STW Integrated Care Board - Appendices

MEETING

31 January 2024 14:00 GMT

PUBLISHED
26 January 2024

Agenda

Location	Date	Time
The Sovereign Suite Shrewsbury Town Football Club	31 Jan 2024	14:00

Contents

Agenda Item

ICB 31-01-008

Chief Executive Report

GIRFT
GETTING IT RIGHT FIRST TIME

NHS

Shropshire & Telford ICB - GIRFT Revisit held on 13th November 2023

Dear Colleagues

It was a pleasure to meet with colleagues at Shropshire, Telford & Wrekin to hear about what you have achieved since our last visit. The pack you produced was excellent, demonstrating a clear understanding of your challenges, your actions, the impact to date, and the next steps you need to take. It is evident that you have made progress in a number of areas since our last meeting, and I'd like to congratulate you on this.

I'd be grateful if you could pass my personal thanks on to all the teams who have worked so hard to deliver this. I'd like to particular the recognise the admin and scheduling teams who are so critical, and I know have been under enormous additional pressure dealing with the impact of industrial action.

With regards to Theatre Utilisation, RJAH already consistently achieves the 85% benchmark, and the focus is now on reducing any dropped/fallow sessions as far as possible. The theatre programme you described at SATH, with the support of the Regional Theatre Lead, has the potential to make the necessary step change in performance, and I would challenge you to rapidly achieve +80% on a consistent basis as your next milestone. We noted that your average cases per list data appears to have declined over the year, particularly in Orthopaedics & Urology, and some of the other major specialties ACPL are lower than peers, so please ensure these metrics are reviewed as part of your programme.

The high-level metrics indicated some good area of performance in relation to Day case Surgery rates, with the system at 80.8% against the target level of around 85%. Clearly, absolutely maximising day case surgery is going to be key to maintaining elective activity through the winter period so we would encourage all teams to continue this positive work and drive the rates even further.

In Ophthalmology, the team have made considerable improvements to the efficiency of the cataract service since our last visit, with 40% of lists now being 8 or 9 cases, compared to all lists being 6 cases previously. This is excellent progress, and I would urge you to keep up this positive momentum and increase this proportion even further. The challenges you described around the Independent Sector and impact on training etc is real, and its therefore imperative we can offer very short waiting times for cataract procedures to rebalance NHS provision.

It was fantastic to see your work on ambulatory orthopaedic pathways, and the positive impact this is having on length of stay for patients. The single point of access for MSK going live earlier this year is also a very positive step.

We discussed your approach to Outpatient Transformation; it`s clearly imperative we increase the pace of our improvement with regards to Outpatient pathways across the NHS. We hope you will find our Further Faster Specialty Handbooks useful to drive this further, enabling the clinical and operational teams for each specialty to work through them and complete the checklist to identify further opportunities for improvement.
.
It was very helpful to hear of your focus areas with regards to Cancer services. There were a number of positive actions you have taken, such as moving LATP into an OP setting, establishing cancer navigators, and increasing FIT testing rates to above 85%. The GIRFT team will be meeting with all Cancer Alliances teams in the coming months, so we look forward to discussing further opportunities for pathway development across the system.

To summarise, I would like to thank you again for the meeting which we felt was very positive. As ever, if there is any further support you need from myself or my team, please don't hesitate to get in touch.

Yours sincerely,

Professor Tim Briggs
National Director of Clinical Improvement & Elective Recovery NHSE
Chair of the GIRFT Programme

Actions

Theatre utilisation	Continue the drive towards 85% utilisation across specialties and maximise cases per list in line with GIRFT guidance
BADS day case rates	Continue the drive towards 85% day case rates across all specialties
Outpatient transformation	Ensure GIRFT Further Faster handbooks are disseminated to all clinical and operational teams and 'checklists' are completed

Useful guidance and resources:

Ophthalmology: Cataracts	• High Flow Cataract pathway (gettingitrightfirsttime.co.uk) • **Improving Efficiency in Ophthalmic Theatres at NUH** - Nottingham clinical lead Dr Adrian Kwa Adrian.Kwa2@nuh.nhs.uk Improving efficiency in cataract
Pre-op assessment	• **Preoperative assessment services guidance – July 23** GIRFT-Pre-operative-assessment-guidance-FINAL-V1-July-2023.pdf (gettingitrightfirsttime.co.uk)
Orthopaedics:	• **South West Ambulatory Orthopaedic Centre (SWAOC)** New video offers a chance to learn from exemplar centre for ambulatory arthroplasty - Getting It Right First Time - GIRFT

	• **Guide to delivering perioperative ambulatory care for patients with hip and knee pain requiring joint replacement surgery – March 23** Ambulatory-Hip-and-Knee-Replacement-Guide-March-2023-FINAL-V1-1.pdf (gettingitrightfirsttime.co.uk) • **South West London Elective Orthopaedic Centre (SWLEOC) has worked with GIRFT to share their working practices and experiences as an established hub** Elective Hub Toolkit – GIRFT Surgical Hub Toolkit (girft-hubtoolkit.org.uk)
Cancer	• **Best Practice Timed Diagnostic Cancer pathways – July 23** Cancer pathways (gettingitrightfirsttime.co.uk)
Children's elective recovery	• **Closing the gap: Actions to reduce waiting times for children and young people – September 2023** Closing-the-gap-Actions-to-reduce-waiting-times-for-children-and-young-people-FINAL-V1-September-2023-1.pdf (gettingitrightfirsttime.co.uk)
Right Procedure Right Place	• **Practical Guide to Right Procedure Right Place – Aug 23** Right Procedure, Right Place - Getting It Right First Time - FutureNHS Collaboration Platform
Outpatient Guidance	• Outpatients - Getting It Right First Time - GIRFT
Virtual wards	• **Making the most of virtual wards** Making the most of virtual wards guide FINAL V1 May 2023 - Getting It Right First Time - FutureNHS Collaboration Platform

Agenda Item

ICB 31-01-009

Specialised Commissioning Briefing Report

Specialised Commissioning

Delegation to Integrated Care Boards

December 2023

Summary of current position

In December 2023 the NHS England Board approved plans to:

- Fully delegate the commissioning of appropriate specialised services to Integrated Care Boards (ICBs) in the East of England, Midlands and the North West regions of England from April 2024.
- Continue to jointly commission appropriate specialised services with ICBs in the South West, South East, London and the North East and Yorkshire regions of England for a further year. This will help support a smooth transition of commissioning responsibility by April 25.

These arrangements are part of a careful and considered approach to delegating full commissioning responsibility across England for appropriate services by April 2025.

Moving to ICB-led commissioning supports a focus on population health management across whole pathways of care, improving the quality of services, tackling health inequalities and ensuring best value.

These plans, which were first set out in our *Roadmap for Integrating Specialised Services within Integrated Care Systems*, have been developed in close collaboration with NHS England's regional teams, ICBs and specialised service providers. They represent the outcome of a thorough assessment of ICB system readiness, and a comprehensive analysis of services to determine their suitability and readiness for more integrated commissioning.

NHS England regional and national teams will continue to work with those ICBs who are continuing with joint commissioning arrangements as we work towards full delegation in those geographical areas from April 2025; and alongside ICBs taking on delegated responsibility to support them in their commissioning.

Why we need to change – the benefits of more integrated commissioning?

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

What is changing - The underpinning principles of delegation

- The delegation model will enable opportunities for end-to-end pathway transformation to improve population health, reduce health inequalities, and maximise value for money
- All services will continue to be prescribed specialised services regardless of whether the are retained for commissioning by NHSE or delegated to ICBs
- All prescribed specialised services will continue to need to adhere to national standards, service specifications and clinical access policies
- ICBs and NHSE will ensure that all prescribed specialised services meet the needs of local populations (regardless of where they live in England) and that inequalities in access are reduced to create high quality care and outcomes for all
- ICBs will build on multi-ICB collaboration and arrangements in 23/24 to ensure the appropriate commissioning footprints for managing delegated services from April 24. While multi-ICB arrangements may evolve over time, the underpinning legal agreement should be future-proofed as much as possible
- The financial architecture will evolve, with an appropriate pace of change, to support delegated commissioning including moving to a needs based population budget allocation to help address underlying inequities of distribution

What will and won't change in 2023/4 and 2024/5

Previous arrangements	Joint Working Arrangements	Delegation arrangements
Governance		
• NHSE is fully legally accountable, responsible and liable for the entire portfolio of specialised services	• Statutory joint committee underpinned by a Joint Working Agreement (JWA) between multi-ICBs and NHSE • Legal accountability remains with NHSE • Responsibility is shared between NHSE and ICBs • Liability remains with NHSE	• ICBs take on delegated commissioning responsibility via delegation agreement (DA) between NHSE and individual ICBs • ICBs would need to form appropriate multi-ICB collaboration arrangement • Legal accountability remains with NHSE • Responsibility and liability is delegated to ICBs
Decision making and voting rights		
• Regionally-led partnership boards in place / being established with ICBs • ICBs have a 'seat at the table' but no decision making rights	<u>For services that are 'suitable and ready':</u> • Shared decision making between ICBs and NHSE <u>For services that are 'suitable but not yet ready':</u> • NHSE retains decision making responsibility and ICBs have a 'seat at the table' so they are able to influence decisions	<u>For services that are 'suitable and ready':</u> • ICBs are fully responsible for decision making and NHSE has a 'seat at the table' <u>For services that are 'suitable but not yet ready':</u> • NHSE retains decision making responsibility and ICBs have a 'seat at the table' so they are able to influence decisions
Finance and Contracts		
• Specialised commissioning budget is provider-based and held by NHS England	• Population based budgets – full budget remains with NHSE • ICBs have sight of budgets and are able to influence how the budget for services that are 'suitable and ready' is spent • Contracting responsibility remains with NHSE	• Population based - the portion of the budget for services that are 'suitable and ready' transfers to ICBs • ICBs have full responsibility for the relevant portion of the specialised commissioning budget • Contracting responsibility is delegated to ICBs
Workforce		
• Commissioning resource sits in NHSE national and regional teams	• NHSE commissioning teams support commissioning of all services	• NHSE Hosted Commissioning Hubs will discharge delegated responsibilities until April 25, when appropriate NHSE staff will transfer to an ICB host to form an ICB Hosted Commissioning Hub.

Key safeguards

NHSE will **retain legal accountability** for the entire portfolio of specialised services – whether day to day responsibility is delegated to ICBs or retained by NHSE

Delegation will be subject to a **further assessment of system readiness** (via the PDAF) – including ensuring appropriate commissioning geographies are maintained

NHSE will maintain its responsibility for developing **national standards, service specifications and clinical access policies**

Only services that are deemed suitable and ready for greater ICB leadership, following a **robust analysis of the service portfolio**, will be delegated. The 59 services being delegated remain unchanged from the Feb 23 Board decision.

NHSE and ICBs will ensure **continued involvement** of **people and communities** in specialised commissioning

The **clinical leadership infrastructure** that supports specialised commissioning will continue and be strengthened to support ICBs to drive improvement and transformational change

NHSE Hosted **Commissioning Hubs** will discharge delegated responsibilities until April 25, when appropriate NHSE staff will transfer to an ICB host to form an ICB Hosted Commissioning Hub.

Controls and safeguards to **mitigate destabilisation of provider sector** when moving to population-based budgets

Delegation will be underpinned by robust **oversight and assurance** arrangements

NHSE will maintain its commercial and funding approaches for both **high cost drugs and devices** across all specialised services

Pre-delegation Assessment Framework

Used to assess ICB readiness and make recommendations to the Board

Health and Care Geography	Transformation	Governance and Leadership	Finance	Workforce Capacity and Capability	Data, Reporting and Analytics Infrastructure
There is a meaningful geographical footprint which respects patient flows, with clear plans in place to manage and mitigate against any risks.	There is a clear understanding of how receiving each new responsibility will benefit population health outcomes, deliver improved care quality, reduce health inequalities, improve preventative capacity, and increase efficient use of resources. There is a shared understanding across all ICS partners on the benefits of delegation.	Governance enables safe, high-quality delivery. Clinical leadership combines the specialist expertise to lead and scrutinise individual functions, and the collaborative working necessary to identify, enable, and oversee clinical improvements.	Major financial risk factors and issues are clearly understood and mitigated, and there is a track record of delivering a balanced budget.	There is an understanding of the workforce and capability and capacity requirements, with any major risks understood and processed for mitigation.	There is a clear understanding of the level of digital maturity required, with any gaps identified and prioritised for improvement.

Domains

Principles

Set against each domain were a series of criteria, which set out the areas that ICBs should have considered, undertaken or have in place by April 2024 in order to be 'ready' to take on greater responsibility. The criteria should be used to support ICBs – both on an individual basis and as part of multi-ICB footprints - as they develop, plan and prepare for the new arrangements.

Criteria

The regionally-led assessment took the form of a series of questions. These were aligned to the criteria, though aimed to recognise that in some cases, areas of activity or planning would still be in relative infancy at the time of the assessment. Examples of supporting evidence - which aim to support systems with 'what good looks like' - were provided against each question, and could be used as prompts for the kind of things that should be considered when drafting the narrative responses. ICBs were not expected to attach copies of evidence (e.g. governance structures, planning documents); however regions were asked to work with ICBs to complete the proforma, including reviewing and verifying any evidence where necessary or appropriate.Ultimately, the assessment required regional teams to judge which of the following three categories (multi-)ICBs had fallen into:

Assessment

Category 1 (Delegation)

Category 2 (Delegation with developmental conditions)

Category 3 (Intensive support required)

Categories

Regional overview

North East North Cumbria	
Population footprint[1]	3,008,913
23/24 Baseline allocation[2] (£m)	**559**

Yorkshire and the Humber	
Population footprint[1]	5,526,350
23/24 Baseline allocation[2] (£m)	**1,028**

East Midlands	
Population footprint[1]	5,152,456
23/24 Baseline allocation[2] (£m)	**976**

East of England	
Population footprint[1]	7,147,885
23/24 Baseline allocation[2] (£m)	**1,321**

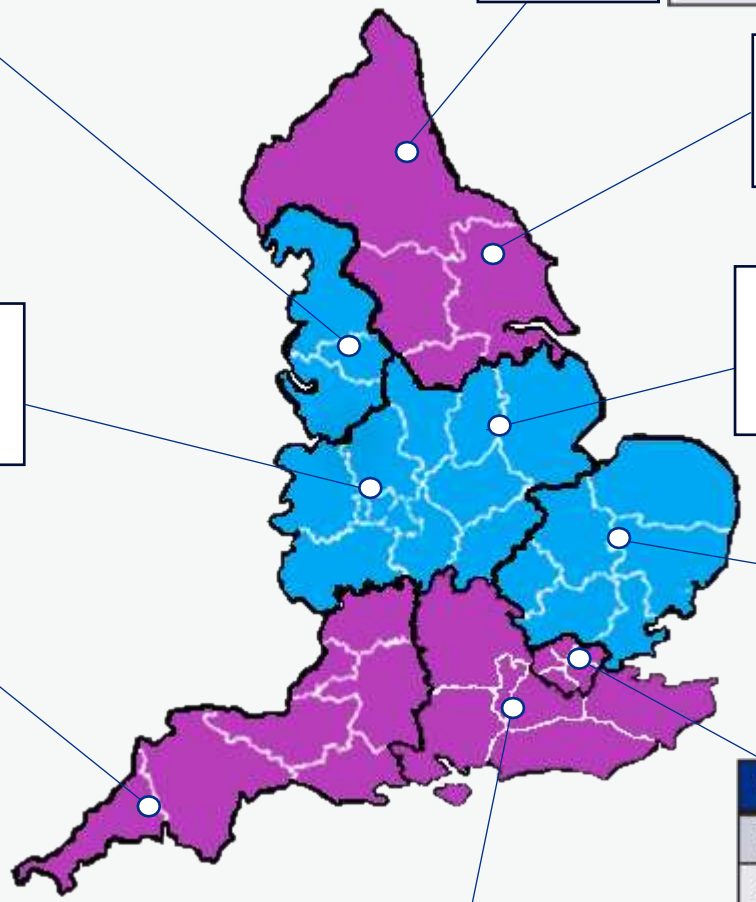
London	
Population footprint[1]	10,580,000
23/24 Baseline allocation[2] (£m)	**2,447**

South East	
Population footprint[1]	~9,100,000
23/24 Baseline allocation[2] (£m)	**1,815**

South West	
Population footprint[1]	6,006,444
23/24 Baseline allocation[2] (£m)	**1,156**

West Midlands	
Population footprint[1]	6,630,428
23/24 Baseline allocation[2] (£m)	**1,297**

North West	
Population footprint[1]	7,693,574
23/24 Baseline allocation[2] (£m)	**1,697**



Delegation

Continuation of joint working arrangements

1. Population footprints used on this slide were provided as part of the pre-delegation assessment process. As a result, several different data sources have been used.

2. These figures are the month 5 23/24 indicative baseline population based allocations (before 24/25 uplifts) for acute services that are suitable and ready for greater ICB leadership.

Service Portfolio Analysis

Output of the Service Portfolio Analysis

Set out below is the outcome of the service portfolio analysis process for 23/24. Joint committees between NHSE and ICBs are now jointly responsible for commissioning the 59 'green' services. From April 24 those 59 services will be fully delegated to ICBs deemed ready by the Board

GREEN
Services suitable and ready for greater ICB leadership:

59*

Value of £13bn*

AMBER
Services suitable but not yet ready for greater ICB leadership:

29*

Value of £1.5bn*

RED
Services remaining commissioned nationally (78 Highly Specialised Services):

89*

Value of £1.3bn*

Review of list for 24/25
Following a further review of the service list for delegation from April 24, it was decided that there would be ***no further changes to the list for 24/25***.

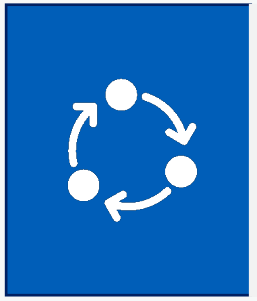
Review of list for 25/26
A process has been agreed by the FCMP Oversight Group to ***review the Amber services by February*** and decide whether they will be Green or Red for 25/26. There will be no Amber category from April 25.

*19/20 baseline
*These numbers show groupings at a prescribed specialised services manual level; however, analysis was carried out at a service line level (some services lines sit across more than one category).
*These figures exclude budgets for high-cost drugs, devices, and other national programmes which will continue to be held centrally.

How are specialised services funded

Currently, funding is allocated according to where a service is provided, rather than on the basis of population health need. While creating minimal transactional burden, this means resources are not always allocated according to the needs of the population in a particular area.

To support delegated commissioning, allocations have **changed from a provider (host regional commissioner) basis in 2022/23 to a population basis from 2023/24.** Allocations are still set at a regional level in 2023/24, but will move to ICB level from 2024/25. Services not suitable for delegation will remain on a host regional commissioner basis.



The methodology being used to set population-based budgets in 2023/24 is historic actual usage of services uplifted with inflation and growth. Over time, from 2024/25, **allocations will gradually move to a needs-weighted population methodology** which should help to address health inequalities.

The convergence policy setting out how allocations will move from an historic actual to a needs weighted basis is being developed based on principles and data analysis set out during 2022/23. There are some exclusions from the move in allocations from a host basis, in particular services not suitable for delegation (which will remain hosted at a regional level) and high cost drugs (which will remain nationally-commissioned).

Through population-based allocations and ICBs being party to contracts that serve their populations, local commissioners will have **much greater line of sight and influence over the services that their patients may be receiving out of area,** making it easier to join up their local services with those specialist elements of pathways.

Financial Architecture

Key changes to financial architecture to support the move to delegated commissioning

Pre-23/24

- Regional allocations
- Hosted basis
- Historic commissioner spend

2023/24

- ICB allocations
- Population basis
- Historic commissioner spend
- Some non-recurrent host transfers back for low value flows and ERF

2024/25 onwards

- ICB allocations
- Population basis
- Needs-based (with appropriate transition / convergence policy)
- Option to continue to make non-recurrent host transfers

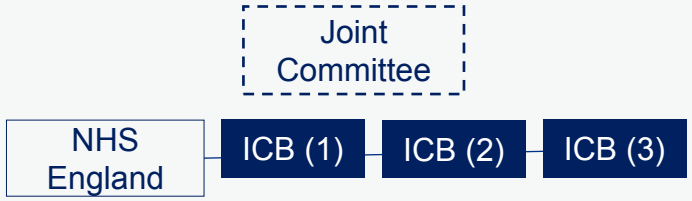
Underpinned by:

- A contracting and payment mechanism which minimises additional burden.
- A financial framework which allow funds to follow appropriate commissioning decisions, but protect against destabilising or precipitative decisions, and manage financial risk appropriately.
- Key SOPs – accounting, change management, reporting, cashflow

Delegation Model

Moving from Joint Working Arrangements to full delegation

Joint working agreement for 2023/24

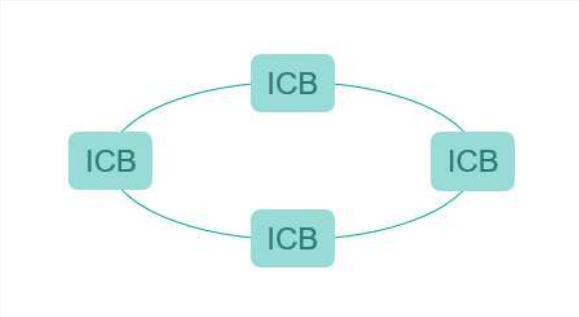


- NHS England introduces a JWA with one or more ICBs to jointly commissioning specialised services.
- Finance and liability remain with NHS England.
- Contracting responsibility stays with NHS England.
- ICBs have joint decision making powers with NHS England within the terms of the JWA, subject to some safeguards.
- Decision making is undertaken through a joint committee of the partners.

