.g. community nursing) were missed – haematology didn't have sight of the offering and ICBs didn't have sight of the service.	Single commissioner will have a view of the entire end-to-end pathway and will have the mechanism to identify and address issues. One accountable group for ensuring quality services. Integrating specialised haematology services in and end-to-end pathway can improve connectivity with ICB core services (maternity, primary care, community support, urgent and emergency care access) for people with Sickle Cell disease.
Fragmented funding and pathways	**Disincentives to improve outcomes and £**	**"steps to the left" and end-to-end pathways**
Neurology Only funded at certain Neurosciences centres – even if the specialist consultant works at multiple hospitals. Neurological needs of patients not seen at a centre are met by hospitals funded by ICBs.	Discourages development of local services outside the neuroscience centre (investment from ICBs) – patients have to travel further. Inconsistent provision leading to inequities. Discourages service evolution, with no common approach to pathway development.	Introduce a consistent approach to commissioning neurology services – enabling improved quality and access, and services closer to home. Enhance collaboration between partners including across larger geographical footprints. Create streamlined pathways leading to faster diagnosis and more cost effective care.

HIV Pilot - Ensuring Comprehensive HIV Screening in Emergency Departments (EDs) Across South London

Almost all hospitals in South London in high or extremely high prevalence areas offer opt-out HIV ED testing.

Cases identified in South London EDs:

- At KCH, the oldest patient identified through ED testing was 95.
- At GSTT, a significant number of patients testing positive in ED have primary infection (20%) with very high viral loads.
- At SGUH, an HIV diagnosis was suspected in only 11 (22%) of the subsequently 50 positive cases.
- At Croydon, newly diagnosed HIV-positive patients now need shorter hospital stays, from an average of 34.9 days down to only 2.4.

2. Opt-out HIV tests are offered to those who need blood tests (c.300,000 people).

5. If a test is reactive, the patient is invited for further tests by the sexual health service.

7. On appropriate treatment, patients with HIV can expect to live as long as someone without HIV. Those with undetectable viral loads cannot pass HIV onto anyone else, even in unprotected sex. Clinicians try to re-engage patients lost to follow-up.

The process of HIV screening in EDs → What happens next → Uptake

1. Over 1 million people attend Emergency Departments* in South London every year.

3. The level of uptake of HIV tests varies across South London, from 34% - 98%.

4. One sample and blood bottle can be used for both the blood tests and the HIV test, meaning the additional costs are largely lab-associated.

6. Newly diagnosed patients are brought into care and put on treatment. Early detection is vital to reduce HIV/AIDS related complications.

This variation across South London means that not all patients who have HIV are being identified. This is due to key factors such as the age of those tested, the length of time before re-testing repeat ED attendees, and general operationalisation of the screening strategy.

This pilot aims to address this through 'levelling up' across south London, supported by a minimum service specification.

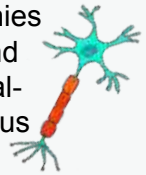
There is variation in lab costs across South London, with costs ranging from £2.50 to £5.55 per test. Some trusts use 2 blood bottles.

~150 patients are newly diagnosed with HIV in EDs in South London every year. Each person living with HIV newly linked to care could avoid NHS costs of over £200,000.

"Making a diagnosis of HIV today does mean spending money on the treatment tomorrow; missing a diagnosis today means greater treatment costs in years to come (and not just for one patient, but for anyone else before or after them in the chain of transmission)."

Home based immunoglobulin therapy (IVIg) in Neurology in South London

1. Home based Immunoglobulin therapy for people with autoimmune neuropathies is safe and effective and less costly than hospital-administered intravenous immunoglobulin (IVIg)



2. Some patients are required to come into hospital (day case units) for recurrent infusions every 3-6 weeks, which may takes place over two to five successive days. Each episode of treatment costs £4k.

3. This is highly disruptive to quality of life. Patients frequently require time off work which makes maintaining employment challenging and costs them greatly through loss of income and travel.

4. Alternatively, many patients are suitable for home therapies – including a subcutaneous injection they can deliver themselves. This can transform the patient experience, and patients report high levels of satisfaction with this option.

5. In addition to being more convenient, this method offers clinical benefits as lower drug doses can be used more frequently. This is better tolerated by patients (reduces adverse reactions), avoids fluctuations in condition between treatment and reduces risk of stroke and other blood related issues related to large doses.

6. This contributes to improved use of hospital estates (freeing capacity in day case units for other activity), reduces drug costs through VAT savings and is cheaper for patients (reduced travel and lost income). Additionally, it offers greater environmental sustainability (reduced travel).

7. The model has been in place at Kings College Hospital for several years. We are proposing to support the Neurosciences centre to establish a service, using learnings from Kings as well as learnings in home care from the OPAT pilot.

8. Funding is available to recruit a CNS to support patients on this pathway. Project management support is available from SLOSS for implementation. **Trust and system support is required to manage and plan for day case activity and income changes.**

Appendix B. 2024-25 priorities – detailed slides

Midlands Oncology Service Review: Fragile		**Lead:** Laura Morris	**Ref:** C1
Delegation Status: Green (HCD retained)	**ICB:** All	**National Priorities: Recovery:** Cancer, Use of Resources. **LTP:** Workforce, Inequalities. **DCG**	
What is the problem in summary? Oncology is identified as a fragile service across the Midlands. Performance challenged, with 8/11 systems in tiered support. Inequity of timely access at Trust and tumour site level. Oncologist vacancy rate is 15% , expected to rise to 25% in 2027 with 20% forecast to retire over 5 years. Midlands has the lowest WTE per population in England. There are also workforce challenges in chemo nurses; therapeutic radiographers and medical physics. Across the Midlands, we spend £522 million on SACT per year (activity, drugs and support costs), plus Radiotherapy spending.		**What are we looking to achieve?** Reduce variation in waiting times; increase productivity and share best practice through the development of new models of care, workforce strategies and shared resource. **Scope:** Workforce; capacity; service models **Specific Partners:** Cancer Alliance (EAG/ECAG); EMAP (priority area); ICB cancer leads	
Planned Deliverables: - Mutual aid framework (Q1). - Develop plans for managing agency/locum costs (Q1). - Review and appraise variety of current financial spends and service models for oncology services (Q2). - Produce Virtual Ward criteria (Q2). - Confirm transformation plans in place at system for virtual or community clinics (Q4)		**How will we know if things have improved (KPI)?** - Reduced and consistent waiting times across systems. - Reduced vacancy rates. - Unit cost reduction. - Consistent approach to managing mutual aid.	

Acute Aortic Dissection		**Lead:** Jon Gulliver	**Ref:** IM1
Delegation Status: Green	**ICB:** All	**National Priorities: Recovery:** UEC, Use of Resources. **LTP:** Workforce, Health Inequalities. **DCG**	
What is the problem in summary? Acute aortic dissection (AAD) is rare and immediately fatal for 48%. For Type A making it to cardiac surgery, mortality is 25%. Surgery is time critical. All cardiac surgery centres have at least one AAD specialist surgeon but with no coordinated regional on-call rota presenting challenges to accessing intervention. There is consensus that coordination will improve outcomes for patients and reduce waits but there is resistance to change.		**What are we looking to achieve?** Reduce variation in access to emergency surgery and improved outcomes through the introduction of coordinated East and West on call rotas. **Scope:** Workforce; capacity; service models **Specific Partners:** Cardiac Transformation Programme, Cardiac Networks.	
Planned Deliverables: - Approved SOP(Q1). - SPOC testing and training(Q1). - Recruit MDT coordinator (Q1). - Establish regional MDT(s) (Q2). - Agree process for collecting and reporting KPI (Q1). - Service go live (Q1 WM, Q2 EM).		**How will we know if things have improved (KPI)?** - In hospital mortality with/without intervention; 1 year mortality. - LOS. - Referral numbers. - Intervention/no intervention. - Time from referral to intervention. - Deaths between diagnosis and intervention Type A. - Deaths between diagnosis and place of safety Type B. - Patient satisfaction.	

Severe Asthma		**Lead:** Jon Gulliver	**Ref:** IM2
Delegation Status: Green	**ICB:** All	**National Priorities: Recovery:** UEC, Use of Resources. **LTP:** Health Inequalities.	

What is the problem in summary?

Severe asthma (SA) is a debilitating, chronic disease with an average of 4 asthma attacks and 4x more A&E visits pa, patients with SA account for ~50% of all asthma-related healthcare costs.

Biologic treatment has the potential to improve lives and reduce the use of healthcare/social resource. Access is variable and ~80% of eligible patients are currently not prescribed a biologic.

What are we looking to achieve?

Increase access to biologics for patients with SA to improve outcomes for patients and reduce the use of other healthcare resource.

Scope: All patients with severe asthma.

Specific partners: Respiratory Network

Planned deliverables:

- Review of current treatment and patient pathways for the management of asthma across primary and secondary care including case finding for biologics, diagnosis and treatment optimisation.
- Review of the data to understand the inequalities that are present in accessing biologics treatment, based on underlying service and/or patient factors.
- Share with respiratory networks and specialist asthma centres to inform options appraisal.

How will we know if things have improved (KPI)?

- Number of new initiations per ICB
- Increase in percentage bio penetration per ICB
- Reduction of variation in bio penetration by ICB

Multiple Sclerosis Service Review: Risk Register		**Lead:** Dom Tolley	**Ref:** T1
Delegation Status: Green	**ICB: BSol; H+W; Black Country**	**National Priorities: Recovery:** Elective, Use of Resources. **LTP:** Workforce, Health Inequalities.	
What is the problem in summary? A review of the MS tertiary service provided by University Hospitals Birmingham to a number of ICBs has found significant waiting times and increasing numbers of patients to be seen for initial consultations to access to Drug Modifying Therapies (DMTs) and lack of structure for the ongoing management of this patient group. There is a lack of good governance with regards to the prescribing and monitoring of these patients, which has a potential of harm.		**What are we looking to achieve?** Improve access of eligible MS patients to DMTs and ongoing care of those already on treatment outside of BSol ICB. **Scope:** All patients eligible MS patients who should fall under the care of UHB. **Specific partners:** None	
Planned deliverables: - Review of West Midlands regional MS DMT pathways and governance and current financial spend for MS DMT patients and produce options appraisal for MASG and JCs, to include the development of Neurology ODNs (Q2) - Develop and implement a revised MS DMT clinical pathway, including shared care agreements (Q4).		**How will we know if things have improved (KPI)?** - Reduction in waiting list and waiting times for MS patients on DMT clinical pathway by the end of 2024/25	

Spinal Cord Injury Services		**Lead:** Dom Tolly	**Ref:** T2
Delegation Status: Green	**ICB: All**	**National Priorities: Recovery:** UEC, Use of Resources. **LTP:** Workforce, Health Inequalities. **DCG**	
What is the problem in summary? The Midlands region only has one commissioned Spinal Cord Injury (SCI) rehabilitation unit (RJAH), which has the second longest waiting times for admission in England. The unit cannot manage high cervical spinal injuries, due to lack of ACC, resulting in out of region transfers. The East Midlands does not have a SCI rehabilitation centre. Patients are managed in Sheffield or Stoke Mandeville where there are long waits. This delay in rehabilitation treatment means poorer outcomes (increased rates of HCAI and pressure sores), potential harm and DTOC.		**What are we looking to achieve?** Improved access to SCI and outcomes. Reduction in harm and DTOC resulting into lower use of healthcare resource. **Scope:** All patients presenting with a SCI and requiring rehabilitation. **Specific partners:** None	
Planned deliverables: - Complete a demand and capacity analysis for SCI rehab, including patient acuity and complexity (Q1-Q2). -Review current financial spend for SCI patients and review potential options costs for SCI services (Q1-Q2) - Present review and options papers to MASG and JCs, including QIA and 13Q (Q3), including weaning and ventilated patient services for high c-spine injured patients.		**How will we know if things have improved (KPI)?** - Reduction in LOS SCI patients. - Reduction in DTOC both from Acute beds base and to CHC services - Reducing periods of bed rest. - Reduction in complications.	

Adult Critical Care (ACC) Rehabilitation & Digital Enablement		**Lead:** Dom Tolly	**Ref:** T3
Delegation Status: Green	**ICB: All**	**National Priorities: Recovery:** UEC, Elective, Use of Resources. **LTP:** Workforce, Health Inequalities. **DCG**	
What is the problem in summary? The Midlands ACC Strategy has continued to develop a more diverse, resilient and holistic model of ACC care across the 29 ACC units. The major quality, clinical and operational improvement drive in the next 3 years of the strategy is to develop consistent 7-day services for ACC rehabilitation in line with national guidance. In doing so this potentially will reduce in LOS for ACC patients by up to 1.5 days, improve patient outcomes, reduce costs for patient episodes.		**What are we looking to achieve?** Digital enablement will provide clinical support, improved decision making through a networked approach to care through virtual ward rounds. Digital critical care platform will reduce clinical errors in transfers of care between providers, by allowing shared care records. **Scope:** All ACC units. **Specific partners:** EM and WM ACC ODNs.	
Planned deliverables: - Complete digital services review paper (Q1). - Complete ACC rehab gap analysis by provider/ICB (Q2). - Review of current spend for ACC rehab and review potential options costs for services (Q2). - Present review and options papers to MASG and JCs, including QIA (Q3).		**How will we know if things have improved (KPI)?** - Reduction in length of stays for ACC patients. - Reduction in pharmacy and parental nutritional spends.	

Haemoglobinopathies		**Lead:** Nick Hey	**Ref:** BI1
Delegation Status: Amber	**ICB: All**	**National Priorities: Recovery:** UEC, Use of Resources. **LTP:** Workforce, Health Inequalities. **DCG**	
What is the problem in summary? The APPG on Sickle Cell and Thalassaemia conducted a review of services and experiences of patients and produced 'No one's listening.' This report revealed many years of sub-standard care, stigmatisation and lack of prioritisation and patients losing trust in the NHS system. A regional review demonstrated wide variance in the level of service on offer to patients and numerous areas for improvement, in particular in improved training and knowledge at non-specialist trusts and A&Es.		**What are we looking to achieve?** Improve outcomes for patients and reduce unnecessary admissions for patients by improving networks of care. **Scope:** All haemoglobinopathy services. **Specific partners:** EM and WM HCCs.	
Planned deliverables: • Med Tech Funding (Spectra Optia) business cases . Potential for approval of additional national funding to support red blood cell exchange services - (Q2). • Review of SCD prevalence, activity and provision (Q1). • Review position against APPG report (Q1). • Review of Specialist Haemoglobinopathy Team provision – Service provision review and re-commissioning (Q4).		**How will we know if things have improved (KPI)?** - Updated review of regional position against No one's listening recommendations demonstrating improvement, especially in non-specialist centres. - Increased access and activity for red blood cell exchange.	

Neonatal Critical Care: Risk Register		**Lead:** Sumana Bassinder	**Ref:** WC1
Delegation Status: Green	**ICB: All**	**National Priorities: Recovery:** Maternity, Use of Resources. **LTP:** Workforce, Health Inequalities. **DCG**	
What is the problem in summary? Neonatal Critical Care remains an area of significant national and regional scrutiny. The Midlands also has one of the highest neonatal mortality rates in the country. There is significant work to do to implement the requirements of the NCCR including configuration, patient pathways, increase cot capacity, workforce strategy, neonatal transport review to support the revised neonatal networks. All against a backdrop of high-profile scrutiny (Ockenden, Thirlwall, Letby, Kirkup).		**What are we looking to achieve?** Improved outcomes for babies and a reduction in mortality rates. **Scope:** All NIC services. **Specific partners:** EM and WM ODNs. Perinatal Programme. LMNS	
Planned deliverables: • Review of WM capacity and configuration (Q1). • Describing patient pathways. • Financial impact of compliance (Q1) • Production of workforce strategy. • Review of neonatal transport. • Ongoing capacity monitoring and compliance review. • Perinatal dashboard (Q1) • Review of PMRT process.		**How will we know if things have improved (KPI)?** - Reduction in mortality rates. - Reduction in babies being transferred out of region for neonatal care. - Reduction in the number of cots closed due to staffing challenges.	

Paediatric Critical Care (PCC)		**Lead:** Sumana Bassinder	**Ref:** WC2
Delegation Status: Green	**ICB: All**	**National Priorities: DCG**	
What is the problem in summary? PCC capacity is an area of concern regionally and nationally for both Level 2 (High Dependency) and Level 3 (Intensive Care). National funding was received in 23/24 to increase Level 2 capacity outside of Level 3 centres but so far only a partial implementation has been achieved. Further work required to identify, increase and progress additional capacity.		**What are we looking to achieve?** Right capacity in the right place. **Scope:** All PIC services. **Specific partners:** EM and WM ODNs.	
Planned deliverables: - Monitoring of delivery of WM plans. - Plan for increase of resilient L2 capacity in the EM in line with GIRFT (Q1) - Demand, capacity and financial review of L2 and L3 provision and production of options appraisal (Q4)		**How will we know if things have improved (KPI)?** - Reduction in OPEL status levels from 23/24 surge baseline during 24/25 surge periods. - Reduction in patients transferring out of area for paediatric critical care. - Improved cot utilisation, closer to home and outside of tertiary centres.	

Agenda Item

ICB 27-03-024

Digital Strategy 2023-26 – Work Programme/Delivery Plan

Integrated Care System

Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Shropshire, Telford and Wrekin

ICS DIGITAL STRATEGY 2023-28

FINAL Draft – for approval, March 2024

Forward

Sir Neil McKay

Chair

NHS Shropshire, Telford & Wrekin Integrated Care System (ICS)

"Developing digital capabilities that support people's health and wellbeing, and enabling the workforce to deliver best care underpins all elements of Shropshire, Telford and Wrekin Integrated Care System's Strategic Plan"

Simon Whitehouse

Chief Executive

NHS Shropshire, Telford & Wrekin Integrated Care System (ICS)

"Digital transformation and the insight it unlocks can improve health and care outcomes. This strategy is a pledge by all ICS partners to embrace technology and use it to help people access the best health and care services for them, at the right time.

By ensuring that our partners have the right technology, system and skills in place we will be able to provide a better work environment where we can deliver safer care.

Using technology, will enhance our citizen's ability to participate in all elements of their care and data, giving better access to information and best practice advice and guidance. This will enable us to focus more on supporting people in their home when that is the more convenient and safer to do so."

Dr Nick White

Chief Medical Officer

NHS Shropshire, Telford & Wrekin Integrated Care System (ICS)

"Clinical colleagues across the system face many challenges delivering care on a day-to-day basis – digital solutions described in this strategy will support improvements in care.

The potential for what we can achieve by having joined-up digital and technology programmes between healthcare and other public bodies is immense.

Better and faster sharing of information between citizens, patients and staff gives people a better experience and makes services more efficient. Digital tools that capture information or carry out analytical tasks will help increase safety and quality."

Digital transformation can realise our collective ICS ambition

Dr Masood Ahmed

Chief Digital Information Officer
NHS Shropshire, Telford & Wrekin Integrated Care System (ICS)

"We will use digital to improve care for citizens, support our staff and enhance how we work together as an Integrated Care System delivering our collective ambitions."

At the heart of our digital journey in the Shropshire, Telford and Wrekin Integrated Care System (ICS), you'll find our most important driving force: you, our community members. Our mission is to weave technology into health and care in a way that enriches all our lives.

We are committed to a "digital-first, but not digital-only" philosophy, taking into account the genuine impacts on healthcare equity. Guided by national standards, we're committed to ensuring no-one is left behind as we navigate the digital tide.

We're aligning our digital initiatives with broader national objectives, striving to create a healthcare experience that meets your needs and expectations. Our diverse portfolio of programs tackles specific digital challenges, all anchored in our larger vision of enhanced community healthcare and reduced digital exclusion.

We're laying the groundwork for a more intelligent, seamlessly connected health and care system. We aim to deliver consistently excellent, easily accessible care transformed by digital innovation and inclusive by design.

My GP, mental health and community support workers are aware of my care needs as they receive high- quality information

I can book my appointments online and have secure video consultations with my GP and hospital

I can securely access my care record and get my test results digitally

I can access information I need from multiple devices, locations & organisations

I can receive care from the comfort of my home

I can access data enabling me to make better decisions about the care of my patients, including children and young people

Our ICS' challenges and ambitions give us focus for prioritisation in digital

An ambitious vision for person-centred, integrated care is central to our Integrated Care Strategy in Shropshire, Telford and Wrekin (STW). Our Joint Forward Plan lays out the practical steps to realise this vision, with our Digital Strategy serving as a critical enabler. Specifically, we aim to address health inequalities and counteract digital exclusion.

Our primary care providers have transitioned predominantly to electronic medical records, laying a solid foundation for digital maturity. As we move toward a system-wide transformation, we remain deeply committed to delivering an equitable and optimised health and care experience for our entire community.

Locally, our ICS faces significant challenges when compared to national averages:

- Currently STW is in segment 4 of the National Oversight Framework which means the ICS has very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support
- The system has a significant deficit that cannot be closed through traditional cost efficiencies
- We have a population and workforce that is ageing and living with more complex needs
- We have a workforce shortage due to unfilled vacancies, poor retention & high sickness rates
- Continuing quality concerns and inefficiencies at our acute trust

We are on a journey to increase our digital maturity

- SaTH's Digital Strategy makes a self-assessment of Level 1 on the HIMSS Electronic Medical Record Adoption Model (AMRAM)
- The system's digital exclusion level exceeds that of the national average
- We have an ageing estate across the system – community hospitals, primary care, Shrewsbury and Telford Hospital, Local Authorities
- We are silos based with digital services and digital management being delivered out of each organisation
- The geographical area of STW has seen digital challenges with rurality, an ageing population and high levels of deprivation

Our ICS

- *NHS Shropshire, Telford and Wrekin ICB*
- *51 General Practices formed into 8 Primary Care Networks*
- *Shropshire Council*
- *Telford & Wrekin Council*
- *The Shrewsbury and Telford Hospital NHS Trust*
- *The Robert Jones Agnes Hunt Orthopaedic Hospital NHS Foundation Trust*
- *Shropshire Community Health NHS Trust*
- *Midlands Partnership University NHS Foundation Trust*
- *Care homes and hospices*
- *Community Pharmacies*
- *Optometry & Dental Practices*
- *The voluntary sector and other core partners, such as Imaging and Pathology Networks*

We want to design a health and care system that puts citizens and patients' [illegible]

Digital can enable the ICS to deliver effective and safe care for the citizens of Shropshire, Telford and Wrekin.

A two-way street of communication with you, our community members and patients is essential to our progress. We're all ears regarding understanding the issues that impact your lives and healthcare needs.

Using technology as a bridge, the partners across our region are uniting to realise your aspirations for a health and care system that meets and exceeds your expectations.

Importantly, as we chart our digital course, we're not going it alone. Both the voices* of our community and our dedicated staff serve as guiding lights, ensuring that our digital priorities are firmly rooted in the needs and insights of those we

*These voices have been captured via numerous engagement routes with citizens, reflecting current feelings surrounding digital transformation within the ICS.

"

My prescriptions are paper-free if I want them to be

All care providers have the most up to date information to provide consistent, reliable, high quality care

My digital experience is tailored to my needs & appropriate for my digital skills

I can contribute information to my healthcare record

I can easily access services that meet my needs via an online directory

My local hospital is modern

"

I can turn up for my blood test without a paper referral copy. The phlebotomist will know what tests I have been referred for and by whom

I know that my clinician has the most up to date information about my care & treatment plan

I am confident my care & personal information is safe & secure

I want my family and me to feel supported at the end of life

I can get access to my test results and status digitally

I can access Wi-Fi throughout the hospital

"

I only have to visit the hospital when I really need to

I have access to information about my care and treatment in a format that I understand

I can receive care from the comfort of my home

Clinicians and nurses can spend more time with me

I can book appointments online, when it suits me and without waiting a long time

I do not have to repeat myself

We will use digital to enable our workforce to deliver effective care

We will support all ICS partners to equip colleagues with the right tools and skills to allow them to focus on effective delivery of care to our communities.

We're committed to rolling out digital services that empower our staff to deliver outstanding patient care and related services. Our eyes are always on the horizon, looking for innovative ways to enhance what we offer while ensuring our team is fully equipped to tap into the potential of these advancements.

Central to our strategy is the intelligent use of data. We'll leverage data-driven insights to fine-tune clinical quality, steer service planning, and manage organisational performance, all to elevate the care experience for you: our community.

"

Aspects of my work are automated, letting me focus on delivery

I can provide and receive effective handovers, supported by digital presentation of data

I can record and analyse information about patient outcomes and experience

I receive alerts or notifications that help me to safely & effectively care for our patients

I can access data that enables me to make better decisions about the care of my patients

We use digital insights to identify what we do well and what we can improve on

"

I only need to log on once to access the information I need

My work is automatically saved and readily accessible

I have the digital tools and skills to work effectively on site and remotely

I can view the results of tests for my patients even when they have been performed outside of this Trust

Patient records are 'digital-first' and I have minimised or eliminated the use of paper

I can access information I need from multiple devices & locations

IT support my needs and I feel involved in digital change

"

I am supported to use new digital solutions

I can view patient records in a way that is meaningful to me

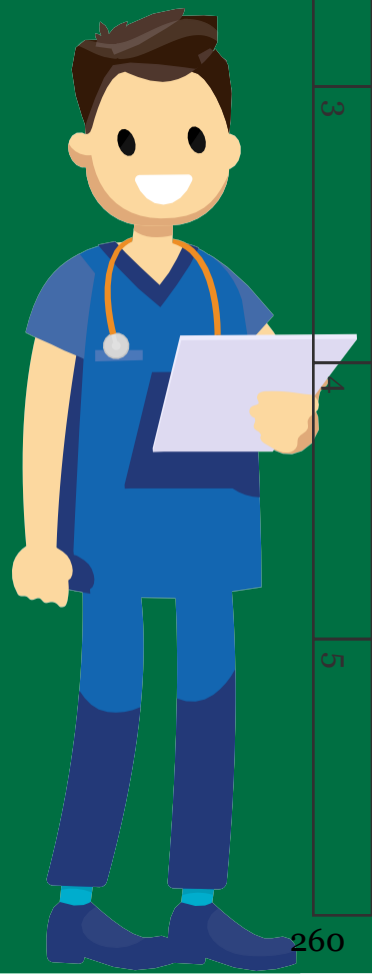
I can access information I need from multiple devices, locations and organisations

I can capture information at the point of care

There is a single point of contact for any digital issues

I can easily request consultations & diagnostic tests digitally

I can share information easily with my colleagues



Our health and care organisations will benefit from taking a digital approach to delivering services

We will use technology that capitalises on effective data management and implementing innovation.

Digital tools will ensure we offer care that's not only safe and clinically sound but also creates a positive experience for you, our patients. These digital advancements will guide our services toward sustainability and effectiveness, ICS future-proofing. cost

Through careful data capture on our community, we'll enable more personalised support, to our focus on thanks health management population

Our strategy is in perfect harmony with the ICS's ambitions. We're committed to delivering exceptional care to our communities, all backed by robust and seamlessly integrated technology.

"

We are striving to be a paper-lite ICS

Data returns are automated and submitted electronically

Our clinicians are involved in digital decision making and influential in shaping the future of digital

We work together to ensure our services are cost effective

"

Services are better connected, resulting in more efficient and effective data analysis

Our systems and services are modelled to meet future demand

We can manage, in real time, our resources or assets across the ICS

Collaborating lessons learnt and resources in relation to key digital programmes

Medical Devices are secure and free of cyber threat

We co-ordinated an infrastructure collaboration group across the ICS

"

We have a single source of truth

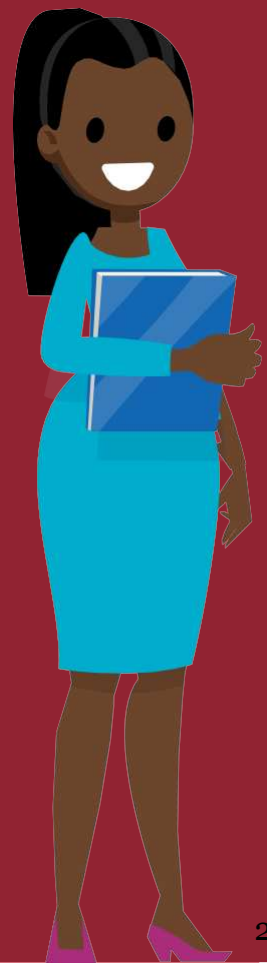
Systems and hardware are safe from Cyber Security threats 24/7

We are able to share patient information between services safely and securely

Procurement and contract renewals are streamlined and converged where possible across the ICS

Test results can be captured electronically from anywhere within the ICS

Our decision making is data-led



Our prioritisation for investment is driven by national ambition

We will prioritise how and where we invest in digital across Shropshire, Telford and Wrekin Integrated Care System.

Nationally, the NHS is focused on meeting future challenges and investing £2 billion to support Digital Transformation. The Secretary of State for Health and Social Care set out in the *Plan for Digital Health and Social Care* (June 2022) the minimum digital foundations expected of all health and social care providers in England.

The national ask of us as an ICS is that we support our health and care organisations to work together to meet digital expectations, including:

- The core capabilities set out in The Frontline Digitisation Minimum Digital Foundations (MDF)
- Implementing standards defined in the *What Good Looks Like (WGLL)* framework for digital services
- Enabling providers to work towards *Level 5* on the *HIMSS EMRAM maturity model* to strengthen performance
- Develop a comprehensive digital strategy for the ICS, which includes a clear vision and objectives for the use and innovation of digital technology as per the *Hewitt Review*
- Establish a digital & data architecture for the ICS, whether this is locally or nationally, aligning to both the *Hewitt Review* and STW Population Health Management Strategy
- Invest in digital skills training to increase digital competencies across the workforce, improve the use of data and analytics that support clinical decision-making, and improve the patient experience as per the *Hewitt Review* and *Fuller Report*
- Deliver the operational planning guidance priority of mitigating digital exclusion
- Support alignment with the social prescribing information standard

As care providers, we are committed to delivering the NHS Long Term Plan, which emphasises transforming care through digital tools and data.

These national frameworks provide a structure for planning digital delivery and focused investment prioritisation.

We will work with NHS England to ensure that the STW ICS digital transformation programme meets the needs of national funding priorities and the expected standards.

Our Digital Strategy will be considered against the 'What Good Looks Like' framework:

WELL-LED	SMART FOUNDATIONS	SAFETY	QUALITY	SUPPORT PEOPLE	IMPROVE CARE	HEALTHY POPULATIONS	EMPOWERING CITIZENS
A clear strategy for digital transformation & collaboration, with citizens & frontline perspectives at the centre.	Digital, data and infrastructure operating environments are reliable, modern, secure, sustainable, and resilient.	Organisations maintain the standards for safe care set by the Digital Technology Assessment Criteria for health and social care.	Sharing information between organisations, technologies that support safer care, and developing analytical capabilities to support learning, knowledge generation, decision support and	We have a workforce that is digitally literate and able to work optimally with data and technology.	Citizens are at the centre of service design, with access to a standard set of digital services that suit all literacy and digital inclusion needs.	Embeds digital and data within our improvement capability to transform care pathways, reduce unwarranted variation and improve health & wellbeing.	We use data to design and deliver improvements to population health and wellbeing, making the best use of collective resources. The insights we produce from data are used to improve outcomes and address health inequalities.

Our ICS' challenges and ambitions give us focus for prioritisation

To tackle these challenges, the ICS recognises a number of high level priorities that are reflected within the ICS Strategy and Joint Forward Plan. These include:

Transformational recovery of the six clinical priority pathways: Urgent and Emergency Care (UEC), Cancer, Cardiac, Diabetes, MSK and Mental Health (*STW Clinical Strategy, March 23*). The clinical strategy has been developed to set the clinical priorities and associated objectives to deliver a 2-year clinical service improvement programme. This is a crucial criterion for exiting segment 4 of the national oversight framework.