Delegation Agreement for 2024/25

- Each ICB will have a delegation agreement with NHS England for specialised services.
- Finances and liability follow the function. Contracts to transfer to ICBs.
- ICBs have decision making powers within the terms of the delegation agreement.
- Depending on the PDAF outcome category, developmental conditions will be used to ensure the transition from joint working to delegation arrangements is tailored to ICB readiness:
  - Cat 1 – Delegation
  - Cat 2 – Delegation with developmental conditions
  - Cat 3 – Intensive support required

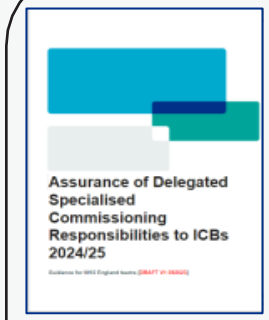
ICB Collaboration Agreement



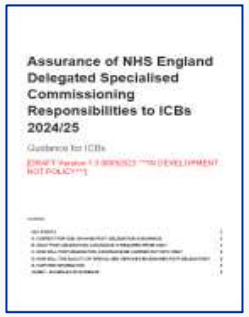
- Aims to support systems to work collaboratively to commission specialised services on an appropriate multi ICB footprint.
- Provides options for how ICBs could collaborate and choose mechanisms to build a multi-ICB arrangement.
- ICA could be used to develop a support mechanism for those ICBs within the wider multi-ICB footprint to which developmental conditions have been applied.

Oversight and Assurance

- The **Delegated Specialised Commissioning Assurance Guidance** sets out for both ICBs and NHSE England teams what is the required assurance in 2024/25 and how will that assurance be achieved. Alongside this document, a consistent but more targeted **summary document** has been developed for ICB leaders, focusing specifically on ICB-NHS England region assurance arrangements.
- Both products are aligned to the **NHS Oversight Framework**, which provides the single overarching approach to identifying and fulfilling support needs for systems that require improvement support and intervention to meet the standards required.



1. **Assurance Guidance** – targeted at NHS England teams



2. **Assurance Guidance Summary** – targeted at ICBs

Same content (but tailored to different audiences)…

- *What* are the core requirements?
- *How* will assurance work?

Assurance - the process by which NHS England is assured that ICBs are discharging NHS England's delegated specialised commissioning responsibilities in accordance with the Delegation Agreement.

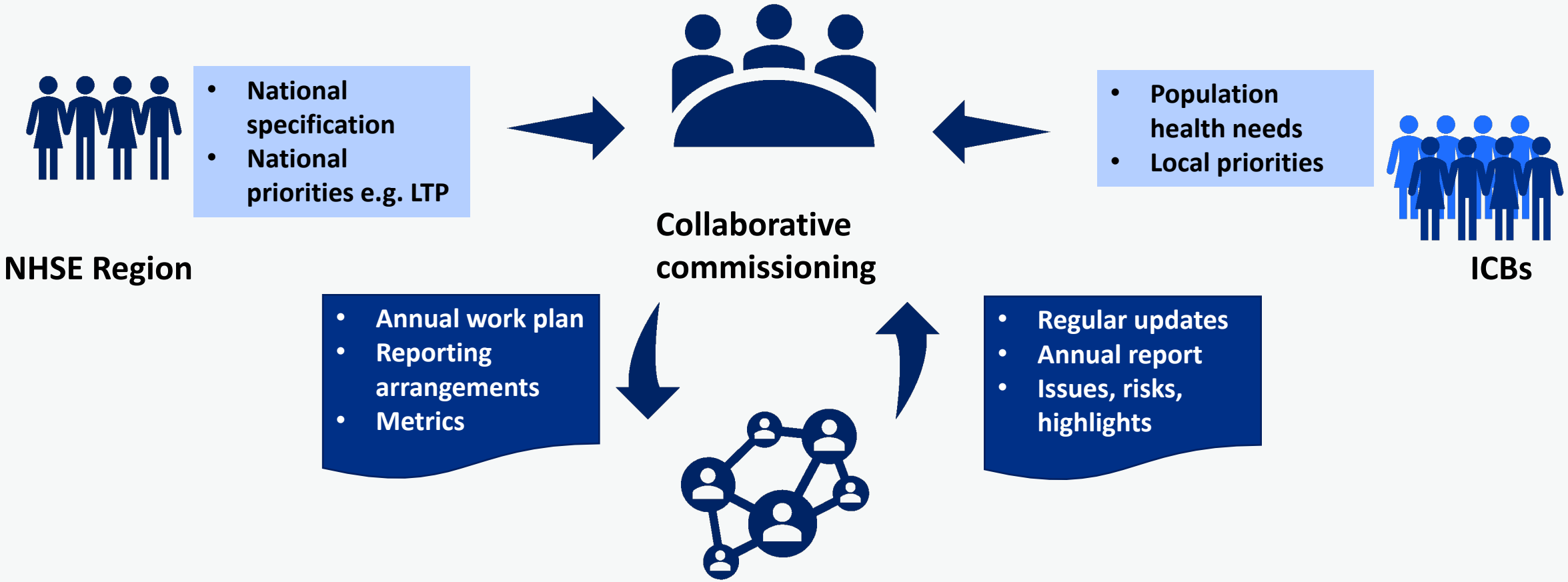
NHS Oversight Framework* -

- How NHSE will oversee the roles & responsibilities of ICBs

**Refreshed framework due for 24/25 – will link to our Assurance Guidance asks*

Oversight - the process of using objective criteria and judgement to determine whether an organisation requires support to meet its duties.

Clinical Network Commissioning



- Specialised services clinical networks are commissioned and are hosted by provider organisations. Staff are employed by those host organisations, with networks operating under a service level agreement. Funding is recurrent.
- Their footprint is usually larger than individual ICBs or PCs. We have therefore agreed that we will move to a model of joint commissioning between NHSE regional teams and ICBs.
- This will ensure that each network's work plan reflects national, regional and local priorities.
- Clinical Network service specifications are available in draft on NHS Futures and will be published shortly

Thank You

If you have any questions please email the Future Commissioning Models Programme team in specialised commissioning on fcmp.england@nhs.net

Additional resources are on NHS Futures – Integrating specialised services within Integrated Care Systems - FutureNHS Collaboration Platform

Financial Risk and Pooling Framework

DOCUMENT CONTROL SHEET
Document Owner: FCAG
Document Author(s): Andrew Morton
Version: 5.2

Change History: Version	Date	Reviewer(s)	Revision Description
v1 Draft		A. Morton	First Draft
v2 Draft		A. Morton	FCAG feedback re: Regional team inclusion Clarity on Contingency Inclusion of allocation methodology change risk
v3 Draft	31/05/2022	A. Morton S. Washbourne P. Pilkington K. Tabor	Increased clarity
v4 Draft	01/07/22	A. Morton S. Gay	Increased clarity on continuation of risk share, wicked problems reviewed, governance in conflict, and sign off of changes to risk share
v5 Draft	01/12/23	E. Finnemore	Refocus on current delegation of Specialised Commissioning services. Development of risk management proposals.
v5.1 Draft	07/12/23	E. Finnemore	OFDG feedback re: Risk Share definition prescription Appendix 2: Worked Scenarios Commissioning Efficiencies
V5.2 Draft	13/12/23	J. Cooke E. Finnemore	FCAG feedback incorporated inc. Appendix 1: Service List Pooling proposal

Contents

Proposed Financial Risk Framework – Specialised Commissioning

1. Service Delegation

This document has been written in response to the upcoming delegation of Specialised commissioning to Integrated Care Boards (ICBs). POD (Pharmacy, Optometry and Dental) services were delegated in April 2023, and Specialised Commissioning Services ("the 59") are scheduled to be delegated in April 2024.

2. What is a financial risk framework?

This financial risk framework is a set of behaviours and rules which govern the management of risk within the NHS Midlands Region. Primarily risks may result from either allocation methodology changes or from in-year service variation.

3. Who does this document concern?

The intended audience for this document is all the ICBs within the Midlands Region as organisations which will be in receipt of delegated Specialised Commissioning budgets at April 2024. The scope does not extend to national level specialised commissioning budgets. Written with a 'commissioner lens' cost variances within providers are out of scope. Such risks should be considered within each ICS.

4. Why do we need a financial risk framework?

4.1 Specialised Commissioned Services have until recently been managed collectively at a regional level within the NHS. Delegating responsibility to ICB localities may result in the amplification of budgetary issues which were previously offset or immaterial at the regional level.

4.2 ICBs are new to the commissioning of delegated services. Operating risk sharing/ pooling arrangements may be deemed desirable to allow the time and space for the establishment of specific commissioning knowledge within systems.

4.3 Budget allocation methodologies are being transitioned from a provider to a population basis (Needs Based Assessment) at the same time as they are moving from a regional to a system level. Such budgetary changes may result in variations to individual ICBs which may be managed collectively through risk sharing.

4.4 The framework may also address additional issues arising from the delegation of services to local systems. Examples may include –

- Minimising variation from plan
- Service changes – investments, policy, pathway

- Withdrawing services from the scope of the risk share
- Managing unilateral ICB changes
- Agreeing changes to risk share arrangements
- Addressing disagreements between participating ICBs

5. Behaviours and Standards

The introduction of ICS/ICB arrangements into the NHS replaced the competitive approach of the internal market with principles of collaboration, openness and transparency. This document has been written in the full expectation of the adoption and implementation of these principles across all NHS organisations.

Organisations should seek to resolve any issues between organisations through the Finance Subgroup. In the last resort where resolution proves unobtainable issues may referred through the escalation procedure outlined in Section 11.

6. Financial Risk Sharing

6.1. The risk share arrangement referred to below relates wholly and exclusively to the 59 Specialised Commissioning services transferred to ICBs w.e.f. April 2024. A list of all the services being delegated is shown in Appendix 1.

6.2. Once in year mitigations have been fully considered and implemented remaining issues may be managed through applying risk management arrangements. The risk share will apply either where the bottom-line position is in surplus, balance, or where there is a deficit.

6.3. Risk sharing arrangements are not applicable to High Cost Drugs and Devices as they are held as retained budgets, nor to unilateral commissioning decisions made by individual ICBs (such as a variance to budget spend caused by investment). All variances will therefore need to be explained before a virement or risk share is made to ensure it is not due to unilateral decisions.

6.4. Where an ICB bottom line for specialised services is in balance but there are underlying deficits within that position budget virements will be undertaken to minimise variations from plan. If the ICB bottom-line for specialised services is in deficit, then the budget virements will be undertaken across all participating ICBs in order to share the deficit proportionately across all ICBs.

6.5. Bottom-line deficits will be shared pro rata to the ICB 2024/25 opening budget position. This will be within the overall specialised commissioning budgets, and not based on non-specialised system allocations.

6.6. Budgetary surpluses will be shared in the equivalent manner to deficits, with ICBs sharing the surplus proportionately to their 2024/25 opening budget position.

6.7. A worked example of surplus, balanced, and deficit positions is shown in Appendix 2.

6.8. There should be options to amend ICB risk share percentages annually by consensus of all ICBs. This may include adjustments for service change covering both the impact of additional pathways within delegated service arrangements or delivered pathway change outside of delegated service arrangements but impacting delegated spend. In the latter scenario it will be based on evidence of quantifiable, sustained and recurrent delivery not production of a business case.

7. Risk Pooling

7.1. Section 14Z3 of the NHS Act 2006 allows and one or more integrated care boards to establish and maintain a pooled fund. Application of this allowance is the preferred approach to the management of financial risk in specialised services.

7.2. Under this arrangement, ICBs would transfer allocations for the commissioning of specialised services to the identified host ICB. The host specialised commissioning finance team would manage specialised services through the host ledger, managing financial risk across all eleven ICBs.

7.3. The selection of a host will be by consensus of all ICBs.

7.4. The lead ICB arrangement will be subject to annual renewal by Finance Subgroup. The existing lead arrangement will continue by default until an alternative is selected by consensus.

7.5. Individual ICBs will record their own pool contributions within their own accounts for the purposes of in-year accounting. The agreed risk sharing arrangement will be applied to the outturn position for individual ICBs as calculated by the lead ICB.

8. In Year Management

8.1. Cost mitigation always precedes any application of risk sharing. Risk sharing may only be considered once Finance Subgroup has satisfied itself that the appropriate mitigations have been implemented.

8.2.

8.3. Quarterly position statements of agreed risk sharing should be produced including a forecast at each quarter. These will form the basis of recommended adjustments, and at Q3 a forecast and recommendation will be made for the year end to support delivery of year end positions. This may be supplemented by a Month 11 update and recommendation.

8.4. Enacting the risk share will be a recommendation of Finance Subgroup to the East/West Joint Committees. The risk share will apply region wide i.e. both East and West Midlands together. This should be part of a review after the first year of operation and a better understanding of budget variations. All services that are part of the delegation will be included in the risk share. Currently there are not specific risk shares for each specialty.

9. **Risk Share Future**

9.1. The risk share is intended to be in place to allow a greater degree of understanding by ICBs of the risks inherited from delegating budgets either from changes in allocation methodology, or in year changes in spend. For the period of its operation the risk share will be subject to an annual review and amendment by consensus agreement.

9.2. The risk share will continue by default in the absence of any agreed changes that would be recommended by Finance Subgroup and approved by the East/West Joint Committee. Service scope changes should be by agreement of all members of the risk share group. An ICS cannot unilaterally leave the risk share. Any changes should not threaten the viability of the risk share.

9.3. All these arrangements within the Risk Management Framework should form part of the review undertaken at the end of the first year.

10. Contingency Funds

10.1. Best practice looks to avoid holding back significant sums from the planning process, in terms of a central contingency. This is in part because of the requirement on the public sector to use the funds allocated for the purposes intended and in part to discourage organisations relying on such funds to 'bail them out' or ending with last minute year-end expenditure resulting in a sub-optimal use of resources. However, there are often unforeseen costs and a small level of contingency set aside to support may be required.

10.2. To meet unforeseen costs a planned contingency of 1% should be made from within the delegated budgets and form a part of the mitigation process. This should be reviewed each time plans are agreed to ensure affordability of contingency creation is possible, and if not possible, a recommended level put forward to Finance Subgroup.

11. Assurance

11.1. Regular reporting to Finance Subgroup will be maintained on an equivalent basis to that undertaken prior to delegation. This will enable monitoring of the financial risks inherent withing contracts.

12. Appeals and Escalation

12.1. While there may be a financial risk sharing agreement, there will need to be a process for dispute resolution where consensus cannot be agreed.

12.2. Primarily risk sharing disagreements will be managed by the chair of Finance Subgroup, unless conflicted. In the case of conflict, an agreed independent party will provide arbitration.

12.3. Escalation to the East and West Joint Committees is required upon recommendation of the Finance Subgroup chair should a disagreement not be settled.

12.4. Should this not be resolved, NHSE will be requested to provide arbitration, however this should be avoided wherever possible and alternative routes identified.

Appendix 1

Specialised Commissioning Service Delegation April 2024 – Service List ("the 59")

Source: NHSE Board Papers, 2 February 2023, Item 7 Annex A - Final SPA Lists

PSS Manual Line & Description		Service Line Code & 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
		29S	Severe asthma
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)
		13H	Cardiac magnetic resonance imaging
		13T	Transcatheter Aortic Valve Replacement (TAVI)
		13Z	Cardiac surgery (outpatient)
9	Adult specialist endocrinology services	27E	Adrenal Cancer
		27Z	Adult specialist endocrinology services
11	Adult specialist neurosciences services	08E	Neurosurgery - Low Volume Procedures (National)
		08F	Neurosurgery - Low Volume Procedures (Regional)
		08G	Neurosurgery - Low Volume Procedures (Neuroscience Centres)
		08O	Neurology
		08P	Neurophysiology
		08R	Neuroradiology
		08S	Neurosurgery
		08T	Mechanical Thrombectomy
12	Adult specialist ophthalmology services	37C	Artificial Eye Service
		37Z	Adult specialist ophthalmology services
13	Adult specialist orthopaedic services	34A	Orthopaedic surgery
		34R	Orthopaedic revision
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
		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
36	Cochlear implantation services (adults and children)	32A	Cochlear implantation services
40	Complex spinal surgery services (adults and children)	06Z	Complex spinal surgery services
54	Fetal medicine services (adults and adolescents)	04C	Fetal medicine services
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
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
61	Specialist dermatology services (adults and children)	24Z	Specialist dermatology services
62	Specialist metabolic disorder services (adults and children)	36Z	Specialist metabolic disorder services
63	Specialist pain management services for children	23Y	Specialist pain management services for children
64	Specialist palliative care services for children and young adults	E23	Specialist palliative care services for children and young adults
65	Specialist services for adults with infectious diseases	18A	Specialist services for adults with infectious diseases
		18E	Specialist Bone and Joint Infection
72	Major trauma services (adults and children)	34T	Major trauma services
78	Neuropsychiatry services (adults and children)	08Y	Neuropsychiatry services
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

PSS Manual Line & Description		Service Line Code & Description	
105	Specialist cancer services (adults)	01C	Chemotherapy
		01J	Anal cancer
		01K	Malignant mesothelioma
		01M	Head and neck cancer
		01N	Kidney, bladder and prostate cancer
		01Q	Rare brain and CNS cancer
		01U	Oesophageal and gastric cancer
		01V	Biliary tract cancer
		01W	Liver cancer
		01Y	Cancer Outpatients
		01Z	Testicular cancer
		04F	Gynaecological cancer
		19V	Pancreatic cancer
		24Y	Skin cancer PSS Manual Line PSS Manual Line Description Service Line Code Service Line Description
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
		33B	Complex inflammatory bowel disease
		33C	Transanal endoscopic microsurgery
		33D	Distal sacrectomy for advanced and recurrent rectal cancer
106A	Specialist colorectal surgery services (adults)	33A	Complex surgery for faecal incontinence
		33B	Complex inflammatory bowel disease
		33C	Transanal endoscopic microsurgery
		33D	Distal sacrectomy for advanced and recurrent rectal cancer
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	23X(b)	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	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
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
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
135	Specialist paediatric surgery services	23X(a)	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 PSS Manual Line PSS Manual Line Description Service Line Code Service Line Description
		139AA	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital
		04P	Complex termination of pregnancy
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	Complex termination of pregnancy
ACC	Adult Critical Care	ACC	Adult Critical Care

Appendix 2

Specialised Commissioning Budget Scenarios
Scenarios showing ICB Positions against Varying Regional Context

Regional Surplus

ICB	Area	Opening Budget	NBA Budget	Variance	Risk Share %	Outturn	Opng. Bud. Variance	NBA Budget Variance
Birmingham & Solihull	West	138,818	136,818	(2,000)	13.8%	138,984	166	2,166
Coventry & Warwickshire	West	78,254	79,254	1,000	7.8%	78,347	93	(907)
Derby & Derbyshire	East	69,161	69,661	500	6.9%	69,244	83	(417)
Herefordshire & Worcestershire	West	105,600	106,100	500	10.5%	105,726	126	(374)
Leicester, Leicestershire & Rutland	East	91,523	89,223	(2,300)	9.1%	91,632	109	2,409
Lincolnshire	East	60,163	60,663	500	6.0%	60,235	72	(428)
Northamptonshire	East	70,018	69,518	(500)	7.0%	70,102	84	584
Nottingham & Nottinghamshire	East	109,015	110,015	1,000	10.8%	109,145	130	(870)
Shropshire, Telford & Wrekin	West	49,789	50,789	1,000	5.0%	49,848	59	(941)
Staffordshire & Stoke-on-Trent	West	105,543	106,043	500	10.5%	105,669	126	(374)
Black Country	West	127,396	128,396	1,000	12.7%	127,548	152	(848)
Total		1,005,280	1,006,480	1,200	100.0%	1,006,480	1,200	-
Gross Under				(4,800)				
Gross Over				6,000				

Regional Balance

ICB	Area	Opening Budget	NBA Budget	Variance	Risk Share %	Outturn	Opng. Bud. Variance	NBA Budget Variance
Birmingham & Solihull	West	138,818	136,818	(2,000)	13.8%	138,818	-	2,000
Coventry & Warwickshire	West	78,254	77,254	(1,000)	7.8%	78,254	-	1,000
Derby & Derbyshire	East	69,161	69,661	500	6.9%	69,161	-	(500)
Herefordshire & Worcestershire	West	105,600	106,100	500	10.5%	105,600	-	(500)
Leicester, Leicestershire & Rutland	East	91,523	89,723	(1,800)	9.1%	91,523	-	1,800
Lincolnshire	East	60,163	60,663	500	6.0%	60,163	-	(500)
Northamptonshire	East	70,018	69,518	(500)	7.0%	70,018	-	500
Nottingham & Nottinghamshire	East	109,015	110,015	1,000	10.8%	109,015	-	(1,000)
Shropshire, Telford & Wrekin	West	49,789	50,789	1,000	5.0%	49,789	-	(1,000)
Staffordshire & Stoke-on-Trent	West	105,543	106,343	800	10.5%	105,543	-	(800)
Black Country	West	127,396	128,396	1,000	12.7%	127,396	-	(1,000)
Total		1,005,280	1,005,280	-	100.0%	1,005,280	-	-
Gross Under				(5,300)				
Gross Over				5,300				

Regional Deficit

ICB	Area	Opening Budget	NBA Budget	Variance	Risk Share %	Outturn	Opng. Bud. Variance	NBA Budget Variance
Birmingham & Solihull	West	138,818	136,818	(2,000)	13.8%	138,431	(387)	1,613
Coventry & Warwickshire	West	78,254	77,254	(1,000)	7.8%	78,036	(218)	782
Derby & Derbyshire	East	69,161	69,661	500	6.9%	68,968	(193)	(693)
Herefordshire & Worcestershire	West	105,600	106,100	500	10.5%	105,306	(294)	(794)
Leicester, Leicestershire & Rutland	East	91,523	89,223	(2,300)	9.1%	91,268	(255)	2,045
Lincolnshire	East	60,163	60,663	500	6.0%	59,995	(168)	(668)
Northamptonshire	East	70,018	69,518	(500)	7.0%	69,823	(195)	305
Nottingham & Nottinghamshire	East	109,015	110,015	1,000	10.8%	108,711	(304)	(1,304)
Shropshire, Telford & Wrekin	West	49,789	50,789	1,000	5.0%	49,650	(139)	(1,139)
Staffordshire & Stoke-on-Trent	West	105,543	106,043	500	10.5%	105,249	(294)	(794)
Black Country	West	127,396	126,396	(1,000)	12.7%	127,041	(355)	645
Total		1,005,280	1,002,480	(2,800)	100.0%	1,002,480	(2,800)	-
Gross Under				(6,800)				
Gross Over				4,000				

Glossary
NBA - Needs Based Assessment

Dated 202\

(1) **NHS ENGLAND**

- and -

(2) **NHS [INSERT NAME] INTEGRATED CARE BOARD**

Delegation Agreement between NHS England and [ ] ICB in relation to Specialised Commissioning Functions

DRAFT - NOT AVAILABLE FOR ACCEPTANCE

Table of contents

Clause heading and number | Page number

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	[Insert Name]
Area	[Insert Area of the ICB as defined in its Constitution]
Date of Agreement	[Date]
	[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	[Insert details of name of manager of this Agreement for NHS England]
NHS England Email Address for Notices	[Insert Address]

1.2 This Agreement comprises:

1.2.1 the Particulars (clause 1);

1.2.2 the Terms and Conditions (clauses 2 to 35);

1.2.3 the Schedules; and

1.2.4 the Mandated Guidance

Signed by **NHS England**

[Name]

[Title]

(for and on behalf of NHS England)

Signed by **[Insert name] Integrated Care Board**

[Insert name of Authorised Signatory]

[Insert title of Authorised Signatory]

[for and on behalf of] [ ] 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 Particulars and Terms and Conditions (clauses 1 to 35);

2.2.2 all Schedules excluding Local Terms;

2.2.3 Mandated Guidance; and

2.2.4 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 By this Agreement NHS England delegates the Delegated Functions to the ICB under section 65Z5 of the NHS Act while retaining the Reserved Functions.

3.2 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.

3.3 This Agreement sets out the terms that apply to the exercise of the Delegated Functions by the ICB and the Parties' associated responsibilities and 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 30 *(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 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;

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 [2] to this Agreement.

6.3 The Delegation in respect of each Delegated Function has effect from the relevant 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 must perform the Delegated Functions in such a manner as to ensure that the ICB complies with its statutory duties including those duties set out in Section 14Z32 to Section 14Z44.

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

7.3.1 the terms of this Agreement;

7.3.2 Mandated Guidance [Schedule 7];

7.3.3 any Contractual Notices;

7.3.4 any Developmental Conditions [Schedule 9];

7.3.5 all applicable Law and Guidance;

7.3.6 the ICB's constitution;

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

7.3.8 Good Practice.

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

7.4.1 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

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

7.5 In exercising the Delegated Functions, the ICB must comply with Mandated Guidance including, but not limited to, ensuring compliance with National Standards and following National Specifications.

7.6 Where Developmental Conditions conflict with any other term of this Agreement the Developmental Conditions shall take precedence until such time as NHS England agrees to the removal or amendment of the relevant Developmental Condition.

7.7 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.

7.8 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 Provider that is a party to Contract or Arrangement. NHS England may add or remove Contracts where this is associated with an extension or reduction of the scope of the Delegated Functions.

7.9 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.

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

8. REQUIREMENT FOR MULTI ICB ARRANGEMENTS ("MIA")

8.1 Subject to the provisions of Clause 12 (Further Arrangements), the ICB shall establish appropriate joint working arrangements with other ICBs in order to ensure that the

commissioning of the Delegated Specialised Services can take place at the level that would deliver that is most efficient and effective for each relevant Specialised Service. [DQ: Such ICB arrangements must be approved in advance by NHS England.]

8.2 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 MIA. The members of the MIA shall have a collective responsibility for the operation of the MIA.

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

8.3.1 Membership which is limited solely to Integrated Commissioning Boards unless otherwise approved by NHS England;

8.3.2 Clear governance arrangements;

8.3.3 [Confirmation of the obligations in relation to the Delegated Functions that will be carried out as part of the MIA];

8.3.4 Financial arrangements and any pooled fund arrangements;

8.3.5 Reporting lines from the MIA to the ICB Board;

8.3.6 Data sharing arrangements including evidence of a Data Protection Impact Assessment;

8.3.7 Terms of reference for decision making;

8.3.8 Limits on onward delegation.

8.4 The ICB must not:

8.4.1 terminate an MIA; or

8.4.2 make any material changes to the terms of the MIA,

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 29 (*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. In the event that 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 the Parties may agree for the ICB to provide administrative and management services ("Commissioning Support Arrangements") 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 Support Arrangements shall be set out in writing.

9.6 Notwithstanding any arrangement for or provision of Commissioning Support Arrangements in respect of the Retained Services, NHS England shall retain statutory responsibility for, and be accountable for, the commissioning of the Retained Services.

10. FINANCE

10.1 Without prejudice to any other provision in this Agreement, the ICB must comply with 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 no less than that necessary 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 allocated to the ICB in accordance with clauses 7.8 to **Error! Reference source not found.** in so far as they relate to the Delegated Functions;

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

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 under Clause 7.5 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;

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 and/or funds transferred (or that should have been transferred) to the ICB and in respect of which the ICB has management or administrative responsibility under Schedule 10 of this Agreement; or

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

Payment and Transfer

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, the ICB agrees that it must use its resources for the purposes of the Delegated Functions 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 the business rules as set out in NHS England's planning guidance or such other documents issued by NHS England from time to time;

10.12.3 any Capital Investment Guidance; and

10.12.4 the HM Treasury guidance *Managing Public Money* (dated September 2022)

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

10.14.4 NHS England and one or more ICBs in accordance with section 65Z6 of the NHS Act.

10.15 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 (including in relation to this Agreement), (and in such form) as set out in Schedule XX, the Assurance Framework for Specialised Servicesor as otherwise 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 MIA agreed in accordance with Clause [ ] (Multi-ICB 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.

12.2 The ICB may only make arrangements with another person (a "Sub-Delegate") concerning the exercise of the Delegated Functions ("Further Arrangements"), including without limitation arrangements under section 65Z5 and section 75 of the NHS Act, with the prior written approval of NHS England.

12.3 The approval of any Further Arrangements may:

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

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

12.4 All Further Arrangements must be made in writing.

12.5 The ICB must not:

12.5.1 terminate Further Arrangements; or

12.5.2 make any material changes to the terms of Further Arrangements,

without the prior written approval of NHS England.

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

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

12.8 Where Further Arrangements are made, and unless NHS England has otherwise given prior written agreement, any positive obligation or duty on the part of the ICB under this Agreement that is relevant to those Further Arrangements shall also require the ICB to ensure that all Sub-Delegates comply with that positive obligation or duty and support the ICB in doing so. In the same way, any negative duty or obligation on the part of the ICB under this Agreement that is relevant to Further Arrangement shall also require the ICB to ensure that all Sub-Delegates comply with that negative obligation or duty and support the ICB in doing so.

13. STAFFING, WORKFORCE AND COMMISSIONING HUBS

13.1 At the date of this Agreement the Commissioning Staff will transfer to the Host ICB.

13.2 The ICB shall enter into appropriate arrangements with NHS England, the Host ICB (where this is not the ICB), and where appropriate, other ICBs, in order to establish appropriate joint working arrangements to allow the provision of Commissioning

Support Arrangements to NHS England and set out the arrangements between ICBs in respect of the Commissioning Staff (the Commissioning Hub Agreement).

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 Conditions or impose new Developmental Conditions;

14.2.5 revoke the whole or part of the Delegation and terminate this Agreement in accordance with clause 26 *(Termination)* below;

14.2.6 exercise the Escalation Rights in accordance with clause 15 *(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 (or, based on the risk register maintained by the ICB in accordance with clause 11.5 or any other information available to it the ICB considers that it may not be able to comply) with this Agreement; or

14.4.2 NHS England notifies the ICB that it considers the ICB has not complied, or 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 considers that it may not be able to comply with this Agreement) or such notification pursuant to clause 14.4.2 setting out:

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

14.4.4 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) 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) 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 Nothing in clause 15 *(Escalation Rights)* will affect NHS England's right to substitute a decision in accordance with clause 6.7, revoke the Delegation and/or terminate this Agreement in accordance with clause 30 *(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 and, 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 The ICB indemnifies NHS England and shall keep it indemnified on a continuing basis from and against any and all Losses which NHS England may incur by reason of any claim by any NHS England Staff:

16.5.1 arising out of a breach of duty by the ICB (whether under common law, statute or otherwise) to the extent that such claim is not met by either the ICB's or NHS England's insurance or indemnity cover;

16.5.2 under the Equality Act 2010 or Part V of the Employment Rights Act 1996 arising out of acts or omissions by the ICB (or any of its employees, directors or officers);

16.5.3 arising from any acts or omissions by the ICB resulting in the termination of their employment, including any claim arising from any instruction by the ICB to NHS England to discipline or dismiss any person.

16.6 Each Party shall co-operate with the other in making all reasonable efforts to minimise any liabilities and Losses in connection with the employment of NHS England Staff in Delegated Functions.

16.7 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/or 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/or

17.3.5 at the request of NHS England, take such action 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 within a reasonable time period 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 in the course of 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 IG 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 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"**).

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

18.5.1 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;

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

18.5.3 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.

18.6 NHS England may, from time to time, issue a FOIA or EIR protocol or update a protocol previously issued relating to the dealing with and responding to of FOIA or EIR requests in relation to the Delegated Functions. The ICB shall comply with such FOIA or EIR protocols.

18.7 Delegated **Services**

NHS England delegates to the ICB the statutory function for commissioning the Delegated Services to the extent set out in Part 2 of this Schedule and subject to the reservations set out in Schedule 3 (the Retained Functions) and the provisions of any Developmental Conditions {Local Developmental Requirements?].

[INCLUDE Specialised Service List]

SCHEDULE 3: Delegated Functions

1. **INTRODUCTION**

1.1 **S**ubject to the reservations set out in Schedule 4 (Reserved Functions) and the provisions of any Developmental Conditions, NHS England delegates to the ICB the statutory function for commissioning the Delegated Services to the extent set out in this Schedule being, in summary:

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

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

1.1.3 undertaking reviews of Delegated Specialised 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 Specialised 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 in order 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 function.

2. **General Obligations**

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

2.2 The ICB shall put in place arrangements for collaborative working with other ICBs.

2.3 The Developmental Conditions set out in Appendix 4 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 their patients and Populations in accordance with the Assurance Processes.

3.2.3 Assure 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 Specialised Services, as required by NHS England, including metrics and detailed reporting in accordance with the Terms of Reference.

4. **Attendance at governance meetings**

4.1 The ICB must ensure that there is appropriate representation at multi-ICB forums.

4.2 The ICB must ensure that an individual(s) has been nominated to represent the ICB at the Delegation Commissioning Group and regularly attends that group. The could be a single representative on behalf of a multi-ICB footprint.

4.3 The ICB should also ensure that they have a nominated representative to attend national standards development forums as requested by NHS England.

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 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.

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

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

6.5 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.

6.6 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 manage complaints function for Delegated Specialised Services.

8. **Commissioning and optimisation of High Cost Drugs**

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

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

8.3 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 Partner in the development access to medicine strategies, and minimising barriers that may exacerbate health inequalities.

8.4 The ICB must ensure:

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

8.4.2 effective introduction of new medicines;

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

8.4.4 consistency of prescribing and unwarranted prescribing variation are addressed.

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

8.6 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.

8.7 The ICB must provide support to prescribing networks and forums, including but not limited to: immunoglobulin assessment panels, HIV prescribing networks and high cost drugs pharmacy networks.

[DN – this is not based on Operating Models as we were not clear on what the requirements were. We need to consider further and establish exactly what the ICB role is for HCDs]

9. **Contracting**

9.1 The ICB shall ensure the performance of the following general obligations:

9.1.1 carry out the process of negotiation as commissioner of delegated services and co-ordinating commissioner for retained services and finalise all contract documents and schedules for inclusion in provider contracts. In order to identify the appropriate scherdules for inclusion in respect of Delegated Services the ICB must seek advice from NHS England.

9.1.2 Where requested by NHS England incorporate into Contracts the schedules provided by NHS England relating to the Retained Services.

9.1.3 Lead on the contract management of the Contracts, acting according to the Collaborative Commissioning Agreement constructed with NHSE and other associates.

9.1.4 Perform all necessary financial transactions associated with Delegated Specialised Services

9.1.5 [oversee the management of the Specialised Services Contracts and, except in relation to payment, performance of the obligations of the commissioner in accordance with the relevant terms;

9.1.6 management of the performance of the Specialised Services Providers in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services, including, as appropriate, by ensuring that timely action is taken to enforce contractual breaches, serve notices or work with Specialised Services Providers to address any issues;

9.1.7 review expenditure and collectively discuss how to obtain value for money;

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

9.1.9 collectively assess quality and outcomes including but not limited to clinical effectiveness, clinical governance, patient safety and the patient safety incident response framework, risk management, patient experience, and addressing health inequalities;

9.1.10 consider any necessary variations to the relevant Specialised Services Contracts or services in accordance with Clinical Commissioning Policies, National Specifications, service user needs and clinical developments, including, where necessary, developing and implementing a service development improvement plan with Specialised Service Providers where they are not in position to meet any new National Standard or amendment to a National Specification or Clinical Commissioning Policy that is published in the future;

9.1.11 agree information and reporting requirements to manage information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);

9.1.12 conduct review meetings and undertake contract management, including the issuing of contract queries and agreeing any remedial action plan or related contract management processes.]

9.2 The ICB shall keep a record of all of the Specialised Services Contracts in respect of the Delegated Specialised Services setting out the following details in relation to each Specialised Services Contract:

9.2.1 name of the Specialised Services Provider;

9.2.2 the name by which the Specialised Services Provider is known

9.2.3 commissioner name;

9.2.4 Specialised Services Contract start date and end date;

9.2.5 description of Specialised Services;

9.2.6 location of provision of services; and

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

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 service to support commissioning of Delegated Services;

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

10.1.4 share expertise and existing reporting tools partner ICBs in the Multi-ICB Arrangement;

10.1.5 ensure interpretation of data is made available to NHS England and other ICBs within the Multi-ICB Arrangmennt;

10.1.6 ensure Data and Analytics teams within ICBs and specialised services work collaboratively on joint agreed programmes of work focussing 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 otherwise required by NHS England, are in place to support the commissioning of the Delegated Specialised Services.

11. **Finance**

11.1 Without prejudice to Clause 10 (Finance) of this Agreement, ICB shall manage each of the relevant Specialised Services Contracts, including by:

11.1.1 ensuring proper financial management and governance for Delegated Specialised Services in accordance with the Finance Guidance;

11.1.2 supporting the move towards management of population-based budgets for Delegted Specialised Services; and

11.1.3 considering and inputting into local price agreements, managing agreements or proposals for local variations and local modifications to be implemented by NHS England.

12. **Freedom of Information and Parliamentary Requests**

12.1 The ICBshall lead on handling, management and response to all freedom of information and parliamentary correspondence relating to Delegated Specialised Services.

13. **Incident Response and Management**

13.1 The ICB shall:

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

13.1.2 support national and regional incident management relating to Delegated Specialised Services.

13.2 In the event that an incident is identified that has an impact on the Delegated Specialised 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 (IFR)

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

15. Innovation and New Treatments

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

16. Mental Health, Learning Disabilities 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.

17. Provider Selection and Procurement

17.1 The ICB shall:

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

17.1.2 Align all procurement processes in line with any changes to national procurement policy (for example new legislation) for delegated specialised services;

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

17.1.4 Monitor and provide advice, guidance and expertise 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/or 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 is able to 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 Specialised Services.

18.1.2 Where systems cross one or more regions define roles and responsibilities for ensuring robust communication and feedback to the lead ICB.

18.1.3 Work with providers and partner organisations to address any issues relating to Delegated Specialised Services and escalate to regional oversight systems if cannot be resolved

18.1.4 Develop and standardise processes that align with regional systems to ensure oversight of the quality of delegated specialised services. and participating in local System Quality Groups

18.1.5 Ensuring processes are robust and concerns are identified, mitigated and escalated as necessary.

18.1.6 Ensure providers are held to account for delivery of safe patient focused quality care for delegated specialised services, including mechanisms for monitoring patient complaints concerns and feedback.

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 quality of the Delegated Specialised 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 Specialised Services is integrated with wider quality governance in the local system and aligns with NHS England quality escalation processes.

18.4 The ICB must ensure that there is a System Quality Group 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 Specialised Services.

19.2 In planning, commissioning and managing the Delegated Specialised 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 Specialised 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. **Service 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 Specialised Services via attendance at governance meetings.

20.2 The ICB shall facilitate engagement with local communities on service specification development

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

21.1.2 Lead ICB/multi ICB driven transformation programmes across pathways for Delegated Specialised Services.

21.1.3 Lead the delivery locally of transformation in areas of national priority (such as Cancer, Mental Health and LDA), including supporting delivery of commitments in the Long Term Plan.

21.1.4 Support NHS England regional and national teams with agreed transformational programmes for NHS England commissioned services.

21.1.5 Supporting NHS England regional and national teams with agreed transformational programmes and identify future transformation programmes for consideration/prioritisation for delegated services where national co-ordination and enablement may support transformation.

21.1.6 Work collaboratively with NHS England national team on the co-production and co-design of transformation and improvement interventions & solutions in those areas prioritised.

21.1.7 Ensure Networks use levers to facilitate and embed transformation at a local level (in line with networks domain) for Delegated Specialised Services.

SCHEDULE 4: Reserved Functions

Introduction

1. **Reserved Functions In Relation To The Delegation Servces**

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 Partners 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 6 in respect of the Delegated Specialised Services.

4. **Assurance and Oversight**

4.1 NHS England shall:

4.1.1 Have oversight of what ICBs are delivering (inclusive of delegated specialised services) for their populations and all patients.

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

4.1.3 Help the ICB coordinate and escalate improvement / 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.

4.1.6 NHS England shall host a Delegated Commissioning Group ("DCG") that will undertake an assurance role in line with the Assurance Processes. This assurance role shall include monitoring and suggesting solutions to mitigate systemic risk to Delegated Specialised Service provision. Through the DCG, NHS England shall assess and monitor the overall coherence, stability and sustainability of the commissioning model of specialised services at a national level, including identification, review and management of appropriate cross-ICB risks.

4.2 Attendance at governance meetings:

4.2.1 NHS England shall ensure that there is appropriate representation in respect of Reserved Functions and Retained Service local governance forums (e.g. Regional Leadership Team) and at NCG.

4.3 NHS England shall:

4.3.1 ensure that there is appropriate representation from a subject matter expert for the relevant region at national standards development forums.

4.3.2 Ensure there is appropriate attendance at clinical governance meetings (e.g. CPAG, Clinical Panel and IFR panel) undertaking a clinical leadership role for the region.

4.3.3 Co-ordinate and support key national governance groups including but not limited to DCG, NCG, CPAG, RADAG Clinical Panel and IFR panels, HSS Programme Board.

4.3.4 Attendance at NCG and DCG to discharge the appropriate national function (e.g. clinical leadership, finance, quality etc) role for specialised

5. **Clinical Leadership**

5.1 NHS England shall be responsible for the following:

5.1.1 Developing local leadership and support for the ICB relating to Specialised Services.

5.1.2 providing clinical leadership, advice and guidance to the ICB in relation to the Delegated Specialised Services.

5.1.3 Providing point-of-contact and ongoing engagement with key external bodies, such as interest groups, charities, NICE, DHSC, Royal Colleges.

5.2 Enable access to clinical trials for new treatments and medicines.

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

5.3.1 Clinical Commissioning Policies;

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

6. Clinical Networks

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

6.2 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

6.3 NHS England shall be responsible for the following in respect of the Relevant Clinical Networks:

6.3.1 developing national policy for the Relevant Clinical Networks;

6.3.2 developing and approving the national specifications for the Relevant Clinical Networks;

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

6.3.4 convening or supporting national networks of the Relevant Clinical Networks;

6.3.5 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;

6.3.6 managing Relevant Clinical Networks jointly with the ICB; and

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

7. Complaints

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

8. Commissioning and Optimisation of High Cost Drugs

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

8.1.1 Support the ICB on strategy for access to medicines used within Delegated Specialised Services, minimising barriers to health inequalities.

8.1.2 Support ICB on commissioning of High Cost Drugs for Delegated Specialised Services including shared care agreements.

8.1.3 Ensure consistency of prescribing across region in line with national commissioning policies, introduction of new medicines, and addressing unwarranted prescribing variation.