Complete alignment and delivery of the two large-scale transformation programmes which includes the implementation of a new EPR system at SaTH and RJAH and the Local Care Transformation Programme, such as delivering Virtual Wards to deliver a sustainable health and care system for the Shropshire, Telford and Wrekin, or deliver digital solutions for children and young people's mental health services, as well as adult mental health transformation.

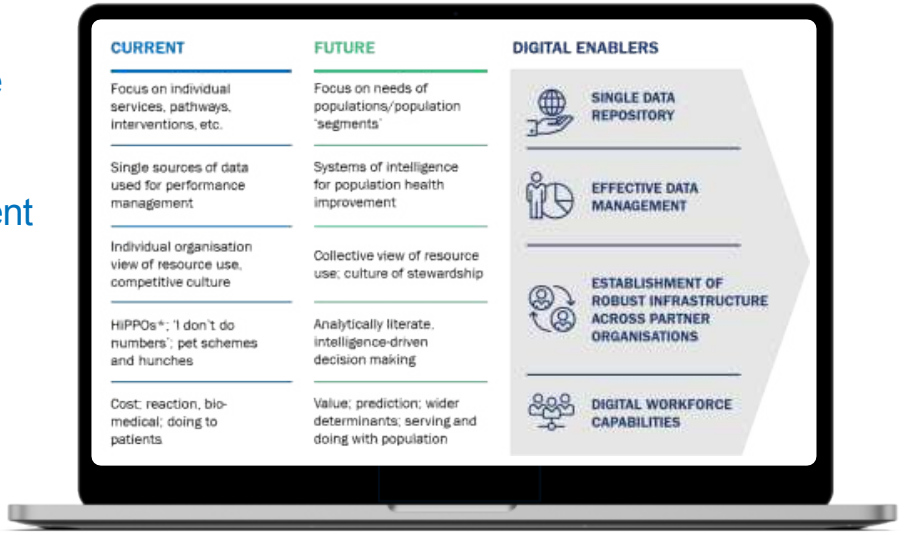
Service recovery including efficiency and productivity improvement.

Population Health Management (PHM) with digital and data at the heart of improving patient outcomes; this will support PHM by establishing a workforce analytics team to support the analytical requirements for PHM. Additionally, Identifying a solution for an 'Engine Room' for a single data repository across the ICS.

Delivery of ambitions in NHS Long Term Plan, including Prevention, Reduction of Health Inequalities, and Joined-up Coordinated Care.

How digital can enable the clinical strategy ambition

How digital can enable Population Health Management



Digital can act as an enabler to the ICS in meeting our key challenges and ambitions.

Our Digital Strategy makes the following pledges for the next five years:

1. Committed to reducing Digital exclusion and inclusive by design
2. Collaborative working across the ICS
3. Sharing resources & meeting workforce challenges together
4. Improved reporting capabilities & confidence in source of truth
5. Improved Cyber Security capabilities & infrastructure
6. Single technology where possible
7. Compliant with national standards and regulations
8. Agreed approach to procurement and contracting

We will be realistic in what we can achieve over the next five years

Our next five years will build upon our collaboration to date and focus on how we can support our organisations to meet national expectations and deliver against local priorities.

Not all of our current digital portfolio programmes are live, resourced or funded. We have no new budget for 2023/24, and we are operating in a financially constrained environment where Integrated Care Boards are having to assess and manage finances to continue to be sustainable. We have a pragmatic and realistic approach to bidding for additional NHSE funding.

As an ICS, we will structure and coordinate around the digital portfolio and make decisions together. In doing so, we can protect our staff's time by prioritising their workload and sharing our resources.

We, therefore, will be realistic in our ambition, deliver what we promise, and set the digital foundations that will enable future transformation and innovation.

Our Digital Strategy takes the needs of our citizens, workforce and organisations combined with the expectations of national bodies and regional partners to prioritise focus for investment and effort in digital over the next five years.

Despite our challenges we have proven that we can support each other to implement digital solutions:

RESILIENCE
Supporting staff to continue working during the COVID-19 pandemic through rapid deployment of home working solutions.

IMPROVED PATIENT EXPERIENCE
Introducing software to support online appointment booking & introducing virtual follow-up appointments for

ENHANCING PERFORMANCE, SAFETY & SECURITY
Replacing ageing devices and infrastructure.

INCREASING COMMUNITY DIGITAL EXPOSURE
Allowing the digitally excluded citizens the opportunity to borrow an iPad to increase

IDENTIFYING DIGITAL LITERACY GAPS
Enabling the over 65s the opportunity to increase their digital literacy with citizens

HOSPITAL OF THE FUTURE
Procurement of a network upgrade solution and commencement a two-year upgrade

'AT A GLANCE' INFORMATION
Introducing digital tools to make it easier for clinical staff to see the information they need.

IMPROVING STAFF EXPERIENCE AND PRODUCTIVITY
Simplifying the sign on process for staff through single on software.

Our digital portfolio will enable us to put in place the core foundations to set us up for future transformation

The ICS will oversee the delivery of this digital portfolio for the next five years.

The digital pledges underpin the prioritised programmes, align to national frameworks and will enable the ICS to meet its local challenges and ambitions. Most of these digital programmes will be managed and delivered by organisations and partnerships within the ICS.

DIGITISE
SAFE PRACTICE, SMART FOUNDATIONS, WELL LED

Electronic Patient Record
Level up access to electronic patient records & prescribing systems, allowing collaboration on implementation

Cyber Security
Ensuring that the ICS partners' cyber & support approach is robust & aligned

Infrastructure Optimisation & Alignment
Upgrade infrastructure across ICS and align technology, suppliers and processes to reduce variation

Digital Diagnostics
Providing joined up solutions to enable optimal diagnostic services at an Imaging and Pathology Network level

Outpatient Transformation
Supporting the digital delivery of outpatient care

Digitise Social Care

CONNECT
EMPOWERING CITIZENS, SUPPORTING PEOPLE

Shared Care Records
Enabling clinicians and staff the ability to access patient records across multiple regions including Shropshire Telford and Wrekin, Staffordshire and the Black Country, and enhancing integration capabilities between primary, secondary and community care across the region

Workforce, Digital Inclusion and Leadership
Enable our workforce and community to thrive through a digital first approach to managing care and supporting transformational change: delivering on a strategy for the clinical & digital leadership, and managing a growing digital & clinical expert workforce

MSK Transformation
Enable a local integrated model using a digital system that standardises referrals, joins up records and creates a single point of access to the service

TRANSFORM
HEALTHY POPULATIONS, IMPROVING CARE

Local Care Transformation Programme
Expand technology such as Virtual Wards to support treatment and care at home and prevent health issues escalating in vulnerable or at-risk groups, and embed electronic prescribing across the system

Citizen Inclusion
Offering greater digital choice for how citizens can access & manage health and care services

Hospital Transformation Programme
Substantial investment into transformation hospitals digitally to deliver a sustainable health and care system for the residents of Shropshire, Telford and Wrekin

Population Health Management
Using digital and data to accurately predict and understand current health care needs and what the local population will require in the future

Collaborative ways of working and model for digital
Putting in place the right Operating Model, Standards and tools to foster collaboration

Data and Analytics
Enable effective data sharing, improve reporting capabilities and drive evidence-based decision making

Delivering this Strategy will allow us to work more collaboratively as an ICS

Most of our digital programmes will be managed and delivered by organisations and partnerships within the ICS.

Successfully implementing ICS digital change cannot be achieved by a single organisation. This requires all organisations as part of STW to unite as partners, challenge individual ways of working, and focus on finding solutions.

To aid this, we will embed sustainable ways of working to ensure we are all best set up to deliver the digital portfolio successfully. Our pledges align with our portfolio and will enable transformation to occur.

By adopting these ways of working, we are promoting continuity across the ICS and enabling all organisations and partnerships to streamline their approach to digital in the same manner. These ways of working encompass the key prioritised digital work programmes across the ICS and allow for a better and more sustainable future.

Ways of working to embed digital across the ICS

WORK FOR PATIENTS COLLECTIVELY FOCUSING ON CITIZEN INCLUSION IN ALL OUR DIGITAL DECISIONS

EMBRACE DIGITAL INTO OUR CULTURE

LEARN AND CONVERGE AS AN ICS

UPSKILLING WORKFORCE AND COMMUNITIES IN DATA LITERACY

GOVERN AND MANAGE OUR DIGITAL PORTFOLIO TOGETHER

COMMIT TO STREAMLINING PROCUREMENT ACROSS THE ICS

Embracing digital into the ICS Culture

As we forge our digital journey, significant transformations are on the horizon for our Integrated Care System. Over the next five years, we'll roll out large-scale digital initiatives, from new Electronic Patient Record (EPR) systems to infrastructure overhauls and enhanced cyber security measures. These changes will profoundly impact how we operate and communicate.

We must share lessons learned and actively reshape our organisational culture. We're challenging outdated modes of operation, aiming to become an ICS where digital tools aren't just facilitators of better care—they're catalysts that inspire our teams and organisations to communicate more effectively and deliver superior care across the entire system.

The culture principles our organisations and partnerships will adopt:

We support and empower our staff and citizens to understand the opportunities of digital ways of working

Staff and citizens are properly prepared for digital change

Digital Communications are honest, timely, relevant and engaging

Actions that our organisations and partnerships will embed to embrace culture:

- Organisations and partnership staff surveys to understand staff confidence and capabilities in digital.
- Digital change management programmes supporting the change in culture and help staff embrace and feel confident with new ways of working.
- Digital skills training to embed digital-first culture within the ICS.
- Super user programmes for ICS Wide digital programmes, which will enable staff to act as champions of new systems.
- Staff feedback sessions to input into digital expectations and current experiences.
- Hold regular digital meetings including a representative from all ICS organisations to raise issues, lessons learnt and direction.

Learn and converge as an ICS

To deliver digital initiatives across the ICS, transparent ways of working that encourage collaboration and learnings from all organisations and partnerships across the ICS are required to embed a ‘Joined Up’ culture.

The momentum behind our Integrated Care System's Digital Transformation journey hinges on robust collaboration. By pooling resources, sharing hard-earned lessons, and aligning behaviours across organisations and partnerships, we're setting the stage for enhanced interoperability and higher-quality care and services throughout Shropshire, Telford, and Wrekin.
This collaborative ethos strengthens our ICS and fosters valuable partnerships with neighbouring ICS’, ensuring patients experience a seamless and consistent continuum of care.

Actions that our organisations and partnerships will embed to embrace collaboration:

- EPR collaboration group to share lessons learnt, strategic direction and challenges.
- Infrastructure collaboration group to share lessons learnt, strategic direction and challenges.
- Post implementation teams to support the transition into business as usual and a managed service.
- Co-ordinate shared resources to make the best use of the capabilities and skillsets across the ICS.
- Converge Digital resources where possible to have one single point of contact.
- The ICS’ Digital plans will support the overall ICS Strategy of being more joined up across organisations and partnerships.
- Collaborate across the ICS to learn and develop and seek opportunities for innovation.

Commit to streamlining procurement across the ICS

To ensure we provide all organisations with ‘value for money’, there is a collective ICS commitment to collaborate with current and future suppliers to procure hardware and software.

Our Integrated Care System is taking steps to future- proof our long-term supply chain strategy by reaching a consensus on a unified approach and shared goals. This will enable us to secure more enduring and sustainable contractual agreements across the ICS network.

We aim to amplify our purchasing power through a coordinated approach to market engagement and supplier selection, thereby forging more resilient and lasting partnerships that best serve our system's needs.

Actions that are required to embed a more streamlined supply chain:

- Coordinate a Contract renewal group that identifies opportunities for collaboration across the ICS.
- Streamline procurement and supplier service offerings across the ICS to achieve more significant economies of scale.
- Review contracts as a system to ensure the ICS is getting the best value for money and achieving purchasing power.
- Ensure decision-making is made at a system level and collaboration with procurement needs.
- Identifying each organisations current procurement & contract renewal to find opportunities for collaboration across the ICS.

Upskilling workforce and communities in data literacy

If, as an ICS, we want to embed a digital-first culture, we must ensure our workforce and community meets a minimum level of data, digital and cyber security literacy to enable this culture to exist within the ICS

As technology advances, it's crucial to equip our workforce across the ICS with the digital skills they need to excel. We're committed to upholding a baseline level of digital, data, and cyber literacy and will support staff in reaching this competency. Focusing on crucial strategies like 'Growing for the Future' and 'Looking after our People' will help cultivate an engaged, skilled workforce eager to develop alongside us, fostering a thriving work culture.

Simultaneously, we aim to empower our community to manage their healthcare digitally, streamlining our services. By encouraging community skill development and listening to citizen needs, we can custom-tailor digital engagement, making health and care more accessible and promoting a 'Digital First' culture.

Actions that are required to embed culture:

- Current capability analysis across ICS workforce and community digital, data and cyber security literacy via surveys.
- Support the workforce through training modules to increase data literacy.
- Utilising new and existing forums through all organisations and partnerships to work with the communities to increase digital health literacy.
- Support all staff to attain a basic level of data, digital and cyber security literacy, followed by continuing professional development.
- Provide a Digital resource with the mandate to support and improve staff digital literacy skills.
- Network of digital champions across the ICS to empower ‘Digital First’ mentality.

Work for patients collectively focusing on citizen inclusion in all our digital decisions

Creating an environment that encourages and empowers citizens' voices when making digital decisions will drive the innovation of the delivery of care. It will be a critical feature in the success of delivering digital transformation across Shropshire, Telford & Wrekin.

As our Integrated Care System matures digitally, it's vital to include citizens in shaping the future of digital healthcare, thereby helping us prioritise initiatives. Drawing on input from partners, clinicians, staff, and users allows us to pinpoint what's effective, what needs refinement, and what truly matters to our community in Shropshire, Telford & Wrekin.

Citizen engagement is a cornerstone of our ICS and aligns with the patient-centred ethos outlined in the recent Hewitt Review. Through interactive platforms like the 'Big Health and Wellbeing Conversation', we actively seek your feedback for service improvement. Council-led efforts further this aim; for instance, our local Councils are expanding community engagement with initiatives like the library tablet lending scheme and the 'Get Connect' Programme. These programs empower citizens, especially seniors, to navigate digital healthcare services comfortably.

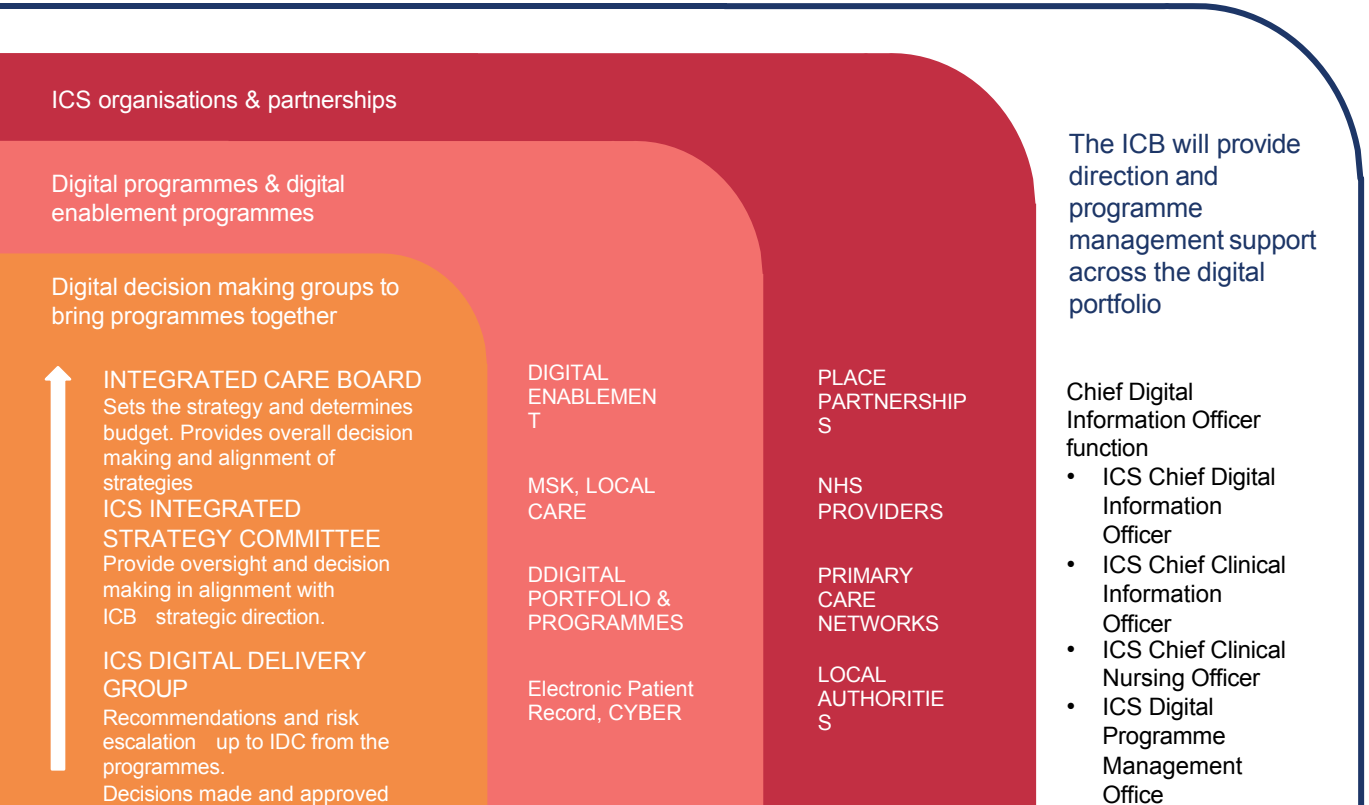
Actions that are required to embed culture:

- Proactively seek community feedback on existing digital functionality for managing your own health, and input into digital developments.
- Develop an ICS Digital inclusion strategy adopting principles from the national strategy, where citizen engagement groups will be included.
- Identify the needs and preferences of the population across STW and use this insight to inform and develop digital strategies.

Embracing digital into the ICS Culture

We will adhere to the formal governance structures and ways of working of the Shropshire, Telford and Wrekin ICS and the Place Partnerships.

Our role is to assist our organisations in planning, executing, and refining digital services for our community. To do this, we'll offer unified strategic oversight across all digital transformation efforts detailed in this Strategy. This governance framework enables us to advocate for a system-wide approach to digital initiatives, ensuring they deliver value for money.



Aligning to What Good Looks Like guidelines we commit to investing in ICS-wide Chief Clinical Information Officer and Chief Nursing Information Officer functions. To deliver against this Strategy and to continue to improve our services through digital we need better digital cohesion, collaboration and coordination. We have identified vital interventions which are needed to take place in order to realise benefits:

- Increase ICB capacity to provide greater structure and oversight to enable effective decision-making aligned to the vision associated with national and local objectives. In enabling and prioritising a portfolio of work, there is an opportunity for financial efficiencies to be explored and realised.
- The ICS must define its digital vision and build capabilities to achieve short and long-term priorities. By creating a centralised workforce and enhancing current capabilities, the ICS can achieve the greatest value and build towards long-term strategic objectives with the future vision of a digital shared service.
- Establishing transparent governance within the ICS to ensure that the direction of travel is clear, staff are supported to deliver against priorities promptly, and there is appropriate accountability and decision-making.
- To achieve the desired digital transformation outcomes across the ICS, identifying opportunities for greater collaboration across all organisations will enable efficiencies across the ICS by sharing knowledge, processes and resources.
- STW ICS' approach to culture change must evolve to secure leadership, clinical and non-clinical buy-in

Contacts & Useful Links

For further information about the Shropshire, Telford & Wrekin (STW) ICS and our partner organisations across health and social care systems, please see the links to the right to find out more about each organisation via their website.
Additionally, you can find links to Organisations Digital Strategies.

The Shrewsbury and Telford Hospital Website

The Robert Jones and Agnus Hunt Orthopaedic Hospital Website

Shropshire Community Health NHS Trust Website

Midlands Partnership University NHS Foundation Trust Website

West Midlands Ambulance Service Foundation Trust Website

NHS Shropshire, Telford and Wrekin Website

Shropshire Council Website

Telford & Wrekin Council Website

Shropshire, Telford & Wrekin Primary Care Networks Website

The Shrewsbury and Telford Hospital Digital Strategy

Shropshire Council Digital Strategy

Telford & Wrekin Council Digital Strategy

Should you wish to contact STW ICS regarding this digital strategy or offer any feedback, please email: stw.generalenquiries@nhs.net

JFP Section: "Digital as an Enabler of Change"

In 2023-24, we took our first steps together on our system digital maturity journey through the development of our first ICS Digital Strategy (June 2023). While sharing our ambitious vision and aligning with national objectives, the strategy provides markers to help system partners 'go together' in ways of working and shines a light on important digital programmes aimed to support clinical and care service development and transformation.

> ***We will use digital to improve care for citizens, support our staff and enhance how we work together as an Integrated Care System, delivering our collective ambitions.***
>
> ***- STW Integrated Care System Digital Vision, 2023-2028***

Moving through the strategy development activities to identify and prioritise our digital programmes, we identified fourteen portfolios of programmes underpinning the strategy.

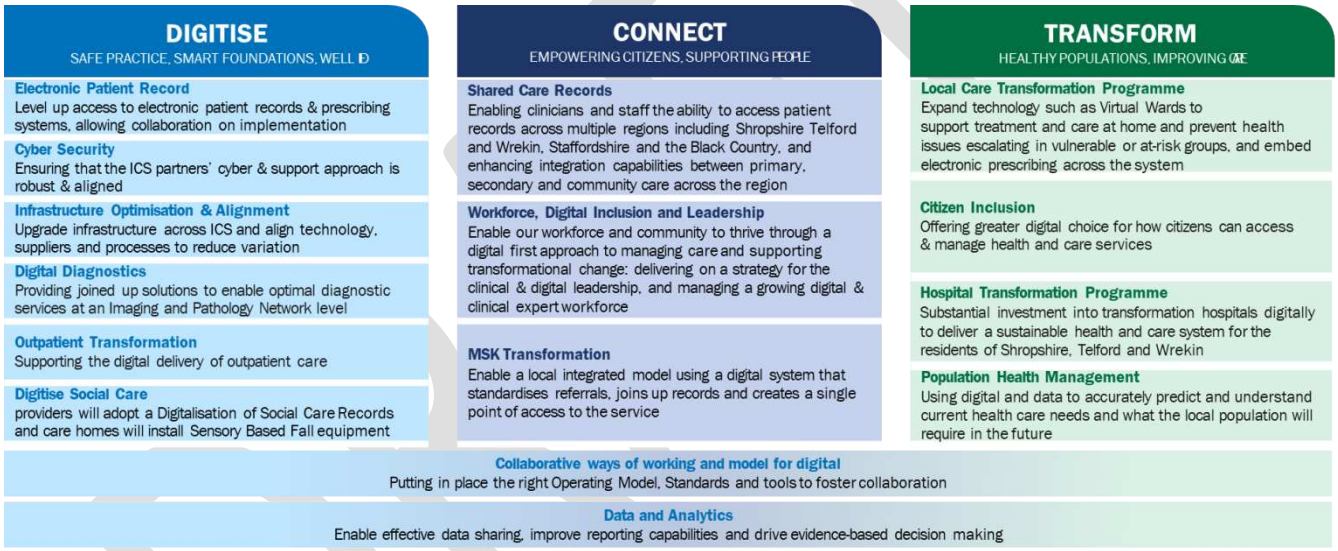


Figure 1 - Our ICS Digital Portfolio 2023-2026

Our ICS Digital Strategy is aligned to the What Good Looks Like Pillars and the aims of the NHS Long-Term Plan. Programmes were selected in line with our system digital maturity assessed as part of the national Digital Maturity Assessment process.

The following table provides a brief description of each portfolio identified. Each portfolio has an initial, prioritised programme of activities. We focussed on key programmes in year one of the delivery of our strategy.

ICS Digital Portfolio	Description
Infrastructure	Upgrade infrastructure across ICS and converge where appropriate to reduce variation
EPR Implementation	Health and care systems were asked to 'converge' on the implementation of electronic patient records (EPRs), sharing information, lessons learnt, challenges and potentially resources to improve the development journey for other digital teams seeking to implement or significantly upgrade existing solutions. This portfolio includes programmes and projects like the refresh of end user devices, providing trolleys into clinical areas, upgrade and networking of vitals medical devices (Welsh Allen) to enable direct input to record, upgrading Trust wi-fi for workforce and public as well as the upgrade and implementation of additional clinical interfaces
MSK Transformation	Enable a centralised musculoskeletal (MSK) service to use our core EPR connected to the national e-Referral Service (eRS) to manage referrals.
Outpatient Transformation	Implement the Electronic eyecare Referral System (EeRS) to enable a secure, electronic system for the two-way transfer of patient and clinical data (including images) between eye care services and with GPs.
Digitalisation for Social Care Records	Aim for 80% of adult social care CQC registered providers will adopt a DSCR by March 2025, with 10% of care homes piloting Sensory Based Fall equipment for our residents most at risk of falls.
Local Care Transformation	Enable patients to receive care at home safely and conveniently, releasing capacity for acutely unwell patients
Cyber Security	Develop our cyber security support to organisations on a 24/7 basis, including services to protect medical devices in our system, while increasing cyber capability across health and social care
Collaborative ways of working	Develop an inclusive framework to for joined up ways of working, establishing key groups where learning is exchanged, and where sensible, shared resources may be utilised.
Data and Analytics	Enable our ICS data set to enable population health management for joined up analytics, reporting tools and capabilities for the system
Shared Care Records	Deliver live, integrated health, mental health and social care records to NHS and social care organisations within ST&W as well as neighbouring ICSs - Black Country and Staffordshire, Stoke on Trent ICS.

Also in our ICS Digital Portfolio, we identified the following programmes which will have more focus in 2024-25:

ICS Digital Portfolio	Description
Citizen Inclusion	Provide clinicians seamless and reliable capability to consent patients for upcoming procedures removing the need for paper and provide citizens the ability to manage their own health and care via digital solutions, where appropriate.
Workforce, digital inclusion and leadership	Enable our staff to thrive through a digital first approach to delivering care
Digital diagnostics	Single ICS wide system that is hosted at SaTH for pathology and radiology services, providing joined up solutions to enable optimal diagnostic services at a network level. In addition, ST&W ICS is seeking to align with the West Midlands Imaging Network to easy sharing and storing images across the sub-region.
Procurement and Supply Chain	Enable a joined up procurement approach across our system partners to maximise our local purchasing power, identify opportunities for potential savings and additional services needed within our investment envelope.

Key Portfolio spotlight:

EPR Implementation, Infrastructure and Cybersecurity

Like an iceberg, there is much users do not see below the water line when considering digital and technology infrastructure. Electronic Patient Records (EPRs) are core digital platforms that capture vital patient and workforce data during the delivery of clinical and care services across our settings – primary care including general practice, pharmacy, optometry, dentistry, community services, mental health, acute services, urgent and emergency care as well as Adult Social Care, Children's Services and care in the community.

These solutions are long-term investments and require significant resource to ensure they are fit for the future. As with all digital technologies, these solutions rely on storage, compute power, have robust and resilient connectivity and must be secure from internal as well as external threats. We might be more familiar with 'digital apps' like the NHS App, mobile and medical devices and the wi-fi connections that enable us to access the information that these solutions -- hold, share and display when we are accessing our personal health and care records including appointments, test results, prescriptions, consultations, care plans and more.

In 2023-24, all of the ICS partners embarked or continued on ambitious programmes to develop their EPRs, improve their connectivity, secure those networks and implement the digital building blocks also known as modern infrastructure and platforms to enable future services like personalised care access, engagement portals, virtual and remote consultations, integrated pathways for diagnostics for faster test results, services to enable care at home and in the community.

Digital Social Care and Adult Social Care Self-Service

- Shropshire has smallest budget in the whole of England, but in the Midlands, ST&W are one of the top performers, ending Year 2 of the national Digitising Social Care (DiSC) Programme with a bang.
- The Digital Transformation fund has supported the digitalisation of social care care records with care providers 2022/2023 and 2023/2024.

Innovation – DHSC CareTech Fund

- Shropshire Council, in partnership with domiciliary care providers, Shropshire, Telford and Wrekin ICB, My Home Life England and TEC suppliers were awarded funding of almost £1.2m over two years to embed technology in people's homes alongside a virtual care delivery service to help meet care and support needs digitally.
- The programme aims to support independence in the home, help people manage their daily needs and promote self-care.

Innovation - NHS Health Tech Adoption and Acceleration Fund (HTAAF)

- Awarded £698,000 to support the adoption and acceleration of technologies that can improve patient care and bring clinical system benefits, our system is focusing on 3 projects supporting MSK service transformation and a pilot to support clinical productivity through advanced clinical guidance search.

From just a few of our achievements to our ongoing system risks, it is important to note that 'Digital' is specifically recognised in two strategic risks in our Board Assurance Framework:

- Strategic Risk No.2: Risk of not delivering sustainable services within available resources.
- Strategic Risk No.5: Lack of capacity and strategy to develop and use digital and data systems to enable efficient and effective care across the ICS

Actions taken in 2023-24 to improve our risk position:

- An ICS Digital Strategy was developed and the related system digital portfolio is planned for Board review/approval March 2024
- A Chief Digital Information Officer function was proposed to convene and drive leadership, collaboration and integrated digital service design and portfolio delivery, making the most of the spread of our digital capabilities across system partners
- STW One Health & Care (our integrated care record) programme has had a health check with actions identified for members January 2024
- Cybersecurity is an identified priority in the system digital portfolio
- Amend our ICS Digital Strategy from a 3 year span to 5 years, aligning with our Joint Forward Plan.

To mitigate these risks while undertaking digital transformation, we require leadership commitment to provide system resources for portfolio alignment, design and delivery of change:

- Invite Digital to review the financial allocation formulae, assumptions in investment forecasting across ICB and system transformation portfolios, and budgets for 3-5 years for approved system digital portfolios (programmes and projects)

- Identify and close gaps between ‘digital’ commissioning, procurement, contracting and supplier management
- Unblock recruitment for vital digital and IT roles that underpin prioritised clinical and care programmes and operations
- Advocate for multi-year digital and IT investment including tooling, operational improvements, aligned analytics and our system commitments to involve our people and communities in decision-making through integrated service design
- Advocate for appropriate investment in workforce digital capacity and community skills, resources and support
- Review and agree where system controls for partner financial risks related to ‘digital’ solutions for integrated care may be incorporated into System Controls
- Make it easier for stretched multidisciplinary teams responsible for digital design, planning and delivery to conduct integrated risk and benefits management that addresses clinical safety, financial sustainability and innovation for essential and enabling digital capabilities that serve the people in Shropshire, Telford and Wrekin ICS
- Ensure digital operations for Primary Care, Pharmacy and Medicines Optimisation, Digital Inclusion, SCC/EPRR, Cybersecurity, Integrated Care Records, decommissioning legacy tech and essential infrastructure, connectivity and productivity are continuously monitored for improvement, further investment, replacement or decommissioning

Despite 2023-24 being a particularly difficult one for ‘digital’ due to significant changes in leadership, the ICB Management of Change, budget pressures, a core data and digital contract review and external pressures, we celebrate the continued commitment and contributions of our partners, teams and communities in our first system digital steps together.

In 2024-25, we aim for wider participation and allocated time with clinical and care professionals, people in our places and communities in evolving and developing our system digital capabilities and this portfolio of portfolios.