8.1.4 Support national and regional procurement, homecare and commercial processes.

8.1.5 Provide expert medicines advice and input into Individual Funding Request process for Delegated Specialised Services, including for patients in prisons Sub Regional Immunoglobulin Assessment panels and selected PoCs/ CRGs.

8.1.6 Collaborate with regional Health and Justice commissioners 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. NHS England funds high cost drugs commissioned by Spec comm and ICBs.

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

8.2.1 Set medicines commissioning policy and criteria for access to certain medicines commissioned by Specialised Services including developing any necessary support tools and establish frameworks to support ICBs in the delivery of cost-effective and high quality support.

8.2.2 Provide clinical and commissioning leadership across pharmacy and medicines domain.

8.2.3 Provide expert medicines advice and input into all specialised activities, e.g. PoCs/ CRGs, including service specification development, policy development, procurement and other projects.

8.2.4 Provide direction and support to medicines leads at ICB and regional level to support discharge of duties and delivery of strategic objectives and national standards.

8.2.5 Lead on improving value / better value medicines strategy and initiatives.

8.2.6 Co-ordinating engagement and shared consensus for drugs where a national approach to commercial discussion and/or commercial mobilisation is beneficial to the system (for example NICE pipeline).

8.2.7 Support Individual Funding Request process, Sub Regional Immunoglobulin Assessment panels and PoCs/ CRGs.

8.2.8 Ensure consistency of prescribing in line with Clinical Commissioning Policies, introduction of new medicines, and addressing unwarranted prescribing variation.

9. Contracting

9.1 NHS England shall retain the following obligations in relation to contracting:

9.1.1 Where the ICB is coordinating commissioner for non-specialised acute and for Delegated Specialised Services and NHS England is associate for Retained Specialised Services NHS England shall:

(a) Perform all contracting duties required of an associate to an ICB contract for NHS England Commissioned Services.

(b) Develop indicative activity plans and finance schedules relating to retained services.

(c) Provide localised versions of national schedules relating to retained services required for inclusion in contracts by ICBs.

(d) Localise and relay advice to the ICBs on schedules which might need to be incorporated into the contract in relation to delegated services.

(e) Perform all necessary financial transactions associated with NHS England directly commissioned services.

9.1.2 Ensure specialised services is included in national NHS England contracting and payment strategy (for example, Aligned Payment Incentives).

9.1.3 Construct model template schedules for Retained services and issue to ICBs.

9.1.4 Provide advice for ICBs on schedules to support the Delegated Specialised Services.

9.1.5 Liaise with national NHSE colleagues to ensure inclusion in contracts of national requirements for retained services eg service specifications, information requirements etc.

9.1.6 Setting, publishing or making otherwise available the Contracting Standard Operating Procedure and other Mandated Guidance detailing contracting strategy and policy for Specialised Services; and

9.1.7 Providing and distributing contracting support tools and templates to the Partners.

10. Data Management and Analytics

10.1 NHS England shall:

10.1.1 Lead on standardised data collection, data acquisition, processing and sharing of data for Retained Services.

10.1.2 Support the ICB by collaborating with the wider data and analytics network (nationally) to support development and local deployment / utilisation of support tools.

10.1.3 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.

10.1.4 Ensure inclusion of SCHJAF data strategy in broader NHS England, DH and government data strategies.

10.1.5 Lead on defining relevant contractual content of information schedule (Schedule 6).

10.1.6 Provide a do-once national service for data receipt, processing and routine reporting and analytics for specialised services.

10.1.7 Professional network development and information dissemination, data / analytics workforce development.

10.1.8 Work collaboratively with the ICB to drive continual improvement of the quality and coverage of data used to support commissioning of specialised services.

10.1.9 Provide a national analytical service to support oversight and assurance of specialised services, and support (where required) to the national Specialised Commissioning team, POCs and CRGs.

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

10.1.11 Ensure sharing and drawing out of best practice around teams doing connected pieces of work and pathway focused work.

10.1.12 Provide leadership of data management and analytics to support the ICB, including professional network development, workforce development and information dissemination.

10.1.13 Set Specialised Services data strategy and ensure alignment with broader NHS England, Department of Health and Social Care and government data strategies.

10.1.14 Secure appropriate resource to support a national service for data processing and analytics for Specialised Services.

10.1.15 Oversee standardised collection, processing and sharing of data used to support Specialised Services commissioning across the Partners, in line with national data strategy.

10.1.16 Work collaboratively with all Partners to drive continual improvement of the quality and coverage of data used to support commissioning of Specialised Services; and

10.1.17 Support ICB data and analytic functions and wider data and analytic networks to develop, deploy locally and utilise business intelligence tools.

11. Finance

11.1 NHS England shall be responsible for:

11.1.1 Providing the ICB with financial management developmental support and supporting the ICB to ensure its financial delivery of the Delegated Specialised Services.

11.1.2 Co-ordinating and facilitating the joint agreement of financial governance and management processes across ICBs and, where appropriate to joint commissioning arrangements, between the regional team and ICB(s).

11.1.3 Performance managing, overseeing and supporting the ICB in the event that additional support has been identified as a Developmental Condition.

11.1.4 Setting financial policy and frameworks and developing the support tools necessary to enable the ICB to plan and deliver against a population-based allocation and drive efficiency.

11.1.5 Setting financial allocations for Specialised Services, including the move from historic actual to needs weighted population-based allocations and including growth, inflation and efficiency targets.

11.1.6 Consolidating and reporting plans and in-year financial delivery against the Specialised Services Budget from a antional perspective.

11.1.7 Developing financial impact assessments for National Specifications.

11.1.8 Overseeing dispute escalation and resolution where there are material changes to out-of-area cross-border flows.

11.1.9 Providing national assurance and oversight against financial business rules, including commissioning changes.

12. **FOI and Parliamentary Requests**

12.1 NHS England shall:

12.1.1 lead on handling, managing and responding to all national FOI and parliamentary correspondence relating to nationally commissioned specialised services; and

12.1.2 coordinate a response when a single national response is required in respect of Delegated Specialised Services.

13. **Incident Response and Management**

13.1 NHS England shall:

13.1.1 Provide guidance and support to the ICB in the event or a complex incident.

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

13.1.3 Lead on monitoring, planning and support for service and operational resilience at a national level and provide support to the ICB.

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

14. **Individual Funding Requests (IFRs)**

14.1 NHS England shall be responsible for the following:

14.1.1 Leading on IFR policy, IFR governance and managing the IFR process for Delegated Specialised Services and Retained Specialised Services; and

14.1.2 Providing pharmacy activity input and public health medicines expertise into IFR decisions.

15. **Innovation and New Treatments**

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

15.2 NHS England shall ensure services are in place for innovative treatments such as Advanced Medicinal Therapy Products (ATMPs), recommended by NICE technology appraisals within statutory requirements.

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

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

16.1 NHS England shall commission and design Provider Collaborative Arrangements for mental health, learning disabilities and autism services. Where it considers appropriate, NHS England shall seek the input of the ICB in relation to relevant Provider Collaborative Arrangements.

17. **Provider selection and procurement**

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

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

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

17.1.3 running provider selection and procurement processes for Specialised Services.

18. **Quality**

18.1 In respect of quality, NHS England shall:

18.1.1 work with the ICB to ensure oversight of Specialised Services through quality surveillance and risk management;

18.1.2 ensure that quality and safety issues and risks are managed effectively and escalated to the National Specialised Commissioning Quality and Governance Group, or other appropriate forums, as necessary;

18.1.3 ensure that the Delegated Specialised Services quality are aligned and integrated with broader clinical quality governance and processes in accordance with National Quality Board guidance;

18.1.4 when quality issues relating to Specialised Services are identified, share concerns and facilitate improvement through programme support, and mobilise intensive support when required on specific quality issues;

18.1.5 facilitating improvement when quality issues impact nationally and regionally, through programme support, and mobilising intensive support when required on specific quality issues pertinent to the region;

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

18.1.7 support ICBs in identifying key themes and trends and utilise data and intelligence to respond and monitor as necessary;

18.1.8 report quality to both NCG and DCG and Executive Quality Group as required

18.1.9 facilitate and support the national quality governance infrastructure (specialised commissioning quality and governance group);

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

19. **Service planning and needs assessment**

19.1 NHS England shall be responsible for:

[TO FOLLOW]

20. **Service standards**

20.1 NHS England shall carry out the following:

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 'Manual' of prescribed Specialised Services and engagement with the Department of Health and Social Care 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 Specialised Services where necessary;

21.1.2 Supporting the ICB to implement national policy and guidance across its populations, for Retained Specialised Services;

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

21.1.4 Providing leadership for transformation programmes and projects that have been identified as priorities for national coordination and support, and / 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 experts including CRGs, NCDs, POC leads for the ICB where it needs support, including in relation to taking forward local priority transformation.

SCHEDULE 5: Retained Services

NHS England shall retain the function of commissioning the Specialised Services set out in this Schedule

21.2 6 (*Further Information Governance and Sharing* Provisions) makes further provision about information sharing and information governance.

22. IT INTER-OPERABILITY

22.1 NHS England and the ICB will work together to ensure that all relevant IT systems operated by NHS England and the ICB in respect of the Delegated Functions and the Reserved Functions are inter-operable and that data may be transferred between systems securely, easily and efficiently.

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

23. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY

23.1 The ICB must and 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.

23.2 Without prejudice to the general obligations set out in clause 23.1, 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.

24. PROHIBITED ACTS AND COUNTER-FRAUD

24.1 The ICB must not commit any Prohibited Act.

24.2 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:

24.2.1 to revoke the Delegation; and

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

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

24.3 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).

24.4 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 and counter-fraud arrangements put in place by the ICB.

24.5 The ICB must implement any reasonable modifications to its counter-fraud arrangements required by a person referred to in clause 24.4 in order to meet the appropriate standards within whatever time periods as that person may reasonably require.

24.6 The ICB must, on becoming aware of:

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

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

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

24.7 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:

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

24.7.2 all Staff who may have information to provide;

24.7.3 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.

25. CONFIDENTIAL INFORMATION OF THE PARTIES

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

25.2 Subject to clauses 25.3 to 25.5, the receiving Party agrees:

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

25.2.2 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

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

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

25.3.1 in connection with any Dispute Resolution;

25.3.2 in connection with any litigation between the Parties;

25.3.3 to comply with the Law;

25.3.4 to any appropriate Regulatory or Supervisory Body;

25.3.5 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 25.2;

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

25.3.7 as permitted under or as may be required to give effect to clause 24 (*Prohibited Acts and Counter-Fraud*); and

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

25.4 The obligations in clauses 25.1 and 25.2 will not apply to any Confidential Information which:

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

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

25.4.3 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.

25.5 This clause 25 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.

25.6 The Parties acknowledge that damages would not be an adequate remedy for any breach of this clause 25 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 25.

25.7 This clause 252 will survive the termination of this Agreement for any reason for a period of 5 years.

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

26. INTELLECTUAL PROPERTY

26.1 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.

26.2 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.

26.3 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 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.

27. NOTICES

27.1 Any notices given under this Agreement must be sent by e-mail to the other Party's address set out in the Particulars.

27.2 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.

28. DISPUTES

28.1 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.

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

28.2.1 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;

28.2.2 if the Agreement Representatives are, for any reason, unable to resolve the Dispute within twenty (20) 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

28.2.3 if the people referred to in clause 28.2.2 are for any reason unable to resolve the Dispute within twenty (20) 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 Solve. 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 Solve. The mediation will start not later than ten (10) days after the date of the ADR notice.

28.3 If the Dispute is not resolved within thirty (30) 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) days, or the mediation terminates before the expiration of the period of thirty (30) days, the Dispute must be referred to the Secretary of State, who shall resolve the matter and whose decision shall be binding upon the Parties.

29. VARIATIONS

29.1 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.

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

29.2.1 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;

29.2.2 where variation is as a result of amendment to or additional Mandatory Guidance;

29.2.3 it is satisfied that any Developmental Conditions are no longer required;

29.2.4 it reasonably considers that Developmental Conditions are required under Clause [ ] (Breach).

29.2.5 [it is satisfied that such amendment is required in order for effective commissioning of the Delegated Services]

29.3 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 14 days after the date on which the notice under that clause is given to the ICB.

29.4 NHS England may, at its discretion, issue Contractual Notices from time to time relating to the manner in which the Delegated Functions must be exercised by the ICB provided that such Contractual Notice provides further information on the manner in which the

Delegated Functions may be exercised and does not vary the extent of any Delegated Function.

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

29.6 Either Party ("the Proposing Party") may notify the other Party (the "Receiving Party") of a Variation Proposal in respect of this Agreement and will identify whether the proposed variation would have the impact of changing the scope of the Delegated Functions and/or Reserved Functions and so require NHS England Board approval.

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

29.8 The Receiving Party must respond to a Variation Proposal within thirty (30) Operational Days following the date that it is issued by serving notice on NHS England confirming either:

29.8.1 that it accepts the Variation Proposal; or

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

29.9 If the Receiving Party accepts the Variation Proposal, 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.

29.10 If the ICB refuses to accept a Variation Proposal or to take such steps as are required to give effect to the variation, NHS England considers that this will have a significant detrimental impact on the commissioning of Specialsed Commissioning Services in the Area, NHS England may impose the variation or may terminate the Agreement in respect of some or all of the Delegated Functions.

29.11 The provisions of this clause 296 are without prejudice to the ability of NHS England to issue Contractual Notices which have the effect of varying this Agreement.

30. TERMINATION

30.1 The ICB may:

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

30.1.2 terminate this Agreement;

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

30.1.3 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 intention to terminate this Agreement;

30.1.4 [do we want to include anything about Staff or MIAs?]; and

30.1.5 the ICB meets with NHS England within ten (10) Operational Days of NHS England receiving the notice set out at clause 30.1.3 above to discuss arrangements for termination and transition of the Delegated Functions to a successor commissioner,

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.

30.2 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 30.4 will apply.

30.3 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:

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

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

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

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

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

30.3.6 failure to agree to a variation in accordance with clause 29 *(Variations)*;

30.3.7 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

30.3.8 the ICB merges with another ICB or other body.

30.4 This Agreement will terminate upon revocation or termination of the full Delegation (including revocation and termination in accordance with this clause 30 *(Termination)*) except that the provisions referred to at clause 32 (*Provisions Surviving Termination*) will continue in full force and effect.

30.5 Without prejudice to clause 14.3 and to avoid doubt, NHS England may waive any right to terminate this Agreement under this clause 30.5 *(Termination)*. Any such waiver is only effective if given in writing and shall not be deemed a waiver of any subsequent right or remedy.

30.6 As an alternative to termination of the Agreement in respect of all the Delegated Functions, NHS England may alternatively 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.

31. CONSEQUENCE OF TERMINATION

31.1 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.

31.2 Subject to clause 31.4, 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:

31.2.1 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 those staff engaged in the Delegated Functions and the date on which the successor delegate will take responsibility for the Delegated Functions;

31.2.2 implement and comply with their respective obligations under the plan for transition agreed in accordance with clause 31.2.1 above; and

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

31.3 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:

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

31.3.2 at the reasonable request of NHS England:

(a) promptly provide all reasonable assistance and information to the extent necessary to effect an orderly assumption of the Delegated Functions by a successor delegate;

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

31.3.3 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.

31.4 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.

32. PROVISIONS SURVIVING TERMINATION

32.1 Any rights, duties or obligations of any of the Parties which are expressed to survive, including those referred to in clause 32.2, 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.

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

32.2.1 Clause 10 (*Finance*);

32.2.2 Clause 13 (*Staffing and Workforce*);

32.2.3 Clause 16 *(Liability and Indemnity*);

32.2.4 Clause 17 (*Claims and Litigation*);

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

32.2.6 Clause 25 (*Disputes*);

32.2.7 Clause 27 (*Termination*);

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

33. **COSTS**

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

34. **SEVERABILITY**

34.1 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.

35. **GENERAL**

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

35.2 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.

35.3 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:

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;
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;
Assigned Staff	means those NHS England staff as agreed between NHS England and the ICB from time to time;
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;

Caldicott Principles	means the patient confidentiality principles set out in the report of the Caldicott Committee (December 1997 as amended by the 2013 Report, The Information Governance Review – "*To Share or Not to Share?"*) and now included in the NHS Confidentiality Code of Practice, as may be amended from time to time;
Capital	shall have the meaning set out in the Capital Investment Guidance or such other replacement Mandated Guidance as issued by NHS England from time to time;
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 (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;
Claim Losses	means all Losses arising in relation to any Claim;
"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;

Combined Authority	means a body of that name established under the provisions of the Local Democracy, Economic Development and Construction Act 2009;
"Commissioning Functions"	the respective statutory functions of the Partners in arranging for the provision of services as part of the health service;
Commissioning Hub	Means the arrangements through which a Host ICB
Commissioning Support Arrangements	Means the administrative and management support provided by the ICB to NHS England in respect of NHS England Reserved Functions and Retained Services;
Complaints Regulations	means the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009/309;
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 and/or the manner in which the Delegated Functions should be exercised by the ICB;
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 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 the Data Sharing Agreement template shared by NHS England in respect of this Agreement;
Data Subject	shall have the same meaning as set out in the UK GDPR;
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;
Delegation	means the delegation of the Delegated Functions from NHS England to the ICB as described at clause 6.1;
Developmental Conditions	Means the conditions set out in Schedule [ ] as amended or replaced
Direct Commissioning Guidance Webpage	means the webpage maintained by NHS England at https://www.england.nhs.uk/commissioning/how-commissioning-is-changing/;
Dispute	a dispute, conflict or other disagreement between the Parties arising out of or in connection with this Agreement;
Effective Date of Delegation	means the Effective Date of Delegation as set out in the Particulars;
EIR	means the Environmental Information Regulations 2004
Escalation Rights	means the escalation rights as defined in clause 15 *(Escalation Rights)*;
"Finance Guidance"	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	the Freedom of Information Act 2000;
Further Arrangements	means arrangements for the exercise of Delegated Functions as defined at clause 12.2;
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 Specialised Services Staff as part of the Commissioning Hub arrangements;
HSCA	means the Health and Social Care Act 2012;
ICB	means an Integrated Care Board established pursuant to section 14Z25 of the NHS Act and named in the Particulars;
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;
IG 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);
"Information"	has the meaning given under section 84 of FOIA;
Information Law	the UK GDPR, the Data Protection Act 2018, regulations and guidance made under section 13S and section 251 of the NHS Act; guidance made or given under sections 263 and 265 of the HSCA; the Freedom of Information Act 2000; the common law duty of confidentiality; the Human Rights Act 1998 and all other applicable laws and regulations relating to processing of Personal Data and privacy;
"Information Sharing Agreement"	any information sharing agreement entered into in respect of the Delegated Functions in accordance with Schedule 7 (Further Information Governance and Sharing Provisions);
IPR	means 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 Authority	means a county council in England, a Combined Authority, a district council in England, a London borough council, the Common Council of the City of London or the Council of the Isles of Scilly;
Local Terms	means the terms set out in SCHEDULE *(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/about/board-meetings/committees/coi/
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 7.4 which at the Effective Date of Delegation shall include the Mandated Guidance set out in the Schedules**;**

Multi ICB Agreement (MIA)	Means the agreement entered into by the ICB in accordance with Clause [8] of this Agreement
National Moderation Panel	Means the NHS England panel in respect of the relevant Delegated Function that will have the delegated authority to approve the ICB arrangements in respect of a Delegated Function;
"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 [ ] of Schedule 6(*Further Information Governance and Sharing Provisions)*;
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 or other legislation from time to time);
NHS Business Services Authority	means the Special Health Authority established under the NHS Business Services Authority (Establishment and Constitution Order) 2005 SI 2005/2414;
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 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;
"Part A Retained Services"	means those services listed in Part A of Schedule 5;
"Part B Retained Services"	means those services listed in Part B of Schedule 5;

Party/Parties	means a party or both parties to this Agreement;
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 hasresponsibility in respect of commissioning the Delegated Services;
Principles of Best Practice	means the Mandated Guidance in relation to property and investment which is to be published either before or after the date of this Agreement;
"Provider Collaborative"	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	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"	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 [ ] and being the Part A Retained Services and the Part B Retained Services;
Secretary of State	means the Secretary of State for Health and Social Care from time to time;
Section 7A Functions	means those functions of NHS England exercised pursuant to section 7A of the NHS Act;
"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"	the member of Staff appointed by each relevant Partner in accordance with Paragraph 14 of Schedule [ ];
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 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);
"Specialised Services"	means the services commissioned in exercise of the Specialised Commissioning Functions;
"Specialised Services Contract"	a contract for the provision of Specialised Services entered into in the exercise of the Specialised Commissioning Functions;
"Specialised Services Provider"	a provider party to a Specialised Services Contract;
"Specialised Services Staff"	means the Staff carrying out the Delegated Specialised 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;
Staffing Model	means the employment model for the exercise of the Delegated Functions;
Statement of Financial Entitlements Directions	means the General Medical Services Statement of Financial Entitlements Directions 2021, as amended or updated from time to time;
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 26.6.

SCHEDULE 2: Delegated Services

Delegated Services

NHS England delegates to the ICB the statutory function for commissioning the Delegated Services to the extent set out in Part 2 of this Schedule and subject to the reservations set out in Schedule 3 (the Retained Functions) and the provisions of any Developmental Conditions {Local Developmental Requirements?].

[INCLUDE Specialised Service List]

SCHEDULE 3: Delegated Functions

36. INTRODUCTION

36.1 **S**ubject to the reservations set out in Schedule 4 (Reserved Functions) and the provisions of any Developmental Conditions, NHS England delegates to the ICB the statutory function for commissioning the Delegated Services to the extent set out in this Schedule being, in summary:

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

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

36.1.3 undertaking reviews of Delegated Specialised Services in respect of the Population;

36.1.4 supporting the management of the Specialised Commissioning Budget;

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

36.1.6 such other ancillary activities that are necessary in order to exercise the Specialised Commissioning Functions.

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

37. General Obligations

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

37.2 The ICB shall put in place arrangements for collaborative working with other ICBs.

37.3 The Developmental Conditions set out in Appendix 4 shall apply.

Specific Obligations

38. Assurance and Oversight

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

38.1.1 the Oversight Framework published by NHS England;

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

38.1.3 any other relevant NHS oversight and assurance guidance;

collectively known as the “Assurance Processes”.

38.2 The ICB must:

38.2.1 Develop and operate in accordance with mutually agreed ways of working in line with the Assurance Processes.

38.2.2 Oversee the provision of Delegated Services and the outcomes being delivered for their patients and Populations in accordance with the Assurance Processes.

38.2.3 Assure Providers are meeting, or have an improvement plan in place to meet, National Standards.

38.2.4 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.

39. **Attendance at governance meetings**

39.1 The ICB must ensure that there is appropriate representation at multi-ICB forums.

39.2 The ICB must ensure that an individual(s) has been nominated to represent the ICB at the Delegation Commissioning Group and regularly attends that group. The could be a single representative on behalf of a multi-ICB footprint.

39.3 The ICB should also ensure that they have a nominated representative to attend national standards development forums as requested by NHS England.

40. **Clinical Leadership and Clinical Reference Groups**

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

40.2 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.

41. **Clinical Networks**

41.1 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.

41.2 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.

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

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

41.5 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.

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

42. **Complaints**

42.1 The ICB shall manage complaints function for Delegated Specialised Services.

43. **Commissioning and optimisation of High Cost Drugs**

43.1 The ICB must support the effective and efficient commissioning of High Cost Drugs for Delegated Specialised Services.

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

43.3 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 Partner in the development access to medicine strategies, and minimising barriers that may exacerbate health inequalities.

43.4 The ICB must ensure:

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

43.4.2 effective introduction of new medicines;

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

43.4.4 consistency of prescribing and unwarranted prescribing variation are addressed.

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

43.6 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.

43.7 The ICB must provide support to prescribing networks and forums, including but not limited to: immunoglobulin assessment panels, HIV prescribing networks and high cost drugs pharmacy networks.

[DN – this is not based on Operating Models as we were not clear on what the requirements were. We need to consider further and establish exactly what the ICB role is for HCDs]

44. **Contracting**

44.1 The ICB shall ensure the performance of the following general obligations:

44.1.1 carry out the process of negotiation as commissioner of delegated services and co-ordinating commissioner for retained services and finalise all contract documents and schedules for inclusion in provider contracts. In order to identify the appropriate scherdules for inclusion in respect of Delegated Services the ICB must seek advice from NHS England.

44.1.2 Where requested by NHS England incorporate into Contracts the schedules provided by NHS England relating to the Retained Services.

44.1.3 Lead on the contract management of the Contracts, acting according to the Collaborative Commissioning Agreement constructed with NHSE and other associates.

44.1.4 Perform all necessary financial transactions associated with Delegated Specialised Services

44.1.5 [oversee the management of the Specialised Services Contracts and, except in relation to payment, performance of the obligations of the commissioner in accordance with the relevant terms;

44.1.6 management of the performance of the Specialised Services Providers in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services, including, as appropriate, by ensuring that timely action is taken to enforce contractual breaches, serve notices or work with Specialised Services Providers to address any issues;

44.1.7 review expenditure and collectively discuss how to obtain value for money;

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

44.1.9 collectively assess quality and outcomes including but not limited to clinical effectiveness, clinical governance, patient safety and the patient safety incident response framework, risk management, patient experience, and addressing health inequalities;

44.1.10 consider any necessary variations to the relevant Specialised Services Contracts or services in accordance with Clinical Commissioning Policies, National Specifications, service user needs and clinical developments, including, where necessary, developing and implementing a service development improvement plan with Specialised Service Providers where they are not in position to meet any new National Standard or amendment to a National Specification or Clinical Commissioning Policy that is published in the future;

44.1.11 agree information and reporting requirements to manage information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);

44.1.12 conduct review meetings and undertake contract management, including the issuing of contract queries and agreeing any remedial action plan or related contract management processes.]

44.2 The ICB shall keep a record of all of the Specialised Services Contracts in respect of the Delegated Specialised Services setting out the following details in relation to each Specialised Services Contract:

44.2.1 name of the Specialised Services Provider;

44.2.2 the name by which the Specialised Services Provider is known

44.2.3 commissioner name;

44.2.4 Specialised Services Contract start date and end date;

44.2.5 description of Specialised Services;

44.2.6 location of provision of services; and

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

45. **Data Management and Analytics**

45.1 The ICB shall:

45.1.1 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;

45.1.2 lead on the provision of data and analytical service to support commissioning of Delegated Services;

45.1.3 ensure collaborative working across the Partners on agreed programmes of work focusing on provision of pathway analytics;

45.1.4 share expertise and existing reporting tools partner ICBs in the Multi-ICB Arrangement;

45.1.5 ensure interpretation of data is made available to NHS England and other ICBs within the Multi-ICB Arrangmennt;

45.1.6 ensure Data and Analytics teams within ICBs and specialised services work collaboratively on joint agreed programmes of work focussing on provision of pathway analytics;

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

46. **Finance**

46.1 Without prejudice to Clause 10 (Finance) of this Agreement, ICB shall manage each of the relevant Specialised Services Contracts, including by:

46.1.1 ensuring proper financial management and governance for Delegated Specialised Services in accordance with the Finance Guidance;

46.1.2 supporting the move towards management of population-based budgets for Delegted Specialised Services; and

46.1.3 considering and inputting into local price agreements, managing agreements or proposals for local variations and local modifications to be implemented by NHS England.

47. **Freedom of Information and Parliamentary Requests**

47.1 The ICBshall lead on handling, management and response to all freedom of information and parliamentary correspondence relating to Delegated Specialised Services.

48. **Incident Response and Management**

48.1 The ICB shall:

48.1.1 lead on local incident management for Delegated Specialised Services as appropriate to stated incident level; and

48.1.2 support national and regional incident management relating to Delegated Specialised Services.

48.2 In the event that an incident is identified that has an impact on the Delegated Specialised 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.

49. **Individual Funding Requests (IFR)**

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

50. **Innovation and New Treatments**

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

51. **Mental Health, Learning Disabilities and Autism NHS-led Provider Collaboratives**

51.1 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.

52. **Provider Selection and Procurement**

52.1 The ICB shall:

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

52.1.2 Align all procurement processes in line with any changes to national procurement policy (for example new legislation) for delegated specialised services;

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

52.1.4 Monitor and provide advice, guidance and expertise on the overall provider market and provider landscape

52.2 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/or guidance on the selection of, and award of contracts to, providers of healthcare services.

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

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

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

52.3.3 made transparently; and

52.3.4 compliant with relevant Guidance and Legislation.

53. **Quality**

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

53.1.1 clearly defined roles and responsibilities for ensuring governance and oversight of Delegated Specialised Services.

53.1.2 Where systems cross one or more regions define roles and responsibilities for ensuring robust communication and feedback to the lead ICB.

53.1.3 Work with providers and partner organisations to address any issues relating to Delegated Specialised Services and escalate to regional oversight systems if cannot be resolved

53.1.4 Develop and standardise processes that align with regional systems to ensure oversight of the quality of delegated specialised services. and participating in local System Quality Groups

53.1.5 Ensuring processes are robust and concerns are identified, mitigated and escalated as necessary.

53.1.6 Ensure providers are held to account for delivery of safe patient focused quality care for delegated specialised services, including mechanisms for monitoring patient complaints concerns and feedback.

53.1.7 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.

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

53.3 The ICB must ensure that the oversight of the quality of the Delegated Specialised Services is integrated with wider quality governance in the local system and aligns with NHS England quality escalation processes.

53.4 The ICB must ensure that there is a System Quality Group to identify and manage concerns across the local system.

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

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

54. **Service Planning and Strategic Priorities**

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

54.2 In planning, commissioning and managing the Delegated Specialised 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.

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

54.4 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.

55. **Service Standards, National Specifications and Clinical Commissioning Policies**

55.1 The ICB shall provide input into national decisions on national standards and national transformation regarding Delegated Specialised Services via attendance at governance meetings.

55.2 The ICB shall facilitate engagement with local communities on service specification development

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

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

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

55.6 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.

56. **Transformation**

56.1 The ICB shall:

56.1.1 Prioritise pathways and services for transformation according to the needs of their population and opportunities for improvement in their services for Delegated Specialised Services.

56.1.2 Lead ICB/multi ICB driven transformation programmes across pathways for Delegated Specialised Services.

56.1.3 Lead the delivery locally of transformation in areas of national priority (such as Cancer, Mental Health and LDA), including supporting delivery of commitments in the Long Term Plan.

56.1.4 Support NHS England regional and national teams with agreed transformational programmes for NHS England commissioned services.

56.1.5 Supporting NHS England regional and national teams with agreed transformational programmes and identify future transformation programmes for consideration/prioritisation for delegated services where national co-ordination and enablement may support transformation.

56.1.6 Work collaboratively with NHS England national team on the co-production and co-design of transformation and improvement interventions & solutions in those areas prioritised.

56.1.7 Ensure Networks use levers to facilitate and embed transformation at a local level (in line with networks domain) for Delegated Specialised Services.

SCHEDULE 4: Reserved Functions

Introduction

57. **Reserved Functions In Relation To The Delegation Servces**

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

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

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

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

58. **Retained Services**

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

59. **Reserved Specialised Service Functions**

59.1 NHS England shall carry out the functions set out in this Schedule 6 in respect of the Delegated Specialised Services.

60. **Assurance and Oversight**

60.1 NHS England shall:

60.1.1 Have oversight of what ICBs are delivering (inclusive of delegated specialised services) for their populations and all patients.

60.1.2 Design and implement appropriate assurance of ICBs' exercise of Delegated Functions including design and implementation of the Assurance Processes.

60.1.3 Help the ICB coordinate and escalate improvement / resolution interventions where challenges are identified (as appropriate).

60.1.4 Ensure that the NHS England Board is assured that Delegated Functions are being discharged appropriately.

60.1.5 Ensure specialised commissioning considerations are appropriately included in NHS England frameworks that guide oversight and assurance of service delivery.

60.1.6 NHS England shall host a Delegated Commissioning Group ("DCG") that will undertake an assurance role in line with the Assurance Processes. This assurance role shall include monitoring and suggesting solutions to mitigate systemic risk to Delegated Specialised Service provision. Through the DCG, NHS England shall assess and monitor 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.

60.2 Attendance at governance meetings:

60.2.1 NHS England shall ensure that there is appropriate representation in respect of Reserved Functions and Retained Service local governance forums (e.g. Regional Leadership Team) and at NCG.

60.3 NHS England shall:

60.3.1 ensure that there is appropriate representation from a subject matter expert for the relevant region at national standards development forums.

60.3.2 Ensure there is appropriate attendance at clinical governance meetings (e.g. CPAG, Clinical Panel and IFR panel) undertaking a clinical leadership role for the region.

60.3.3 Co-ordinate and support key national governance groups including but not limited to DCG, NCG, CPAG, RADAG Clinical Panel and IFR panels, HSS Programme Board.

60.3.4 Attendance at NCG and DCG to discharge the appropriate national function (e.g. clinical leadership, finance, quality etc) role for specialised

61. **Clinical Leadership**

61.1 NHS England shall be responsible for the following:

61.1.1 Developing local leadership and support for the ICB relating to Specialised Services.

61.1.2 providing clinical leadership, advice and guidance to the ICB in relation to the Delegated Specialised Services.

61.1.3 Providing point-of-contact and ongoing engagement with key external bodies, such as interest groups, charities, NICE, DHSC, Royal Colleges.

61.2 Enable access to clinical trials for new treatments and medicines.

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

61.3.1 Clinical Commissioning Policies;

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

62. **Clinical Networks**

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

62.2 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

62.3 NHS England shall be responsible for the following in respect of the Relevant Clinical Networks:

62.3.1 developing national policy for the Relevant Clinical Networks;

62.3.2 developing and approving the national specifications for the Relevant Clinical Networks;

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

62.3.4 convening or supporting national networks of the Relevant Clinical Networks;

62.3.5 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;

62.3.6 managing Relevant Clinical Networks jointly with the ICB; and

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

63. **Complaints**

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

64. **Commissioning and Optimisation of High Cost Drugs**

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

64.1.1 Support the ICB on strategy for access to medicines used within Delegated Specialised Services, minimising barriers to health inequalities.

64.1.2 Support ICB on commissioning of High Cost Drugs for Delegated Specialised Services including shared care agreements.

64.1.3 Ensure consistency of prescribing across region in line with national commissioning policies, introduction of new medicines, and addressing unwarranted prescribing variation.

64.1.4 Support national and regional procurement, homecare and commercial processes.

64.1.5 Provide expert medicines advice and input into Individual Funding Request process for Delegated Specialised Services, including for patients in prisons Sub Regional Immunoglobulin Assessment panels and selected PoCs/ CRGs.

64.1.6 Collaborate with regional Health and Justice commissioners 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. NHS England funds high cost drugs commissioned by Spec comm and ICBs.

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

64.2.1 Set medicines commissioning policy and criteria for access to certain medicines commissioned by Specialised Services including developing any necessary support tools and establish frameworks to support ICBs in the delivery of cost-effective and high quality support.

64.2.2 Provide clinical and commissioning leadership across pharmacy and medicines domain.

64.2.3 Provide expert medicines advice and input into all specialised activities, e.g. PoCs/ CRGs, including service specification development, policy development, procurement and other projects.

64.2.4 Provide direction and support to medicines leads at ICB and regional level to support discharge of duties and delivery of strategic objectives and national standards.

64.2.5 Lead on improving value / better value medicines strategy and initiatives.

64.2.6 Co-ordinating engagement and shared consensus for drugs where a national approach to commercial discussion and/or commercial mobilisation is beneficial to the system (for example NICE pipeline).

64.2.7 Support Individual Funding Request process, Sub Regional Immunoglobulin Assessment panels and PoCs/ CRGs.

64.2.8 Ensure consistency of prescribing in line with Clinical Commissioning Policies, introduction of new medicines, and addressing unwarranted prescribing variation.

65. Contracting

65.1 NHS England shall retain the following obligations in relation to contracting:

65.1.1 Where the ICB is coordinating commissioner for non-specialised acute and for Delegated Specialised Services and NHS England is associate for Retained Specialised Services NHS England shall:

(a) Perform all contracting duties required of an associate to an ICB contract for NHS England Commissioned Services.

(b) Develop indicative activity plans and finance schedules relating to retained services.

(c) Provide localised versions of national schedules relating to retained services required for inclusion in contracts by ICBs.

(d) Localise and relay advice to the ICBs on schedules which might need to be incorporated into the contract in relation to delegated services.

(e) Perform all necessary financial transactions associated with NHS England directly commissioned services.

65.1.2 Ensure specialised services is included in national NHS England contracting and payment strategy (for example, Aligned Payment Incentives).

65.1.3 Construct model template schedules for Retained services and issue to ICBs.

65.1.4 Provide advice for ICBs on schedules to support the Delegated Specialised Services.

65.1.5 Liaise with national NHSE colleagues to ensure inclusion in contracts of national requirements for retained services eg service specifications, information requirements etc.

65.1.6 Setting, publishing or making otherwise available the Contracting Standard Operating Procedure and other Mandated Guidance detailing contracting strategy and policy for Specialised Services; and

65.1.7 Providing and distributing contracting support tools and templates to the Partners.

66. **Data Management and Analytics**

66.1 NHS England shall:

66.1.1 Lead on standardised data collection, data acquisition, processing and sharing of data for Retained Services.

66.1.2 Support the ICB by collaborating with the wider data and analytics network (nationally) to support development and local deployment / utilisation of support tools.

66.1.3 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.

66.1.4 Ensure inclusion of SCHJAF data strategy in broader NHS England, DH and government data strategies.

66.1.5 Lead on defining relevant contractual content of information schedule (Schedule 6).

66.1.6 Provide a do-once national service for data receipt, processing and routine reporting and analytics for specialised services.

66.1.7 Professional network development and information dissemination, data / analytics workforce development.

66.1.8 Work collaboratively with the ICB to drive continual improvement of the quality and coverage of data used to support commissioning of specialised services.

66.1.9 Provide a national analytical service to support oversight and assurance of specialised services, and support (where required) to the national Specialised Commissioning team, POCs and CRGs.

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

66.1.11 Ensure sharing and drawing out of best practice around teams doing connected pieces of work and pathway focused work.

66.1.12 Provide leadership of data management and analytics to support the ICB, including professional network development, workforce development and information dissemination.

66.1.13 Set Specialised Services data strategy and ensure alignment with broader NHS England, Department of Health and Social Care and government data strategies.

66.1.14 Secure appropriate resource to support a national service for data processing and analytics for Specialised Services.

66.1.15 Oversee standardised collection, processing and sharing of data used to support Specialised Services commissioning across the Partners, in line with national data strategy.

66.1.16 Work collaboratively with all Partners to drive continual improvement of the quality and coverage of data used to support commissioning of Specialised Services; and

66.1.17 Support ICB data and analytic functions and wider data and analytic networks to develop, deploy locally and utilise business intelligence tools.

67. **Finance**

67.1 NHS England shall be responsible for:

67.1.1 Providing the ICB with financial management developmental support and supporting the ICB to ensure its financial delivery of the Delegated Specialised Services.

67.1.2 Co-ordinating and facilitating the joint agreement of financial governance and management processes across ICBs and, where appropriate to joint commissioning arrangements, between the regional team and ICB(s).

67.1.3 Performance managing, overseeing and supporting the ICB in the event that additional support has been identified as a Developmental Condition.

67.1.4 Setting financial policy and frameworks and developing the support tools necessary to enable the ICB to plan and deliver against a population-based allocation and drive efficiency.

67.1.5 Setting financial allocations for Specialised Services, including the move from historic actual to needs weighted population-based allocations and including growth, inflation and efficiency targets.

67.1.6 Consolidating and reporting plans and in-year financial delivery against the Specialised Services Budget from a antional perspective.

67.1.7 Developing financial impact assessments for National Specifications.

67.1.8 Overseeing dispute escalation and resolution where there are material changes to out-of-area cross-border flows.

67.1.9 Providing national assurance and oversight against financial business rules, including commissioning changes.

68. **FOI and Parliamentary Requests**

68.1 NHS England shall:

68.1.1 lead on handling, managing and responding to all national FOI and parliamentary correspondence relating to nationally commissioned specialised services; and

68.1.2 coordinate a response when a single national response is required in respect of Delegated Specialised Services.

69. **Incident Response and Management**

69.1 NHS England shall:

69.1.1 Provide guidance and support to the ICB in the event or a complex incident.

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

69.1.3 Lead on monitoring, planning and support for service and operational resilience at a national level and provide support to the ICB.

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

70. **Individual Funding Requests (IFRs)**

70.1 NHS England shall be responsible for the following:

70.1.1 Leading on IFR policy, IFR governance and managing the IFR process for Delegated Specialised Services and Retained Specialised Services; and

70.1.2 Providing pharmacy activity input and public health medicines expertise into IFR decisions.

71. **Innovation and New Treatments**

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

71.2 NHS England shall ensure services are in place for innovative treatments such as Advanced Medicinal Therapy Products (ATMPs), recommended by NICE technology appraisals within statutory requirements.

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

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

72.1 NHS England shall commission and design Provider Collaborative Arrangements for mental health, learning disabilities and autism services. Where it considers appropriate, NHS England shall seek the input of the ICB in relation to relevant Provider Collaborative Arrangements.

73. **Provider selection and procurement**

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

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

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

73.1.3 running provider selection and procurement processes for Specialised Services.

74. **Quality**

74.1 In respect of quality, NHS England shall:

74.1.1 work with the ICB to ensure oversight of Specialised Services through quality surveillance and risk management;

74.1.2 ensure that quality and safety issues and risks are managed effectively and escalated to the National Specialised Commissioning Quality and Governance Group, or other appropriate forums, as necessary;

74.1.3 ensure that the Delegated Specialised Services quality are aligned and integrated with broader clinical quality governance and processes in accordance with National Quality Board guidance;

74.1.4 when quality issues relating to Specialised Services are identified, share concerns and facilitate improvement through programme support, and mobilise intensive support when required on specific quality issues;

74.1.5 facilitating improvement when quality issues impact nationally and regionally, through programme support, and mobilising intensive support when required on specific quality issues pertinent to the region;

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

74.1.7 support ICBs in identifying key themes and trends and utilise data and intelligence to respond and monitor as necessary;

74.1.8 report quality to both NCG and DCG and Executive Quality Group as required

74.1.9 facilitate and support the national quality governance infrastructure (specialised commissioning quality and governance group);

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

75. **Service planning and needs assessment**

75.1 NHS England shall be responsible for:

[TO FOLLOW]

76. **Service standards**

76.1 NHS England shall carry out the following:

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

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

76.1.3 maintenance and publication of the 'Manual' of prescribed Specialised Services and engagement with the Department of Health and Social Care on policy matters; and

76.1.4 Determination of content for national clinical registries.

77. **Transformation**

77.1 NHS England shall be responsible for:

77.1.1 Co-ordinating and enabling ICB led specialised service transformation programmes for Delegated Specialised Services where necessary;

77.1.2 Supporting the ICB to implement national policy and guidance across its populations, for Retained Specialised Services;

77.1.3 Supporting the ICB with agreed transformational programmes where national transformation support has been agreed for Delegated Specialised Services;

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

77.1.5 Co-production and co-design of transformation programmes with the ICB and wider stakeholders; and

77.1.6 Providing access to subject matter experts including CRGs, NCDs, POC leads for the ICB where it needs support, including in relation to taking forward local priority transformation.