We will also include portfolios of programmes that commenced while we were developing our strategy, such as:

- Modernising General Practice
- Building our Data analytics and population health capabilities
- Developing our digital inclusion framework supporting health equity, alongside a system digital change management framework
- Pharmacy, Optometry and Dentistry – including our work on Pharmacy First and the Community Pharmacy model of care
- Developing our system Cyber Security Strategy
- Live programmes to identify and build digital literacy skills, resources and support for our communities and workforce

Our next steps include Board approval of our ICS Digital Strategy 2023-2028, continuing to socialise the vision, adapting our approaches for delivering programmes across the system, developing mechanisms for inclusive co-production by evolving our digital practices in

engagement and co-design, while building on our evolving digital capabilities for sustainable delivery.

Action	Owner	Timescale
Embrace Digital into our culture	Digital Transformation Lead	Carry over from 2023-24
Learn and converge as an ICS	Digital Transformation Lead	Carry over from 2023/24
Streamline procurement across the ICS	Digital Transformation Lead	Carry over from 2023/24
Upskill workforce and communities in data literacy	Digital Transformation Lead	Carry over from 2023/24
Work for patients collectively focusing on citizen inclusion in all digital decisions	Digital Transformation Lead	Carry over from 2023/24
Govern and manage our digital portfolio together	Digital Transformation Lead	Carry over from 2023/24
SATH EPR programme - Implement Careflow Patient Administration System (PAS)	Director of Digital Transformation	April 2024 Go Live
SATH EPR programme - Implement Careflow Connect, Electronic Prescribing and Medicines Management (EPMA) and Order Comms	Director of Digital Transformation	Moved from 2024-25 to 2025-26

Agenda Item

ICB 27-03-026

Integrated Care System Performance Report

Integrated Performance Report

March 2024

Operational Performance

The validated activity data month for the purposes of this report is January 2024 however, where possible more current unvalidated data from providers has been included. Some Mental Health Indicators may lag behind the January data month.

This month, charts show performance against national targets using the Making Data Count (MDC) methodology: this uses Statistical Process Control (SPC) to better illustrate variation in performance over time and enable the identification of Special Cause Variation in performance data. SPC is far more useful at identifying significant changes than, for example, comparing year-on-year or month-on-month performance. Charts produced in this manner feature the following key:

Variation				Assurance		
						
The default grey line is for common cause variation, with no significant change.	Variation points highlighted in orange: special cause of concerning nature or higher pressure due to values being H – higher or L – lower.	Variation points highlighted in blue: special cause of improving nature or lower pressure due to values being H - higher or L – lower.	Purple arrows represent special cause variation; neither a concern nor an improvement	A question mark indicates inconsistent performance, with indicator passing and failing target.	Charts with a blue P are those in which metrics consistently achieve target. Such charts will not normally feature in this report unless a significant risk is foreseen.	Where indicated with an orange F the target is consistently missed, and no assurance can be given based on past performance.

The charts feature a black line to represent the mean, and a red line to indicate relevant targets.

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Performance against the operational metrics using the MDC principles is summarised below in a matrix of assurance against current performance:

SPC Matrix		Assurance		
		Consistently Failing the Target	Inconsistently Achieving the Target/No Target	Consistently Achieving the Target
Variation	Concerning Variation	◆ UEC: A&E 4 hour performance achievement (Type1&3) - STW ◆ UEC: A&E 12 hour DTA breaches	◆ LDA: CYP with LDA in a MH Inpatient Unit (per million)	
	Normal Variation	◆ Cancer: Referral to treatment < 62 days % ◆ Mental Health: Talking Therapies access ◆ LDA: Adults with LDA in a MH Inpatient Unit (per million) ◆ LDA: No. of Annual LDA Health Checks for persons aged 14 years	◆ UEC: Cat 2 Response Mean time ◆ UEC: No Criteria To Reside – Average patients not discharged - SATH ◆ Community: Virtual Ward occupancy % of capacity ◆ Primary Care: Total Primary care appointments ◆ Primary Care: No. of GP appointments attended within 2 weeks ◆ Primary Care: No. of GP appointments attended same or next day ◆ Primary Care: GPs in Post (FTE) ◆ Primary Care: Direct Patient Care in Post (FTE)	◆ Community: 2hr Urgent Community Response
	Improving Variation	◆ Planned Care: Incomplete RTT pathways of 65+ weeks - STW ◆ Diagnostics: All Diagnostics - < 6ww against target ◆ Cancer: 28 Day Faster Diagnosis Standard (STW) ◆ Cancer: Waits >62 days for treatment (SaTH) ◆ Mental Health: OAP - Number of inappropriate bed days ◆ Mental Health: Dementia diagnosis rate ◆ Mental Health: CYP - persons U18 supported with at least 1 contact ◆ Mental Health: Adult CMH - number of people who receive 2+ contacts ◆ Mental Health: Adult SMI Physical Health Checks	◆ Primary Care: ARRS - WTE	◆ Mental Health: Patients accessing perinatal mental health
Insufficient data			◆ Planned Care: VWA - STW	

1. Primary Care

KPI	Latest Month	Value	Target	Variation	Assurance	Mean
Primary Care: Total Primary care appointments	Jan 24	276183				243,038
Primary Care: No. of GP appointments attended within 2 weeks	Jan 24	85.0%	88%			84.4%
Primary Care: No. of GP appointments attended same or next day	Jan 24	54.9%	54%			53.0%
Primary Care: GPs in Post (FTE)	Jan 24	305				301
Primary Care: Direct Patient Care in Post (FTE)	Jan 24	152				149
Primary Care: ARRS - WTE	Feb 24	283	260			213

1.1 The new GP contract has been published and focuses on:

- Cutting bureaucracy
- Helping practices with cash flow and increasing flexibilities
- Giving PCNs more staffing flexibility
- Simplification of directed enhanced service (DES) requirements
- Increasing autonomy for PCNs
- Improving patient experience of access

1.2 Eight key reporting metrics are required from practices with reporting to become automated in October 24. An updated delivery plan will be published though the date has yet to be confirmed.

1.3 Reviews of PCN Capacity and Access Improvement Plans (CAIP) have been undertaken with all eight PCNs in February to assess progress and provide additional support to teams where required. The ICB will be working with PCN teams to ensure that they have the evidence available for the end-of-year reviews scheduled in May. The panel and approach for the reviews will be based around the three national measures that each plan has to contain:

- Patient experience of contact
- Ease of access and demand management
- Accuracy of recording in appointment books

1.4 The Primary Care Access Recovery Plan (PCARP) included 13 metrics to manage performance, however, for some metrics the target or calculation methodology for STW is yet to be confirmed. Performance against the measures available are detailed below.

1.4..1 Except for Additional Roles Reimbursement Scheme (ARRS) posts which is showing improving variation, all reported metrics are showing normal variation and inconsistently meeting the target.

1.4..2 The Pharmacy First Scheme commenced 31st January, to supply some prescription-only medication where clinically appropriate for 7 conditions, without the need for a GP appointment or prescription. STW were the only system in the Region to have 100% sign up by community pharmacies. Together with the expansion of blood pressure checks and provision of oral contraceptives this has the potential to remove 10 million appointments a year (nationally) when fully scaled. Activity data for STW will be available at the end of March.

1.4..3 Digital workstreams are showing positive progress with 98% of practices already having advanced telephony systems in place. For the remaining practices installation has been delayed due to supplier capacity but should be implemented by mid-April 2024. All practices have high quality online/workflow tools in place.

2. Urgent Emergency Care

KPI	Latest Month	Value	Target	Variation	Assurance	Mean
UEC: No Criteria To Reside – Average patients not discharged - SATH	Feb 24	104	113			134
UEC: Cat 2 Response Mean time	Feb 24	00:50:21	00:30:00			00:55:37
UEC: A&E 4 hour performance achievement (Type 1&3) - SATH	Feb 24	49.9%	76%			52.5%
UEC: A&E 12 hour DTA breaches	Feb 24	860	0			748
Community: Virtual Ward occupancy % of capacity	Feb 24	65.3%	80%			62.2%
Community: 2hr Urgent Community Response	Jan 24	73.5%	70%			93.0%

2.1 STW was moved into Tier 1 oversight by NHSE for UEC in February. NHSE are supporting the system to agree programmes of work for 2024/25 that will deliver the goals and targets to improve UEC performance. The programme will consist of the following workstreams and reporting structures and project documentation will be agreed by the end of March:

- Alternatives to ED
- Accident & Emergency Medicine
- Medical and internal Professional Standards (IPS)
- System Discharge
- System-wide Frailty
- Care Coordination
- 4-hour Performance

2.2 Several factors, in addition to normal seasonal variation have impacted on the system's UEC performance over the winter period and include Industrial Action and Critical incidents with the following impact.

2.2.1 A&E performance metrics have been showing concerning variation for several months and consistently fail the national targets at both 4-hour performance and 12-hours following a decision to admit (DTA). Improvements have been seen in time to initial assessment within 15 minutes with performance at or near target for the last 3 months.

This improvement in performance has been sustained through the winter period, when historically performance has worsened.

2.2.2 Ambulance metrics for Category 2 response times and handovers within 60 minutes are both showing normal variation and are failing the target.

2.2.3 The number of patients with no criteria to reside (NCTR) and not discharged from hospital beds whilst showing normal variation has improved over the last six months and exceeded the year-end target in February. The average length of stay of patients with NCTR has also reduced and has exceeded plan in month.

2.2.4 Pre-hospital services of Virtual Wards (VW) utilisation rates and 2-hour Urgent Care Response (UCR) rate remain within normal variation in February, with UCR consistently exceeding the target. VW capacity increases incrementally in line with the plan but unless occupancy increases in line with capacity utilisation will decrease. A risk has been highlighted to the ICB UEC Board regarding challenges with the ability to recruit and a higher than planned number of face-to-face visits.

3. Planned Care

KPI	Latest Month	Value	Target	Variation	Assurance	Mean
Planned Care: VWA - STW	Jan 24	104%	100%			103%
Planned Care: Incomplete RTT pathways of 65+ weeks - STW	Jan 24	730	0			1,374
Diagnostics: All Diagnostics - < 6ww against target	Jan 24	75.5%	85%			65.5%
Cancer: Waits >62 days for treatment (SaTH)	Feb 24	263	212			463
Cancer: Referral to treatment < 62 days %	Jan 24	49.4%	85%			46.8%
Cancer: 28 Day Faster Diagnosis Standard (STW)	Jan 24	70.5%	75%			64.4%

3.1 Whilst Cancer services continue to be challenged, the system has achieved and exceeded the fair shares target of 212 for the backlog of patients waiting more than 62-days for treatment on the 13th March with 193 still waiting. Work is ongoing between SaTH and the ICB to meet the criteria for exit from Tier 1 by the end of Quarter 1 24/25.

3.2 The latest data shows that the Faster Diagnosis Standard (FDS) has continued to improve to 77.9% in February against the end of March target of 75%. Lower GI referrals with a FIT result have also exceeded target for several months. As performance of FDS improves, more patients will be seen within the referral to treatment (RTT) cancer waiting targets. January performance is 49.4% which is significantly below the current 85% target.

3.3 The 2023-24 Operational Plan sets a target of zero patients waiting more than 65 weeks by the end of the year, however, STW is forecasting there will be under 800 breaches in total. SaTH are predicting 550 breaches and RJAH 257. The system is performing better than revised H2 forecasts for 65-week waits which were expected to be 1124 in total.

3.4 A small number of 78-week breaches remain a concern and the system is forecasting there will be 4 at the end of March.

3.5 Because of the effect of Industrial Action (IA) in year, the System Activity Target (VWA) has been revised to 100%. The system VWA latest position in January is 102.5% which is 1.9% below the H2 submitted plan of 104.5% and a slight deterioration in month in line with the impact of IA. The system is forecast to achieve the ERF additional £5m.

3.6 The ICS is in recovery against the overall 6 weeks standard for diagnostics but is showing sustained improving performance with the latest validated position for January of 75.5% against plan of 85%. The ambition to have zero patients waiting over 13 weeks by the end of June 2023 was not achieved, with 962 patients waiting at the end of January. Whilst there has been significant improvement in MRI and CT there are several challenged modalities which are preventing achievement of this target; Endoscopy, Audiology and Urodynamics.

3.7 Business cases to increase capacity for Endoscopy and Urodynamics will need to be assessed through ICB and NHSE governance due to the system financial deficit. The Audiology service procurement is currently on hold, awaiting clinical review of risk by the ICB CMO. CDC Phase 3 to provide cardiorespiratory and tele-dermatology services has been delayed until the end of May due to building works issues.

4.0 Mental Health, Learning Disabilities and Autism

KPI	Latest Month	Value	Target	Variation	Assurance	Mean
Mental Health: Talking Therapies access	Jan 24	739	12948			605
Mental Health: Patients accessing perinatal mental health	Jan 24	885	501			759
Mental Health: OAP - Number of inappropriate bed days	Dec 23	370	0			487
Mental Health: Dementia diagnosis rate	Feb 24	61.1%	66.7%			59.1%
Mental Health: CYP - persons U18 supported with at least 1 contact	Jan 24	5700	8341			5,283
Mental Health: Adult SMI Physical Health Checks	Feb 24	2094	2879			1,751
Mental Health: Adult CMH - number of people who receive 2+ contacts	Jan 24	4280	4984			4,177
LDA: No. of Annual LDA Health Checks for persons aged 14 years	Feb 24	281	1858			152
LDA: CYP with LDA in a MH Inpatient Unit (per million)	Feb 24	20.0	10.0			20.0
LDA: Adults with LDA in a MH Inpatient Unit (per million)	Feb 24	58.5	30			50.2

4.1 NHS Talking Therapies access is showing normal variation in January following months of concerning variation due to necessary changes in counting and coding resulting in a recovery improvement and trajectory to achieve 7,064 referrals by March 2024. Recruitment of both qualified and trainee Psychological Wellbeing Practitioners (PWP) is progressing at pace and a communications programme launched in December is increasing referrals providing a revised forecast of 6,700 by the end of March.

4.2 Dementia diagnosis rates are showing significant and sustained improvement and have exceeded 61% in February with current projections of 61.5% by March 2024 against a target of 66.7%. A recovery plan has been in place since August

to increase the pace and rate of diagnosis. Temporary increases in capacity will now be extended into 24/25 whilst a review and service redesign are undertaken.

4.3 A core long term plan is for children under 18 to receive at least 1 contact against a target of 8,341 by March 2024. Performance is showing significant improvement but remains behind plan in January. The Forecast for March is 6,000 contacts,72% of the target. An improvement plan is in place but will take time to show in the metric due to it be being calculated on a rolling 12-month basis.

4.4 Psychiatric Intensive Care Unit (PICU) and Acute Out of Area placements demand is volatile but occupied bed days for inappropriate placements are circa 350 each month and remain above local plan of 180. The high demand is a national issue and is continually under review. A bed base review across STW and Staffordshire Systems led by MPFT and supported by NHSE commenced in January and will report in June/July 2024.

4.5 Women accessing Perinatal Mental Health services continues to exceed target by 76%. Waiting times from referral have seen improvement since December with the percentage of patients seen within 6 weeks at 100%.

4.6 The number of physical health checks for serious mental illness (SMI) remains below target with the rolling 12-month performance in February 2,094 against a target of 2,879 by March 2024. Activity increases significantly in Quarter 3 but it is not expected to meet the year-end target. A revised service specification was agreed at Commissioning Working Group which will improve the number and recording of health checks.

4.7 Adult access to community Mental Health teams is showing sustained improvement at the end of January and activity will continue to increase as Eating Disorders starts to flow into Mental Health Services Data Set (MHSDS) in 24/25.

4.8 Annual Health Checks (AHC) for patients with LD has an annual target of 75% of registered patients with February performance 1,536 year-to-date against a plan of 1858 and on trajectory to meet the target by March 2024. MPFT are supporting patients to increasing uptake of checks and reduce non-attendance (DNAs).

4.9 Inpatient stays for adults with a Learning Disability (LD) are 23 inpatients (58 per million population) in January against a plan for Quarter 4 of 11. A root cause analysis is completed for all new admissions to determine how the admission could have been avoided and that the admission was clinically appropriate and unavoidable.

4.10 There are 2 children (20 per million population) with LD in inpatient beds in February against a target of 1 child at the end of Quarter 4. Plans are in place to discharge 1 child in Quarter 1 24/25. Changes in an inpatient's condition can result in planned discharge being put on hold but the situation is closely monitored.

5. Quality

A summary of quality indicators is provided at Appendix B.

5.1 The System has exceeded its Infection Prevention and Control Metrics. C difficile has exceeded its annual national objective of 76 cases, with 127 cases to the end of January 2024. Quality assurance is provided by peer review visits but capacity issues at SaTH continue to prevent a consistent approach to the deep cleaning programme. Other infection metrics are also exceeding objectives and relevant partners all have action plans internally which are monitored through Infection Prevention and Control Groups. NHSE and ICB specialists provide support.

5.2 In response to the higher than the national average neonatal deaths SaTH has commissioned an external Neonatal Mortality Review from the Royal College of Physicians to review neonatal deaths occurring in the calendar years 2021-22, the final report is still awaited.

5.3 CHC 28-day assessment compliance is below national standard at 32.3% in quarter 3 from 47% in November 23 report which remains a declining position, however an action plan and improvement trajectory is having impact since this period and is under close analysis. NHSE regional support and oversight is in place with monitoring. The backlog of 52 cases is also expected to improve in the next reporting period.

5.4 There have been no reported never events in this period.

6. Finance

Month 9 Financial Position

Revenue:

6.1 At Month 11 the system has a year-to-date deficit of £71.1m, which is £65.2m adverse to plan, the year-to-date deficit is reduced following the receipt of a national allocation as detailed below.

6.2 In Month 11 the reported forecast of £72.7m (reduced from £129.8m) included the additional estimated costs of Industrial action. In Month 11 the system received a national allocation of £57.1m to fund the plan deficit – this was allocated to SaTH (£45.5m) and the ICB (£11.6m), this reduced the £129.8m forecast deficit down to £72.7m which incorporates the additional industrial action impact.

6.3 The main areas of overspend continue to be in SaTH and the ICB. For SATH these relate to key drivers around escalation costs, elective activity costs and staffing issues. The ICB 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.

6.4 Now At Month 11 most costs are now known so the risk has fallen to reflect that much of this risk is now crystallised into the position. The remaining unmitigated risk to delivery of the forecast position is reported as £5.2m at Month 11.

Capital:

6.5 At Month 9 an allocation to include IFRS16 impact was distributed to all systems to manage within. Current information suggests that there is £1.5m risk for the STW system based on current forecasts. All organisations are reporting slippage in phasing of internal programmes. Providers operational capital forecasts are in line with the full year allocation, a small amount of slippage may be expected.

7. Workforce

Cost & WTE

7.1 Our monthly ICS workforce dashboard enables us to track our trajectory of planned staff in post (WTE) and planned cost of that workforce against actual staff in post and actual cost. Data is taken from the Provider Workforce Returns and Provider Financial Returns to NHSE. The workforce dashboard does not contain Whole Time Equivalent (WTE) plan data for MPFT, and so it is therefore not possible to include MPFT in the actual vs plan part of the analysis.

- **Substantive WTE and Costs:** At the end of January 2024, when considering RJAH, SaTH and SCHT combined, the planned workforce requirement submitted to NHSE in Q1 for 2023-2024 has been exceeded by +331 WTE substantive staff, with costs for substantive staff exceeded by +£3.325M in month.
- **Bank WTE and Costs**: At the end of January 2024, when considering RJAH, SaTH and SCHT combined, the planned bank workforce has been exceeded by +141 WTE bank staff, with costs for bank staff exceeded by +£2.114M in month.
- **Agency WTE and Costs**: At the end of January 2024, when considering RJAH, SaTH and SCHT combined, the planned (anticipated) agency utilisation has been exceeded by +130 WTE agency staff, with costs for agency staff exceeded by +£1.6M in month.

7.2 SaTH is significantly above plan for substantive (+524 WTE), bank (+116 WTE) and agency (+74 WTE). This is due to:

- an improved vacancy position from 5.42% April 23 to 1% January 24. The cost of planned substantive workforce remains within funded establishment.
- higher than planned bank/agency is because of 300wte escalation workforce to ensure patient and system safety, 200wte for higher than planned workforce unavailability due to sickness, maternity and essential workforce training and 100wte due to higher than planned double-running whilst international workforce is supernumerary in preparation for required evidence for registration onto professional regulatory registers.

7.3 Despite variances from the operational plan, trends show improving position for agency WTE at system level with overall WTE and cost reducing from £4.5m in April 23 to £2.5m January 24.

Vacancy Position

7.4 The combined vacancy rate for MPFT, RJAH, SaTH and SCHT has been improving throughout the financial year and appears to have stabilised over the last three months to the region of 5.1-5.3%. The combined rate in January 2024 was 5.27%. This compares favourably against the national NHSE workforce vacancy rate of around 8.9% (Q2).

7.5 The Despite the low overall vacancy rate, there are some providers carrying greater risks with shortages across staff groups with critically higher vacancy rates which is reflective of the National Critical workforce shortage list. This is compounded by Shropshire's rurality where there is a disparity between available critically short workforce health care professionals in rural areas, compared to larger cities.

- There is an increasing shortfall trajectory across the Allied Health Professionals staff group, which is reflective of the national trend, STW ICS has an NHS provider vacancy rate of 13.4% with 126wte vacancies. The ICS has a workforce sharing agreement which enables mutual aid across NHS provides and more latterly Hope House as the first non-NHS provider. Provider partners are utilising this agreement and during 24-25 we will begin to see more workforce portability at pace, in particular the workforce sharing agreement has been utilised across theatre workforce between RJAH and SATH.
- The ICS received investment from NHSE to provide leadership to establish a system AHP faculty whose objective was to work together to attract and retain AHP workforce. The faculty has been stood down in 23-24 due to no further investment into leadership capacity. There is a risk that that there is no AHP Council to progress the AHP, medical or dental workforce workstreams. There will be a system nursing and midwifery council led by RJAH Director of Nursing

Sickness and Turnover Position

7.6 Considering sickness and turnover (in-month, not 12-month average), all NHS employers are performing well. Each employer set targets in their operational plan and the average of these is our system target. For sickness absence, our system average target is 5.3% and for turnover is 11.9%. At month 10, system sickness is at 5.52%, and turnover at 11.2%; both below target. Trajectories for SaTH, RJAH, MPFT and SCHT are consistently low with an improving trend.

7.7 In comparison with previous 12 months leavers rate trend by ICS's, STW and one other ICS has seen the greatest improvement in workforce retention compared to all other ICSs across East and West Midlands. Whilst it is difficult to

quantify any one action that has led to this improved position a combination of the activities at both system and individual provider level aligned to the people promise may be a contributory factor.

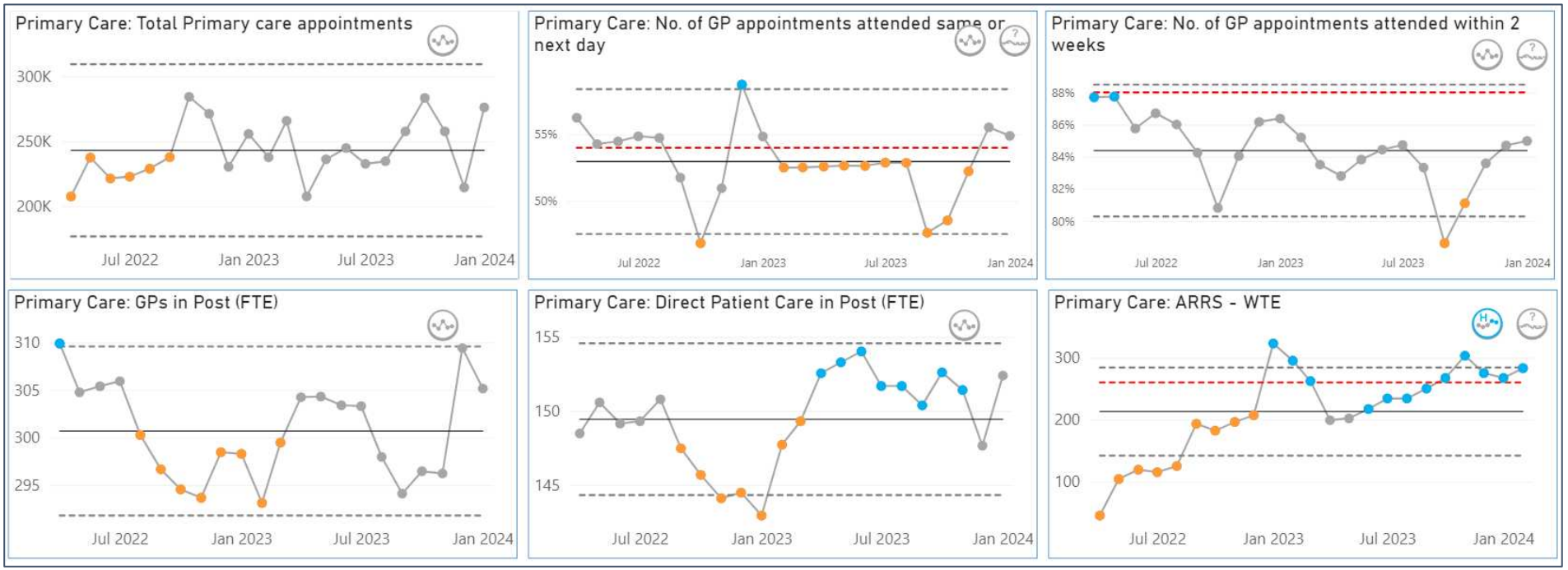
Next Steps

7.8 Our workforce plan for 2024/2025 has identified seven critical workforce roles by profession with the greatest workforce deficits. Where there is capacity to do so the system people programmes will focus on these seven areas, recognising some actions will be immediate and targeted, and others will be medium to long term.

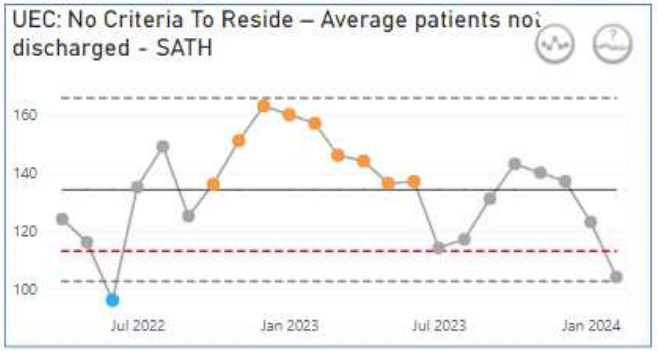
7.9 Through our system People Culture and Inclusion Committee, workforce and agency steering groups there will be greater oversight of workforce monitoring of changing trends or trajectories against plan and cost, escalation of risk and any necessary early required intervention to ensure this year's workforce plan remains on plan.