SCHEDULE 5: Retained Services

NHS England shall retain the function of commissioning the Specialised Services set out in this Schedule

SCHEDULE 6: Further Information Governance And Sharing Provisions

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 Delegated Functions and NHS England's Reserved Functions.

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 Delegated 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, 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 Partner 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 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 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 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. giving consideration to 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 cooperate 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 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.

Each Party shall provide evidence (further to any reasonable request) that all personnel 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.

7.4. The Partners shall ensure that:

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

7.4.2. 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

7.4.3. specific limitations on the Staff who may have access to the 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 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 cooperate 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 Partner

8.4.1. 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

8.4.2. becomes aware of 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 cooperate 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;

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 protected 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. In particular, teach 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 in order 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 into 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 **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 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, so as to ensure that the correct patient record / 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 Partner shall keep an audit log of Relevant Information transmitted and received in the course of 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 cross cut shredder or subcontracted to a confidential waste company that complies with European Standard EN15713.

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

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

11.9. In the event of any bad or unusable sectors of electronic storage media that cannot be overwritten, the Partner shall ensure complete and irretrievable destruction of the media itself in accordance with policy requirements.

12. Governance: Complaints and Access to Personal Data

12.1. The Partners shall assist each other in responding to any requests made under Data Protection Legislation made by persons who wish to access copies of information held about them ("**Subject Access Requests**"), as well as any other exercise of a Data Subject's rights under Data Protection Legislation or complaint to or investigation undertaken by the Information Commissioner.

12.2. Complaints about information sharing shall be reported to the Single Points of Contact and the ICB. Complaints about information sharing shall be routed through each Partners' own complaints procedure unless otherwise provided for in the Delegation Agreement or determined by the ICB.

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 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.
- IG 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.

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 'Manual' for Specialised Commissioning

SCHEDULE 8: Local Terms

Guidance notes are provided in red text and can be deleted prior to completing the agreement.
This Schedule should be used by the Parties to agree local terms to the Agreement. Headings and guidance have been provided as areas that may need local agreement. Additional headings can be added as required to support local arrangements.

Sufficient detail should be provided to describe what both the ICB and NHS England have agreed to do. The workforce and hub arrangements must be included in this Schedule. See Part 3 for further information.

General

Where there is a dispute as to the content of this schedule, the Parties should follow the Disputes procedure set out at Clause 24.

Following signature of the Delegation Agreement, this schedule can be amended by the parties using the Variations procedure at [Clause 26].

NHS England can amend this schedule with the ICB's consent by using the variation process set out in [Clause 26.2] but the expectation is that variations should be by consent.

[*Note – Local terms must not derogate from the terms and conditions of this Agreement. Please note that Local Terms may include:*

- *The services that will be planned/commissioned at an ICB level and multi-ICB level;*
- *details of any pooled funds of NHS England and the ICB;*
- *resourcing arrangements between NHS England and the ICB;*
- *details of ancillary services provided to Primary Care Providers such as clinical waste;*
- *details of any particular services that the Assigned Staff will provide to the ICB under* **Error! Reference source not found.*Error! Reference source not found.***; and*
- *Staffing arrangements.*

If there are no Local Terms, state "None" in this SCHEDULE .]

Part 1 – the services to be planned or commissioned at an ICB level

This Part should set out the services that will be planned on the footprint of the ICB. The list should be developed with NHS England, the commissioning hub and partners of the multi-ICB arrangement.

This list will form part of the basis for any multi-ICB arrangement introduced by the ICBs and the agreement to establish and support the commissioning hub arrangement.

During 2024/25, it is recommended that the ICBs have consistent lists of services across their patch to aid clarity and consistency.

Part 2 – the services to be planned or commissioned at a multi-ICB level

This Part should set out the services that will be planned on the footprint of the multi-ICB. The list should be developed with NHS England, the commissioning hub and partners of the multi-ICB arrangement.

This list will form part of the basis for any multi-ICB arrangement introduced by the ICBs and the agreement to establish and support the commissioning hub arrangement.

During 2024/25, it is recommended that the ICBs have consistent lists of services across their patch to aid clarity and consistency.

Part 3 – Funding arrangements

Where it has not been addressed elsewhere in this agreement, in accordance with Schedule [ ], paragraph [ ], NHS England can use this Part to set out the funding arrangements for 2023/24 (the Specialised Services Delegated Funds). In advance of the commencement of each subsequent financial year, NHS England will notify the ICB of the amount of the Specialised Services Delegated Funds in accordance with Schedule [ ], paragraph [ ]. The parties may determine that the funding arrangements for subsequent years should also be included in this Part.

Part 3 – Workforce and Hub Arrangements

The parties may include the agreed arrangements for the workforce and hub in this part, or can refer onwards to the relevant commissioning hub agreement or arrangement that has been implemented across the patch.

Part 4 – Multi-ICB Arrangements

For specialised services, Clause [8] requires ICBs to establish joint working arrangements with other ICBs to ensure that the commissioning of Specialised Services can take place at the most efficient and effective level. The ICB(s) should ensure that the multi-ICB arrangement is documented and includes all the required elements set out at Clause [8.3].

The Parties should reference the multi-ICB arrangements in this Part, although it is acknowledged that a separate document is likely to be required between the ICBs that are party to that arrangement. A template multi-ICB agreement is available for ICBs to use to develop their arrangements. This is available at: [INSERT LINK TO MIA TEMPLATE].

Part 5 – Pooled Funds and Non-Pooled Funds

[INSERT CLAUSE] permits the ICB to establish pooled fund arrangements under Section 65Z5 or section 75 of the NHS Act 2006. These should be with the prior approval of NHS England.
Whilst it is not necessary to detail the pooled funds in this Part, it may be beneficial to do so to ensure all arrangements pertaining to the Delegated Services are documented in this agreement.

Part 6 – Provider Collaboratives

Whilst it is not envisaged that this Part will be in use for 2023/24, any provider collaboratives that are established and receive functions, either delegated or not, would be detailed in this part.
In accordance with [INSERT CLAUSE] any provider collaboratives that NHS England identifies as being part of this Delegation Agreement should be detailed in this Part.

Part 7 – Further Governance Arrangements

The Parties can use this Part for any governance arrangements not covered by the main agreement or the existing Schedules.

It is advised that sub-committees (those forums with decision making power) and sub-groups (those forums without decision making power, but are advisory in nature) are set out in this part. It is advised that the role, purpose and membership of the sub-committees or sub-groups are set out in this part.

SCHEDULE 9: Developmental Conditions

These Developmental Conditions take precedence over the terms of this Agreement including other Schedules and the Agreement shall be read as varied by these Developemental Conditions. Save as varied by these Developmental Conditions the Agreement remains in full force and effect.

The developmental conditions

The following developmental conditions apply to this delegation agreement:

1. [TO BE INSERTED PRIOR TO SIGNATURE]

SCHEDULE 10: Administrative and Management Services

The Parties may agree that the ICB provides Commissioning Support Arrangements to NHS England.

Dated 2024

(1) **[●] INTEGRATED CARE BOARD**

- and -

(2) **[●] INTEGRATED CARE BOARD**

- and -

(3) **[●] INTEGRATED CARE BOARD**

ICB Collaboration Agreement

DRAFT - NOT AVAILABLE FOR ACCEPTANCE

Table of contents

Clause heading and number | Page number

THIS AGREEMENT is made on the_____ day of _____2024

BETWEEN[1]**:**

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

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

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

[DN – Add in any partners including NHS E if to be a partner]

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

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

BACKGROUND

(A) NHS England 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 are able to 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 the ICB. NHS England has retained responsibility for the NHS England Reserved Functions and commissioning of the Retained Services.

(E) It is agreed that in order to exercise the Delegated Functions in the most efficient and effective manner that some of the Delegated Services would be best commissioned on a multi-ICB footprint.

(F) This Agreement sets out the arrangements that will apply between the ICBs in relation to the joint commissioning of Specialised Services for the ICBs' Populations.

(G) This Agreement is intended to govern the relationship between the ICBs in respect of the commissioning of Specialised Services.

[DN: to add guidance on expanding this section]

[1] Complete Partners' names as appropriate.

NOW IT IS HEREBY AGREED as follows:

1. **COMMENCEMENT AND DURATION**

1.1 This Agreement has effect from the date of this Agreement and will remain in force for the Initial Term 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 at all times in good faith towards each other.

2.2 The Partners agree:

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

2.2.2 to seek to continually improve whole pathways of care 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;

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;

2.3.2 [GUIDANCE: the Partners can insert further aims of the Collaboration Agreement here.]

3. SCOPE OF THE ARRANGEMENTS

3.1 This Agreement sets out the arrangements through which the Partners will work together to commission Services. This may include one or more of the following commissioning mechanisms:

3.1.1 Lead Commissioning Arrangements where some or all of the commissioning Functions in respect of designated Services are delegated to another Partner (Lead Partner);

3.1.2 Aligned Commissioning where there is no further delegation of any Functions. However, the Partners agree mechanisms to co-operate in the commissioning of identified Services;

3.1.3 Joint Working where the Partners exercise the commissioning Functions jointly this may take effect through one or more of the Flexibilities listed in this clause 3.1;

3.1.4 the establishment of one or more Joint Committees;

3.1.5 development of a Commissioning Hub;

3.1.6 the establishment of one or more Pooled Funds;

3.1.7 the use of one or more Non Pooled Fund;

3.1.8 [GUIDANCE: Partners can include ICB non-delegated functions within the scope of this Agreement here];

collectively referred to as the "Flexibilities".

3.2 At the Commencement Date the Partners agree that the following 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 Development of a Commissioning Hub through which some Services may be commissioned as set out in [the Commissioning Hub Agreement].

3.2.3 [Establishment of a Joint Committee].

3.2.4 [Establishment of the following Lead Commissioning Arrangements:

(a) [GUIDANCE: partners to detail lead commissioning arrangements].

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 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 [1].

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 introduction of any Individual Scheme will be subject to business case approval in accordance with the variation procedure set out in Clause [13] (Variations).

4.6 The Partners shall work in cooperation and shall endeavour to ensure that Services in fulfilment of the Functions are commissioned with all due skill, care and attention irrespective of the Flexibilities utilised.

4.7 Where there are Lead Commissioning Arrangements in respect of any Individual Scheme, unless the Scheme Specification otherwise provides, the Lead Partner shall:

4.7.1 exercise the Functions of each Partner as identified in the relevant Scheme Specification;

4.7.2 endeavour to ensure that all Functions included in the relevant Scheme are funded within the parameters of the Financial Contributions of each Partner set in respect of that Scheme in each Financial Year;

4.7.3 contract with Provider(s) for the provision of the Services on terms agreed with the other Partners;

4.7.4 comply with all relevant legal duties and guidance of all Partners in relation to the Services being commissioned;

4.7.5 where Services are commissioned using the NHS Standard Form Contract, perform the obligations of the "Commissioner" and "Co-ordinating Commissioner" with all due skill, care and attention and where Services are commissioned using any other form of contract to perform its obligations with all due skill and attention;

4.7.6 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;

4.7.7 make payment of all sums due to a Provider pursuant to the terms of any Services Contract; and

4.7.8 keep the other Partner regularly informed of the effectiveness of the arrangements including any Overspend or Underspend where there is a Pooled Fund or Non Pooled Fund.

5. COMMISSIONING HUB

5.1 The Partners agree to establish a Commissioning Hub(s) as set out in Schedule [7] (Commissioning Hub Arrangements).

6. STAFFING

6.1 The staffing arrangements shall be as set out in the relevant Scheme Specification and/or the Commissioning Hub Agreement.

7. JOINT COMMITTEE

[GUIDANCE: a template terms of reference for the joint committee is available as part of the release materials for this agreement].

7.1 Where the Partners intend to form a joint committee then the arrangements for the joint committee shall be as set out in: the relevant Scheme Specification; Schedule [5]: approach to governance; 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 secured 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 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 ICB.

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].

10. REVIEW

10.1 Save where the Partners agree alternative arrangements (including alternative frequencies) the Partners shall undertake an annual review ("**Annual Review**") of the operation of this Agreement, any Pooled Fund and Non Pooled Fund and the provision of the Services within three Months of the end of each Financial Year.

10.2 Annual Reviews shall be conducted in good faith.

11. COMPLAINTS

11.1 The Partners shall agree the procedure for management of complaints arising from this Agreement or the provision of Services. This shall be set out in Schedule [3]/ each Individual Scheme.

12. FINANCES

12.1 The financial arrangements shall be as agreed between the Partners in the relevant Scheme Schedule and Schedule [4]: approach to finances.

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** [2]

13.1 The Partners acknowledge that the scope of the 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. 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 of the Partners. The notice period for any variation unless otherwise agreed by the Partners shall be three Months or in line with the notice period for variations within the associated Service Contract(s), whichever is the shortest.

[GUIDANCE: Partners to consider the following, if not used mark as N/A]

13.5 [The following approach shall, unless otherwise agreed, be followed by the Partners:]

13.5.1 on receipt of a request from one Partners 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;

13.5.2 the Partners will agree any action to be taken as a result of the proposed variation. This shall include consideration of:

(a) whether any Service Contracts affected by the proposed variation should continue, be varied or terminated, taking note of the Service Contract terms and conditions and ensuring that the Partners holding the Service Contract/s is not put in breach of contract; its statutory obligations or financially disadvantaged; and/or

(b) whether the proposed variation could have an impact on the Commissioning Hub and/or any Staff;

[2] The Partners may find it helpful to set out a procedure for agreeing to add a new scheme to the framework arrangement and the alternative drafting in Clauses 30.1 to 30.3 sets out an example of a more detailed variation procedure.

13.5.3 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

13.5.4 should this not be possible and one Partner is left financially disadvantaged as a result of the proposed variation, then the financial risk will, unless otherwise agreed, be [shared equally between the Partners[3].]]

14. DATA PROTECTION

14.1 The Partners must ensure that all Personal Data processed by or on behalf of them in the course of 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 Joint Committee 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 Data Security and the Protection Incident Reporting tool. 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 NHS England and the Joint Committee 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 where 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 in particular 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 other Partners save as agreed by the Partners in writing.

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[3] Risk sharing arrangements will be for local agreement between the Partners.

14.8 Schedule [6] 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 Functions are inter-operable and that data may be transferred between systems securely, easily and efficiently.

15.2 The Partners will use their respective 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 Joint Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under section 65Z5 and section 75 of the NHS Act. The Partners must comply with any Guidance around the commissioning of Joint 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 Relevant Information in response to a specific request under FOIA or EIR, in which case:

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

17.2.2 each Partner shall consult the other regarding the possible application of exemptions in relation to the 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 Each Partner is aware and recognises that NHS England may, from time to time, issue a FOIA or EIR protocol or update a protocol previously issued relating to the dealing with and responding to of FOIA or EIR requests in relation to the Delegated Functions and that the Partners shall comply with such FOIA or EIR protocols.

18. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY

18.1 The Partners must and must ensure that, in delivering the 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.

18.2 Each ICB must maintain a register of interests in respect of all persons involved in decisions concerning the Functions. This register must be publicly available. For the purposes of this clause, an ICB may rely on an existing register of interests rather than creating a further register.

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

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;

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 Party; 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 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 or any Services Contract 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 or the [Partnership Board].

20.3 If any third party makes a claim or intimates an intention to make a claim against either Partner, which may reasonably be considered as likely to give rise to liability under this Clause 20, the Partner that may 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);

20.3.3 give the Other Partner and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the Indemnifying 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 Agreements 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 NHS England and send to NHS England all copies of such correspondence;

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

20.6.4 at the request of NHS England, take such action 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.

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"). [4]

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; or

22.2.3 [terminate this Agreement in accordance with Clause [23] *(Termination and Default)* below;

22.2.4 exercise the dispute resolution procedure in accordance with Clause [21] *(Dispute Resolution).*

23. TERMINATION & DEFAULT[5]

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 prior agreement by NHS England. Such notification shall only take effect from the end of 31 March in any calendar year and shall not take effect prior to the termination or expiry of all Individual Schemes.

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 Services will continue to be appropriately commissioned.]

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[4] In this template there is no right to terminate this Agreement as a result of breach by either Partner.

[5] We have set out a suggested approach to termination and default here as a basis for discussion.

23.3 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].

23.4 The ICBs will work together to ensure that there are suitable alternative arrangements in place in relation to the exercise of the Functions.

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, so as to minimise costs and liabilities of each Partner in doing so;

24.1.2 where there are Commissioning Hub 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 into a Service Contract in exercise of the Functions of any other Partner which continues after the termination of this Agreement, any Partner for whom that shall continue to contribute to the Contract Price in accordance with the agreed contribution for that Service prior to termination and will enter into all appropriate legal documentation required in respect of this;

24.1.4 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 the 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 a Service Contract held by a Lead Partner relates all or partially to services which relate to the other Partner's Functions then 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 mutatis mutandis as the original contract.

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

24.2 The provisions of Clauses [14] (Data Protection), [17]17 (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.

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, or render any Partner directly liable to any third party for the debts, liabilities or obligations of any Partner.

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

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 either of them and that, if in the course of the performance of this Agreement, unfairness to either of them does or may result, then the other shall use its reasonable endeavours to agree upon such action as may be necessary to remove the cause or causes of such unfairness.

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 date stated at the beginning of it.

SIGNED by ....

for and on behalf of NHS England (Signature)

.....

(Date)

SIGNED by ....

for and on behalf of [●] Integrated Care Board (Signature)

.....

(Date)

SIGNED by ....

for and on behalf of [●] Integrated Care Board (Signature)

.....

(Date)

SIGNED by ....

for and on behalf of [●] Integrated Care Board (Signature)

.....

(Date)

SCHEDULE 1: DEFINITIONS AND INTERPRETATIONS

DEFINITIONS AND INTERPRETATION

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

"Agreement"	this agreement between the Partners comprising these terms and conditions together with all schedules attached to it;
"Aligned Commissioning"	means a mechanism 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;
"Arrangements"	means the joint working and delegation arrangements set out in this Agreement;
"Assurance Processes"	has the meaning in Paragraph 8 of Schedule 4 (Oversight and Assurance);
"Authorised Officer"	the individual(s) appointed as Authorised Officer in accordance with the agreed Terms of Reference;
"Change in Law"	a change in Law that is relevant to the arrangements made under this Agreement, which comes into force after the Commencement Date;
"Claim"	means for or in relation to the 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 Hub”	
“Commissioning Hub Arrangements”	Means the arrangements in respect of the Commissioning Hub;
“Commissioning Hub Agreement”	Means the agreement that sets out the arrangements for the Commissioning Hub between [ ] and NHS England;
"Confidential Information"	means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement or arrangements made pursuant to it and: (a) which comprises Personal Data or which relates to any patient or his treatment or medical history; (b) the release of which is likely to prejudice the commercial interests of a Partner; or (c) which is a trade secret;
“Contracting Standard Operating Procedure”	means the Contracting Standard Operating Procedure produced by NHS England in respect of the Joint Specialised Services;
“Core Membership”	means the voting membership of the Joint Committee as set out in the Terms of Reference;
“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 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 Incident Reporting tool"	the incident reporting tool for data security and protection incidents, which forms part of the Data Security and Protection Toolkit available at https://www.dsptoolkit.nhs.uk/;
"**Delegated Commissioning Group**" **"DCG"**	means a group hosted by NHS England whose terms shall include providing an assurance role in compliance with the Assurance Processes;
"Delegation Agreement(s)"	Means the Delegation Agreements under which NHS England delegate NHS England Commissioning Functions to each ICB;
"Delegated Functions"	Means Commissioning Functions of NHS England delegated to each ICB under a Delegation Agreement;
"Delegated Services"	Means those services commissioned in exercise of the Delegated Functions
"Dispute Resolution Procedure"	the procedure set out in Clause 21 (Dispute Resolution);
"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 [ ]
"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;
"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;

"Governance Arrangements"	Means the governance arrangements in respect of the Arrangements agreed by the Partners and as set out in Schedule [4]
"High Cost Drugs"	Means medicines not reimbursed though national prices and identified on the NHS England high cost drugs list;
"ICB Functions"	the Commissioning Functions of an ICB;
"ICB Reserved Functions"	Where there is any delegation of ICB Functions or further delegation of Delegated Functions, those functions that remain reserved to each ICB
"Individual Scheme"	Means a scheme which has been agreed by the Partners to be included within this Agreement;
"Information"	has the meaning given under section 84 of FOIA;
"Indemnity Arrangement"	mean 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);
"Information Sharing Agreement"	any information sharing agreement entered into in accordance with Schedule 7 (Further Information Governance and Sharing Provisions);
"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);
"Initial Term"	Means [INSERT AGREED INITIAL TERM]
"Joint Committee"	means the joint committee(s) established under this Agreement on the terms set out in the Terms of Reference;
"Joint Functions"	any Functions that are delegated to a Joint Committee
"Law"	means: (a) any statute or proclamation or any delegated or subordinate legislation; (b) any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and (c) any judgment of a relevant court of law which is a binding precedent in England;
"Lead Commissioning Arrangements"	means the arrangements by which one Partner commissions Services in relation to an Individual Scheme on behalf of the another Partner or Partners in exercise of the Commissioning Functions of the ICB Partners;

"Lead Partner"	means the Partner responsible for commissioning an Individual Service under a Lead Commissioning Arrangement;
"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 7;
"NHS Act"	the National Health Service Act 2006;
"NHS England Functions"	NHS England's statutory 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
"**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;
"Partners"	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 of the ICBs have the responsibility for commissioning health services;
"Provider Collaborative"	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 contracting arrangements entered into in respect of a Provider Collaborative;
"Provider Collaborative Guidance"	Means any guidance published by NHS England in respect of Provider Collaboratives;

"Regional Quality Group"	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?"*);
"Request for Information"	has the meaning set out in the FOIA;
"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;
"Shared Care Arrangements"	these arrangements 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"	the member of Staff appointed by each relevant Partner in accordance with Paragraph 14 of Schedule 7;
"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 Functions and Reserved Functions as specified in Schedule [ ] *(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"	a contract for the provision of Specialised Services entered into in the exercise of the Specialised Commissioning Functions;
"Specialised Services Provider"	a provider party to a Specialised Services Contract;
"Specialised Services Staff"	means the Staff carrying out the Specialised Services Functions;
"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 or not the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors' and their sub-contractors' personnel;
"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;
"Term"	the Initial Term, as may be varied by: (a) any extensions to this Agreement that are agreed under Clause 1.1 (Commencement and Duration); or (b) the earlier termination of this Agreement in accordance with its terms;
"Terms of Reference"	means the Terms of Reference for the Joint Committee agreed between the Partners at the first meeting of the Joint Committee, a draft of which is included at Schedule 2 (Joint Committee;

“Triple Aim”	the duty on each of the Partners in making decisions about the exercise of their functions, to have regard to all likely effects of the decision in relation to: (a) the health and well-being of the people of England; (b) the quality of services provided to individuals by the NHS; (c) efficiency and sustainability in relation to the use of resources by the NHS;
“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;
"Working Day"	any day other than Saturday, Sunday, a public or bank holiday in England.

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

[GUIDANCE: the relevant governance arrangements and decision making processes should be detailed in this schedule in relation to the overarching relationship between the Partners and where they are not covered by the Scheme Schedule, or further information is required to be provided].

[RECOMMENDATION: where a Partnership Board or joint committees are being used: whilst not a requirement for completion of the MIA, the Partners may wish to insert the agreed terms of reference for the joint committee into this Schedule 2 to set out the governance arrangements being implemented].

SCHEDULE 3: INDIVIDUAL SCHEMES

Part 1 – Template Scheme Schedule

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

- *Insert details including:*
    - *Name of the Individual Scheme*
    - *Relevant context and background information*

2 AIMS AND OUTCOMES

- *Insert agreed aims of the Individual Scheme*

3 THE ARRANGEMENTS

Set out which of the following applies in relation to the Individual Scheme. It could be more than one that applies:

(1) Aligned Commissioning
  (a) How are decisions being taken?
  (b) Will there be other agreements in place such as Collaborative Commissioning Agreements?

(2) Lead Commissioning;
  (a) Who is the Lead Partner
  (b) Which ICBs are delegating commissioning functions?
  (c) What are the responsibilities of the Lead Partner
  (d) What functions are being delegated?
  (e) What functions are being retained?

(3) Joint Commissioning;

(4) Establishment of a Joint Committee

(5) The establishment of one or more Pooled Funds and/or Non Pooled Funds as may be required.

  (a) What (if any) Pooled Funds and Non Pooled Funds will be in place
  (b) Who will hold the Pooled Funds

4 FUNCTIONS

- *Set out the Functions which are the subject of the Individual Scheme including where appropriate the delegation of such functions for the commissioning of the relevant service.*

- *Consider whether there are any exclusions from the standard functions included*

5 SERVICES

- What Services are going to be provided within this Scheme.
- Are there contracts already in place?
- Are there any plans or agreed actions to change the Services?
- Who are the beneficiaries of the Services?

6 COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

Set out what arrangements will be in place.. How will these arrangements work?

Contracting Arrangements

Insert the following information about the Individual Scheme:

(a) relevant contracts

(b) arrangements for contracting –

(i) Will terms be agreed by all partners or will a Lead *Partner* have authority to agree terms?

(ii) Are there other relevant agreements or arrangements such as a Collaborative Commissioning Agreement?

(iii) Any funding arrangements in respect of contracts?

(c) what contract management arrangements have been agreed?

(d) What happens if the Agreement terminates?

Access

Set out details of the Service Users to whom the Individual Scheme relates. How will individuals be assessed as eligible.

7 FINANCIAL CONTRIBUTIONS

- What are the financial contributions of each ICB?
- How will this be determined going forwards?

8 FINANCIAL GOVERNANCE ARRANGEMENTS

(1) Management of the Pooled Fund

If there is a Pooled Fund (s) in respect of the Individual Scheme?.

(2) Audit Arrangements

What Audit arrangements are needed?

(3) Financial Management

- Which financial systems will be used?
- What monitoring arrangements are in place?
- Who will produce monitoring reports?
- What is the frequency of monitoring reports?
- What are the rules for managing overspends?
- Do budget managers have delegated powers to overspend?
- Who is responsible for means testing?
- Who will own capital assets?
- How will capital investments be financed?
- What management costs can legitimately be charged to pool?
- What re the arrangement for overheads?
- What closure of accounts arrangement need to be applied?]6

9 GOVERNANCE ARRANGEMENTS

Is there a Scheme Lead
Will there be a relevant Committee/Board/Group that reviews this Individual Scheme?
Who does that group report to?
Who will report to that Group?
How will any changes to a scheme be agreed? Are there different changes to be agreed at different levels?
Will there be a joint committee in relation to this Individual Scheme?

10 NON FINANCIAL RESOURCES

[6] We note that some of the information overlaps with the information that is included in the main body of Agreement, however, we consider it is appropriate that this is considered for each Scheme in order to determine whether the overarching arrangements should apply.

Premises			
Assets and equipment			
Contracts			
Central support services			

11 STAFF

Consider:

- Who will employ the staff?
- Is a TUPE transfer secondment required?
- How will staff increments be managed?
- Have pension arrangements been considered?
- Will there need to be any secondment arrangements?

12 ASSURANCE AND MONITORING

Set out the assurance framework in relation to the Individual Scheme. What are the arrangements for the management of performance? Will this be through the agreed performance measures in relation to the Individual Scheme.
Consider the following:

- What is the overarching assurance framework in relation to the Individual Scheme?
- Has a risk management strategy been drawn up?
- Have performance measures been set up?
- Who will monitor performance?
- Have the form and frequency of monitoring information been agreed?
- Who will provide the monitoring information? Who will receive it?

13 LEAD OFFICERS

Partner	**Name of Lead Officer**	**Telephone Number**	**Email Address**

14 INTERNAL APPROVALS

- *Consider the levels of authority from the scheme of delegation and standing financial instructions in relation to the Individual Scheme;*
- *Consider the scope of authority of the Pool Manager and the Lead Officers*

15 RISK AND BENEFIT SHARE ARRANGEMENTS

Has a risk management strategy been drawn up?
Set out arrangements, if any, for the sharing of risk and benefit in relation to the Individual Scheme.

16 REGULATORY REQUIREMENTS

Are there any regulatory requirements that should be noted in respect of this particular Individual Scheme?

17 INFORMATION SHARING AND COMMUNICATION

What are the information/data sharing arrangements?
How will charges be managed (which should be referred to in Part 2 above)
What data systems will be used?

Consultation – staff, people supported by the Partners, unions, providers, public, other agency
Printed stationary

18 DURATION AND EXIT STRATEGY

What are the arrangements for the variation or termination of the Individual Scheme.
Can part/all of the Individual Scheme be terminated on notice by a party? Can part/all of the Individual Scheme be terminated as a result of breach by either Partner?
What is the duration of these arrangements?

Set out what arrangements will apply upon termination of the Individual Service, including without limitation the following matters addressed in the main body of the Agreement

(1) maintaining continuity of Services;

(2) allocation and/or disposal of any equipment relating to the Individual Scheme;

(3) responsibility for debts and on-going contracts;

(4) responsibility for the continuance of contract arrangements with Service Providers (subject to the agreement of any Partner to continue contributing to the costs of the contract arrangements);

(5) where appropriate, the responsibility for the sharing of the liabilities incurred by the Partners with the responsibility for commissioning the Services and/or the Host Partners.

Consider also arrangements for dealing with premises, records, information sharing (and the connection with staffing provisions set out in the Agreement.

19 COMPLAINTS

-
- Is there a single approach to complaints or will this differ between Schemes?

20 OTHER PROVISIONS

Consider, for example:

- *Any variations to the provisions of the Agreement*
- *Bespoke arrangements for the treatment of records*
- *Safeguarding arrangements*

PART 2 – AGREED SCHEME SPECIFICATIONS

[GUIDANCE: each of the Schemes agreed by the Partners should be set out in this Part of the Agreement.]

SCHEDULE 4: FINANCIAL ARRANGEMENTS

1 ESTABLISHMENT OF A POOLED FUND[7]

1.1 The Partners have agreed to establish and maintain such pooled funds for revenue expenditure as agreed by the Partners. Any Pooled Funds established at the Commencement Date shall be included at Annex A of this Schedule [X].

1.2 Each Pooled Fund shall be managed and maintained in accordance with the terms of this Agreement and the provisions of this Schedule [X] – Pooled Funds shall apply.

1.3 Subject to Clause [redacted], it is agreed that the monies held in a Pooled Fund may only be expended on the following:[8]

1.3.1 the Contract Price;

1.3.2 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

1.3.3 Approved Expenditure as set out in the relevant Scheme Specification or as otherwise agreed in advance in accordance with the relevant Scheme Specification

("Permitted Expenditure")[9]

1.4 The Partners may only depart from the definition of Permitted Expenditure to include or exclude other revenue expenditure with the express written agreement of each relevant Partner.

1.5 For the avoidance of doubt, monies held in the Pooled Fund may not be expended on Default Liabilities unless this is agreed by all Partners included within the relevant Pooled Fund in accordance with Clause [ ].[10]

1.6 Pursuant to this Agreement, the Partners agree to appoint a Host Partner for each of the Pooled Funds set out in the Scheme Specifications. The Host Partner shall be the Partner responsible for:

1.6.1 holding all monies contributed to the Pooled Fund on behalf of itself and the other Partners;

1.6.2 providing the financial administrative systems for the Pooled Fund; and

1.6.3 appointing the Pooled Fund Manager;

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7 Pooled Funds can be used for Lead Commissioning or Integrated Commissioning arrangements. Furthermore, each Service, can have different Lead Commissioners. The host arrangements for pooled funding is for ensuring that there is streamlined management and accountability of the Pooled Funds with the Host Partner being the accounting body and having responsibility for appointing a Pooled Fund Manager.

8 This dictates what can be funded out of the Pooled Fund and, therefore, what would constitute an overspend if it exceeded the amount in the Pool. Money spent on other things would be in breach of this agreement and, therefore not recoverable by the Host Partner.

9 Parties should discuss how to deal with management costs in relation to hosting arrangements. For example, should these be charged or will each Party provide the services without recharging. If management costs and costs for hosting a Pooled Fund such as audit costs are to be charged to the Pooled fund this should be included as an additional point at clause 7.3.

10 This links liabilities of the Host Partner for default to the indemnity provisions.

1.6.4 ensuring that the Pooled Fund Manager complies with its obligations under this Agreement.

2 POOLED FUND MANAGEMENT

2.1 When introducing a Pooled Fund, the Partners shall agree:

2.1.1 which of the Partners shall act as Host Partner;

2.1.2 which officer of the Host Partner shall act as the Pooled Fund Manager.

2.2 The Pooled Fund Manager for each Pooled Fund shall have the following duties and responsibilities:

2.2.1 the day to day operation and management of the Pooled Fund;

2.2.2 ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this Agreement and the relevant Scheme Specification;

2.2.3 maintaining an overview of all joint financial issues affecting the Partners in relation to the Services and the Pooled Fund;

2.2.4 ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund;

2.2.5 reporting to the Partnership Board as required by this Agreement and by the Partnership Board;

2.2.6 ensuring action is taken to manage any projected under or overspends relating to the Pooled Fund in accordance with this Agreement;

2.2.7 preparing and submitting Reports as required by the relevant Scheme Specification;

2.3 The Partners may agree to the viring of funds between Pooled Funds or amending the allocation of the Pooled Fund between Individual Schemes.

3 NON POOLED FUNDS[11]

3.1 Any Financial Contributions agreed to be held within a Non Pooled Fund will be notionally held in a fund established solely for the purposes agreed by the Partners.

3.2 When introducing a Non Pooled Fund in respect of an Individual Scheme, the Partners shall agree:

3.2.1 which Partner if any[12] shall host the Non-Pooled Fund

3.2.2 how and when Financial Contributions shall be made to the Non-Pooled Fund.

3.3 The Host Partner will be responsible for establishing the financial and administrative support necessary to enable the effective and efficient management of the Non-Pooled Fund, meeting all required accounting and auditing obligations.

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[11] These are funds that are notionally held in a joint fund but are not a pooled fund.
If there are Lead Commissioner/Integrated Commissioner arrangements, the funds need to be held but they will be separately accounted for. The Lead Commissioner will still be responsible for managing the fund effectively.

[12] The non pooled fund can be a virtual pool with contributions identified but held separately.

3.4 [The Partners shall ensure that any Services commissioned using a Non Pooled Fund are commissioned solely in accordance with the relevant Scheme Specification]

3.5 Where there are Joint (Aligned) Commissioning arrangements, both Partners shall work in cooperation and shall endeavour to ensure that the Functions funded from a Non-Pooled Fund are carried out within the relevant Partner's Financial Contribution to the Non- Pooled Fund for the relevant Service in each Financial Year.

4 FINANCIAL CONTRIBUTIONS[13]

4.1 The Financial Contribution of the to any Pooled Fund or Non-Pooled Fund for the first Financial Year of operation shall be as set out the relevant Scheme Specification.[14]

4.2 The Financial Contribution to any Pooled Fund or Non-Pooled Fund for each subsequent Financial Year of operation shall be subject to review by the Partners [*Insert Provisions around how Financial Contributions will be determined going forward*][15]

4.3 Financial Contributions will be paid as set out in [Schedule [INSERT]. [16]

4.4 With the exception of Clause [ ], no provision of this Agreement shall preclude the Partners from making additional contributions of Non-Recurrent Payments 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.

5 RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPENDS[17]

Risk share arrangements

5.1 The Partners have agreed risk share arrangements as set out in Annex [X] of this Schedule [X], which provide for risk share arrangements arising within the commissioning of services from the Pooled Funds as set out in National Guidance.

Overspends in Pooled Fund[18]

5.2 Subject to Clause [12.2], the Host Partner for the relevant Pooled Fund shall 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.

5.3 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

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13 Partners should consider how to deal with financial contributions. The starting point is the NHS Better Care contribution, net of any amounts retained pending reductions in emergency admissions. Is either Partner able to commit a minimum amount per year? When and how will the Partners agree the contributions each year? What happens if the Partners disagree? Are there any particular factors that must be taken into consideration when establishing the level of commitment for subsequent years?

14 Parties need to deal with the fact that some services will not have pooled funds. In respect of this, parties should decide how the invoicing/payment arrangements will work and whether this will vary from service to service.

15 Include any information that the Partners have agreed as to how future contributions will be agreed.

16 If there is to be a set mechanism for funding to be paid this needs to be inserted here

17 We have provided a suggested approach to overspends and underspends, however, the details will need to considered by the Partners in the context of the specific risk sharing arrangements agreed between the Partners.

18 Although the contributions are being calculated by reference to the agreed contract value, there are a number of variables that could still contribute to an overspend.

expenditure from a Pooled Fund has been in accordance with Permitted Expenditure and it has informed the Partnership Board in accordance with Clause 12.4.[19]

5.4 In the event that the Pooled Fund Manager identifies an actual or projected Overspend the Pooled Fund Manager must ensure that the Partnership Board is informed as soon as reasonably possible and the provisions of the [relevant Scheme Specification][20] and Schedule [3] shall apply.

Overspends in Non Pooled Funds[21]

5.5 Where in Joint (Aligned) Commissioning Arrangements either Partner forecasts an Overspend in relation to a Partners Financial Contribution to a Non-Pooled Fund that Partner shall as soon as reasonably practicable inform the other Partner and the Partnership Board.

5.6 Where there is a Lead Commissioning Arrangement the Lead Partner is responsible for the management of the Non-Pooled Fund. The Lead Partner shall as soon as reasonably practicable inform the other Partner [and the Partnership Board].

Underspend

5.7 In the event that expenditure from any Pooled Fund or Non Pooled Fund in any Financial Year is less than the aggregate value of the Financial Contributions made for that Financial Year or where the expenditure in relation to an Individual Scheme is less than the agreed allocation to that particular Individual Scheme the Partners shall agree how the monies shall be spent, carried forward and/or returned to the Partners and the provisions of Schedule 3 shall apply. Such arrangements shall be subject to the Law and the Standing Orders and Standing Financial Instructions (or equivalent) of the Partners.

6 CAPITAL EXPENDITURE[22]

6.1 Except as provided in Clause 6.2], neither Pooled Funds nor Non-Pooled Funds shall normally be applied towards any one-off expenditure on goods and/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.

6.2 The Partners agree that capital expenditure may be made from Pooled Funds where this is in accordance with National Guidance.

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[19] In this example, this is drafted like this because such expenditure is permitted and, therefore, although an Overspend occurs it is not because of a breach by the Lead Commissioner of its obligations. It is legitimate expenditure for which there are insufficient Financial Contributions. However parties may want to consider whether there should be an obligation on the Host Partner to ensure that demand is appropriately managed and so include a provision that the Host Partner would be in breach if they failed to take the requisite steps to notify the other Partner/JCB of the potential overspend and arrange an action plan?

[20] Consider whether the Overspend provisions will be the same across all of the different Services

[21] This is just a suggestion of how overspends in relation to non-pooled funds may be dealt with. It may be that this needs to be set out in each individual Scheme Specification and there is not a generic approach

Annex to Schedule

Insert any Pooled Fund/ Non Pooled Fund/ Risk Share Arrangements

SCHEDULE 5: JOINT COMMITTEES

The ICBs have established a Joint Committee which will operate in accordance with the agreed Terms of Reference (Terms of Reference) known as [INSERT NAME OF JOINT COMMITTEE]. The Joint Committee (and each member of the Joint Committee) will act at all times in accordance with the Terms of Reference.

The Partners shall nominate Authorised Officers to the Joint Committee in accordance with the Terms of Reference.

The Partners may establish sub-groups or sub-committees of the Joint Committee with such terms of reference as may be agreed between them from time to time.

The ICBs shall ensure that their Authorised Officers have appropriate delegated authority, in accordance with each ICB's internal governance arrangements, to represent the interests of each ICB in the Joint Committee and any other sub-groups or sub-committees established by the Joint Committee.

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

The Joint Committee must establish effective, safe, efficient and economic arrangements for the discharge of the Joint Functions.

The Partners shall identify the Functions that will be delegated to the Joint Committee ("Joint Functions"). The Joint Committee must exercise the Joint Functions in accordance with:

the terms of this Agreement;

all applicable Law;

Guidance;

the Terms of Reference; and

Good Practice.

The Joint Committee must perform the Joint Functions in such a manner as to ensure each Partner's compliance with their own statutory duties in respect of the Joint Functions and to enable each Partner to fulfil its Reserved Functions.

SCHEDULE 6: FURTHER INFORMATION GOVERNANCE AND SHARING PROVISIONS

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 Functions and NHS England's Reserved Functions.

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 Joint Specialised 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, 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 Partner 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 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 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 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. giving consideration to 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 cooperate 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 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.

Each Party shall provide evidence (further to any reasonable request) that all personnel 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.

7.4. The Partners shall ensure that:

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

7.4.2. 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

7.4.3. specific limitations on the Staff who may have access to the 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 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 cooperate 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 Partner

8.4.1. 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

8.4.2. becomes aware of 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 cooperate 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;

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 protected 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. In particular, teach 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 in order 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 into 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, so as to ensure that the correct patient record / 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 Partner shall keep an audit log of Relevant Information transmitted and received in the course of 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 cross cut shredder or subcontracted to a confidential waste company that complies with European Standard EN15713.

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

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

11.9. In the event of any bad or unusable sectors of electronic storage media that cannot be overwritten, the Partner shall ensure complete and irretrievable destruction of the media itself in accordance with policy requirements.

12. Governance: Complaints and Access to Personal Data

12.1. The Partners shall assist each other in responding to any requests made under Data Protection Legislation made by persons who wish to access copies of information held about them ("**Subject Access Requests**"), as well as any other exercise of a Data Subject's rights under Data Protection Legislation or complaint to or investigation undertaken by the Information Commissioner.

12.2. Complaints about information sharing shall be reported to the Single Points of Contact and the Joint Committee. Complaints about information sharing shall be routed through each Partners' own complaints procedure unless otherwise provided for in the Joint Working Arrangements or determined by the Joint Committee.

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 7: COMMISSIONING HUB ARRANGEMENTS

[DN: to be developed should the commissioning hub arrangement require inclusion in the template ICB Collaboration Agreement].