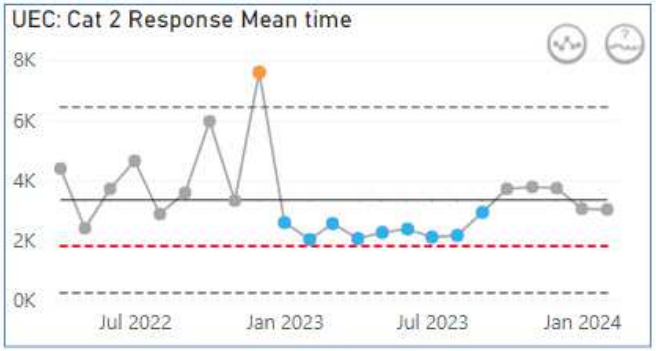
Appendix A – Operational Metrics

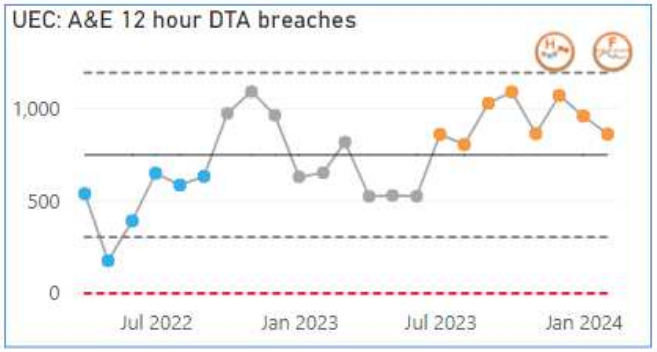
Primary Care

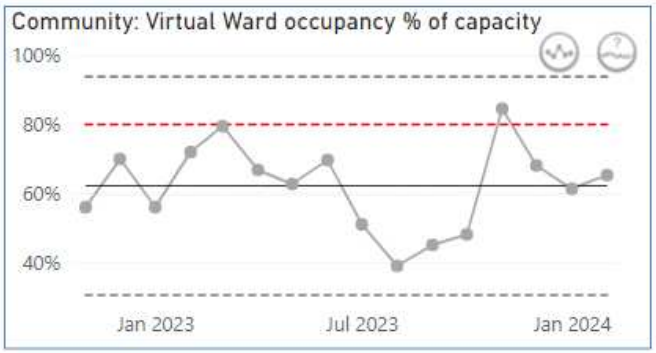


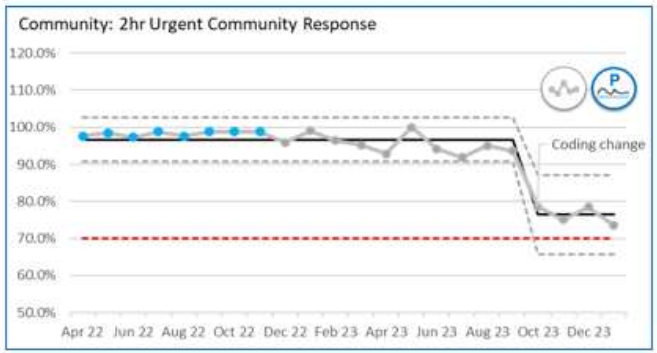
Urgent & Emergency Care



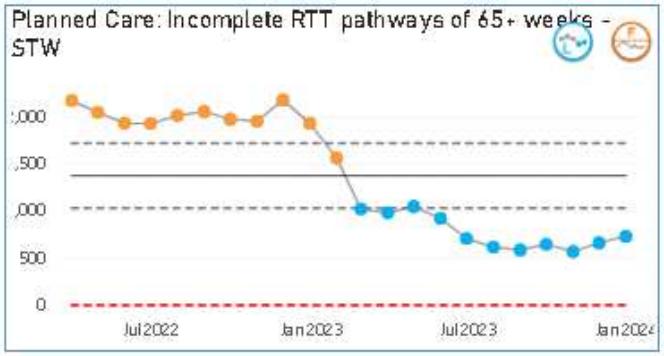


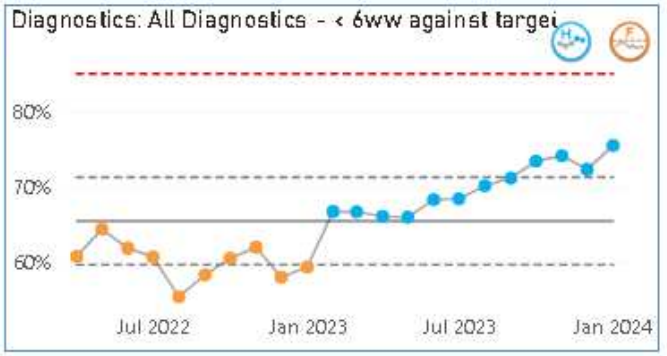


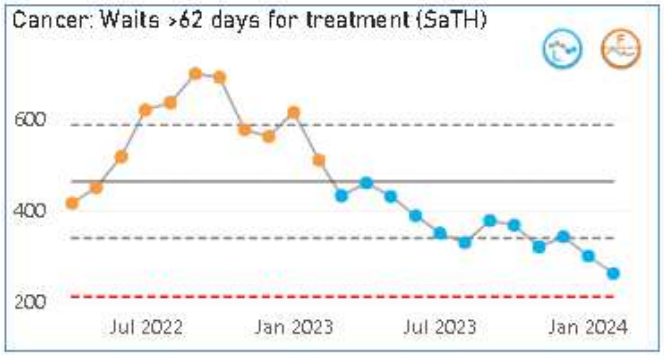


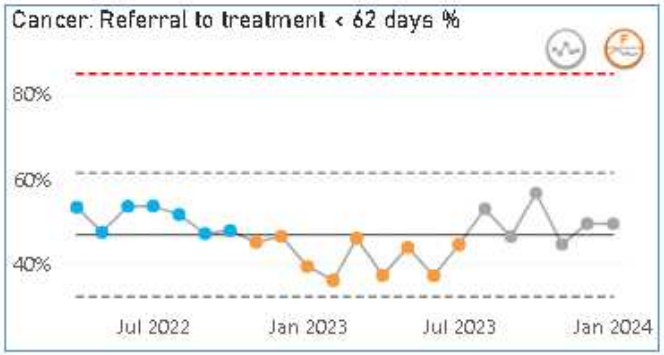


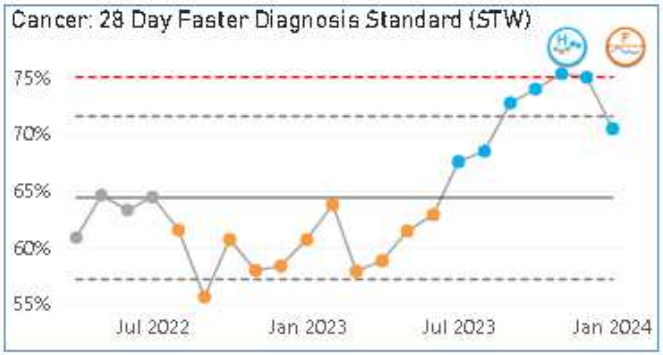
Planned Care – Elective



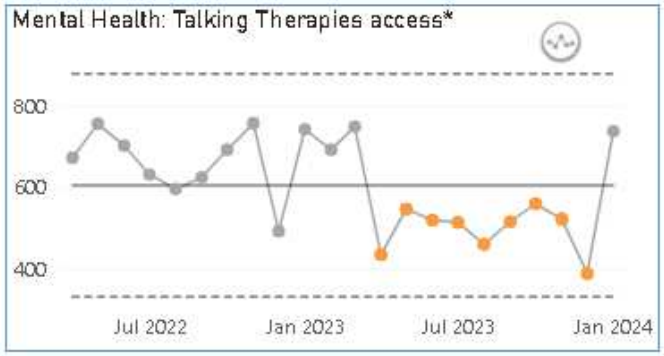


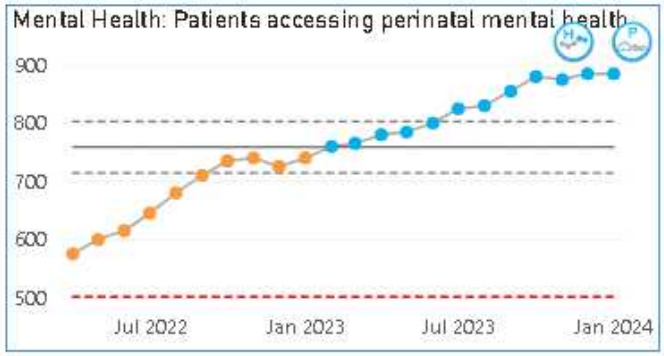


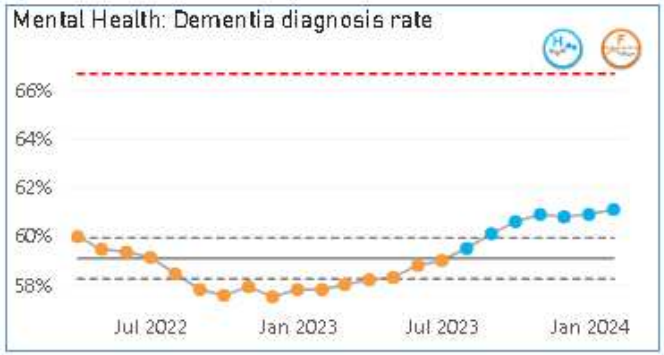


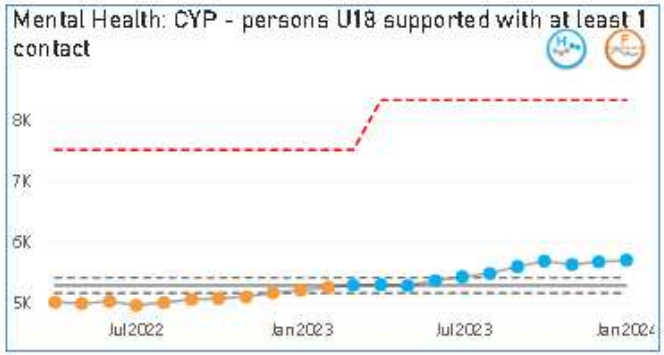


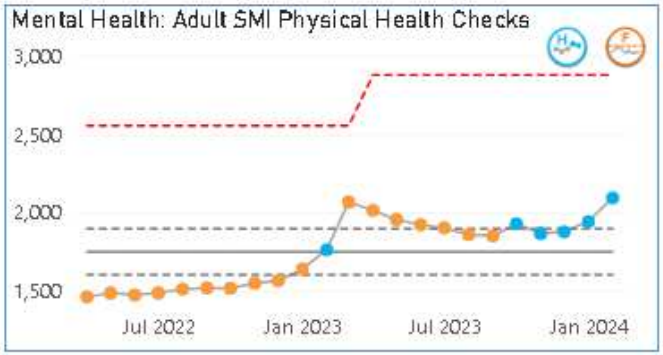
Mental Health, Learning Disabilities & Autism

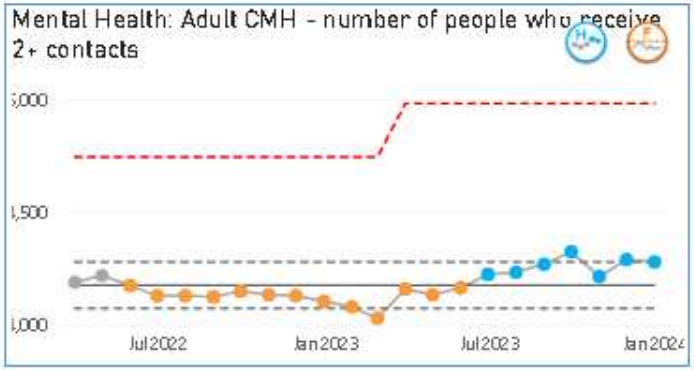


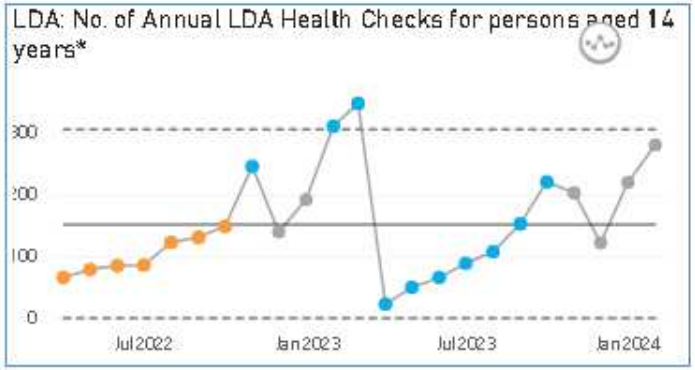


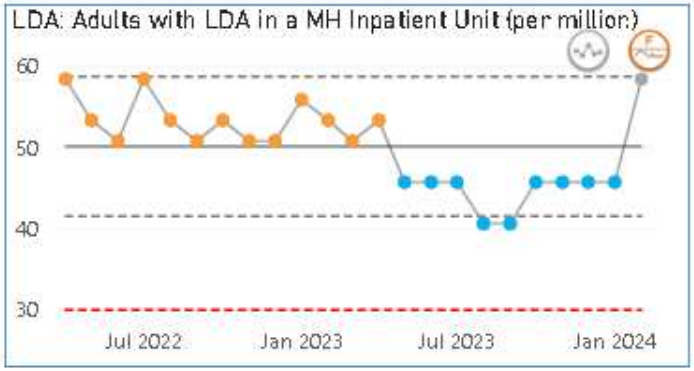


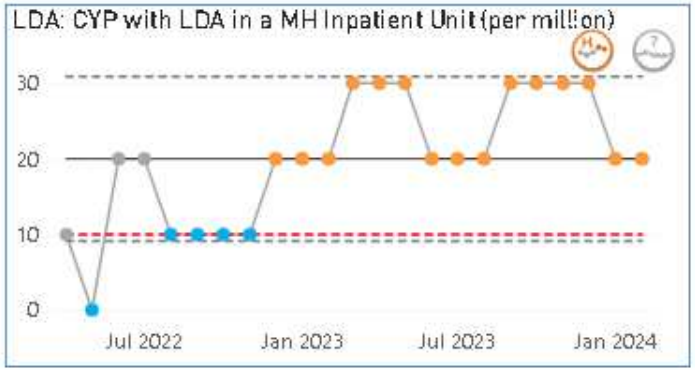





Mental Health: Adult CMH - number of people who receive 2+ contacts
,000
,500
,000
Jul 2022
Jan 2023
Jul 2023
Jan 2024


LDA: No. of Annual LDA Health Checks for persons aged 14 years*
300
200
100
0
Jul 2022
Jan 2023
Jul 2023
Jan 2024


LDA: Adults with LDA in a MH Inpatient Unit (per million)
60
50
40
30
Jul 2022
Jan 2023
Jul 2023
Jan 2024

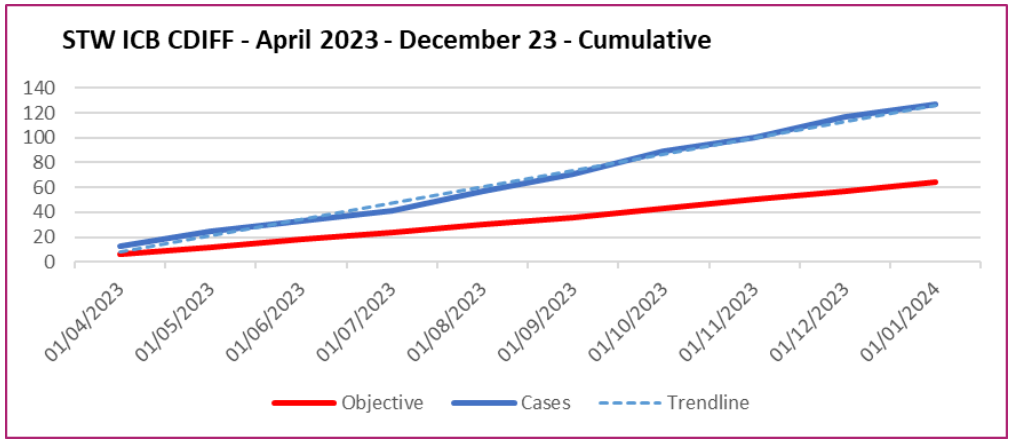

LDA: CYP with LDA in a MH Inpatient Unit (per million)
30
20
10
0
Jul 2022
Jan 2023
Jul 2023
Jan 2024

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Appendix B – Quality Metrics

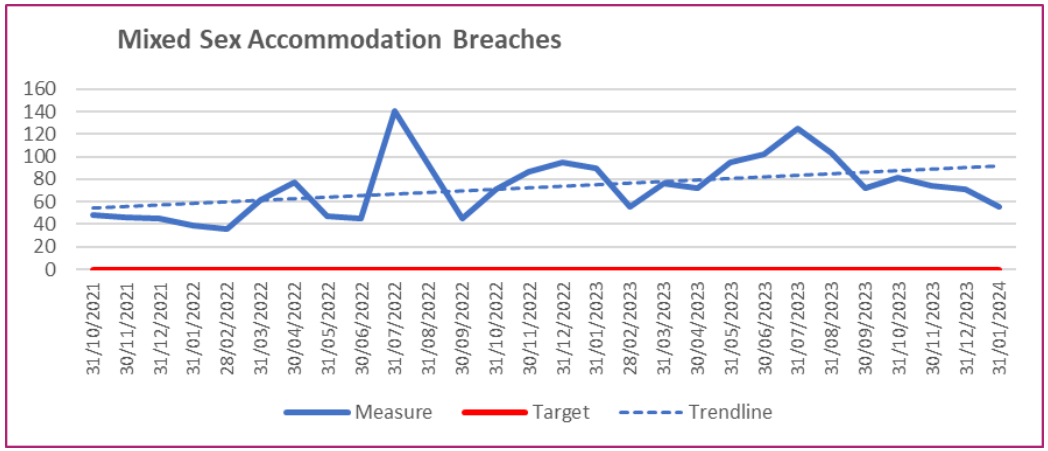
Area	Indicator *Please Note Indicators affected by changes to Occupied Bed Data For Detail See Reference Sheet	STW CCG - M2L0M	STW ICB - M2L0M				SaTH			RJAH			MPFT			SCHT		
							Large acute trust			Acute specialist trust (including children)			Mental Health provider to STW only			Shropshire Community		
		Value	Objective	Value	Reporting Period	Standard / England rate	Value	No of reponses	Trend	Value	No of reponses	Trend	Value	No of reponses	Trend	Value	No of reponses	Trend
IPC	C.difficile		64	127	Cumulative Apr 23 - Jan-24	SATH Objective = 27 RJAH Objective = 2	83			5								
IPC	E.coli Bacteraemia		261	399	Cumulative Apr 23 - Jan-24	SATH Objective = 75 RJAH Objective = 1	119			7								
IPC	Pseudonmonas aeruginosa Bacteraemia		28	28	Cumulative Apr 23 - Jan-24	SATH Objective = 15 RJAH Objective = 0	17			0								
IPC	Kiebsiella spp Bacteraemia		60	86	Cumulative Apr 23 - Jan-24	SATH Objective = 19 RJAH Objective = 1	27			3								
IPC	MRSA Bacteraemia		0	9	Cumulative Apr 23 - Jan-24	SATH Objective = 0 RJAH Objective = 0	4			1								
IPC	MSSA Bacteraemia		0	110	Cumulative Apr 23 - Jan-24	No trajectory set	47			1								
Maternity	Stillbirths per 1,000 total births	3.3			2018 - 20	England = 3.9												
Maternity	Neonatal deaths per 1,000 total live births	3.2			2018 - 20	England = 2.8												



Clostridioides difficile continues to be above trajectory for SaTH and while RJAH is above annual objective they have regained monthly trajectory. Actions include review of antibiotic usage and deep clean as bed capacity allows. Gram negative and MRSA bacteraemia cases also remain higher than plan. Improvements to screening and Infection prevention and control practices are the areas of action.

Stillbirths are below the national average, however, the neonatal death rate is above the national average. An external review was commissioned by SaTH and undertaken in November 23 with the report awaited and there are system workshops aimed at understanding key actions. West Midlands Neonatal deaths are higher than the national average as a region.

Area	Indicator *Please Note Indicators affected by changes to Occupied Bed Data For Detail See Reference Sheet	STW CCG - M2L0M	STW ICB - M2L0M				SaTH			RJAH			MPFT			SCHT		
							Large acute trust			Acute specialist trust (including children)			Mental Health provider to STW only			Shropshire Community		
		Value	Objective	Value	Reporting Period	Standard / England rate	Value	No of reponses	Trend	Value	No of reponses	Trend	Value	No of reponses	Trend	Value	No of reponses	Trend
CHC	% Referrals completed within 28 days			32.3%	2023/24 Qtr 3	England = 76.5%												
	Incomplete Referrals delayed >12 weeks			52	2023/24 Qtr 3													
	% of IRPs taking place in 6 months or less from IRP request date																	
Incidents	Number of Never Events				Cumulative Apr 23 - Jan-24	0	1			1								
	Number/Trend Serious Incidents				Monthly Apr 23 - Jun-23		1452			133			1557			45		
Friends & Family Test	Friends & Family Test - Inpatient				Jan-24 Public	Not applicable Higher is better	98.2%	1112		98.5%	334							
	Friends & Family Test - Maternity (Birth)				Jan-24 Public	Not applicable Higher is better	100.0%	6										
	Friends & Family Test - Community				Jan-24 Public	Not applicable Higher is better										97.0%	233	
	Friends & Family Test - A&E				Jan-24 Public	Not applicable Higher is better	67.7%	697										
	Friends & Family Test - Mental Health				Jan-24 Public	Not applicable Higher is better							91.40%	279				
MSA	Mixed Sex Accommodation Breaches				Jan-24	Zero Lower is better	56											



Mixed sex accommodation breaches continue to reduce at SaTH at 56 in January 24.

Serious incident data reporting is now suspended due to the Implementation of PSIRF, an assurance framework is in development to reflect new ways of learning from incidents.

A Continuing Healthcare recovery plan and trajectory is in place to improve compliance with the 28-day standard and the back log by end of March 24.

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Appendix C – Finance M1

Organisation	MONTH Plan Surplus/ (Deficit) £000	MONTH Actual Surplus/ (Deficit) £000	MONTH Variance to Plan £000	YTD Plan Surplus/ (Deficit) £000	YTD Actual Surplus/ (Deficit) £000	YTD Variance to Plan £000	FULL YEAR Plan Surplus/ (Deficit) £000	FULL YEAR Forecast Surplus/ (Deficit) £000	FULL YEAR Variance to Plan £000	PRIOR YEAR Actual £000	Prior Month FOT Actual £000	Movement £000
Commissioners												
NHS Shropshire, Telford and Wrekin	10,579	8,908	(1,671)	0	(11,810)	(11,810)	(228)	(16,249)	(16,021)	(21,516)	(27,849)	11,600
Total Commissioners	**10,579**	**8,908**	**(1,671)**	**0**	**(11,810)**	**(11,810)**	**(228)**	**(16,249)**	**(16,021)**	**(21,516)**	**(27,849)**	**11,600**
Providers												
The Shrewsbury and Telford Hospital NHS Trust	39,130	34,023	(5,107)	(6,095)	(57,673)	(51,578)	38	(54,582)	(54,620)	(47,206)	(102,206)	47,624
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT	410	641	231	113	(2,237)	(2,350)	191	(1,884)	(2,075)	2,454	(2,745)	861
Shropshire Community Healthcare NHS Trust	(174)	121	295	166	616	450	0	0	0	1,092	0	0
Total Providers	**39,366**	**34,785**	**(4,581)**	**(5,816)**	**(59,294)**	**(53,478)**	**229**	**(56,466)**	**(56,695)**	**(43,660)**	**(104,951)**	**48,485**
TOTAL SYSTEM Performance Financial Position Surplus/(Deficit)	**49,945**	**43,693**	**(6,252)**	**(5,816)**	**(71,104)**	**(65,288)**	**1**	**(72,715)**	**(72,716)**	**(65,176)**	**(132,800)**	**60,085**

Key Data

- £71.1m YTD System deficit
- £6.3m in month adverse variance to plan
- £65.3m adverse to plan YTD at M11.
- In Month 9 the forecast outturn change protocol was enacted for all organisations. The reported forecast of £132.8m includes the additional costs of December and January Industrial Action of £3.3m. The agreed forecast with NHSE of £129.8m excluded the Industrial Action impacts. In Month 11 the System received a national allocation of £57.1m to fund the plan deficit – this was allocated to SaTH (£45.5m) and the ICB (£11.6m). All Industrial Action costs need to be absorbed within the reported FOT.
- The remaining un-mitigated risk to delivering this forecast is £5.2m. If the full unmitigated risk was added to the forecast deficit this would result in a £77.9m in year system deficit.
- £15.7m above agency expenditure plan at M11 and £26.1m above the agency cap (£24.9m cap ytd) for the system. Excluding the LLP costs core agency spend is £13.2m above plan. £2.5m of the ytd spend relates to LLP staff costs at RJAH which are now required to be accounted for as agency costs.

What have we done and next steps

All organisations continue to work through additional phased mitigation plans for the year to address risks in the position and improve wherever possible.

- Medium to Long Term Financial Plan Development underway in line with system demand and capacity modelling.
- Operational leads working collectively on system bed model, discharge schemes and reducing escalation costs.
- Strengthening system-wide financial governance, particularly around pay controls. Fortnightly agency reduction meeting chaired by ICB Chief Medical Officer.
- Efficiency and transformation plan development led through the Financial Improvement Programme Group.

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Finance Position by Organisation – M11

SATH

At month 11 SaTH has a deficit of £57.7m, an adverse position to plan of £51.6m YTD. This variance is split between elements within SaTHs control (£14.6m) and outside of SaTHs direct control (£37.0m).
Of the elements within SaTHs control, the key drivers are detailed below and are partially offset by substantive vacancies not covered through temporary staffing.

Of the elements outside of SaTHs control, the key drivers are:

Escalation - £15.2m – additional costs over escalation above funded levels, driven by high levels of NCTR patients and critical incidents declared in year.
Increased elective activity costs £8.5m – additional costs linked to ERF both insourcing and internal costs.
Industrial action impact - £4.8m – direct costs and income loss associated with covering the junior doctor and consultant industrial action, partially offset by £3.7m if IA funding.
Pay award - £2.1m – additional costs above funding relating to the 2023/24 pay award for both agenda for change and medical staff.
Enhanced Care Support (ECS) £2.0m – increased 1-2-1 care linked to high levels of NCTR patients and patient acuity and use of temporary staffing to cover vacant substantive posts.

SCHT

The Trust is reporting a £0.6m adjusted surplus for month 11 year to date compared to the planned surplus of £0.2m, which is a favourable variance of £0.5m. In month surplus of £0.1 is £0.2m favourable compared to phased forecast submitted on 28 November. The favourable performance in month and year to date is due mainly to non recurrent overperformance on CIP delivery.

- The overall pay position is a favourable variance of £1.5m year to date compared to plan. The main driver for the overall favourable pay position is slippage in the opening of the SAU Acute wards (£0.9m) which went live in January, 1 month later than planned. There was also slippage in recruiting to our new services (Virtual Wards, IDT and MSK) which contributed further to the favourable pay position. The savings accrued from substantive vacancies are being partly utilised to offset bank and agency usage above plan. Agency spend in month 11 was £0.7m, £0.1m above month 10 run rate reflecting increased usage in sub acute wards. Year to date agency cost is exceeding plan by £1.8m but in line with our FOT. A weekly Agency Scrutiny Group, which reports to the newly created Financial Recovery Group (FRG), is in place and its role is to safely manage the level of agency spend.
- Non pay underspend YTD of £0.2m is due mainly to interest receivable.
- The favourable position in pay and non pay is partly offset by lower than planned income from new services.
- CIP delivery year to date of £3.9m, an overperformance of £0.3m compared to plan. Full year delivery is expected to be £0.4m ahead of target of £4.1m.
- The risks to our FOT have now been fully managed and mitigated, therefore we expect to maintain a favourable position at year end.

RJAH

In month £0.6m surplus, £0.2m favourable to plan driven by non recurrent income from NHSE spec comm to offset previously recognised ERF income loss linked to spinal injuries (this is separate to the baseline error issue).
YTD £2.4m adverse to plan driven by:

- Industrial action impact on income £1.3m (net of support income)
- Technical income (Road traffic accident and low value agreements) £1.1m
- Excess inflation £1m
- NHSE ERF baseline error £0.8m
- Offset by non recurrent mitigations and operational interventions.

Forecast outturn requirement of £1.9m deficit incl industrial action, this is at risk due to £0.8m NHSE Specialised Commissioning ERF baseline error which has been escalated to NHSE.
Efficiency delivery is £263k favourable YTD, with total delivery of £4.4m (95% of annual target), of which £0.4m is non recurrent.

Agency performance:
Core agency is £95k favourable to cap YTD.
Insourcing costs £0.3m in month and £2.5m YTD and are now reportable as agency aligned with national guidance and NHSE advice. It should be noted this cost is planned and delivers an overall financial contribution to the Trust. We will continue to overspend against the cap for this component of agency.

STW ICB

YTD deficit of £11.8m, £11.8m adverse variance to plan mainly driven by individual commissioning £13m and Prescribing £4.2m overspends.

£5.8m year to date surplus on pharmacy, optometry and dental predominantly due to primary care dental underspends

The year-to-date variance continues to be made up predominantly of overspends in CHC and prescribing (mainly price driven) and non-receipt of Welsh elective recovery income

£1.6m of remaining unmitigated risk has been assessed which relates to potential volatility in prescribing and CHC expenditure.

NHS

Financial Risk

System Risk	23/24 Gross Risk £'000	Mitigation £'000	Un-Mitigated Risk £'000	Prior Month Un-Mitigated Risk £'000	Movement from Prior Month	Un-Mitigated 23/24 Plan Risk £'000	Movement from Plan £'000
NHS Shropshire, Telford & Wrekin ICB	6,767	(5,217)	1,550	3,100	1,550	17,661	16,111
Robert Jones & Agnes Hunt Hospital	1,232	(1,100)	132	1,496	1,364	7,066	6,934
Shrewsbury & Telford Hospitals	96,749	(93,249)	3,500	3,700	200	63,678	60,178
Shropshire Community Hospital Trust	225	(225)	0	250	250	4,876	4,876
Grand Total	**104,973**	**(99,791)**	**5,182**	**8,546**	**3,364**	**93,281**	**88,099**

The current net risk for each organisation is presented above including the movement from prior month and since the plan submission.

As a result of updating the forecasts in Month 11 the un-mitigated risk total has improved by £3.4m overall since Month 10 as most risks are now factored into the revised forecasts.

The SaTH risk is largely due to delivery of CIP schemes, escalation, activity growth including drugs and devices and establishment costs – but is largely fully mitigated.

The key themes of the remaining un-mitigated risk are:

- Elective recovery delivery and receipt of associated income
- Prescribing – volatility of national pricing that is out of the ICB control
- CHC – volatility of high-cost cases that cannot be predicted

Efficiency

EFFICIENCIES	YTD			FULL YEAR			Prior Month FOT	Movement	High Risk	Medium Risk	Low Risk
Organisation	Plan £000	Actual £000	Variance to Plan £000	Plan £000	Forecast £000	Variance to Plan £000	Actual £000	Actual £000	Forecast £000	Forecast £000	Forecast £000
NHS STW ICB - Recurrent	17,135	19,062	1,927	18,731	21,032	2,301	21,032	0	0	0	21,032
NHS STW ICB - NonRecurrent	6,407	5,480	(927)	7,216	5,715	(1,501)	5,715	0	0	0	5,715
	23,542	**24,542**	**1,000**	**25,947**	**26,747**	**800**	**26,747**	**0**	**0**	**0**	**26,747**
SaTH - Recurrent	14,721	7,106	(7,615)	17,079	10,543	(6,536)	10,543	0	566	1,502	8,475
SaTH - NonRecurrent	11,632	7,578	(4,054)	18,373	8,268	(10,105)	8,268	0	0	0	8,268
	26,353	**14,684**	**(11,669)**	**35,452**	**18,811**	**(16,641)**	**18,811**	**0**	**566**	**1,502**	**16,743**
RJAH - Recurrent	3,524	3,976	452	3,933	4,146	213	4,013	133	0	170	3,976
RJAH - NonRecurrent	567	378	(189)	630	420	(210)	420	0	0	42	378
	4,091	**4,354**	**263**	**4,563**	**4,566**	**3**	**4,433**	**133**	**0**	**212**	**4,354**
SCHT - Recurrent	2,130	2,049	(81)	2,386	2,191	(195)	2,091	100	0	0	2,191
SCHT - NonRecurrent	1,548	1,892	344	1,722	2,317	595	2,017	300	0	0	2,317
	3,678	**3,941**	**263**	**4,108**	**4,508**	**400**	**4,108**	**400**	**0**	**0**	**4,508**
TOTAL SYSTEM - RECURRENT	37,510	32,193	(5,317)	42,129	37,912	(4,217)	37,679	233	566	1,672	35,674
TOTAL SYSTEM - NONRECURRENT	20,154	15,328	(4,826)	27,941	16,720	(11,221)	16,420	300	0	42	16,678
TOTAL SYSTEM	**57,664**	**47,521**	**(10,143)**	**70,070**	**54,632**	**(15,438)**	**54,099**	**533**	**566**	**1,714**	**52,352**

- The systems efficiency plan totals **£70m** and consists of core efficiency, system stretch targets and additional efficiency related to reducing the costs of escalation beds,in total this represents **6.2%** of total allocation.
- Forecasts have recently been reviewed by each organisation and the most likely savings positions are included in the table above.
- There has been significant progress to date in identifying further savings to meet the stretch target.
- £ 10.5m of slippage against SaTHs efficiency plan directly relates to ongoing escalation costs.

Finance – Capital

CAPITAL PROGRAMME	MONTH			YTD			FULL YEAR			IFRS 16 & Other Allocations		PRIOR YEAR	Prior Month FOT	Movement
Organisation	Plan £000	Actual £000	Variance to Plan £000	Plan £000	Actual £000	Variance to Plan £000	Plan £000	Forecast £000	Variance to Plan £000	Plan £000	Forecast £000	Actual £000	Actual £000	Actual £000
Total Capital Plan - Providers	**(1,803)**	**(1,477)**	**326**	**(25,752)**	**(14,300)**	**11,452**	**(29,251)**	**(26,506)**	**2,745**			**(32,432)**	**(28,228)**	**1,722**
5% over programming - tolerance	81	0	(81)	1,155	0	(1,155)	1,312	0	(1,312)	1,312	0	0	0	0
Additional RAAC Uplift			0			0	(200)	0	200	(200)	0			0
IFRS16 CDEL Uplift			0			0	(5,823)	(5,823)	0	(5,823)	(5,823)			(5,823)
Difference to IFR Report							(56)	798	854	(56)	798			
Total Charge against Capital Allocation (including impact of IFRS16)	**(1,722)**	**(1,477)**	**245**	**(24,597)**	**(14,300)**	**10,297**	**(34,018)**	**(31,531)**	**2,487**	**(4,767)**	**(5,025)**	**(32,432)**	**(28,228)**	**(4,101)**
Total Charge against Capital Allocation (including impact of IFRS16)														
The Shrewsbury and Telford Hospital NHS Trust	(1,469)	(852)	617	(19,306)	(10,416)	8,890	(21,992)	(20,179)	1,813	(2,601)	(1,550)		(20,207)	28
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT	(114)	(380)	(266)	(7,165)	(3,823)	3,342	(7,480)	(5,443)	2,037	(120)	(90)		(7,167)	1,724
Shropshire Community Healthcare NHS Trust	(358)	456	814	(4,028)	(3,657)	371	(4,546)	(5,909)	(1,363)	(2,046)	(3,385)		(6,632)	723
Total Charge against Capital Allocation (including impact of IFRS16)	**(1,941)**	**(776)**	**1,165**	**(30,499)**	**(17,896)**	**12,603**	**(34,018)**	**(31,531)**	**2,487**	**(4,767)**	**(5,025)**	**0**	**(34,006)**	**2,475**
Providers	(1,803)	(1,477)	326	(25,752)	(14,300)	11,452	(29,251)	(31,531)	(2,280)			(32,432)	(28,228)	1,722
NHS Shropshire, Telford and Wrekin ICB	(111)	(140)	(29)	(660)	(250)	410	(883)	(801)	82			(1,243)	(883)	82
Per Integrated Finance Return	**(1,914)**	**(1,617)**	**297**	**(26,412)**	**(14,550)**	**11,862**	**(30,134)**	**(32,332)**	**(2,198)**			**(33,675)**	**(29,111)**	**1,804**
Internal Leases	0	0	0	0	0	0	0	1,448	1,448			0	0	1,448
Additional Allocations	81		0	1,155		0	(4,767)		0			0	0	0
TOTAL SYSTEM - Base allocation including impact of IFRS16 - adjusted	**(1,833)**	**(1,617)**	**297**	**(25,257)**	**(14,550)**	**11,862**	**(34,901)**	**(30,884)**	**(750)**			**(33,675)**	**(29,111)**	**3,252**
Total CDEL														
NHS Shropshire, Telford and Wrekin ICB	(133)	(1,105)	(972)	(883)	(1,215)	(332)	(1,150)	(1,912)	(762)			(1,243)	(1,994)	82
The Shrewsbury and Telford Hospital NHS Trust	(6,452)	(3,874)	2,578	(61,195)	(39,811)	21,384	(69,226)	(78,530)	(9,304)			(19,798)	(78,558)	28
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT	(227)	(1,022)	(795)	(9,789)	(7,383)	2,406	(12,080)	(12,204)	(124)			(10,137)	(12,570)	366
Shropshire Community Healthcare NHS Trust	(358)	456	814	(4,028)	(3,657)	371	(4,546)	(5,909)	(1,363)			(2,497)	(6,632)	723
TOTAL SYSTEM	**(7,170)**	**(5,545)**	**1,625**	**(75,895)**	**(52,066)**	**23,829**	**(87,002)**	**(98,555)**	**(11,553)**			**(33,675)**	**(99,754)**	**1,199**

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Appendix D - Workforce

System position – substantive WTE plan v actual:

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Operational Plan	9,323	9,329	9,353	9,386	9,402	9,445	9,584	9,591	9,696	9,741	9,741	9,750
Actual	9,285	9,359	9,388	9,479	9,603	9,756	9,903	9,990	10,022	10,072		
Variance	-38	30	35	93	201	311	319	399	326	331		

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

System position – substantive staff cost (£000) plan v actual

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Operational Plan	37,448	37,669	37,603	37,460	40,525	40,473	38,532	38,496	38,763	38,941	38,936	39,169
Actual	38,247	38,036	40,343	39,207	42,360	42,785	41,748	41,552	42,189	42,266		
Variance	799	367	2,740	1,747	1,835	2,312	3,217	3,056	3,426	3,325		

System position – bank WTE plan v actual:

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Operational Plan	677	677	677	668	668	668	668	668	658	649	649	649
Actual	732	754	689	724	784	753	768	784	746	789		
Variance	55	78	11	56	117	85	100	116	88	141		

System position – bank staff cost (£000) plan v actual

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Operational Plan	2,361	2,352	2,359	2,339	3,885	1,951	2,528	2,536	2,474	2,495	2,487	2,480
Actual	4,520	6,042	3,448	5,042	4,729	3,417	4,655	4,632	5,264	4,609		
Variance	2,159	3,690	1,089	2,703	843	1,466	2,127	2,096	2,790	2,114		

System position – agency WTE plan v actual:

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Operational Plan	532	479	515	413	400	390	380	365	312	299	286	272
Actual	592	596	542	510	506	498	474	458	414	429		
Variance	60	117	28	97	106	108	94	92	102	130		

System position – agency staff cost (£000) plan v actual

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Operational Plan	4,475	3,425	3,641	2,938	4,762	3,180	3,073	2,982	2,695	2,484	2,483	2,425
Actual	4,924	5,284	5,294	4,737	4,805	4,287	13,079	-4,126	3,489	4,104		
Variance	449	1,859	1,653	1,799	43	1,108	10,006	-7,107	794	1,620		

Staff Costs Actual vs Plan - (£000)

NB: variation in agency cost in October and November data is due to NHSE advice to SATH to include insourcing, however, this decision was then reversed requiring correction in November's PFR return.

NB: this excludes the wte and cost of the LLP Workforce at RJAH.

			MPFT		RJAH		SaTH		SCHT		SYSTEM	
Metric	Staff Group	Data Period	Value	Variation	Value	Variation	Value	Variation	Value	Variation	Value	Variation
Agency WTE	Total	Jan 2024	78.8		26.5		325		77		508	
Agency WTE %	Total	Jan 2024	4.85%		1.65%		3.99%		5.02%		3.93%	
Vacancy %	Total	Jan 2024	13.2%		4.40%		1.08%		16.3%		5.28%	
	Nursing, midwifery and health visiting	Jan 2024	14.5%		5.60%		1.62%		22.0%		7.49%	
	Infrastructure and Administration	Jan 2024	10.9%		0.141%		-1.02%		10.8%		2.27%	
	HCSW	Jan 2024	20.3%		10.9%		9.45%		10.5%		11.0%	
	GP, Medical and dental	Jan 2024	29.0%		2.69%		0.702%		40.0%		4.00%	
	Allied Health Professionals	Jan 2024	32.7%		9.36%		8.30%		18.3%		13.4%	
Vacancy WTE	Total	Jan 2024	218		69.0		77.6		275		640	
	Nursing, midwifery and health visiting	Jan 2024	67.6		17.5		32.9		140		258	
	Infrastructure and Administration	Jan 2024	41.3		0.8		-18.2		47.9		71.8	
	HCSW	Jan 2024	38.5		23.3		104		17.3		183	
	GP, Medical and dental	Jan 2024	19.4		4.19		5.92		14.6		44.1	
	Allied Health Professionals	Jan 2024	34.4		16.7		37.1		37.9		126	
Sickness %	Total	Jan 2024	4.78%		4.55%		5.88%		5.47%		5.52%	
Turnover %	Total	Jan 2024	9.45%		8.02%		11.9%		11.9%		11.1%	

System position – agency, sickness, turnover and vacancy metrics by staff group

Summary	

Concerning variation	• System AHP vacancies (High at 13.4% (126 WTE) but reducing consistently on last three months)
	• System pharmacy substantive WTE (concerning low trend due to sharp decline in Jan 2023 (142.8 WTE down to 130.6WTE in July 2023), but showing improvement and signs of recovery in month 10 at 138 WTE)
	• Vacancies in SCHT - vacancies across all staff groups are high with a total of 16.3% (275 WTE) in month 10.
	  ○ 40% in the GP, Medical and Dental (14.6wte)
	  ○ 22% in Nursing, Midwifery & Health Visiting (140wte)
	  ○ 18% in Allied Health Professionals (38wte).
	• Vacancies in MPFT – vacancies across a number of staff groups are high with a total v of 13.2% (218wte) in month 10.
	  ○ 32.7% Allied Health Professionals (34.4wte)
	  ○ 29% GP, medical and dental staff group (19.4wte)
	  ○ 20% Health Care Support Workers (38.5wte).
	• Agency WTE SCHT - sharp increase in month 10 to 77wte from 42.5wte. This increase is owing to the sub-acute wards and virtual ward.

Normal variation	• Nursing midwifery and health visiting system vacancies
Improving variation	• System turnover (11.1% at M10, on consistent downward trajectory) • System sickness (5.52% at M10, on consistent downward trajectory) • System Agency WTE (508 WTE at M10, down from 657.27 WTE in April 2023, on consistent downward trajectory although above plan) • System Vacancy (639.64 vacancies in month 10, consistently around this level for four consecutive months, and down from 1008.34 WTE in April 2023)

Agenda Item

ICB 27-03-028

System Board Assurance Framework

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

NHS STW – SYSTEM BOARD ASSURANCE FRAMEWORK

2023/24

Version 3 March 2024

Risk Matrix

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

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

NHS Shropshire, Telford and Wrekin Strategic Objectives:

1) Reducing Health Inequalities:

- **Wider determinants**
- **Tackling health inequalities**

2) Improving population health

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

3) Improving Health and Care

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

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

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

Risk Lead	ICB Chief Executive Officer	Assurance committee	Board

System Controls	Assurances reported to ICB Board and committees
Strategies and Plans • ICB Constitution • ICP Terms of Reference • Governance Handbook / Functions and Decisions Map • System Development Plan • Better Care Fund Plans • Primary Care Strategy • Clinical and Professional Leadership Programme • Integrated Care Strategy • Joint 5 year forward plan • People Priorities [AT – 18.01.2024] Partnerships and Services • Integrated Care Partnership • ICS Chief Executive Group • ShIPP • TWIPP • Health and Wellbeing Boards • ICS People Strategic Workstreams 2024- 2027 [AT – 14.02..2024] Governance & Engagement Structures • Integrated Care Partnership; Board of the Integrated Care Board and Integrated Delivery Committee • STW Mental Health Collaborative • GGI Review of ICB/ICS governance structures • ICB Strategic Partner on development of ICB version 3.0 [ST – 23.01.2024] • People Culture and Inclusion Committee [AT – 14.02..2024]	First Line of Assurance • Monitoring and oversight at ICB Executive Group and ICS Chief Executive Group Second Line of Assurance • Population Health Board Third Line of Assurance • Integrated Care Partnership oversight • National Health Service England Integrated Care Board Establishment Assessment and Establishment Order
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
1. Independent assessment (NHSE, CQC) 2. Development of provider collaborative and supporting governance structure	1. Complete self-assessment against NHSE/CQC regulatory framework - Q4 2a Interim ICS Director of Strategy leading development of STW Provider Collaborative ~~– Q3~~ 2b.Creation of dedicated Director level role to support development of Provider Collaborative. [ST – 23.01.2024] 2c.Establishment of Provider Collaborative Committees in Common (CiC) [ST – 23.01.2024] 2d CB CEO co-chair of HWBB's 2e Director of Partnerships and Place supporting delivery of JFP priorities and integrated place working

Current Performance – Highlights
Development of provider collaborative and partnerships is now progressing with some dedicated ICB capacity. An action plan is in development to provide structure and timescales to the programme of work to develop the STW approach to collaboration ~~by end of October 2023.~~ CiC now in place and key priority areas of work agreed. Focus on establishing appropriate resourcing, infrastructure and reporting for the Collaborative is underway [ST – 23.01.2024]

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

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

Strategic Aim: ALL	Risk score 25 Almost Certain 5 x Catastrophic 5
Strategic Risk No.2: Risk of not delivering sustainable services within available resources.	

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

	Consequence	Likelihood	Score	Risk Trend
Current	Almost certain 5	Catastrophic 5	25	⇧
Target	Possible 3	Major 4	12 High	

Risk Lead	ICB Chief Finance Officer	Assurance committee	ICB Finance Committee

System Controls	Assurances reported to ICB Board and committees

Strategies and Plans
• System Financial Strategy, incorporating:
  ○ Healthcare Financial Management Association (HFMA) Financial sustainability checklist
  ○ Triple Aim framework
  ○ Value based decision making approach
• Financial Revenue Plan
• Financial Capital Plan
• Joint 5 year forward plan
• Efficiency and Transformation Plans
• General Practice Estate Programme
 	
Partnerships and Services
• ShIPP
• TWIPP
• ~~Digital Board~~ ICS Digital Delivery Group [TT – 04.02.2024]
• Estates Board
• People Board
• Planned Care Board
• UEC Delivery Board
 	
Governance & Engagement Structures
• Finance Committee
• Investment Panel
• Integrated Delivery Committee
• Audit Committee
• Provider Collaborative Committees in Common [ST – 23.01.2024]
	First Line
	• Monitoring delivery of System Financial Strategy and Financial Plan by CFO group
	• Standing Orders, Standing Financial Instructions and Delegated Financial Limits
	• Financial Accounting Performance Metrics
	• HFMA Financial Sustainability Checklist
	• Better Payment Practice Code
	• Productivity review informed by:
	  ○ Getting It Right First Time (GIRFT)
	  ○ Model Health System
	  ○ ICS Patient Level Information and Costing Systems (PLICS) dashboard
	  ○ Health Expenditure benchmarking tool (HEB)
	
	Second Line
	• Finance Report to Finance Committee
	• Integrated Performance and Finance Report to the Board
	
	Third Line
	• Monthly Integrated (Care System) Finance Return and Provider Finance Returns reporting to NHSE
	• Quarterly NHSE Financial Stocktake
	• NHSE Annual planning process (and triangulation of Finance, Activity and workforce planning)

Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
1. Joint financial plan across ICS partners 2. Independent assessment (NHSE, CQC)	1. Develop financial sustainability plan 2. Complete self-assessment against NHSE/CQC regulatory framework

Current Performance – Highlights
Long term system financial model submitted at a high level in line with NHSE regional planning deadlines

(Sept 23). [CS – 04.02.2024]

Detailed long term demand and capacity model and medium term financial plan ~~underway - consultancy support procured~~ based on 23/24 plan as starting point developed and presented to finance committee in November 23. [CS – 04.02.2024]

~~Development of five year transformation plans through Financial Improvement Programme Board and overseen by IDC~~

Longer term transformation to be developed as part of the strategy and embedded within the financial recovery plan, overseen through Financial Improvement Programme Board and Chief Executive Transformation Group. [CS – 04.02.2024]

Development of system financial strategy document underway to dovetail with long term financial modelling and development of ICB joint forward plan [CS – 04.02.2024]

Contract rebasing exercise underway for in system contracts to agree contract arrangements and risks sharing framework for 24/25

Establishment of Provider Collaborative which will both provide a future mechanism for commissioning on outcomes to support efficient, joined up service provision and service transformation and as a vehicle for Providers to collaborate on innovative ways to deliver services in a more sustainable way [ST – 23.01.2024]

Associated Risks on the System Strategic Operational Risk Register	
Risk no.	Description
System Risk 8	Financial Plan 23/24
System Risk 9	Financial Sustainability

Relevant risks on system partners risk registers
Description
SaTH BAF 5 - The Trust does not operate within its available resources RJAH BAF 8 – Adverse impact of system financial deficit Shropcom BAF 8.1 – Costs exceed plan MPFT BAF R1 - There is a risk to the financial sustainability of the Trust and Integrated Care System due to not delivering the future system and trust efficiency plans resulting in a deteriorating underlying deficit position MPFT BAF R13 - There is a risk to the financial sustainability of the Trust and Integrated Care System due to not having an aligned financial strategy and implementation plan resulting in poor allocation of resources, financial restrictions and regulatory action Telford & Wrekin Council – Corporate Risk Register R2 - Inability to: a) Match available resources (both financial, people and assets) with statutory obligations, agreed priorities and service standards b) deliver financial strategy including capital receipts, savings and commercial income c) fund organisational and cultural development in the Council within the constraints of the public sector economy Shropshire Council – Corporate Risk Register: a) Extreme pressures upon partners (social care, health, and criminal justice) within the system impacting on Shropshire Council through increased expectation, demand, need and complexity. b) Sustainable budget

Strategic Aim: ALL			Risk score 20 Likely 4 x Catastrophic 5
Strategic Risk No.3: STW is seeing a growing and ageing population; services and the workforce will need to adapt and shape to meet these needs. There is a risk that this capacity and capability will not be sufficient to meet population needs nor be able to focus on tackling identified and emergent health inequalities in every instance.			
If we are unable to find sufficient staffing or expert/technical resources in ICB and across all system partners	*Then* we will not be able to meet increase health inequalities in our services	*Resulting in* poorer outcomes for our population, adverse impacts on our partner organisations and increased scrutiny of our effectiveness	

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

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

System Controls	Assurances reported to ICB Board and committees
Strategies and Plans • 5 Year Forward Plan • System Development Plan • Inequalities Implementation Operational Plan • Primary Care Winter Plan • Integrated Care Strategy Partnerships and Services • CEO Group • Urgent and Emergency Care Board • Finance Advisory Board • ShIPP • TWIPP • Mental Health Delivery Board • Emergency Preparedness Resilience and Response Framework • System People Board • Local Maternity and Neonatal System • Primary Care Networks • System Quality Group Governance & Engagement Structures • Integrated Care System CEO Group • ICB Board • ICB Strategy Committee • ICB Quality and Performance Committee • ICB System People Committee • ICB Strategy Committee • Integrated Care System Health Inequalities Board • Population Health Board	First Line of Assurance • Routine Quality Monitoring and Triangulation by Quality Team • General Practice Appointment Data Monitoring • Performance Dashboard • Monthly Key Lines of Enquiry for areas of underperformance / concern • Monthly Oversight System Review Meetings • Monitoring and oversight by command structure Second Line of Assurance • Cancer and Planned Care Report to ICB Quality Safety and Performance Committee • Urgent and Emergency Care Report to ICB Quality and Performance Committee • Integrated Performance Report to ICB Quality and Performance Committee • Learning Disability and Autism Assurance Report to ICB Quality and Performance Committee • Performance Report to ICB Quality and Performance Committee • Annual Operating Plans to Finance Committee • Local Maternity and Neonatal System Report to ICB Quality and Performance Committee • Primary Care Quality reporting to Primary Care Commissioning Committee • Integrated Provider Report to ICB Quality and Performance Committee • Quarterly reporting to Board Third Line of Assurance • National System Oversight Framework • NHSE Quarterly System Review Meetings • Coare 20 +5 reporting to regional NHSE
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
1. Independent assessment (NHSE, CQC)	1. Complete self-assessment against NHSE/CQC regulatory framework - CQC - timeframe yet to be published nationally.

Current Performance – Highlights
• Health inequalities – system Board focussed on health inequalities has been established. Additional ICB staff capacity fixed term secured. Improved partnership working including engaged Exec Lead in all providers. • Population Health - Population Health analysts capacity secured in Planning and Performance directorate. Population Health Board now reports into Strategy Committee to clarify assurance reporting lines.

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

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

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

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

Risk Lead	ICS Chief People Officer	Assurance committee	System People Committee

System Controls	Assurances reported to ICB Board and committees
Strategies and Plans • One People Plan Recommendations and Insights Report • workforce information dashboards to consider workforce information (sickness, turnover, vacancies, staff in post, Agency and bank usage etc) • 5 year Joint forward Plan Partnerships and Services • People related workstreams being led by the ICS People Team Governance & Engagement Structures • System People Committee provides oversight of the development of our system people strategy and annual programmes and strategic direction of travel • System People Committee oversight of Annual operational workforce planning process to set direction of travel for next 12 months	First Line of Assurance • Workforce information dashboards outputs Second Line of Assurance • People Plan Programme Progress Report to the People Committee of the Integrated Care Board
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
Gaps in controls: 1 The System People Strategy and priorities are not agreed by system CEOs. 2 The System People Collaborative approach, including HRD SROs and refreshed operational delivery and oversight processes/meetings, is not agreed by system CEOs. 3 An appropriate and resourced structure – within the system People Team and through provider partner employers – is not agreed by system CEOs. 4 The system People Committee is not meeting regularly and its authority and remit requires a refresh. 5 There is no consistent system oversight of workforce metrics, workforce supply or the delivery of our People Strategy, or progress on the delivery of the 10 people outcomes.	1 Finalise our ICS People Strategy and priorities by September 2023 4 GGI Making Meetings matter review includes System People Committee – due to report in September 2023 1/2/3/CEO decisions on system people collaborative approach, structures and resources – following discussion papers taken to CEOs meetings and HRD meetings for consideration. 4. Refresh of the System People Committee as the oversight function. 5. Refresh of the People Delivery Committee as the operational delivery programme board.

Gaps in assurances: 2) Regular minutes from the System People Committee	2. see (4) above

Current Performance – Highlights
Paper presented to CEOs with options/proposal for consideration.

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

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

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

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

Risk Lead	ICB Chief Medical Officer	Assurance committee	ICB Strategy Committee

System Controls	Assurances reported to ICB Board and committees
Strategies and Plans • Integrated Care Strategy • Joint Forward Plan • Population Health Roadmap • Joint Strategic Needs Assessments • Digital Strategy [TT – 04.02.2024] Partnerships and Services • Population Health Management Board • ~~Digital Transformation Board~~ ICS Digital Delivery Group [TT – 04.02.2024] • TWIPP • ShIPP Governance & Engagement Structures • ~~Integrated Delivery Committee~~ [TT – 04.02.2024] • Strategy Committee • System Digital Governance Model [TT – 04.02.2024]	First Line of Assurance • Routine progress reports from key workstreams • Regular Population Health Management Workstream Update to the Population Health Board • Regular Inequalities Workstream Update to the Population Board Second Line of Assurance • Population Health Report to Integrated Delivery Committee
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
Gaps in controls: 1. Digital Strategy in place 2. Joint information and data strategy across ICP 3. Independent assessment (NHSE, CQC) 4. Identified resources to support delivery of the Digital Strategy Gaps in Assurances: 5. System digital governance	1. ICS Digital Strategy and portfolio for Board approval ~~scheduled September 2023~~ March 2024 [TT – 04.02.2024] 2. Develop information and data strategy across ICP 3. Complete self-assessment against NHSE/CQC regulatory framework 4. Consideration of system resources for support delivery of the Digital Strategy 5. Develop system digital ~~governance~~ operating model following adoption of the Strategy and portfolio [TT – 04.02.2024]

Current Performance – Highlights
• Draft Digital Strategy has been developed and ~~scheduled to be presented to Board on 27 September~~ the related system digital portfolio is planned for Board review/~~for~~ approval March 2024 [TT – 04.02.2024]

- STW One Health & Care (our integrated care record) programme has had a health check with actions identified for members January 2024 [TT – 04.02.2024]
- Cybersecurity is an identified priority in the system digital portfolio [TT – 04.02.2024]
- Work in progress on a conceptual system digital operating model [TT – 04.02.2024]

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

Relevant risks on system partners risk registers
Description
SaTH BAF 7A - Failure to maintain effective cyber defences impacts on the delivery of patient care, security of data and Trust reputation. SaTH BAF 7B - The inability to replace implement modern digital systems impacts upon the delivery of patient care RJAH BAF 6 - IT unable to support new ways of working RJAH BAF 7 – Loss of data/unable to restore services following a cyber attack MPFT BAF R14 - There is a risk that the appropriate cyber security controls are not in place services following a cyber attack Shropshire Council - Corporate Risk Register - Critical skills shortage impacting on Retention, Recruitment & Succession Planning

Strategic Aim: ALL		Risk score 16 major 4 x likely 4
Strategic Risk No.6: Inability to respond strategically to ICS objectives due to the impact of external factors beyond the influence of the ICS. for example, EPRR, Climate change, economic and political changes		
If we are unable to respond collectively to the external challenges facing our local area	*Then* we will not be able to ,meet our ICS objectives to improve the health and wellbeing of our population.	*Resulting in* poorer outcomes for our population andwith further pressure on health and care services.

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

Risk Lead	ICB Chief Executive	Assurance committee	ICB Board Audit Committee - EPRR

System Controls	Assurances reported to ICB Board and committees
Strategies and Plans • Integrated Care Strategy • Joint Forward Plan • Health and Wellbeing Strategies • Local Authority Strategies • NHS EPRR Framework • NHS England Incident Response Plan • Local Authorities EPRR Response Plans • ICB Incident Response Plan • ICB EPRR Policy • ICB Business Continuity Plans (Corporate & Directorate) • ICB EPRR Communications Plan • ICB On Call Policy • STW Health Protection Strategy • Regional ICB Mutual Aid Agreement • ICS Green Plan • Individual NHS organisations Green Plans • ICB Risk Management Policy [ST – 23.01.2024] Partnerships and Services • Integrated Care Partnership • Local Resilience Forum • Local Health Resilience Partnership • Health Emergency Planning Operational Group • Population Health Board • ShIPP • TWIPP • Primary Care Networks • ICS Climate Change Group Governance & Engagement Structures • Integrated Care Partnership • Health and Wellbeing Boards • Local Resilience Forum • Local Health Resilience Partnership • Health Emergency Planning Operational Group (HEPOG) (ST – 23.01.2024) • Themed HEPOG sub groups (ST – 23.01.2024)	First Line of Assurance • Population Health Board and IDC • Audit Committee Second Line of Assurance • NHS E EPRR Annual Assurance Process • NHSE Quarterly Green meetings
Gaps in Controls and Assurances	Actions and mitigations to address control / assurance gaps

1. No operational lead on Climate Change for the ICS 2. No system lead for Vaccination and Immunisation 3. Requirement to finalised EPRR Plans: Mass Casualty, Shelter and Evacuation, Countermeasures 4. Independent assessment (NHSE, CQC)	1. ICB CEO to write out to partner CEOs with request for operational lead 2. Escalated to CEOs for decision 3. Action to complete plans included in EPRR annual work programme 23/24 4. Complete self-assessment against NHSE/CQC regulatory framework

Current Performance – Highlights
• The ICB has an annual EPRR work programme in place to ensure there is s continuous cycle of improvement in place. This work plan covers, training, exercising and incident response arrangements • IC submitted its annual EPRR self assessment against NHSE's Core Standards at end of August. The outcome of this assessment ~~will be reported to the Audit Committee and Board by the end of the year and any areas for improvement will be included in the work plan~~ was that the ICB was non-compliant with these standards. An improvement plan is being finalised with some elements already underway. This improvement plan will be overseen by the ICB Audit Committee. A review of EPRR resourcing has also been undertaken to inform new ICB staff structures [ST – 23.01.2024]

Associated Risks on the System Strategic Operational Risk Register	
Risk no.	Description
Risk 11	EPRR

Relevant risks on system partners risk registers
Description
Shropcom – BAF 4.1 External pressures impact on capacity (wider system escalation or rising pandemic levels) Telford & Wrekin Council – Corporate Risk Register – R4 - Significant business interruption affecting ability to provide priority services, e.g. critical damage to Council buildings, pandemic, etc. Telford & Wrekin Council – Corporate Risk Register R7 - Inability to respond adequately to a significant emergency affecting the community and/or ability to provide priority services. Telford & Wrekin Council – Corporate Risk Register R8 - Inability to respond to impact of climate emergency on severe weather events including heat, cold and flood. Shropshire Council – Corporate Risk Register: a) Responding and Adapting to Climate Change b) Delivery of the Economic Growth Strategy c) Sustainable Budget

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

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

Risk Lead	ICB Chief Executive Officer	Assurance committee	ICB Board

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

Current Performance – Highlights
• GGI review phase 1 due to report proposed revised governance structure for ICB/ICS in October 2023. • Population Health - Population Health analysts capacity secured in Planning and Performance directorate. Population Health Board now reports into Strategy Committee to clarify assurance reporting lines.

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

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

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

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

Risk Lead	ICS Director of Communications and Engagement	Assurance committee	Integrated Delivery Committee Equality and Involvement Sub Committee

System Controls	Assurances reported to ICB Board and committees
Strategies and Plans • Integrated Care Strategy • 5 Year Forward Plan • Big Health and Wellbeing conversation comms and engagement plan socialised and approved by Board • Communications and Engagement Strategy for STW ICB approved by the Board Partnerships and Services • Presence of Healthwatch for both areas at Board meetings and Quality and Performance Committee • System Involvement and Engagement Network established • Communications and Engagement teams working jointly across ICB, ICS and Providers providing more capacity and expertise in planning and delivery • Board meetings are held in public and board papers published to the ICB website to increase transparency. • Substantive ICS Director of Comms and Engagement now appointed and overseeing ICB and ICS functions • System-wide Integrated Impact Assessment (IIA) tool developed to streamline the way we identify the impact of change on equality groups Governance & Engagement Structures • Integrated Care Partnership and Integrated Care Board and associated committees	First Line of Assurance • Reporting on Engagement as part of wider reporting and decision making at IDC, SC and Q&P Committee Second Line of Assurance • Reporting to Equality and Involvement Sub-Committee. EIC now receiving comms and engagement plans from commissioners and Integrated Impact Assessments (IIA), Chair provides reports to IDC Third Line Assurance • Health and Overview Scrutiny Committees (HOSC) • NHSE Annual ICB assessment includes component on statutory responsibility to engage with the local population and partners.

• Reports to Governing bodies/Committees require section completing on Patient involvement • Equality and Involvement Sub-Committee as part of ICB Governance • Non Executive Director for Inequalities in place on Board to act as specific check and balance with regard to patient involvement	
Gaps in Controls and Assurances	Actions and mitigations to address control / assurance gaps
Gaps in Controls: 1) Limited engagement capacity within the comms and engagement team Gaps in Assurances: None	1a) CSU comms and engagement capacity is used when required. 1b) People's network established to enable ongoing engagement on a regular basis

Current Performance – Highlights
Update not provided – to be confirmed

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

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

Agenda Item

ICB 27-03-029.1

Minutes of Quality and Performance Committee meetings held on 30 November 2023 and 25 January 2024, and revised Terms of Reference.

NHS Shropshire Telford and Wrekin
ICS Quality & Performance Committee Meeting

Thursday, 30th November 2023 at 2.00pm to 4.00pm

Via Microsoft Teams

Present:

Meredith Vivian	Chair & Non-Executive Director, NHS STW
Alison Bussey	Chief Nurse, NHS STW
Vanessa Whatley	Director of Quality and Safety/Deputy Chief Nurse, NHS STW – part only
Tracey Slater	Assistant Director of Quality, NHS STW
Julie Garside	Director of Performance and Delivery, NHS STW
Sam Cook	Deputy Director of Performance, NHS STW
Sharon Fletcher	Senior Quality Lead/Patient Safety Specialist, NHS STW
Rosi Edwards	Non-Executive Director, SaTH
Jill Barker	Associate Non-Executive Director, SCHT
Sara Reeve	Deputy Director of Quality, MPFT
Anne MacLachlan	Clinical and Care Director, MPFT
Hassan Paraiso	Deputy Medical Director, SaTH
Sara Bailey	Deputy Chief Nurse, SaTH

Attendees:

Sam Cook	Deputy Director of Performance NHS STW
Vickie Jones	Head of Transformation and Commissioning Children and Young People Learning Disabilities and autism NHS STW
Gareth Robinson	Director of Delivery & Transformation NHS STW
Tracey Slater	Associate Director of Quality NHS STW
Lisa Rowley	PA to CNO , note taker, NHS STW

1.0 Minute No. QPC-23-11.154– Welcome/Apologies by: Meredith Vivian

1.1 The Chair of the Committee welcomed members and attendees to the meeting and introductions were made. It was noted that there was no representative at the meeting from RJAH and Alison Bussey would pick this up with them to ensure that the Trust would be represented in meetings going forward,

1.2.1 Apologies:

Apologies were received from:

- Clair Hobbs SCHT
- Lynn Cawley Healthwatch Shropshire
- Ruth Longfellow RJAH.
- Liz Lockett MPFT – Sara Reeve representing.

- Paul Kavanagh -Fields, RJAH

2.0 QPC-23-11.155 - Members' Declarations of Interests

2.1 No new declarations of interest were noted.

3.0 Minute No. QPC-23-11.156- Minutes of Meeting held on 26th October 2023

3.1 The minutes of the meeting held on 26th October 2023 were reviewed and accepted as an accurate record except for the following:
Meredith Vivian asked for clarity regarding reference made in the Minutes to MPUFT which stands for Midlands Partnership University Foundation Trust. Sara Reeve clarified that MPUFT is the full name of the Trust however the organisation should be referred to as MPFT as all emails use this abbreviation and this should be used to avoid confusion.

3.3 Meredith Vivian referred to 10.6 of the minutes **Deep Dive Mental Health & Learning Disabilities and Autism** and the sentence "Vanessa Whatley was aware of really good work taking place in the background and some project work with dementia and has suggested Helen White consider publishing and stated that that he felt that the sentence was incomplete. Alison Bussey commented that the conversation was around great work that had happened, and that consideration should be given to taking that forward, to helping to get it published, Meredith Vivian suggested removing the word publishing, as this will happen anyway.

3.6 Meredith Vivian highlighted that his name had been incorrectly spelt in a few Places and asked for the minutes of 26th October are amended.

Action: Lisa Rowley to amend all instances of MPUFT to MPFT and also correct Meredith's name where spelt incorrectly in the minutes of 26th October 2023.

4.0 QPC-23-11.157 - Matters Arising and Action Log

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

5.0 Minute No. QPC-23-11.158 - System Quality Risk Register – Vanessa Whatley

The report was taken as read, a discussion took place, and the following key points were highlighted:

5.1 Rosi Edwards referred to the Diabetes risk which she noted had been updated and, commented that the register stated that 63% of people were on continuous blood glucose monitoring (CBG) for type one diabetes as these were considered the most suitable patients and wondered what proportion of type one patients are classed as suitable as it is difficult to ascertain who is getting the glucose monitoring kit and said she would be interested to know whether it is 63% of how many people have the glucose monitoring kit?

5.2 Meredith Vivian suggested that Vanessa Whatley provides a response to Rosie's question above.

5.3 Rosie Edwards commented that sometimes CBG can be more accessible to affluent groups and deprived areas are less likely to be seen as suitable and asked how fair the distribution of the availability of CBG is.

5.4 Meredith Vivian added that this was a good question and Fiona Smith will be attending a QPC meeting in either early 2024 and this should be part of the update.

5.5 Liz Noakes raised a question on diabetes and highlighted that the covering report refers to an escalation to execs but does not provide a time scale against when the Committee would hear back. Meredith Vivian commented that he has had detailed correspondence with Simon Whitehouse about this and was not happy with the responses that we were getting. He had a lengthy email from Simon setting out the various pieces of work. On the risk register the SRO should be listed as Gemma Smith, Director of Strategic Commissioning. Simon also said that senior clinical leadership is being identified and picked up in SaTH to assist with this, and asked if Hassan and Rosie knew where the senior clinical leadership lies in SaTH around diabetes? Rosie Edwards responded That the last she heard John Jones was looking into this but was finding it difficult to find someone to take this on and said she could not provide an answer at present. Hassan Paraiso commented he too did not have an update however, SaTH has appointed a clinical director but is unable to comment further.

5.10 Meredith Vivian said he would be interested to know who will be the clinical director for diabetes and the fact that John Jones is finding it difficult fits in with the overarching message he is getting around diabetes, and that it is proving too difficult and asked if it were possible for SaTH colleagues to support the drive to identify the clinical leadership and update at next QPC.

5.11 Hassan Paraiso said that he would be happy to raise this with SaTH.

5.12 Meredith Vivian concluded that he got a strong sense that Simon Whitehouse was keen to make sure this was delivered across the whole transformation programme rather than it being picked up bit by bit in different parts and expected to have more to say about this and more evidence of progress and asked that this programme is closely monitored by the Committee and its members.

Action: Hassan Paraiso to raise with SaTH the identification of Clinical Leadership for Diabetes.

The Committee:

- Discussed the risks for assurance of ongoing progress/action.

6.0 Minute No QPC-23-11.159 – Performance Exception Report – Julie Garside

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

6.1 Julie Garside opened the discussion by advising the Committee that the new Community Diagnostic Centre went live at the beginning of October. Feedback both from patients and staff has been positively received and this put STW in good stead in terms of diagnostic recovery; STW is also now slightly ahead of it's trajectory for delivery of the faster diagnosis cancer standard, which is important for our population and will help improve survival with the delivery of the target of 75% by the end of March. The uptake of fit testing is now one of the best in the region in terms of up take and STW is consistently delivering upwards of about 76%, against a target of 80%.

6.2 Julie Garside felt it appropriate to raise the issue that there will be a real challenge for the remainder of this year on elective and long waits so as not to lose the good work that has already been done because of the national letter

received instructing us to reduce the over tariff/ premium costs that are being invested in insourcing and outsourcing capacity. This has been a major contributor to the reduction in long waits seen this financial year and that will leave a significant consequence for our patients' long waits and a challenge for the system. The system needs to maintain a real focus on achieving the level of activity that has now been committed to by the end of the year, because if we do not deliver the required level value weighted activity, that would reduce the ERF income the ICB could receive which has already been included in our forecast outturn which would add to the substantial financial deficit. All providers are working incredibly hard to maintain that over the next few months.

6.3 Rosi Edwards commented on the impact from SATH's point of view. SaTH have been looking at over 65 week waits and over 78 week waits and that both would be impacted. Rosi advised that she had received an update recently advising that SaTH were going to protect the 78 weeks wait. but that the loss of insourcing and outsourcing would mean that their trajectory for getting the 65 week waits down could not now be achieved. The October figures looking quite good. Contracts have had to be cancelled and the Trust will have to explain to patients what's happening. Harm Reviews will need to be carried out which means that you take clinicians away from seeing and treating patients. Rosi expressed her disappointment with the situation around the national change in the direction of priorities.

6.4 Julie Garside said she shared Rosi's sentiments particularly when staff work so hard.

6.5 Julie Garside informed the Committee that progress has been made on UEC since the report was submitted. There is now a revised improvement trajectory for the four-hour performance for the remainder of this year, rather than the 76 %, is going to get us to 69% at a system level of which SaTH's component is 59%. There will be a further iteration of this to see how much closer the system can get to the 76% target, and she is hopeful to be able to share that formally in January by when hopefully it will be signed off by UEC board and ICB board. There is still potential for some movement but is confident that this will be available to be shared with the Committee in January 2024.

6.6 Julie Garside added that the workforce, particularly at SATH is looking better. The Trust are able to recruit staff and are actually above their recruitment plan year to date. but they need to make sure that this is converting into patient care and that coverts into improvement in performance metrics and also efficiency and productivity because that means , more patients can be treated with the resources that we have.

6.7 Liz Noakes, referred to the improvement in terms of the time for diagnosis in cancer is in the right direction but added that waiting for treatment at the other end of the pathway is not looking so good. She asked if the loss of above tariff insourcing capacity would make this worse.

6.8 Julie Garside responded that there are concerns about the time to treatment, however, if the time to diagnosis is right, then the time to treat will come down as well. Without achieving the 75% for FDS, we will never give ourselves an opportunity to be able to deliver those times to treat. It is about focusing on that first part of the pathway. The direction of travel will then be on that time to treat and the 62 day referral to treatment target (RTT). It will also depend on any changes to cancer performance targets within the planning guidance for next year, which has been delayed. She would expect 62day RTT to be the next part of the priorities within cancer recovery.

6.9 Julie Garside added that regarding the CYP mental health where we have been asked to redirect SDF monies. There is a quality impact assessments and an EQIA being completed at the moment which is being co-ordinated by Tracey Jones which will inform those decisions; Julie stated that she is aware that no final decision has yet been made and has not been signed off because neither the provider or the ICB Boards have had sight of the completed EQIA in order for them to be able to make those decisions.

Action: Julie Garside to ask Tracey Jones to keep Liz Noakes informed of decisions

6.10 Liz Noakes advised that Tracey Jones has shared with Rachel Rogers and herself the EQIA for that particular area and both Rachel and Liz, as Directors of Public Health are concerned around that and we will be emailing Traceyto that effect.

6.11 Sara Reeve referred to the eating disorder targets in the report and said that it didn't look like there was Q1 data included and added that in MPFT's Board papers they are reporting an improvement to the four week target, They are not at 95% yet but 93.8% is being reported and commented that she is not entirely sure whether the data in the performance report pulls out, Shropshire Telford, and Wrekin or whether it is Trust wide e.g. Staffs and STW.

6.12 Sara Reeve added that the one-week urgent referrals are being reported at their Trust Board paper as 100% seen within the target timescale.

6.13 Julie Garside advised the Committee that the recovery trajectory for talking therapies has been received and is currently being worked through by commissioners and formulating a joint position statement across the ICB and MPFT and will look to bring that back to the Committee in January 2024 which will summarise where we were, what's happened and what the improvement trajectory is and any risks to delivery.

6.14 Meredith Vivian commented on the slow but steady increase in dementia diagnosis. And asked whether performance numbers align with quality as well. So as diagnosis numbers increase is the provision of services for people with dementia keeping up?

6.15 Julie Garside responded that she thought that it is because of the work that has been done not only around the provision of access to diagnosis but that such a diagnosis then provides access to support both for individuals and their families and carers. It is part of the picture that we have the capacity those that wish to be diagnosed as not everyone does. We can then signpost them to what is then available and wrap around the support and the care that they need.

6.16 Anne MacLachlan agreed with Julie's comment about it being part of the picture and it's helpful for some people that it's diagnosed and that they know and it's not other things, especially for young people, when there can be all sorts of other things going on. She also said increasingly it's going to be important as more pharmacological treatments are rapidly becoming available in the States which we are going to follow here in the UK, but then that has a massive cost implication to the health service but it will slow that cognitive decline.

6.17 Sara Bailey echoed Julie and Anne's comments and said that from MPFT'S perspective, when they look at their quality nursing metrics monthly, it's one of the key KPIs and actually triangulating that from that assessment of dementia, also the impact and then signposting appropriately for the care. It is important that it is looked at in the round of all care provision and ensuring that those assessments are taking place and the so what question from a quality perspective.

6.18 Meredith Vivian said that he would like to see evidence around it, so that assumptions can be evidenced.

6.19 Julie Garside responded that it should all be about that patient experience. We can count the numbers being diagnosed, but if that doesn't then deliver access to the care and support they need , then it's another case of hitting the target and missing the point.

Action: Julie Garside said that she would raise this with Vanessa Whatley and see if there is anything that can be done around linking diagnosis rate to that patient experience post diagnosis.

6.20 Meredith Vivian referred to the increase in CHC demand. and asked what lay behind that.

Action: Julie Garside said that she was not cited on that and she would catch up with Brett Toro-Pearce to find out what is driving this increase and will provide the Committee with an update.

The Committee:

- Noted the content of the report and provided any feedback for incorporation into future reports, particularly with reference to the standardisation of charts into SPC.
- Noted the mitigations to address current risks/trends supporting continual improvement journey across the ICS, noting that the report straddles two months due to data lags and that national targets may have changed from last year.
- Noted there will continue to be improvement in the detail of the recovery actions and associated timescales for recovery included in this report as performance recording is developed by the team.
-

7.0 Minute No QPC-11-160 - System Quality Metrics Vanessa Whatley

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

7.1 Liz Noakes, raised two points firstly the increase in the postpartum haemorrhage in the maternity dashboard and that the paediatric deaths and paediatric transformation is there. But there is not that broader piece around child mortality necessarily referred to within the metrics which needed development.

7.2 Vanessa Whatley responded that some performance improvement metrics which will to go into the contract around the paediatric issues that were at SATH that should help to provide combining this with the outcome of CQC she would be look combining this into that bigger picture of child mortality early in the new year.

7.3 Sharon Fletcher informed the Committee that PPH was brought up at the Maternity Safety Champions meeting last month within SATH. The Trust are doing a piece of work why they are showing as a greater rate of postpartum haemorrhage for more than 1.5 litres and any themes. This quality improvement piece of work that is ongoing and is being reported through the maternity governance and is looking at blood loss over 500mls as the Trust has exhausted learning from 1.5 litre which is innovative to expand the scope of learning. This will continue to be monitored/overseen through the Maternity Safety Champions and Maternity Governance and it gets fed through to the LMNS and Perinatal Quality Surveillance Group.

7.6 Jill Barker referred to the harm due to ambulance waiting times and noted that it has been an ongoing problem in terms of the increased handover time and asked where this is reported. Vanessa Whatley responded that there has been a struggle with capacity and that a co-produced piece of work needs to be done with SaTH to have a look harms, as it is how this piece of work is done collectively across the system as some patients could have had care in the community. Vanessa Whatley said she is keen that this is looked at as a system issue and advised that she has had conversations with Quality Leads about this; Provided ideas and have a chat about two other partners in the system and is keen to get this sorted before winter sets in.

7.9 Rosi Edwards commented that SaTH has been looking at this. One study looked at harm arising from long ambulance waits during a 6 month period and another at the rise in deaths in ED. This detailed review of increased mortality in ED in Q3 2022-23 found no pattern of omissions in care, noting that the increased deaths within ED are likely to have been in part related to the increased length of stay within the ED. There is published evidence that morbidity and mortality increase in older patients who have to wait overnight or for long periods of time in the ED for a ward bed. While improvements eg in documentation could be made there was no evidence of significant omissions or pattern of omissions in care."

7.10 Meredith Vivian commented on the reference in the metrics to dentals services for children and asked for more information on that. Vanessa Whatley responded that there are some interesting new information dental and it is something that needs to be looked at generally as a whole. There is emerging evidence regarding access to dentists and health inequalities. However now that the ICB has commissioning responsibility for dental care more information is being seen.

7.12 Meredith Vivian asked whether this will be picked up at System Quality Group Vanessa Whatley responded it will be picked up by SQG in the New Year

7.14 Liz Noakes referred to the Healthwatch complaints report but was unsure whether it was for Shropshire or Telford and Wrekin, and said it sounded like people do not feel they are communicated well enough in terms of understanding the risks, which is a key issue and asked what the response was to that was and that a response to that report should be given. Alison Bussey commented that there was work to be done on this and the Experience of Care Group will be looking at this in more detail along with other relevant groups. A discussion was held around the importance of getting complaints processes right and SQG will be following up and the MedLed training which has been delivered in SSOT and STW systems which highlighted the lived experience of complaining.

7.27 MPFT now have weekly learning review meetings which look at any incidents that are both unexpected deaths, natural cause deaths and moderate harm incidents Which are attended by their family liaison officer who brings the family's questions early that form part reviews. The Trust have also set up earlier family meetings which is in its early stages but are struggling with the time it takes. Anne extended an invitation to the Committee to attend these meetings.

7.28 Vanessa Whatley wished it to be noted by the Committee that the CDOP annual report has been received regarding child mortality concerns. There will be a workshop on 11th December with system partners around child mortality which will include the suicide prevention strategies. The CDOP reporting processes are also being strengthened through Safeguarding Partnerships.

7.29 Vanessa Whatley added that national concerns around paediatric hearing assessment accuracy which is being managed through the EPRR route by NHS

England to address as a widespread issue across the country. This has been looked at locally with SaTH who provides the community service, Good processes are in place and there were minimal actions, around making sure that equipment was revalidated and audits reflected current NICE guidance. There were no issues with clinical care,

The Committee:

- Considered the metrics with performance metrics and system risks.

8.0 Minute No. QPC-23-11.161- Exception Report - System Quality Group Chairs Update – Vanessa Whatley

The report was taken as read.

8.1 Vanessa Whatley advised the Child Death processes has been reviewed, a report and action plan was taken to System Quality Group for discussion. Some actions are moving forward, and owner details are awaited for some of the other actions. This service was set up some time ago and requires workload and governance review as well as how learning is shared. Partners, public health and SCHT, who run the service, are all engaged. The annual report is being tabled at the next System Quality Group with quarterly reports to follow. The annual report will also go to Safeguarding Groups in December.

The Committee:

- Accepted the report.

8.0 Minute No QPC-23-11-162 - Health Protection board Update – Liz Noakes for information only.

8.1 Noakes, Liz highlighted that this paper was presented for information only however wished to highlight the following points:-

8.2 Migrant hotels are putting some pressure on the system in terms of being able to respond from a primary care point of view. But then also from a wider Health Protection point of view with TB screening in particular Health Protection services, primary care and immunisations,

8.3 The start of the COVID and Flu immunisation programme is welcomed with a good start in care homes.

8.4 UKHSA colleagues highlighted the need for trusts to make sure that occupational health screening processes are adequate for Measles and TB. The West Midlands are now getting clusters of measles and the unimmunised healthcare staff will be in a period of 21 days exclusion if they are exposed to measles which is impacting in other parts of the Country.

The Committee:

- Noted the contents of the report.

9.0 Minute No – QPC23-11-163 - Deep Dive – Children & Young People's Healthcare – Vicki Jones

9.1 There is a lot of work around children which is multifaceted of working with parent carers and local authorities and our health providers. There are big pieces of work being undertaken, the biggest piece is the review of CAMHS (BeeU

9.4 There was discussion around governance, Vanessa Whatley asked if we are going to work as together as a system how will this happen will there be system Governance group with a risk register? Vickie Jones responded that one of the actions is to develop the system governance to be started in the New Year. There will be two levels an Oversight Group and CYP Operational Group; there are several work streams that will continue to meet and it's about developing that operational group and then a higher-level board that sits above that So there is somewhere to mitigate risks, share practice and work together. CYP voices, needs to be systematically delivered too. VW confirmed she would be happy to provide quality support to the Group.

9.7 Liz commented that she welcomed Vickie's appointment in terms of having a Children's Commissioner and asked that focus is given to physical health as well as the mental health. Liz stated that although Vickie's paper does cover this it was not specific enough and said that in terms of the Committee, there needs to be a detailed action plan and agreed that with the absence of a system wide approach for Children & Young Persons Board has been missed. Liz also pointed out that there was no timescale against this recommendation. Vickie Jones responded that this timeline is being guarded and advised that she is having discussions to see if a CYP launch event to relaunch everything in February or March next year. Vickie advised that she has been working with SCHT to start to do some terms of reference for both groups. Vickie is hoping by the end of January 2024 that an initial Oversight Group can be formed.

9.10 Further discussion was around outcome measures. Vickie Jones added that in the regular reporting to NHSE there must be outcome measures, showing the impact of a service. MPFT have a new data system where they have been able to look at children and schools that they had before and after going into a programme and the national average is only about 50% of children come out of an intervention of programme in a better state than where they were before. MPFT are currently running around 62%. So, what it shows locally our services are delivering a better outcome for children than nationally and we have still got an issue with waiting lists and we are working really hard to address that with the provider. What is not evident is the impact of being on the waiting list

9.11 Meredith Vivian raised a question on the complaints feedback and noted that there will be direct engagement to produce the new CAHMS model and highlighted that there is probably a lot of feedback already about the current service and said he wanted to make sure that the intelligence already provided through various forms of feedback, whether that be complaints or panels or letters from MPs will be used.

9.12 Vickie Jones responded that she will be doing that as well with MPFT and other partner organisations and that she is working closely with the local authority and voluntary sector and 3rd party sectors to gather this intelligence.

9.13 Alison Bussey requested that in the children's and Young Peoples Board, children in care (formerly known as LAC Looked After Children) isn't just an add on and that , it is not just a little strand that sits somewhere over in the corner because there are challenges currently around the prescribing of melatonin, I'm sure that you're well aware of that the shared care stuff saying this is mental health, but it's also in physical health as well around the initial health assessments etcetera.

Action Alison Bussey to have a conversation with Maria Hadley as some pathways need to be strengthened and that's something that she can work closely with you and others on.

9.14 Gareth Robinson referred to the setting up of the Children's Board, which was a specific ask from the board development session a while ago, following on from that board development session, He had Kathy Rowley and Tracey to meet to discuss how this is handled , as we may overcomplicate things in the presence of the mental health LDA board with the overlap between mental health and physical health for children, and then the role of the SEND Partnership boards. Which is a piece of work that needs to be done to make sure that the Children's Board is adding value and is specific rather than either than allowing something to be missed,

The Committee:

- Noted they have received this report.
- Have understood the size of the CYP transformation programme and the commitment required from the system to meet them.

To Note: No Updates were Received from Healthwatch Shropshire and Healthwatch Telford & Wrekin

Action: Gareth to discuss this with Vickie outside of the meeting regarding the Childrens Board

9.15 Vickie Jones confirmed that she has already had these discussions with Tracey Jones.

9.16 Meredith Vivian requested that CYP update is brought back to QPC in six months' time to see how it is all panning out because it feels like we're at the developmental stage and there is lots happening.

9.17 Julie Garside said that it would be useful to present an CYP draft Plan at QPC in January 2024.

10.0 Minute No QPC-23-11-164 - Primary Care Access Implementation Plan

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

10.1 Gareth Robinson advised that the Improvement Plan paper has been to a number of other forums, including operational leads, the Integrated Delivery Committee, which has approved this and then forwarded it to the board yesterday for noting and approval and it is for Shrewsbury HOSC briefing session next week ahead of January's HOSC detailed dive and it is being scheduled for joint HOSC. It has been to TWIPP and SHIPP.

10.2 The plan sets out the requirements for the primary care access recovery programme, which places the emphasis on primary care recovery at the same level of focus as the urgent and emergency care and elective care agendas. Colleagues will be aware that there are subgroups of the Integrated Delivery Committee that look solely at those areas. They are focused on those single-issue items and the purpose of this is to place this at the same level of importance to systems, which is a real key drive from NHSE and the government that the improvement plan is to

improve access to general practice, maintain and improve patient satisfaction and work to streamline care and advice. This is underpinned by 4 national pillars. (1) The first is around empowering gap patients. Which specifically includes the rollout of the NHS app; Increasing self-referrals; increasing the use of community pharmacy, all of which are self-evident in terms of their value of providing better quality care and reducing pressure into the health services Uh,(2) The implementation of modern general practice.at i's most pragmatic level. Focussing on improving telephone, improving digital telephony, so access to our primary care is much better managed and we don't deal with the 8:00 AM Monday morning. Can't get in touch with the GP and it also focuses on improving online access again for a significant proportion of the population. This is a really helpful access point into our services and it is primary way we've seen an increase in activity in primary care services since before COVID. (3) Building capacity in both workforce and estates, parallel strategies around workforce and estates development are being worked up in parallel (4) Cutting bureaucracy, trying to take out pressure and necessary pressure from primary care, but also improving the need for better relationships between primary care and other providers predominantly acute.

10.3 The plan sets out the detail and the current position. What is underway and what will be delivered it also sets out a restructure of the way that we will oversee the implementation of these plans through the development of a primary care recovery board this still subject to a developmental session, with the primary care commissioning community to rework the way that we will oversee and implement the actions within the plan

10.4 This is an important step forward in terms of using primary care networks to help deliver improvement in access to primary care however it will not fundamentally resolve the capacity issue within primary care. it is about making sure that the capacity that we have is deployed in a better and more effective way in the interests of our patients.

10.5 Noakes, Liz commented that poorer experience is being voiced by a resident in Telford and Wrekin. Healthwatch are concluding their survey and there has been over five and a half thousand responses locally and asked how does the ICB ensure that the improvement plans are focused on those practices that really need it to make sure that we level up the patient experience and issues with access as opposed to improving the best even further?

10.6 Gareth Robinson agreed with Liz Noakes' question and said that he acknowledges the different outcomes in both access and GP satisfaction surveys, and there is a difference between Shropshire and Telford and Wrekin, and this is the same set of actions being carried out by each of the practices and primary care networks, so in its own right it should help with the health inequality d. Not because we're necessarily focusing more on Telford than we can because unequivocally we're not. Not because we're necessarily focusing more on Telford than we can because unequivocally we're not. We're taking the same approach across both areas, there is a greater opportunity within Telford & Wrekin to deliver improved outcomes, the impact of the changes should deliver more benefit within Telford and Recon than it does within Shropshire because they have greater capacity to improve, and the impact of each individual intervention should therefore be greater.

10.7 Julie Garside wished to assure the Committee that we're building into the plan 13 new performance measures; delivery to the delivery committee will need to provide assurance to this committee in terms of the performance report; we are doing a

number of balancing metrics; we are also looking at the IT which would be the patient survey results of this.

10.8 Jill Barker asked how primary care are going to e incentivized to deliver this?

10.9 Gareth Robinson responded that it is part of the expectation of care networks. The funding for the desk comes through primary care networks which is not directly linked to their funding, and this is part of the consequences of the contractual and commissioning arrangements with primary care, the levers we have are more influencing than directing. GM contracts are difficult to enforce, there is a positive group of 51 practices. They each have their own challenges but one of the challenges we don't have is bringing into the engagement on this kind of work. There's no there's no standard performance management process we can put in other than to share and use the data to influence behaviour.

The Committee:

- Noted the contents of the STW System-level Primary Care Access Improvement Plan.
-

11.0 Minute NO QPC-23-11-165- QPC Terms of Reference

11.1 Vanessa Whatley advised that all feedback received regarding the TOR have been included including Primary Care Input.

11.2 Meredith Vivian highlighted that there is a contradiction around chairing the meeting. In one place it says that in the absence of a chair, a chair will be nominated by the committee and then later it says the deputy chair is the Chief Nursing Officer. And said he would prefer that to be a non-executive from another organization.

Action: Vanessa Whatley to update TOR in line with Meredith's points raised above. following the amendments the Committee agreed to sign off the QPC TOR.

The Committee:

- Approved the TOR subject to the above amendments being made.

12.0 Minute No QPC-23-11-166 - Evaluation of Meeting

12.1 Meredith Vivian asked that members to send comments through via email on what worked and what could be better? How yo would like to adjust things? What would enable you to be at your best? How can members be assured feeling like it was a good use of their time?

13. AOB

None noted.

14.0 Minute No QPC -23-11-167 - ADHD – for information

14.1 Vanessa Whatley highlighted that ADHD went to SQG and a risk is currently being worked up,

Date and Time of Next Meeting

Thursday 25th January 2024 at 2.00pm to 4.00pm via Microsoft Teams.

SIGNED ……. DATE …….

NHS Shropshire Telford and Wrekin
ICS Quality & Performance Committee Meeting

Thursday, 25th January, 2024 at 2.00pm to 4.00pm

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
Anne MacLachlan	Clinical and Care Director, MPFT
Sara Bailey	Deputy Chief Nurse, SaTH

Attendees:

Sam Cook	Deputy Director of Performance NHS STW
Andy Riley	Pharmaceutical Advisor NHS STW
Jane Williams	Performance & Assurance Manager NHS STW
Helen Rowney	Head of Transformation & Commissioning - Mental Health NHS STW
Lisa Rowley	PA to CNO, note taker, NHS STW

1.0 Minute No. QPC-24-01.01- Welcome/Apologies by: Meredith Vivian

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

1.2.1 Apologies:

Apologies were received from:
Hayley Flavell – SATH Sara Bailey deputising
Claire Hobbs – SCHT Sara Ellis-Anderson deputising
Lynn Cawley – Healthwatch Shropshire
Jacqueline Small - MPFT
Laura Tyler – Shropshire Council
Ruth Longfellow - RJAH
Sharon Fletcher NHS STW
Tracey Slater NHS STW
Dr Ganesh - SCHT

2.0 QPC-24-01.02 - Members' Declarations of Interests

2.1 No new declarations of interest were noted.

3.0 Minute No. QPC-24-01.03- Minutes of Meeting held on 30th November 2023

3.1 The minutes of the meeting held on 30th November 2023 were reviewed and accepted as an accurate record except for the following:

3.2 Meredith Vivian advised the note taker of amendments that were required to be made to the minutes. The minutes of 30th November 2023 have been updated to include Meredith Vivians and Rosi Edwards comments and have since been forwarded to the chair for approval and sign off. `

4.0 QPC-24-01.04 - Matters Arising and Action Log

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

5.0 Minute No QPC-24-01.05 – Performance Exception Report – Julie Garside

5.1 Julie Garside informed the Committee that the ICB had received very positive feedback form the national team regarding how the ICB are using the making data count and statistical process control within their reporting. Sam Riley, the national lead for making data count has asked if she could use our IPR as a national exemplar; she also offered to do sessional training, either for the ICB's quality and performance subcommittee or the ICB board itself on the making data count.

5.2 Julie Garside advised that improvements have been made in relation to elective and cancer care. Faster Diagnosis Standard is now being achieved and the percentage of referrals with an accompanying FIT test is >80%. There has been a positive improvement in relation to long waits however, due to the national directive (last November) to stop the insourcing and outsourcing this has slowed the rate of reduction. Providers are doing as much as they possibly can within the resources they've got and with the added complication of industrial action. Elective, cancer, and diagnosis is in a positive position and moving in the right direction.

5.3 Sustainable improvements are being seen in relation to mental health and LDA too.

5.4 There has been some significant improvement in one UEC metric, the time to initial triage <15mins which is now above the regional average for the first time.

5.5 However there has been no improvement, in relation to 4-hour performance. There are still risks around the ambulance handovers; Julie Garside commented that she has concerns about the number of patients being in the ED department for over 12 hours and despite underlying improvement in some of the flow metrics e.g. reduction in the number of NCTR patients and improvement in length of stay of NCTR patients this has not translated into improvements in waiting times in ED. There has been an improvement overall in our UEC performance for Dec23 compared to Dec 22 which is important to build on.

5.6 Rosie Edwards commented that when December 2022 data is compared against December 2023 data, significant improvements have been noted and said that in terms of the bigger problem this still relates to the long waits/people on trolleys.

5.7 Rosie Edwards added that she has had sight of a report which is due to be presented at a internal meeting at SaTH on the Perfect Week on triage and initial assessment for adults, that will be extended to ED. It shows that there are things that can be done within the department so that people know how serious their case. It also shows that some issues are in the rest of the hospital and beyond into the wider system as to why people are staying too long. This should be looked at across the system rather than individually.

5.8 Sam Cook referred to the actions around CHC and said there had been a question about what was driving the demand in the fast tracks which is included within the report

and highlighted that this is a bit of an unknown at this stage but there are increasing numbers of positive checklists being received from the local authority, thought to be around acuity. There is a deep dive into that to try and understand the cause and effect for this demand.

5.9 Julie Garside advised the Committee that there is a further piece of work being carried out around the impact of Local Care Programme on emergency demand. In addition the impact analysis has shown is that length of stay also has a massive impact on pressures in SaTH, not just demand through the door; this piece of work is being carried out across the whole system and not in isolation. It the first time we've had that the data to explain why SaTH are feeling the pressures they are.

5.10 Meredith Vivian suggested that Lisa Keslake is extended an invitation to a QPC meeting to give an update on local care.

5.11 Julie Garside summarised that this impact work has been done to support the development of the HTP, final business case. The ICB are trying to demonstrate the impact, however, cannot prove causality to individual interventions such as the Local care Transformation Programme. What can be proved is that between 2021/2022 and 2022/2023, the system suppressed non elective demand in terms of ~2500 admissions which is the equivalent of 33 beds in that period. There was a slight increase in Los during the same period. However, from 2022/23 into this year 2023/24, there has been little bounce back in terms of admissions but a reduction in length of stay.

5.13 Julie Garside commented that there is data that can quantify the impact of length of stay across the system and we need to understand what collectively all the different parts of the system need to do to contribute to bringing length of stay down, which will remove the overall pressure, improve patient care and experience and reduce pressure on staff.

5.14 Meredith Vivian commented that good evidence gives rise to further questions but that if we can link that to a conversation with Lisa Keslake and bring an update on the whole picture to a future QPC

Action: Lisa Keslake to be invited to a QPC meeting to provide an update which summarises the impact of social care.

5.15 Meredith Vivian then moved on to the performance of the virtual ward (VW) and said he would be interested to get either SaTH or SCHT view on the effect and impact of this. Julie Garside said the BI team were working with SCHT to improve the data around VW to enable us to demonstrate the impact it had had on acute services, but it would be another 2-3 months before that was ready.

5.16 Sara Ellis-Anderson added that virtual wards is a hot topic and is a regular agenda item on the SATH/SCHT meeting and wished to reassure the Committee that regular dialogue is taking place between the two providers and clinicians to ensure that the pathways are optimised.

5.17 Meredith Vivian said that the Committee would like to get a sense of confidence that the arrangements are in place to deliver the data that Julie Garside requires to prove that this service is working.

5.18 Julie Garside commented that there is confidence around what is being targeted by the two providers and the areas that they're focusing on to improve clinical relationships associated pathways. Secondly, she is monitoring the work underway to deliver the data quality improvements and associated time scales. If any concerns arise, she will escalate back to the committee. There was a meeting already scheduled with Claire Horsfield and Gemma McIver in SCHT who have been very supportive of this work.

5.19 Sara Ellis-Anderson advised that referrals to virtual wards decreased in December 2023. SCHT are still promoting virtual wards with primary care colleagues and Shropdoc, there is a daily in-reach into SaTH to try and pull patients onto the virtual

ward. SCHT are currently working up two other pathways with partners. Heart failure and acute respiratory infection. Once these pathways have been agreed, it is hoped that an increase in referrals to Virtual Wards will be seen. SCHT are also looking at patients with long term conditions being able to self-refer.

5.20 Meredith Vivian asked how patients know that they could self-refer into the virtual ward?

5.21 Sara Ellis-Anderson responded that Shropcom are working on a step-by-step guide as when to refer and for what reasons.

5.22 Meredith Vivian commented that there is a wide range of voluntary and community sector organisations delivering everyday care, and asked whether this was a better route to get the message out rather than relying just on the Trust.

5.23 Sara Ellis-Anderson said that this was a helpful suggestion and would be happy to take that back to the to the team that are looking at that pathway.

5.24 Sara Bailey referred to virtual wards and advised that she did not have any further updates and that she is not close enough to the detail and said she could bring an update to the February QPC meeting,

Action: Sarah Bailey to provide an update on virtual wards to QPC in February 2024.

5.25 Vanessa Whatley said she was concerned about the fast track as the shortest time from outcome to the package is still 0 days, but the longest has crept up from of 15/16 over a three-month period to 35 days that people are waiting for care to be put into place, which is a concern and said she was uncertain whether this is a target being looked at elsewhere.

5.26 Sam Cook responded saying the analysis by length of wait was not available this month but will be available next month and it will show that the majority of patients are dealt with within the 24 hours.

5.27 Meredith Vivian said that it is having an upsetting effect on individuals and families and said that having clear figures would be helpful.

5.28 Meredith Vivian referred to data recording around adults with severe mental illness.

5.29 Julie Garside advised that the major issue with the current delivery model for SMI health checks is being resolved. A new process was agreed at the Commissioning Working Group earlier this month which improve the delivery SMI health checks going forwards as they will be entirely managed by MPFT from April onwards. There is a specific issue around a backlog of recording health checks that have been done this year and have not been entered onto general practice systems, Julie advised that she has picked this up personally with Nicola Williams Interim Head of Primary Care; Nicola had given the commitment that she will get that resolved and any outstanding recording of completed checks will be registered onto the system by the end of March. The new process will make everything better coordinated, which in turn will be better for our patients and also give a greater degree of confidence in the level of checks that are being carried out.

5.30 Finally Meredith Vivian highlighted that the ICB are receiving national recognition for the quality of reporting and analysis and asked members for their thoughts on the content and how the report is presented.

5.31 Anne MacLachlan said the reports was very clear and easy to understand and felt it accurately reflects where we have performance issues in their care group.

5.32 Vanessa Whatley added that she and Julie Garside are working towards integrating quality into this report, thereby losing the separate quality report. It will be one single report where it will be clear what is quality and what is performance, as sometimes these overlap which results in the same data being repeated across the two existing formats.

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.

5.1.2 Deep Dive Schedule

5.1.3 Meredith Vivian referred to the Deep Dive Schedule and asked members for their comments.

5.1.4 Julie Garside clarified that there was a change in responsibility, so it has moved from Brett and is now with Helen Rowney. Julie added that there had also been a change in relation to elective from Gloria to Maureen which is due to a change in personnel.

The Committee:

The Q&P Committee approved the Deep Dive schedule for 2024-5.

5.2 Talking Therapies Improvement trajectory – Jane Williams & Helen Rowney

5.2.1 Julie Garside highlighted that this was a position statement.

5.2.2 Meredith Vivian asked the Committee members for comments/questions or points of clarification in relation to the Position Statement.

5.2.3 Jane Williams advised that PWP is Psychological Wellbeing Practitioners. Jane Williams added that PWP are the workhorses in the talking therapies service, they see the bulk of people needing support and therapeutic intervention, and they are crucial to the success and the continuation of the service. More complex patients requiring more complex interventions get seen by higher intensity practitioners (HIP). The position statement outlines that an adequate workforce of PWP is required to deliver a sustainable service.

5.2.4 Meredith Vivian said he assumed there is a finite amount of people with the skills, experience and training to fulfil the roles that are required.

5.2.5 Anne MacLachlan commented that MPFT have traditionally struggled, particularly with the Shropshire side of what is now one countywide service. Anne explained that PWPs see people on a very fast turnover. Short term, brief interventions and they are the least complex, so can recover quickest. The Trust are on an ongoing recruitment drive. There is another challenge in that there is a shortage because the community mental health transformation also recruited more psychologists. This adds to the challenge of being a rural county. Julie Garside suggested MPFT contact Chester University to ascertain whether they provide counselling training courses for PWPs.

5.2.6 Meredith Vivian commented that getting the workforce in place is fundamental.

The Committee:

- Noted the contents of the Position Statement.

7.0 **Minute No QPC-24-01.07 - System Quality Risk Register – Vanessa Whatley**

7.1 Vanessa Whatley said that Committee members will be the aware that the draft CQC report for SaTH is anticipated any day now, and it is hoped that there is a positive in some of these areas which will influence the section 31 for children and young People's mental healthcare, which is an important aspect of that risk.

7.2 The maternity, children and paediatric risk is a highlight this month and hopefully next month with improvements expected.

7.3 The emergency care risk has been reviewed and is key risk with a refreshed harm review process.

7.4 Diabetes – further information is required regarding this risk regarding next steps and an updated report will come to the next meeting.

7.5 Two new risks had two new risks: ADHD waiting lists. This risk has been discussed at the Quality System Group and briefly discussed previously at QPC particularly around large waiting lists with no effort clinical triage of those patients that are on that ADHD waiting list. There is also a subset of patients that have serious mental illness. The ICB and MPFT colleagues are working on how to address this waiting list and there is a weekly group meeting task and finish group, which is reporting into System Quality Group

7.6 SQG 12 is done individualised commissioning, and this is a brand-new risk is that the first time it it's it was put on the risk register just this month. It has not been to System Quality Group yet, but this is around the compliance with individualised commissioning, just currently 2% of assessments undertaken within 28 days as the statutory function which is a risk to both patient care and quality, but also to performance than reputation and if we've got a problem which is going to drive costs as well.

7.7 Rosi Edwards referred to the Diabetes Risk and said that a decision needed to be made as a system regarding looking at preventative measures. Rosie added that she would like to see the diabetic risk remodelled and focus changed in the way this disease is managed in this country as prevention should be the main focus so that people who are pre-diabetic should be identified before becoming diabetic and to stop people from becoming pre diabetic. In order to achieve this the issue of obesity needs to be addressed.

7.8 Liz Noakes commented that in in terms of both local authorities, Shropshire is slightly ahead of Telford & Wrekin; Shropshire have developed a healthy weight strategy which was presented at the last meeting of their Health and Wellbeing Board, it was also presented to the ICB Strategy Committee. Telford and Wrekin Council are adopting the same approach, and this will be going to their Health & Wellbeing Board in March 2024.

7.9 Liz Noakes added that T&W Council had a meeting with the ICP which is the two health and wellbeing boards joined together where a discussion was held about prevention priorities against many of their priorities.

7.10 Meredith Vivian highlighted that a news report recently published informed that research is becoming clearer about the long-term effects of COVID19 on young children and the effects of long-term obesity.

7.11 Jill Barker referred to child mortality and advised that this has been on the Trusts risk register for a few months now and wondered why it's not on the system risk register about the child Death Overview Panel. This panel has been without a permanent chair since February 2023 and is aware that Vanessa Whatley is carrying out work to address this.

7.12 Vanessa Whatley said the whole issue of child mortality and how it is managed is a bigger piece of work more than the whole system piece. An independent chair has been appointed for the system for CDOP and will commence in March. The service has been based in SCHT and it has been acknowledged that SCHT is not the right place for it to sit going forward. Vanessa and Sara Ellis-Anderson are connected and carrying out a piece of work to migrate the service to the ICB.

7.13 Vanessa Whatley advised that SQG9 the children's risk is on risk register and suggested that this risk is looked at with a view to putting a number of key actions against this risk which are effective which is shown in their data and their outcomes. She would like to propose that more detail around this risk is presented to QPC in February 2024, telling the whole story.

7.14 Meredith Vivian asked whether the CDOP work needed to be reflected on the risk register and it was suggested that his question is taken to SQG to seen how best to frame it and address it. Vanessa Whatley responded That this risk is being mitigated however, would be happy to have this discussion at SQG.

7.15 Jill Barker commented that If Doctor Ganesh had been present at this meeting, he would have some further input. Jill Barker added that in terms of their learning from deaths report, which is a very comprehensive review of the adult deaths however, there is a less comprehensive view in terms of children. If the CDOP independent chair is now in place this should be addressed.

7.16 Meredith Vivian advised that a discussion took place about this issue at the Integrated Care Board meeting in September 2023 where it was made clear that this would be an area that the Quality and Performance Committee would keep an eye on and said that it was appropriate to set that out in a meaningful way.

7.17 Meredith Vivian referred to risk 8 Diabetes Programme and said he would like to see this risk updated; he is aware that work is ongoing, however, the way in which it is described on the register is not accurate. And said that he would expect the register to accurately show where the gaps in control were. This risk states that Fiona Smith is the SRO when it should be Gemma Smith.

The Committee:

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

8.0 Minute No QPC-24-01-08 - System Quality Metrics Vanessa Whatley

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

8.1 Vanessa Whatley highlighted that falls requiring admission have reduced. In 2023 work was carried out around increasing the number of people that were referred to the Falls Prevention Services. Vanessa Whatley stated that whilst this was a positive there the falls pathway needs to be looked at in more detail particularly across Shropshire Telford and Wrekin as a whole.

8.2 Urgent care pressures; the harm review process and *C. dIff* remain off track within all parts of the system exceeding their annual trajectory. The annual objective set by NHS England every year has been exceeded. SaTH did manage to deep clean some areas over Christmas Including ED and some wards further discussion was required at SQG.

8.3 Vanessa Whatley highlighted that this is the last report that will have serious incident metrics in the format where serious incidents are counted, However PSIRF has now been introduced all of our organizations including independent providers excluding WMAS who the ICB do not Commission which is an area of caution. This means that we will start getting trends that link to PSIRF priorities that have been set. The report will be developed to contain meaningful information can be reported both at QPC and SQG.

The Committee:

- Considered the metrics with performance metrics and system risks.

9.0 **Minute No. QPC-24-01.09 - Exception Report - System Quality Group Chairs Update and TOR– Vanessa Whatley**

The report was taken as read.

9.1 Vanessa Whatley informed the Committee of the alerts from SQG particularly on new risk that we've already discussed and the challenge around the initial health assessments, getting the data from MPFT and this is in relation to children in care. The children in care annual report was presented and there is work being monitored via contract review meetings to make sure that children are identified as being in care when they're on the waiting list. There is now 1700 children in care in Shropshire county, they are not all Shropshire or Telford and Wrekin children, they are from all over the country, This high number of children is putting demand on services and some of these are unaccompanied asylum seeking children who get registered to Shropshire, Telford and Wrekin but then they go usually to either the Black Country or Birmingham once identified.

9.2 Vanessa Whatley referred to the LeDeR report presented at QPC last year and highlighted there are seven cases there that have breached the six months trajectory, these cases should be reviewed within six months. There is contract issue with the contractor which is currently being reviewed and a replacement service is currently being sought.

9.3 Meredith Vivian highlighted that when the LeDeR report was presented last year, the Committee ran out of time to approve the report prior to it going to the ICS Board and said that it had been agreed that this Committee would have early sight of the report in March 2024. Vaness Whatley confirmed that this is the aim but timescales are very tight as nationally controlled.

9.4 Meredith Vivian referred to the Terms of Reference and said after reading the TOR he did not have any points of concern and said that he was happy to approve the TOR.

Action: Vanessa Whatley to advise Tracy Slater that the annual LeDeR report is to be presented to QPC in advance of ratification for 2024.

The Committee:

- Considered the alerts in this report and further assurance required.
- Accepted the report
- Approved the Terms of Reference for the Group.

10.0 **Minute No QPC-24-01-10 -** Deep Dive – Urgent & Emergency care – Betty Lodge

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

10.1 Betty Lodge advised that UEC is in an extremely challenged position, however, the marginal gains and those small improvements that are seen with the support of Maddie and Julie Garside's team,

10.2 A reflective piece of work has been carried out to compare last winter with this winter and what went well, moving forward further deep dives will be carried out into the impact of specific winter schemes and also to drive the wash up of the 202/24 improvement plan

10.3 The 111 prehospital care programme, an impact has started to be seen from this service from the direction of patients being signposted to the right service that link to

the local care program and the delivery of the right care in the right place pre hospitality.

10.4 The system was in a difficult position last winter with a call abandonment rate of over 50% from 111 which was driving a lot of patients to seek help from emergency departments. That abandonment rate has dropped to 4% which is being monitored closely and it is staying within those limits.

10.5 Betty Lodge advised that DHU have a process in place to make sure those calls are validated and not being transposed into more ambulances arriving at ED.

10.6 The Single Point of Access Team are now fully engaged with daily tactical operational calls through the System Control Centre; SaTH have a new process in place allowing them to challenge anything at the at the front door that they believe to be an inappropriate conveyance. Therefore, at that point of triage and streaming, if there is an alternative pathway for that patient, WMAS will either ring the single point of access if they haven't, or SaTH champion with a view to the turning the patient around to return home for rapid response, GP primary care or no intervention at all.

10.7 There is still a significantly high number of ambulance hours lost at handover point and there are a significant number of patients that are waiting too long in the Community, however, there has been an improvement to last year's winter position. All providers have signed up to what is effectively a system full trigger process.

10.8 Betty Lodge advised that the emergency departments on both sites carried out a significant piece of work in November specifically focused on adult and paediatric triage., where there has been an improvement in the percentage of patients seen within the 15 minutes which is above the regional average of 51 percent, this has been sustained for two months. This is a good news story for patients and clinical safety at the front door, and those staff that have been working to make those improvements in really difficult circumstances.

10.9 With regard to length of stay, the discharge position is still improving but remains a challenge some patients are still not going home until after 5:00 o'clock in the evening and

10.10 There has been a significant improvement with the OPAT service and the introduction of a consultant specifically for the virtual ward.

10.11 Sara Ellis-Anderson asked about discharges and whether it is it aggregated data across Monday to Sunday as in seven days and if you just did the Monday to Friday, would it be in an improved position of which is the pinch point at the weekends rather than in the week.

10.12 Julie Garside responded that to have consistency across all seven days. A target was set, in theory we should get we get enough out Monday to Friday to allow weekends to be at a lower level and ironically, when we look at, we are achieving the overall position for Saturday and Sunday rather consistently. It's Monday where we lose it

The Committee:

- Noted the improvements and be assured that a deep dive and trajectory review will be completed for each metric in 2023/24 to inform the 2024/25 Improvement plan Noted the contents of the report.

11.0 Minute No – QPC24-01-11 - Diabetes Programme Board Assurance – Fiona Smith

The Committee agreed to defer the diabetes paper to the meeting in February to allow for a more in-depth discussion next month.

12.0 Minute No QPC-24-01-12 - Valproate Oversight Group purpose and plan – Andy Riley

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

12.1 Andy Riley highlighted that a special sort of a committee was formed to review valproate prescribing and pregnancy.

12.2 Andy outlined the back ground to the need to for a Valporate Oversight Group in response to a patient safety alert. This has been put in place to oversee and seek assurance from all providers that they have taken appropriate action and clinical protocols are reviewed. There has been good system engagement from a variet y of partners.

12.3 All the specialists are required to complete a risk acknowledgement form with patients. So they take the patient through or the patients carer or parent through a detailed review of the treatment that they're on for women of childbearing age who are likely to become pregnant or could become pregnant and this is in planning to achieve by the nationally set deadline.

12.4 Vanessa Whatley highlighted that Andy Riley provides a regular report on Valporate at SQG.

12.5 Sara Ellis-Anderson asked whether Andy had linked in with Susan Watkins who regularly reports to SCHT Patient Safety Group about this and he confirmed he did.

12.6 Meredith Vivian asked how general practices are providing their input.

12.7 Andy Riley responded that he has attended a GP Forum meeting to raise this and that GPs are aware of this risk , GP practices will be communicated with around the new risk acknowledgement form as there is a need for two consultant signatures to go on the new form.

12.8 Vanessa Whately confirmed that this report is a requirement of the national alert and has come to QPC directly without SQG first as it is the requirement is for discussion at a system quality meeting by end of January.

The Committee:

- Noted the contents of the report

13.0 Minute NO QPC-24-01-13 – Healthwatch Shropshire Update

There was no representation at the meeting from Healthwatch Shropshire to provide an update

14.0 Minute No 24-01.14 Healthwatch Telford & Wrekin Update

There was no representation at the meeting from Healthwatch Shropshire to provide an update

The Committee:

Items for Escalation/Referral to Other Board Committees

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

15.0 There were no items for escalation/referral to Other Boad Committees raised.

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

MCA Policy 2024 for approval – Paul Cooper

15.1 Paul Cooper explained that since 2018 a multi-agency Mental Capacity Act policy with extensive sign up from the two local authorities, from all the trusts from the IMCA service which is the statutory advocate service that is required under the Mental Capacity Act from the police and from the independent sector. The policy has been refreshed in three specific areas (1) it was important to enhance the guidance about the importance of documentation when there are unresolved or disputed issues of capacity between agencies, there has been learning from statutory case reviews about one agency who felt that the person had capacity but was basing this on formation 2 years ago and so therefore were not responding as they should have to other agency concerns, enhancing the documentation and using the documents in the appendices (2) increase the guidance about the information sharing that is required and (3) It has been updated from what was executive functioning, which again nationally; there is to be a new Mental Capacity Act code of practice which does address executive capacity in the way that it has not done previously. Pau proposed the policy for approval.

15.2 The reason it hasn't been published is because of the Liberty protection safeguards have been paused and there is no publication date for that,

15.3 Sara Reeve said that from an MPFT perspective they have their own policies and asked what the expectation on providers is with regard to this policy? Sara suggested having a conversation with Paul Cooper about this outside of the meeting.

15.4 Paul Cooper responded that he has had helpful discussions about this in previous versions and Dawn at MPFT, who has provided an explanation that because and MPFT work across multiple local authority areas and they do not have the sign up from those particularly the interface with the DOLS aspects of it that you would carry on the MPFT policy. When the multi-agency operational group have ratified the final version, it is then up to all of the individual agencies to make that final determination as to whether or not they use it.

15.5 Meredith Vivian suggested that the policy is updated to outline which organisations will be using which Policy and agreed the policy.

The Committee:

- Supported and approved the revised MCA Policy.

Date and Time of Next Meeting

Thursday 29th February 2024 2.00pm to 4.00pm via Microsoft Teams.

SIGNED …… DATE ……

Integrated Care Board Quality and Performance Committee

Terms of Reference

1. Constitution

The Quality and Performance Committee (QPC) is established by the Integrated Care Board (ICB) as a Committee of the ICB in accordance with its constitution.

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

The Committee is non-executive chaired, and its members, including those who are not members of the Board, are bound by the standing orders and other policies of the ICB.

2. Authority

The Quality and Performance Committee is authorised by the ICB to:

- Investigate any activity within its terms of reference.
- Seek any information it requires within its remit, from health and care partners within the ICS.
- Create task and finish sub-groups to take forward specific programmes of work as considered necessary by the Committee's members.

Scope

The QPC is concerned with all services:

- Commissioned by the NHS (either the ICB or NHS England).).
- Jointly commissioned by the NHS and local authorities.
- Commissioned by local authorities from NHS and non-NHS providers.

It includes services within its population boundary regardless of whether NHS STW ICB commissions services from that provider, consideration of out of area placements and providers that cross ICS and regional boundaries. Independent providers are also included.

3. Purpose

The purpose of the QPC is:

For Quality

- To assure the ICB that regulatory elements of quality are being met as set out in the Health and Care Act 2022 and in line with The National Quality Board, Shared Commitment to Quality https://www.england.nhs.uk/publication/national-quality-board-shared-commitment-to-quality/.
- To assure the ICB that our services are safe, effective, caring (which aligns with positive experience in NQB definition of quality), well-led, sustainable, and equitable and in line with STW Pledge 1 – Improving Quality.

- To assure the ICB that there is an effective system of quality governance and internal control that supports the development and delivery of sustainable, high-quality care.
- To provide the ICB with assurance that the STW ICB Quality Strategy, with particular emphasis on addressing health inequalities and quality improvement, is being delivered.
- To assure the ICB that quality risks are recognised, controlled, mitigated and escalated as appropriate.

For Performance

- To assure the ICB that all system providers have oversight of their key performance indicators and / or oversight frameworks and are reporting to the national / required standards.
- To provide the ICB with intelligence with forecasting against demand across the providers and appropriate plans to meet that demand.
- To provide the ICB with assurance that our system providers are utilising performance reporting to for the purposes of quality improvement (QI).
- To provide the ICB with assurance that performance risks are recognised, controlled, mitigated and escalated as appropriate.

4. Membership and attendance

The Committee members will be appointed by the ICB in accordance with the ICB Constitution. The ICB will appoint no fewer than four members of the Committee including one Non-Executive Member of the ICB and one independent lay member. Other members of the Committee need not be members of the ICB.

Chair

The meeting will be chaired by an STW ICB non-executive director. In the event of the chair being unable to attend, a nominated deputy will chair the meeting.

The chair will ensure full participation during meetings, all relevant matters and agenda items are discussed, and that effective decisions are made and communicated to the partners within the ICS.

Members

Members include:

- ICB Non-Executive Director – Chair
- ICB Chief Nursing Officer (Deputy Chair)
- ICB Chief Medical Officer
- ICB Director of Planning and Performance
- Shropshire Council Director of Public Health
- Telford and Wrekin Council Director of Public Health
- Shropshire Council senior leadership representative
- Telford and Wrekin Council senior leadership representative
- Primary Care representative
- SCHT Executive representative
- SaTH Executive representative

- RJAH Executive representative
- MPFT Executive representative
- SCHT Non-Executive representative
- SaTH Non-Executive representative
- RJAH Non-Executive representative
- MPFT Non-Executive representative
- Shropshire Healthwatch
- Telford and Wrekin Healthwatch

Members may nominate suitably informed deputies to have decision-making authority if they are unable to attend the meeting. Where necessary, this should be limited to maintain a trusting group dynamic.

Executive members can commit resources within the boundaries of their own organisations Standing Financial Instructions.

Attendees

Only members of the Committee have the right to attend Quality and Performance Committee meetings, however others may be invited to attend all or part of any meeting, as and when appropriate, to assist with discussions on any particular matter.

5. Meetings Frequency, Quoracy and Decisions

Frequency
The Quality and Performance Committee will meet monthly, 10 times a year, (with the exception of August and December or January). Members are expected to attend a minimum of 8 meetings a year.

Where necessary, apologies should be sent prior to the start of a meeting. The membership of any member who misses 3 consecutive meetings will be re-considered by the Chair.

Quoracy
- Chair or deputy chair
- ICB Chief Nursing Officer
- Director of Planning and Performance
- Shropshire Council representative.
- Telford and Wrekin Council representative
- NHS Provider representative from each NHS provider (either Exec or non-exec)

If the quorum has not been reached, the meeting may proceed if those attending agree, but no decisions may be taken. Decisions deemed by the Chair to be 'urgent' can be taken outside of the meeting via email communication, and with the agreement of a quorate number of members.

Decision making and voting
The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote for committee members only and in the event of a tie, the Chair will have the casting vote. The outcome will be recorded in the minutes.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis using telephone, email or other electronic communication.

6. Responsibilities of the Committee

6.1 Quality

The Committee will ensure regulatory requirements of the Health and Care Act 2022, relating to quality are met, that quality is considered in context of NQB Shared Commitment to Quality (2021), and that Pledge 1- Improving Quality, is delivered. This will be achieved through the delivery of the Quality Strategy. Key responsibilities therefore include:

1. Assurance and Regulatory Compliance

- To be assured that there are robust structures and processes in place for the effective management of quality planning, control and improvement for the system.
- To be assured that system wide safeguarding arrangements for children and adults meet statutory responsibilities.
- To be assured that system wide area prescribing, and medicines safety arrangements are compliant with statutory requirements.
- To be assured that system wide infection prevention and control arrangements are compliant with statutory requirements.
- To be assured that actions align with addressing health inequalities.
- To approve ICS statutory quality reports in line with reporting framework and seek Board approval for publication.
- Oversee and scrutinise the ICB's response to quality directives, regulations, national standards, policies, reports, or reviews from external agencies (including for example, CQC and Ockenden) to gain assurance that they are appropriately reviewed and required actions are being taken, embedded and sustained.
- Maintain an overview of changes in the methodology employed by regulators and changes in legislation / regulation and assure the ICB that these are disseminated and implemented across all sites.

2. Quality Structure and Processes

- Ensure this committee, and groups that feed into it, remain aligned to the wider organisational governance structure.
- Promote alignment of system wide, quality culture and methodology.
- Ensure Integrated Care System (ICS) systems and processes track quality information from patient / client to ICB through a clearly defined Information Governance framework and in line with GDPR.
- Seek assurance that opportunities to pool skill, knowledge, competence and other resources lead to coordinated actions that drive improvement, whilst respecting statutory responsibilities of member organisations.
- Adopt a culture of operational efficiency and effectiveness by ensuring quality monitoring is fit for purpose, reporting is aligned and all opportunities to share learning are taken (including but not limited to incidents, complaints, mortality reviews, resident engagement).
- Have oversight of and approve the System Quality Group Terms of Reference.

- Consider and, where appropriate invite, additional assurance from independent sources.

3. Quality Strategy

- To recommend updates and revisions and agree the Quality Strategy and seek approval by the STW ICB Board.
- To receive updates on progress against quality priorities and actions outlined in the Quality Strategy.

4. Risk

- To maintain oversight of a system quality risk register for all risks relating to system quality. This does not include provider specific risks managed at source, and in line with provider's risk appetite.
- To consider any provider specific risks that rate high and emerging risks that may threaten wider service delivery. This does not preclude any individual organisation within the system calling a Rapid Quality Review, as set out in National Guidance on Quality Risk Response and Escalation in Integrated Care Systems (National Quality Board, June 2022).
- To receive, consider and escalate for ICB action, any system quality risks that manifest across organisational boundaries to a Rapid Quality Review where these cannot be resolved locally.
- To acknowledge, mitigate and escalate / de-escalate risks within the Committee's remit and escalate in line with STW ICB Board appetite for risk.
- To ensure risks associated with quality are incorporated in the Board Assurance Framework as appropriate, mitigation and gaps in control remains current.

6. Quality Metrics

- To approve system quality metrics recommended by ICB System Quality Group.
- To seek assurance that the system is meeting the system quality metrics and where this is not happening, escalate with recommendations to the STW ICB Board for a system approach to be agreed.
- To ensure as the system matures, quality metrics remain fit for purpose.

5. Quality Improvement

- To be assured that a system wide process is in place to identify and escalate matters for quality improvement.
- To seek assurance that quality improvement programmes demonstrably reduce health inequalities, improve patient / client safety, outcomes and / or experience.
- Ensure that system barriers to quality improvement are addressed and where possible, removed.
- Implement evidence-based practice, recognised good practice and new and innovative procedures to further increase the skills, knowledge and competence of staff.

- Empower those who access the services to own their health and wellbeing with clear signposting when and how to access the most appropriate support.
- Receive deep dives into QI initiatives as required.

6.2 Performance

The Performance Directorate aim to turn data into information and then information into insight for the Committee to consider as part of a quality improvement journey.

The Committee will ensure regulatory requirements relating to performance are met and Pledge 1 is delivered. Key performance responsibilities of the Committee are:

1. Performance Assurance Framework (PAF)
   - To recommend updates and revisions and agree the PAF and seek approval by the ICB Board.

2. Regulatory compliance
   - To approve ICB statutory performance reports for publication.
   - To be assured that provider level performance is the best it can be, and on a journey of Quality Improvement (QI).

3. Risk
   - To receive, consider and escalate for ICB action, any System Performance risks that manifest across organisational boundaries to a Risk Summit where these cannot be resolved locally.
   - To consider any provider specific risks that rate high, and emerging risks at may threaten wider service delivery.
   - To consider the commissioning prioritisation framework at least annually before approval at Strategy Committee.

4. Outcome Measures
   - The purpose of collecting data is to provide a basis for action, recommendation, and acknowledgement to support a culture of Quality Improvement.

6.3 General

Triangulation
- Triangulate quality and performance outcomes to ensure context is understood, the current position is clear and decisions around next steps are both valid and reliable.

The QPC does not have executive powers and will not:
- Directly intervene in performance management, contractual or regulatory functions, though it can advise on necessary changes and improvements.
- Substitute the need for individual organisations to act promptly when pressing concerns become apparent.

Conflicts of Interest

Members are required to declare any interests that may conflict with the QPC's business prior to or at the meeting. The chair is required to ensure that any interest is recorded in the minutes of the meeting and managed accordingly within the meeting in accordance with the following NHS Guidance issue 2017.

Confidentiality

To enable the exchange of information between attendees at this meeting to be carried out in accordance with the Data Protection Act 2018, the Human Rights Act 1998, the Freedom of Information Act 2000 and the Common Law Duty of Confidentiality, all attendees must undertake to:

- Ensure all information shared and exchanged within the confines of this meeting is for the specific purpose of the meeting and members agree to:
  - not to reveal any confidential information to any person outside of the meeting.
  - store all confidential information securely.
  - not to make copies or duplicates of the confidential information except to the extent that it is reasonably necessary to carry out any follow up actions.
- Use information exchanged within this meeting for the purpose of identifying any action that can be taken by any of the agencies or departments in attendance to resolve the problem under discussion.
- Treat a disclosure of information outside the meeting, beyond that agreed at the meeting, as a breach of the subjects' confidentiality and a breach of the confidentiality of the agencies involved.

Unless exempt, all papers should be considered as subject to the Freedom of Information Act (FOI). Information sharing agreements between members will be agreed as a principle of working together. All papers that are exempt from public release under the FOI Act must be clearly marked 'in confidence, not for publication'. These papers may not be copied or distributed outside of the Group membership without the expressed permission of the Chair. FOI exemption 41 (duty of confidence) applies.

8. Behaviours and Conduct

Members will be expected to conduct business in line with the ICB values and objectives ensuring that everyone can be present without harassment, interruption, fear or intimidation.

Valuing equality, diversity and inclusion

All delegates attending the meeting, must undertake to:

- treat all people with respect and act in a way which does not unlawfully discriminate against or exclude anyone.
- encourage and enable representation from under-represented groups.
- ensure that the meeting is enabled for people with disabilities, e.g., availability of hearing loops, use of virtual chat functions.
- act in a fair and responsible way to any staff, fellow delegates or volunteers they encounter.
- communicate in advance to the chair, facilitator or nominated officer any information necessary to help them at the meeting or event.

Collective responsibility

All people coming to the meeting agree they will:

- Always observe the authority of the chair or facilitator if one is present, raising points and matters for discussion only through the chair at formal meetings.
- Listen to and respect the views and experiences of other people contributing.

Equality and diversity
Members must demonstrably consider the equality and diversity implications of decisions they make to ensure health and care is accessible and available.

9. Accountability and reporting

The Committee is accountable to the ICB and provides assurance to the ICB and separately to NHS Midlands via the Regional Quality Surveillance Group.

The QPC also reports, through local authority representation, into the relevant Shropshire, Telford and Wrekin Local Authorities Assurance Committees and to the regional NHS England teams on risks and issues.

Individual members and advisory/task and finish group leads are responsible for reporting back on activities.

The QPC will consider reports from national policy work and other sources.

The QPC will receive reports from:

For quality
- ICS Quality Risk Register
- Health Protection Board
- LMNS Programme Board
- Providers by exception
- Healthwatch
- Safeguarding Adult and Child including Looked After Children Group
- System Quality Group
- Learning Disability, and Autism Board
- Children's and Young Peoples Board
- Statutory Quality Reports

For performance
- Primary care (ICB Lead)
- Shropshire Doctors (Provider/Shropshire Doctors)
- Shropshire Community (Provider/SCHT)
- Urgent and Emergency Care Board
- ICB Cancer and Planned Care Board
- Mental Health Provider (Provider/MPFT)
- Elective Recovery Fund (ICB Business Intelligence and Planning)
- ICS Performance Risk Register

The chair and relevant local authority lead member shall draw to the attention of STW ICB any issues that require its consideration or executive action.

Reporting arrangements may change and will be updated to reflect the changes.

The minutes of the meetings shall be formally recorded, supported with an action log and risk registers.

10. Secretariat and Administration

The meeting will be administered by STW ICB and this arrangement is to be kept under review. The secretariat function will ensure that:

- The agenda and papers are prepared and distributed in accordance with the time line below
- Attendance is monitored and non-attendance flagged to the Chair
- Minutes are taken and an action log is maintained
- The agreed business cycle is maintained and reviewed annually or more frequently if required
- Meetings are recorded and made accessible via MS Teams if conducted by virtual means

Agenda and Papers
Requests to add agenda items should be made to the chair no later than 5 working days prior to each meeting.

A business cycle of reporting will be maintained.

A final agenda and relevant papers will be circulated electronically to members in 5 working days in advance of each meeting.

Organisational representatives are responsible for ensuring papers are submitted in correct format and on time. Any papers for the Group should be accompanied with a front sheet outlining the purpose, summary of points and clear recommendations.

Minutes
Draft minutes approved by the chair are to be circulated no later than 10 working days after the meeting date. Minutes will be signed off as a true and accurate record of the meeting at each subsequent meeting as a standing agenda item.

11. Review

The Committee will review its effectiveness at least annually.

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

Date of approval: November 2023

Date of review: November 2024

Agenda Item

ICB 27-03-029.3

Minutes of Finance Committee meeting held on 23 January 2024

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

NHS Shropshire,Telford, and Wrekin
ICB Finance Committee (Section 1) Meeting
Tuesday 23rd January 2024, at 2.00pm
Via Microsoft Teams

Present:

Name	**Title**
Trevor McMillan (Chair)	Non-Executive NHS STW
Laura Clare (Deputising for CS)	Deputy Director of Finance NHS STW

Attendees:

Angela Szabo	Interim Director of Finance NHS STW
Kate Owen	Head of PMO NHS STW
Cynthia Fearon	Corporate PA NHS STW (Note taker).

Apologies:

Claire Skidmore	Chief Finance Officer NHS STW
David Bennett	Non-Executive NHS STW
Gareth Robinson	Directory of Delivery and Transformation NHS STW

Minute No. SFC-24-01.001 – Introduction and Apologies

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

Minute No. SFC-24-01.002 – Declarations of Interests

2.1 No declarations of interest were noted.

Minute No. SFC-24-01.003 – Minutes from the Previous Meeting held on: 30th November 2023.

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-24-01.004 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-24-01.005 - ICB M9 Financial position

Report received as read.

5.1 LC highlighted that at Month 9 the ICB is reporting a £14.6m YTD deficit against a £9.9m YTD deficit plan, i.e., a £4.7m adverse variance. This position currently includes the full £4.7m additional allocation provided by NHSE shown in the ICB position so without this the YTD position is £19.3m YTD deficit, a £9.4m adverse variance to plan.

LC stated that after closing the Month 9 position, Directors of Finance have agreed the re-distribution of the £4.7m and at Month 10 this fund will pass to SATH and RJAH with a risk mitigation top slice as a year-end reconciliation item which is contingent on delivery of their individual elective recovery forecasts.

LC emphasised 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), a lack of elective recovery income received from Wales and these are 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 stated at month 9 the forecast outturn protocol has been enacted to formally amend our forecast position based on the re-forecast exercise carried out and approved by Board on 11th January. **LC** added, for the ICB the revised forecast is a £27.8m deficit with the £4.7m additional allocation currently sitting with the ICB taking the overall forecast to £23.1m deficit. As noted above the £4.7m benefit will be passed to providers at Month 10 leaving the ICB with a £27.8m deficit forecast.

LC highlighted that the ICB position is based on a number of key actions being delivered and a weekly forecast outturn recovery meeting is taking place to monitor those actions with the ICB Senior Leadership Team. The key things that have been discussed at that meeting, are the elective recovery position; the additional cash out efficiency savings; negotiations with both authorities regarding their contributions to discharge expenditure. The meeting also reviews the ICB's overall financial position to ensure appropriate mitigations are in place where required.

£4.6m of unmitigated risk is reported at Month 9.

TMcM queried if the £27.8 m forecasted deficit has been agreed by NHSE. **LC** confirmed that it has been agreed with NHSE.

TMcM queried if the current risks were to go in the wrong direction, what would the £27.8 m deficit turn into. **LC** responded that if the risks specifically for prescribing and CHC materially moved in the wrong direction, the ICB would not be able to mitigate those two risks.

The ICB Finance Committee noted:

- The M9 headlines for the ICB financial position (£14.6m YTD deficit, £4.7m adverse position to plan (though noting that the £4.7m additional system allocation is included here and this will pass to providers and change our position to a £19.3m YTD deficit, £9.4m adverse to plan.)
- That the forecast outturn change protocol has now been actioned and therefore the ICB is forecasting a deficit of £27.8m by the end of the year (whilst the £4.7m additional allocation sits in the current position this shows as £23.1m at M9 reporting)
- The remaining level of unmitigated financial risk currently reported alongside the forecast position (£4.6m).
- The key actions that need to be delivered in order for the ICB to meet its re-forecast position and that a weekly financial recovery meeting is overseeing these actions.

Minute No. SFC-24-01.006 ICB M9 Efficiency update

Report received as read.

6.1 **KO** highlighted that £17.3m of savings have been delivered against a year-to-date plan of £18.6m providing an adverse variance to plan of £1.3m.

KO added that the adverse variance in Month 9 is mainly caused by a shortfall in the delivery of unidentified savings which were profiled to be met in month, however additional savings will be reported in the remaining months of the year and the year-to-date variance is expected to level out in month 10.

KO stated that overall good progress has been made in delivering the savings programmes to date and the ICB has made significant progress in identifying further savings opportunities to meet the stretch targets set at the beginning of the year.

A revised efficiency forecast is reported which totals **£25.6m** which is 98% of the plan (-£340k).

KO stated that there are a number of programmes that are being monitored within the PMO team regarding the efficiency programmes. There are not just cash out, but also helping to evidence value for money and the impact of the growth avoidance programme. **KO** added that included within the revised plan is a further £500k cash out savings that the ICB has committed to deliver by the end of the year.

The ICB Finance Committee noted:

- Month 9 Efficiency delivery and the progress that has been made towards bridging the gap in the unidentified savings plans.
- The revised efficiency forecast position that has been agreed with NHSE which includes a commitment to deliver a further £500k cash out savings by March 2023.

Minute No. SFC-24-01.007 – Budgetary control framework

Report received as read.

7.1 **LC** explained that the Budgetary Control Framework is a key element of ICB's internal control environment and is designed to assist budget holders and managers in the discharge of their responsibilities. **LC** added that It sets out the rules for the financial year within which the budgets are to be operated, clarifies roles and responsibilities, and ensures that the ICB's budgetary processes form part of the overall assurance framework.

The existing Budgetary Control Framework required updating and has been refreshed to incorporate the following changes:

- Presentation updated to reflect the latest corporate template.
- Guidance and embedded documents updated to reflect the latest versions of finance policies.
- 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).

LC stated that it is intended that this document will be shared on the ICB staff intranet, promoted in the staff newsletter, and issued to the budget holders.

LC highlighted that there is one caveat that is put in this paper, as there is work being done with NHSE regarding further triple lock controls for existing expenditure. **LC** added that the process is not in place at the moment. But the intention is for it to be in place by the end of this financial year.

The ICB Finance Committee

Did not approve the revised Budgetary Control Framework as TMcM requested that it should go to the Executive team for approval and then come back to February's meeting for final sign off.

Action: *Budgetary Control Framework to go to Executive team for approval and then come back to February's meeting for sign off.*
Any update on the triple lock in the meantime will be included in the Budgetary Control Framework

Minute No. SFC-24-01.008 – IFP Reversal

Report received as read.

8.1 **LC** highlighted that the November 2023 System Financial Planning and Productivity Group (SFPPG) considered a paper regarding a proposal to recurrently reverse Intelligent Fixed Payment (IFP) arrangements for 24/25 and revert to contracting under national API (Aligned Payment Incentive) arrangements. **LC** added that the proposal also considers a non-recurrent arrangement with SATH for one year while SATH complete their contract rebasing work.

LC stated that it was agreed at SFPPG that all parties would take the paper through their individual finance committees ahead of seeking approval at the system finance committee. **LC** added that since the meeting SATH have highlighted that they do not currently agree with the figures in the paper and would like to do further work with the ICB to agree the income/start point contract value for 2024/25.

The ICB Finance Committee did not take steps to agree the recommendations in the paper given the development in position from SATH. LC agreed to bring an update to the next meeting.

Action: LC *requested that this paper comes back to the System Finance Committee for the February meeting for approval, with the view that further work with the ICB is agreed for the income/start point contract value for 2024/25.*

Minute No. SFC-24-01.009 – ICB 24/25 planning update

Report received as read.

9.1 **LC** highlighted 24/25 NHSE planning guidance was due to be issued at the end

of December 2023 but at the time of writing this report - it has not yet been issued. **LC** added that ahead of the release of the planning guidance, preparation work is underway across organisations and the system to prepare both a 24/25 operational plan and develop a longer-term planning model and associated financial trajectory towards break even and a sustainable financial position. **LC** added that this includes work from the Operational Planning Group and the Investment Panel.

LC stated that as plans develop, and guidance is released all finance committees will be regularly updated on progress.

The ICB Finance Committee:

- Noted the context and arrangements in place to produce a financial plan for both 23/24 and onwards, the timetable at appendix A and current assumptions at appendix B.
- Noted that further regular updates on the plan will be presented to future finance committee meetings.
- Approved the planning principles for the system.
- Approved the principle to hold system growth monies centrally to which individual organisations will then apply for exceptional funding through the Investment Committee.
- Approved the recurrent reversal of IFP arrangements and a return to operation under national contracting rules (API), noting that the final start point recurrent contract values and any non-recurrent arrangements with SATH are subject to further work being undertaken and an update will be provided at the next meeting.

Minute No. SFC-24-01.010 – ICB 24/25 Efficiency update

Report received as read.

10.1 **KO** highlighted that this report provides an update on the preparation.
underway across the ICB to develop a set of efficiency plans for both 2024/25 and the longer term plan which will help to deliver a sustainable financial position.

KO mentioned that a workshop was held towards the end of November 2023. Department/ Finance leads across the system and finance leads from NHSE attended the workshop. **KO** added that they looked at listing opportunities which can be developed into the pipeline plan.

KO added that at this stage the National Guidance has not been released and teams are working towards a set of local timeframes to ensure plans are developed ready for implementation from April 2024. **KO** added that regular updates will be provided to Finance Committee on the development of plans as they progress.

LC stated that the first cut would be for each organisation to put forward 2.2% business as usual efficiency. Recognising that all organisations will need to stretch that to afford any of the cost pressures.

The ICB Finance Committee:

- Noted the preparation in place to provide a robust efficiency plan for both 24/25 and onwards.
- Noted that further regular updates on the efficiency programme will be presented to future finance committee meetings.

Minute No. SFC-23-10.011 – Any Other Business

There was no other business for discussion under this agenda item.

Meeting closed at 13.47.

Date And Time of Next Meeting

Thursday 22nd February 2024, 2.00pm via Teams.

NHS Shropshire, Telford and Wrekin
Integrated Care System Finance Committee (Section 2) Meeting
Tuesday 23rd January 2023 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
Glenn Head (Deputising for Chris Sands)	Deputy Chief Finance Officer – MPFT
Sarfraz Nawaz	Non-Executive - RJAH
Richard Miner	Non-Executive – SATH
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:

Laura Clare	Deputy Chief Finance Officer NHS STW
Kate Owen	Head of PMO NHS STW
Cynthia Fearon	Corporate PA NHS STW (Note Taker)
Sarah Downes	High potential Scheme Participant (Observer)
Angela Szabo	Interim - Director of Finance NHS STW

Apologies:

Gareth Robinson	Director of Delivery and Transformation NHS STW

1.0 Minute No. SFC-24-01.001 Introductions and Apologies

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

2.0 Minute No. SFC-24-01.002 Members' Declarations of Interests

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

3.0 Minute No.SFC-24.01.003 Minutes of the Previous Meeting held on: 30th November 2023.

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-24.01.004 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-24.01.005 - CS M9 Financial Position

5.1 **Report received as read.**

In Month 9 **CS** reported that the forecast outturn change protocol has been enacted for all organisations. The reported forecast of £132.8m includes the additional estimated costs of December and January Industrial action of £3.0m. NHSE have confirmed recognition of a forecast deficit of £129.8m which excludes the additional industrial action impact. Individual and System Boards signed off the reforecast position in early January in advance of submission of the month 9 position. **CS** stated that, now that a reforecast is in place, our assessment of risk has fallen to reflect that much of this risk is now crystallised into the position. The remaining unmitigated risk to delivery of the forecast position is reported as £12.3m at Month 9.

CS explained that in defining the re-forecast and reassessing where we think expenditure will outturn this year, we anticipate a worsening of approximately £30m in the underlying position.

SL stated that SCHT have a financial recovery group in place, which focus on key areas of spend and savings including CIP delivery, Efficiency, agency usage. living within pay funding and elective activity**.** Each of the areas have improved each month. Which has given increased confidence in delivering SCHT's break even plan.

CM stated that one of the issues RJAH are experiencing is hitting the activity target. An assumption was made that activity would be on track for the remainder of the year but in M9, RJAH lost half a million pounds net which was driven by activity shortfalls. **CM** added that it is likely to continue into quarter four. RJAH are therefore reporting a £2m net unmitigated risk.

CM stated that RJAH are still very committed to landing the forecast position and continue to work through a list of interventions.

HT stated that SATH are reasonably confident in delivering the reforecast position. SATH have included in the forecast significant costs around escalation. Which is the most volatile area of SATHs overall expenditure. **HT** added that SATH's income is variable month by month, so that is also an area of concern.

CS stated, the ICB are as confident as they can be however, she is conscious of the things that we are unable to control such as nee high costs cases being required or changes to national prescribing tariffs. **CS** added one of the biggest concerns to delivery of the reforecast is the assumption of overall system ERF income compared to the delivery that will be achieved. Maureen Wain is currently leading conversations with provider colleagues, to ensure a close eye is kept on the activity and associated income risk.

TMcM queried the level of NHSE scrutiny regarding delivery of the ICB and System reforecast. **CS** responded that we are left to deliver the forecast though we are under significant scrutiny given the scale of our deficit.

The System Finance Committee noted the following:

- the M9 headlines for the system financial position (£106.9m YTD deficit, £53.8m adverse to YTD plan).
- that the system is now reporting a forecast deficit of £132.8m including £3m of additional industrial action cost in December and January. 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-24-01.006 ICS Efficiency Update

Report received as read.

6.1 **KO** highlighted that £33.7m of savings have been delivered against a year-to-date plan of £43.7m, therefore the system is reporting an adverse variance to plan of £10m.

KO stated that the main underperformance is within SaTH (£8.7m YTD) and the majority of slippage directly relates to the lack of reduction in escalation costs which has been previously reported, (this is adversely affecting SaTH's savings plan by £6.4m YTD). SaTH are also reporting underperformance of core efficiencies within corporate services (£889k), nurse recruitment (£590k), corporate estates (£399k). **KO** added each partner organisation oversees its own risk of Core CIP delivery and updates are managed through local sustainability working groups.

KO highlighted that overall good progress has been made in delivering the savings programmes to date and there has been further progress in identifying savings opportunities to meet the stretch targets set at the beginning of the year.

KO reported a revised efficiency forecast which forms part of the overall financial position; this totals £52.9m which is 75% of the total plan. (-£17m). Included within the revised plan is a further £500k cash out savings the ICB has committed to deliver by the end of the year, progress is being reviewed at weekly forecast outturn meetings chaired by the Chief Finance Officer.

The System Finance Committee noted:

- Month 9 efficiency delivery and the adverse YTD variance to plan of £10m
- A revised efficiency forecast position which totals £53m, this includes a commitment by the ICB to deliver a further £500k cash out savings by March 2024.
- Focus is now drawn to ensuring that robust sustainability plans are in place for next year and beyond.

7.0 Minute No. SFC-24-01.007 - ICS 24/25 Planning update

Report received as read.

7.1 **LC** stated 24/25 NHSE planning guidance was due to be issued at the end of December 2023 but at the time of writing it has not yet been issued. **LC** added, ahead of the release of the planning guidance, preparation work is underway across organisations and the system to prepare both a 24/25 operational plan and develop a longer-term planning model and associated financial trajectory towards break even and a sustainable financial position.

LC stated that Julie Garside, Director of Performance and Planning, has now set up a weekly group, to oversee the development of the overall weekly plan. Which includes activity, finance, workforce, and performance.

LC highlighted that the paper presented describes the national context for finance as we know it so far, the planning arrangements set up locally and the timeline for developing the detailed revenue financial plans both for the short and longer term.

LC explained that last Friday (19/01/24) was the deadline for the first cut submissions to land, at a system level for all organisations. These covered activity, workforce, and finance. **LC**

added that each of the System Leads are now working through that information for the 24/25 plan and for future years.

LC anticipates a very high intent submission will go into NHSE at the end of February 2024 with more detail by the end of March 2024.

CS mentioned that in the 23/24 plan, the underlying exit deficit was £83m. Based on our revised forecast, this is now £113m. **CS** added the allocation for growth the system is likely to get is around £20m. Inflation incurred is estimated to be around £44m. **CS** stated therefore that we have limited scope for growth or investment unless we are able to unlock funding from within the current cost base.

CS stated that we need to look at a short to medium plan as it will take more than a year to get to a break-even position as a system.

HT requested if further transparency could be given on page 28 of the report regarding the table outlining the £30m movement in the underlying position. **CS** noted that the Deputies are testing these numbers. For the ICB, this has been particularly driven by the increased expenditure in CHC and prescribing.

HT noted that she believes that the IFP arrangement is masking the true drivers of the deficit and that the System would make a more coherent case for the pace of recovery if income were to be distributed where it needs to fall. She believes that the current reversal methodology for the IFP does not achieve that and therefore this has not been signed off by her organisation. She talked about the need to set credible plans and her concern that for 2023/24, the System was pushed to plan with too great a level of risk.

TMcM responded that regardless of the plan for this year, our position has still worsened year on year.

CS stated that we need to build a recovery plan for the system that is credible for us and that we can realistically deliver, which will take up to five years to be in a break-even position.

CS mentioned that from next year, systems that are in deficit are expected to start to repay the debt. A 0.5% top slice to allocation is expected.

TMcM stated that we need to have some head room in things that we could invest in that will lead to transformation**.**

SL stated that SCHT are not happy to support continuing the IFP as things currently stand within the System and that position has been agreed by SCHT. **SL** added that she is happy to relook at the methodology for doing that. **CM** confirmed that RJAH were in a similar position. **CM** also added that he believes we need to review costs specifically around workforce and explore various areas of funding not currently received that could assist in reducing some of the costs that we are incurring as a system, for example, Welsh ERF income.

The System Finance Committee:

- Noted the context and arrangements in place to produce a financial plan for 24/25 and onwards, the timetable and current assumptions.
- Noted that further regular updates on the plan will be presented to future finance committee meetings.
- Approved the planning principles for the system.
- Approved the principle to hold system growth monies centrally to which individual organisations will then apply for exceptional funding through the Investment Committee.
- **Noted** that the recurrent reversal of IFP arrangements and a return to operation under national contracting rules (API) was supported by all partners but that SATH were not supportive of the proposed methodology and that further rapid work was being undertaken. An update was requested for the next meeting.

Action: A methodology for the redistribution of System income, supported by all Directors of Finance to be shared with the next Finance Committee Meeting

Action: PF requested if the PA report on the model could be resent to him. **CF** to re-send report to **PF.**

8.0 Minute No. SFC-24-01.008 - ICS 24/25 Efficiency update

Report received as read.

8.1 **KO** highlighted that the report provides an update on the preparation underway across the ICS to develop a set of efficiency plans for both 2024/25 and the longer term which will help to deliver a sustainable financial position.

KO stated at this stage national guidance has not been released and teams are working towards a set of local timeframes to ensure plans are developed ready for implementation from April 2024. Regular updates will be provided to Finance committee on the development of plans as they progress. Things are discussed in detail at the Financial Improvement Programme meetings which are chaired by Simon Whithouse**.**

The System Finance Committee:

- Noted the preparation in place to provide a robust efficiency plan for both 24/25 and onwards.
- Noted that further regular updates on the efficiency programme will be presented to future finance committee meetings.
- Agreed that PMO reporting should be streamlined to ensure a consistency in the level of detail received to enable a coordinated approach to tracking and reporting of system wide efficiency.

9.0 Minute No. SFC-24.01.009 Any Other Business

9.1 There were no items raised as AOB. Meeting closed at 16.12.

Date and Time of Next Meeting

Thursday 22nd February 2024, 3.15pm via Teams.

Agenda Item

ICB 27-03-029.5

Minutes of Strategy Committee

meeting held on 14 February 2024

NHS Shropshire Telford and Wrekin
Strategy Committee

Wednesday 14 February 2024 at 2pm.
Via Microsoft Teams

Present:

Cathy Purt	Chair and Non-Executive Director, Shropshire Community Health NHS Trust
Mark Large	Non-Executive Director, Midlands Partnership NHS Foundation Trust Partnership Foundation Trust
David Brown	Non-Executive Director, Shrewsbury and Telford Hospital NHS Trust
Peter Featherstone	Non-Executive Director, Shropshire Community Health Trust
Nigel Lee	Interim Director of Strategy and Partnerships Shrewsbury and Telford Hospital NHS Trust
Rachel Robinson	Executive Director of Health, Shropshire Council
Gemma Smith	ICB Director of Strategic Commissioning NHS STW

In Attendance:

Simon Whitehouse	ICB Chief Executive NHS STW
Mr Nick White	ICB Chief Medical Director NHS STW
Dr Ian Chan	Clinical Director of TELDOC PCN
Jonathan Gould	Interim Head of Finance Shropshire Community Health Trust
Edna Boampong	ICB Director of Communications and Engagement NHS STW
Sam Tilley	ICB Director of Collaborative Programmes NHS STW
Claire Parker	ICB Director of Partnerships and Place NHS STW
Colin Anderson	Associate Director Strategy & Commercial Development, Midlands Partnership NHS Foundation Trust Partnership Foundation Trust
Mahadeva Ganesh	Medical Director Shropshire Community Health Trust
Jayne Knott	Corporate PA and Minute taker NHS STW

Minute No. SC-14-02.11 Introduction and Apologies:

11.1 The Chair opened the meeting of the STW Strategy Committee and welcomed everyone.

The following apologies were noted:

Liz Noakes	Director Health & Wellbeing Telford & Wrekin Council
Dr John Jones	Executive Medical Director Shrewsbury and Telford Hospital NHS Trust
Julie Garside	ICB Director for Planning and Performance NHS STW
Craig MacBeth	Finance Director Robert Jones Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Claire Skidmore	ICB Director of Finance NHS STW

Minute No. SC-14-02.12 Minutes and action list from the meeting held on 10 January 2024

12.1 The minutes were approved as an accurate record of the meeting.

Action List

12.2 All actions noted as on-going or closed.

Minute No. SC-14-02.13 Declarations of Interest:

13.1 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.

Mr Peter Featherstone had updated his DoI with Shelly Ramtuhul stating that he was now an Associate NED for Dudley Integrated Health Care and will be a full NED from 1 April 2024.

The Register of Board Members Interests can be found at: Register of Interests - NHS Shropshire Telford and Wrekin (shropshiretelfordandwrekin.nhs.net)

Minute No. SC-14-02.14 Strategic Commissioning intentions

14.1 It was agreed that this item would form the agenda today. Mrs Gemma Smith introduced the presentation (attached) and the following was noted.

Commissioning Intentions system wor

- This paper is being shared with the Strategy Committee as a working draft to commence system strategic discussions.
- Feedback from the Committee will be incorporated with work also being undertaken via Programme Boards. This is not a final version for approval.
- Timeframes for delivery are draft and indicative and as a system we also need to consider what we prioritise for delivery whilst also recognising a lot of areas have significant work programmes underway.
- Suggestions for areas aligned to Place and Provider Collaboratives have been identified but will be refined as discussions commence with input from all system partners.

14.2 After the presentation a discussion was held, and the following questions were asked:

14.3 Mr Jonathan Gould asked about slide 4 – The golden threads and thought more clarity could be given to the picture that this slide creates.

- Mrs Smith responded saying that a lot of work was being done with Mrs Julie Garside and team within the ICB. We will be looking across the Population Health Management Group as well and how do we quantify some of these pieces of work. We have got the baseline data through the data packs.

14.4 Mr Peter Featherstone commented that the presentation was very well written, and the scope and content was good. He was pleased to see that we talk about the broader social and economic development.

We need to try and connect with public health and our local authority partners more so that they can use within their respective councils just to try and gain leverage on things.

The wider determinants of health in a population and reducing health inequalities, do we need to give more focused consideration on maternity and Dementia?

14.5 Mr Nigel Lee mentioned that we are trying to refine and revise the ICP strategy and wanted to work with Mrs Smith to ensure that nothing is missed.

The commissioning intentions are not the only thing, we have the ICP strategy from that and with key strategy working with the health and well-being boards. We have also developed the joint forward plan.

14.6 Mr David Brown mentioned that on slide 4 it mentioned using a balanced scorecard, and he asked if there was a modified scorecard elsewhere within the document.

- Mrs Smith/Mr Lee responded saying the balanced scorecard is set out in our integrated performance reports.

14.7 Mr Mark Large commented on slide 5 it mentioned that decision making will be devolved to most appropriate level. He asked how you achieve the devolvement without losing the grip and control that is required.

- Mrs Smith responded saying the devolvement, contracting, and the commissioning piece of work will be picked up in the revised governance structure.

14.8 Mr Colin Anderson asked if there was a process of prioritisation through the intentions?

- Mrs Smith responded saying that a live conversation and feedback was welcomed from this Committee today.

14.9 The Chair commented that it was pleasing to see that we want to reduce inequalities for towns and the rural population featured in the document.

14.10 Mrs Smith went through the presentation further and updated on

1. System Architecture and areas of and future integrated commissioning across the ICB and Local Authorities
2. Commissioning via Provider Collaboratives – proposed areas of focus
3. Commissioning via Place – proposed areas of focus
4. NHS STW deliverables

14.11 The Chair asked where the PCNs fit in, are they part of the collaborative or CiC?

14.12 Dr Ian Chan felt that the provider collaborative was very hospital centric and then on paper it would seem that general practice primary care has been excluded from that intention. It is important to ensure they are not excluded from it.

- Mrs Smith responded saying that It is a pathway based provider collaborative and then how does it feed into the wider governance around committees in common. But this was not excluding Primary Care and PCNs.

14.13 Mrs Sam Tilley stated that we need to make a distinction between provider collaborative infrastructure. Where providers come together to look at the best way to collaborate and take things forward and then the programmes of work where collaboration will enable delivery. This is the beginning of an evolving piece of infrastructure. We would want every partner who has a role to play in delivering better outcomes for the population to be involved.

14.14 Mr Lee commented that we need to think of provider collaboration as one mechanism, and place partnership boards as another mechanism and look at how best we can stimulate models of care and delivery that are most effective and to stimulate a different way of working.

14.15 The Chair reiterated again that primary care and PCNs are a very important part of our system, and we must make sure that they play the full part in what we are trying to do with strategic commissioning.

14.16 Mr David Brown commented on slide 17 and the first entry on the slide ***Improve access to same day care and support for residents eligible for CHC fast track and approaching end of life.*** The forum for delivery is stated as being PEoLC steering group which he thought needed to be more strategic than this as they are not able to discuss all these issues. Mr Brown suggested separating them out or have a different forum for delivery.

14.17 Dr Ian Chan commented on slide 25 and the advice and guidance entry and said we need to be mindful on the wording.

14.18 The Chair asked members if they were happy with the layout and if it was clear what the outcomes are, as this will form part of a discussion with the general public so needs to be understandable.

- Mrs Gemma Smith responded saying that this level of detail would not be shared. Another element around this, is NHS England, are interested in taking the commissioning intentions, the JFP and our operating model as a system and starting to triangulate how that comes together.
- This is a working document and will be refreshed and priorities will evolve as we improve things.

14.19 Mrs Edna Boampong mentioned that a patient/public working group had been set up to test this before going out to the public.

14.20 Mr Jonathan Gould stated that as there is so much detail in the document which feeds up into the overall intentions, so it would be useful to have another column in the documents that describes how it delivers on the golden threads and what the contribution is to that.

14.21 Mr Nigel Lee suggested that there was a context document alongside which describes what the strategic family of documents is that we have. Should we refresh our website to reflect this in a different way.

14.22 Mr Colin Anderson commented that we need to get to what are our clear priorities as a system that we can do at scale which will be delivered. What intentions will be picked up through the provider collaborative, what will be business as usual, what are potentially going to sit in the JFP as part of the transformation programme. And is there an opportunity to include the evolving MH &LDA Provider Collaborative in the areas of focus.

- Mrs Smith responded saying that she agreed with Mr Gould comments about adding something in, in terms of golden threads as well as the strategy as this would be helpful.
- Agreed with Mr Lees comments around context document and having something live on the Internet.
- There is a meeting scheduled for early March around Mental Health, CYP and LD&A, to look at how we work in the new way taking the commissioning attentions versus business as usual.

14.23 Mrs Gemma Smith asked for all feedback/comments to be sent directly to her. She advised Committee members that 5the document had been shared at TWIPP and would also be shared at SHIPP next week.

14.24 Mr Simon Whitehouse commented that this also needs to be shared at a CEO meeting as this will need to support the planning process for 24/25 as the outline framework and context.

Action: Mr Nigel Lee and Mrs Gemma Smith to work on this to ensure Mr Whitehouse is happy for this to be shared with CEOs

14.25 Mrs Smith stated that she would like us to be a much more strategic Commissioner, commissioning for outcomes and working with our partners to deliver that.

14.26 Mrs Smith asked for feedback and clear views on what out provider colleagues think about the priorities could be. She thanked everyone for their positive feedback and comments today and that it has been received in a positive way in working as a system.

14.27 Dr Chan raised concerns around cuts in funding which will see a substantial issue with capacity in general practice.

Action: Mrs Gemma Smith and Dr Ian Chan to discuss the wording of document.

14.28 Mr Nigel Lee thought it would be useful to have a more focussed conversation with Dr Chan and Primary Care and get broader colleague feedback.

14.29 Mr David Brown asked that Patient Participation Groups who had not been mentioned in the document could be considered as they are an important element in what we are doing as a system.

14.30 Mr Mark Large commented on slide 48 – Data Lake and data storage, asked if the cloud is being considered as part of this rather than trying to maintain it internally.

- Mrs Smith responded saying that she would defer this to Mrs Julie Garside and come back with a response to the question.

Meeting closed at 3:15pm