Dated 2024

(1) **NHS ENGLAND (SPECIALISED COMMISSIONING)**

AND

(2) **INTEGRATED CARE BOARD**

- and -

(3) **INTEGRATED CARE BOARD**

- and -

(4) **INTEGRATED CARE BOARD**

Commissioning Team Agreement for Delegated Specialised Services support via NHS England Commissioning Teams in Financial Year 2024/25

DRAFT - NOT AVAILABLE FOR ACCEPTANCE

Guidance notes

This is a template Commissioning Team Agreement for the provision of administrative and management services by NHS England Commissioning Hubs in respect of the Delegated Specialised Services for financial year 2024/25 in accordance with Clause 9.6 of the Delegation Agreement for Specialised Services.

Clause 6.4 of the Delegation Agreement for Specialised Services states: *'…decisions of the ICB in respect of the Delegated Functions and made in accordance with the terms of [the Delegation Agreement] shall be binding on NHS England and the ICB.'*

Governance and decision-making arrangements are for local agreement but must clearly recognise and detail the leading role of ICBs in the arrangements for 2024/25.

Please note Guidance and recommendation notes have been provided to that will support development and to inform discussions around this Agreement.

This document has been provided as Word document prior to finalisation the Partners should:

- delete these guidance notes from their final Agreement;
- where this template offers draft text within square brackets, add, delete, or substitute text as appropriate and remove the square brackets.

Contents

THIS AGREEMENT is made on the_____ day of _____2024

Between

[insert name] Integrated Commissioning Board whose principal office is at *[insert address]*

[insert name] Integrated Commissioning Board whose principal office is at *[insert address]*

[insert name] Integrated Commissioning Board whose principal office is at *[insert address]*

NHS England, whose [Regional Team] principal office is at *[insert address*

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

[l] ICB, [l] ICB and [l] ICB are together referred to in this Agreement as the “ICBs”, and “ICB” shall mean any of them.

Introduction

The ICBs and NHS England wish to enter into this Commissioning Team Agreement (the “Agreement”).

This is an Agreement to define the administrative and management services (the “Administrative and Management Services”) to be provided by the NHS England regional teams currently commissioning Specialised Services (the “Commissioning Teams”) to the ICBs during the financial year 2024/25 (1 April 2024 – 31 March 2025) for all Delegated Specialised Services.

Background

a) NHS England has statutory functions to arrange for the provision of prescribed services for the purposes of the NHS. This includes the services known as Specialised Services.

b) The ICBs have statutory functions to arrange for the provision of services for the purposes of the NHS in their areas, apart from those commissioned by NHS England.

c) NHS England will enter into a Delegation Agreement for Specialised Services with each ICB under Section 65Z5 of the NHS Act 2006 (*delegation and joint working*). The Delegation Agreement for Specialised Services will delegate to ICBs the statutory functions for commissioning those Specialised Services that have been deemed ‘suitable and ready’ for greater ICB involvement (Delegated Specialised Services) from April 2024. The intention of this delegation is that this will help ICBs join up the specialist elements of pathways with prevention activity and primary, community and secondary care services for which they are responsible.

d) Staff who supported the commissioning of the Delegated Specialised Services immediately prior to delegation (the “Staff”), will come together within NHS England to form commissioning teams (the “Commissioning Team”).

e) In August 2023 an Executive decision was made that Commissioning Teams will remain hosted by NHS England during 2024/25 for a one-year transition period. The Commissioning Teams will be supporting the Delegated Specialised Services, as well as those specialised services retained by NHS England (“Retained Specialised Services”). This ensures stable support for the delegation of Specialised Services. The Delegation Agreement for Specialised Services provided that, as part of the delegation and joint

working arrangements under Section 65Z5 of the NHS Act 2006, NHS England could provide Administration and Management Services to the ICBs in respect of the Delegated Specialised Services (Clause 9.6 of the Delegation Agreement for Specialised Services).

f) The delegation of the Delegated Specialised Services supports NHS England's long-term and continuing ambition to put decision-making at as local a level as possible to meet the 'triple aim' of better health for everyone, better care for all patients, and efficient use of NHS resources, both for local systems and for the wider NHS.

g) In April 2025, the intention is that NHS England Staff supporting Delegated Specialised Services will be transferred to host ICBs.

h) This Agreement sets out the arrangements that will apply between ICBs and NHS England to enable the Hubs to provide Administrative and Management Services to the ICBs in 2024/25 to support the ICBs in exercising the statutory functions of commissioning the Delegated Specialised Services. There is no delegation of functions under this Agreement and as such the Commissioning Teams will not have the authority to take decisions in respect of the Delegated Services except as instructed by the ICBs in accordance with this Agreement.

It is agreed:

1 Commencement, duration and status of this Agreement

1.1 This Agreement shall come into force on the 1 April 2024 and continue until 31 March 2025 (the "Period") unless extended by written agreement from all Partners or terminated in accordance with Clause 7 (Termination) below.

1.2 Unless otherwise provided, the words and expressions defined in the Delegation Agreement shall have the same meaning and effect in this Agreement.

2 Principles and aims

2.1 In performing their respective obligations under this Agreement the ICBs and NHS England acknowledge that in exercising their obligations under this Agreement, each Partner must comply with the statutory duties set out in the NHS Act, and must:

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

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

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

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

2.2 The Partners agree:

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

2.2.2. to seek to continually improve whole pathways of care 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;

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 and as far as is reasonably practicable take such needs and views into account.

2.2.8. 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.

3 Scope of the arrangements

3.1 In accordance with the Delegation Agreements NHS England agrees to provide to the ICBs the Administrative and Management Services as set out in this Agreement.

3.2 The Partners agree that the costs associated with the provision of the Administrative and Management Services by the Hub shall not be included within the Delegated Funds allocated or transferred to the ICBs for the Period and that NHS England shall meet those costs.

4 Administrative and Management Services

4.1 NHS England, through the Hub, shall provide the Administrative and Management Services as set out in Schedule 1 or as otherwise agreed in writing between the Partners.

[GUIDANCE: The Partners to set out in Schedule 1 what Management Services the NHSE Hub will provide]

5 Staffing

5.1 The provisions of Schedule 2 shall apply in respect of the NHS England Staff providing Administrative and Management Services.

6 Governance and Decision Making

6.1 The Partners have agreed that the governance and decision-making arrangements as set out in Schedule 3 shall apply to this Agreement.

[GUIDANCE: NHS England and ICBs to collectively develop and agree appropriate governance and decision-making frameworks and reference / detail them at Schedule 3]

7 Variation and Termination

7.1 This Agreement may be varied by the written agreement of all Partners.

7.2 This Agreement may only be terminated prior to the end of the Period by mutual agreement in writing by all Partners.

7.3 The Escalation and Dispute provisions as set out in the Delegation Agreement shall apply to this Agreement.

8 Confidential Information

8.1 Each Partner shall at all times 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. No Partner shall disclose such information except with the consent of the other Partners. A disclosure by a Partner in accordance with an Act of Parliament or legislation made under it or in compliance with a Court Order shall not be an actionable breach of confidence.

8.2 The obligations of each Partner shall continue without limit in point of time but shall cease to apply to any information that is put into the public domain otherwise than by a Partner breaching its obligations.

8.3 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.

8.4 Save as expressly set out in this clause or otherwise with the written consent of the other Partners, no Partner shall make any press announcements about this Agreement or publicise this Agreement or any of the terms in any way and each Partner shall ensure that any such information disclosed is solely for the purpose of performing its obligations under this Agreement.

8.5 Notwithstanding the provisions of this clause, each Partner shall be entitled to disclose any information relating to this Agreement in the following circumstances:

8.5.1 for the purpose of any examination of this Agreement by the National Audit Office pursuant to the National Audit Act 1983 or otherwise;

8.5.2 for parliamentary, governmental, statutory or judicial purposes;

8.5.3 in relation to any other legal obligation on the disclosing Partner; or

8.5.4 where such information is already in the public domain.

8.6 Each Partner shall take all reasonable steps to ensure the observance of this clause by all its servants, employees, agents and consultants.

9 Data and Business Intelligence

9.1 All Partners will comply with all applicable requirements of the Data Protection Legislation. The Partners shall ensure that all Personal Data processed by or on behalf of them in the course of carrying out the Administrative and Management Services 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.

9.2 The Partners are satisfied that each of them have the appropriate legal basis for the processing of the data required in order for the ICBs to exercise their function in commissioning the Delegated Services and NHS England to provide the Administrative and Management Services.

9.3 NHS England shall complete a data protection impact assessment (DPIA) in respect of the provision of the Administrative and Management Services to ICBs and shall share this with the ICBs. The ICBs agree to enter into an appropriate data sharing agreement where this DPIA suggests this is required for the provision of the Administrative and Management Services.

9.4 Each ICB must carry out their own assurances (DPIA) in respect of the arrangements set out in this Agreement.

10 Assignment

10.1 No Partner shall assign, transfer, mortgage, charge, subcontract, delegate, declare a trust over or deal in any other manner with any or all of its rights and obligations under this Agreement without the prior written consent of the other Partners.

11 Costs and Liabilities

11.1 Except as otherwise provided, the Partners shall each bear their own costs and expenses incurred in complying with their obligations under this Agreement.

11.2 No Partner excludes or limits liability to the other Partners for:
11.2.1 death or personal injury caused by its negligence; or
11.2.2 Fraud; or
11.2.3 fraudulent misrepresentation.

11.3 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.

12 Status

12.1 Unless otherwise stated, this Agreement is not intended to be legally binding, and no legal obligations or legal rights shall arise between the parties from this Agreement. The Partners enter into the Agreement intending to honour all their obligations.

IN WITNESS OF WHICH the Partners have signed this Agreement on the date shown below

ICB Name
Authorised Officer **Date**

ICB Name
Authorised Officer **Date**

ICB Name
Authorised Officer **Date**

[NHS England
Authorised Officer **Date**

Schedule 1 – Administrative and Management Services

[GUIDANCE NOTE – FOR LOCAL REVIEW AND DETERMINATION. This schedule should set out what and how the Hub will be providing the Administrative and Management Services in 2024/25]

NHS England shall provide the following Administrative and Management Services under this Agreement:

1 General

1.1 NHS England will provide such Services as it agrees with the ICBs as required for the ICBs to exercise the Statutory Functions as set out in Schedule 3 to the Delegation Agreement which shall include, but is not limited, to the Administrative and Management Services set out below.

2 Contract Management

2.1 The Hub shall provide contract management and support in respect of the Delegated Services in order to facilitate the ICBs to meet the Delegated Functions set out in Schedule 3 of the Delegation Agreement *(delegated functions)*. Such support shall be in compliance with the agreed regional contracting strategy and Standard Operating Procedures.

[GUIDANCE: NHS England and ICBs to include as required a schedule (as set in Schedule 5 (contracting arrangements) which sets out further detail on the approach for contract management (for example, which organisation will hold the responsibility for preparing and actioning the schedules under the contracts, for example: payment; governance; reporting and information requirements). This Schedule could also include the relevant contracts, by provider, and show which organisation is the coordinating commissioner or associate commissioner.]

3 Finance

3.1 The financial arrangements in respect of the provision of the Administrative and Management Services by NHS England to the ICBs shall be as set out in Schedule 4 [financial arrangements].

4 Data Management and Analytics

[This Agreement is specifically about how the data arrangements will work in relation to NHSE providing the Services to the ICBs in 24/25.]

4.1 The Hub shall provide such data management and analytic services as NHS England considers necessary to ensure that the ICB meets its obligations under Schedule 3 of the Delegation Agreement (*Delegated Functions*).

5 Freedom of Information and Parliamentary Requests

5.1 The Hub shall provide such reasonable support as required by an ICB to ensure the appropriate handling, management and response to all freedom of information and parliamentary correspondence relating to Delegated Specialised Services.

6 Incident Response and Management

6.1 The Hub shall provide such reasonable support as required by an ICB in relation to local incident management for Delegated Specialised Services

7 Provider Selection and Procurement

7.1 The Hub shall act on instructions from the ICBs in relation to provider selection and procurement processes for the Delegated Specialised Services.

8 Quality

8.1 The Hub shall ensure appropriate arrangements for quality oversight are in place in respect of the provision of the Administrative and Management Services.

Schedule 2 – Staffing Model

Hub Staff Model

1. NHS England will ensure such resource as it considers reasonably required is allocated to the provision of the Administrative and Management Services.

2. Under this Agreement NHS England shall be providing the Administration and Management Services to the ICB to assist the ICB in meeting its obligations in respect of the Delegated Functions under the Delegation Agreement for Specialised Services.

3. There is no delegation of statutory functions under this Agreement and therefore the responsibility for the Delegated Specialised Services, along with the decision-making responsibility, rests with the ICBs.

Availability of NHS England Staff

4. In addition to any Staff deployed in any communicated arrangement, NHS England may deploy additional Staff to the Hub to perform Management Services.

5. NHS England will take all reasonable steps to ensure that the NHS England Staff deployed for the purposes of carrying out the Delegated Functions shall:

    a. faithfully and diligently perform duties and exercise such powers as may from time to time be reasonably assigned to or vested in them; and

    b. perform all duties assigned to them pursuant to this Schedule 8.

6. The ICB shall notify NHS England if the ICB becomes aware of any act or omission by any NHS England Staff which may have a material adverse impact on the provision of the Services or constitute a material breach of the terms and conditions of employment of the NHS England Staff.

7. NHS England shall use all reasonable efforts to make its Staff available whilst the NHS England Staff are absent:

    a. by reason of industrial action;

    b. as a result of the suspension or exclusion of employment or secondment of any Staff by NHS England;

    c. in accordance with the NHS England Staff's respective terms and conditions of employment and policies, including, but not limited to, by reason of training, holidays, sickness, injury, trade union duties, paternity leave or maternity or where absence is permitted or required by Law;

    d. if making the NHS England Staff available would breach or contravene any Law;

    e. as a result of the cessation of employment of any individual NHS England Staff; and/or

    f. at such other times as may be agreed between NHS England and the ICB.

Employment of the NHS England Staff

8. NHS England shall employ its Staff and shall be responsible for the employment of its Staff at all times on whatever terms and conditions as NHS England and its Staff may agree from time to time.

9. NHS England shall pay its Staff their salaries and benefits and make any deductions for income tax liability and national insurance or similar contributions it is required to make from salaries and other payments.
10. NHS England shall not hold out its Staff as employees of the ICBs, and shall procure that its Staff do not hold themselves out as employees of the ICB.

Management of NHS England staff

11. NHS England where appropriate, shall in consultation with the ICBs, make arrangements to ensure the day-to-day control of the activities of their Staff is shared with the ICBs and deal with any relevant management issues concerning their Staff including, without limitation, performance appraisal, discipline and leave requests.

12. The ICBs agree to provide all such assistance and co-operation that NHS England may reasonably request from time to time to resolve grievances raised by NHS England Staff and to deal with any disciplinary allegations made against NHS England Staff arising out of or in connection with the provision of the Services which shall include, without limitation, supplying NHS England with all information and the provision of access to all documentation and NHS England Staff as NHS England requires for the purposes of considering and dealing with such issues and participating promptly in any action which may be necessary.

Conduct of Claims

13. If an ICB becomes aware of any matter that may give rise to a claim by or against a member of NHS England Staff, notice of that fact shall be given as soon as possible to NHS England. NHS England and the ICB shall co-operate in relation to the investigation and resolution of any such claims or potential claims.

14. No admission of liability shall be made by or on behalf of an ICB and any such claim shall not be compromised, disposed of or settled without the consent of NHS England.

Schedule 3 - Governance and Decision-Making Arrangements

[GUIDANCE: the responsibility for commissioning the delegated specialised services will transfer to ICBs from 1 April 2024. However, the staffing and teams that commission those services will remain with NHS England in 2024/25. The Hubs will undertake administration and management services on behalf of the ICBs, but will require decisions and instructions from the ICBs as to how those commissioning activities should be undertaken]

***RECOMMENDATION**: this Schedule should be used to describe the governance and decision-making arrangements that will be in place between the Partners for 2024/25. This could include:*

- *The role of the joint committee established between the partners, with reference to the revised joint committee terms of reference;*
- *The issues that should be referred to the joint committee. For example, approval of the financial or contracting strategy; general strategy for specialised services in 2024/25; transformation proposals for specialised services;*
- *Whether there are any limitations on spending by the NHSE Hub and how ICBs should be involved in monitoring expenditure and approving any exceptional spending, or change in spending, in accordance with their standing financial instructions;*
- *Where appropriate, the financial governance or arrangements can be set out in Schedule 4 (financial arrangements);*
- *Whether there are any limitations on the NHSE Hub in relation to contracts on changes to contracts and how ICBs should be involved in the approval process for changes, variations or amendments to contracts;*
- *What the process for signing new contracts will be that affect the ICB or ICBs in future years;*
- *The extent to which ICBs should be involved in any procurement processes undertaken by the NHSE Hub and how the final award will be determined by the ICBs;*
- *Where there is no joint committee, this section will need to describe the relevant decision making body that includes all of the partners, its role and any limitations on decision making.*

Schedule 4 - Financial Arrangements

[GUIDANCE: in 2024/25, budgets for the delegated specialised services will be allocated to ICBs, who will manage the funds in accordance with the delegation agreement. Particular reference to Clause 10 (Finance) of the delegation agreement is advised]

The term of the Commissioning Team Agreement is intended to be for one year, covering the 2024/25 financial year and the specific arrangements required (i.e. NHS England providing administration and management services to ICBs). It is envisaged that from April 2025, the Commissioning Team will transfer to a host ICB and therefore the arrangements described in this financial schedule will either no longer be required or will require revision to support those arrangements.

***RECOMMENDATION**: this section needs to detail the following:*

- *The scope of the NHSE hub's discretion relating to finances (i.e. is the hub able to make decisions relating to spend);*
- *Are there any limitations on the NHSE hub's discretion relating to financial decision making (i.e. when would the hub need to consult the ICBs on spend);*
- *How the ICBs will make payments in accordance with the contracts and how the relationship between the NHSE Hub and ICB finance teams will operate;*
- *Any expectations in relation to financial reporting, including the ICBs providing financial reports to the NHSE hub;*
- *What processes should be in place if there is a dispute relating to finance or the activities undertaken by the NHSE Hub;*
- *Does the NHSE hub have access to the ICB ledgers and how is this going to be describe and detailed?*

Schedule 5 - Contracting Arrangements

[GUIDANCE: this schedule could be used to set out which organisation is responsible for which contract management activities and also set out the list of contracts and detail which organisation holds the contract with the provider and whether there are coordinating and associates to the CCA.]

Agenda Item

ICB 31-01-011

Tackling Inequalities in Access, Experience and Outcomes

NHS

Shropshire, Telford and Wrekin

Prevention and Health Inequalities Board

Highlight Report (Quarter 3 2023/24)

December 2023

Document Purpose

This slide set provides an overview of progress against each of the objectives identified in the Shropshire, Telford & Wrekin 2023/24 NHS Health Inequalities Implementation Plan.

Those objectives align with the commitments in the NHS Long Term Plan to support people to keep healthier, for longer. Thereby focusing on supporting people to live healthier lives and treating avoidable illnesses early and delivery of The National Healthcare Inequalities Improvement Programme (HiQiP) five priority areas:

1. Restoring NHS services inclusively
2. Mitigating against digital exclusion
3. Ensuring datasets are complete and timely
4. Accelerating preventative programmes (including the initiatives outlined in the NHS Prevention Programme, Core20PLUS 5 Key Clinical Areas for Adults and Core20PLUS 5 Key Clinical Areas for Children & Young People.
5. Strengthening leadership and accountability

A summary of progress against key objectives has been provided on slide 3.

The remainder of this pack provides high-level progress updates from respective system leads for each work programme, against planned activity for 2023/24.

Overview of Progress

	Objective	Work Programme / Project	Lead/s	Slide	RAG
1	KLOE1: Restore NHS Services Inclusively	Elective restoration programme	Barrie Reis-Seymour	5	
2	KLOE 2: Mitigate Against Digital Exclusion	2023/24 Digital Strategy	Tristi Tanaka	6	
3	KLOE 3: Datasets are Complete and Timely	System-wide data-sharing	Craig Kynaston Craig Lovatt	7	
		Provision of baseline data and intelligence to support objectives (using a PHM approach)		8	
		Improved ethnicity recording		9	
4	KLOE 4: Acceleration of preventative programmes are reported via objectives 6 – 20				
5	KLOE 5: Leadership and Accountability	Established senior roles across all organisations	Tracey Jones Alex Mace	10	
		Improved governance (system-level and Provider)			
		Improved HI awareness and training		11	
		Standardised approach to assessing impact			
		Equality, Diversity and Inclusion (EDI)	Mandee Worrall Alison Lester	12	
6	LTP 1: Alcohol Care Teams	Implementation of Alcohol Care Teams	Edith Macalister	14	
7	LTP 2: Tobacco Dependency	Implementation of Tobacco Dependency Teams	Alex Mace	15	
8	LTP 3: Obesity/Weight Management	NHS Digital Weight Management Programme		16	
9	Core20PLUS Group 1: Learning Disabilities	LD Physical Health Checks	Janet Gittins	18	
		LeDeR Action Plan	Tracey Slater Jennifer Morris	19	
10	Core20PLUS Group 2: People Living in Rural Areas	Exploration of the impact of rurality	Berni Lee Paula Mawson Rachel Robinson	20	

	Objective	Work Programme / Project	Lead/s	Slide	RAG
11	Core20PLUS5 ADULT 1: Maternity	LMNS Equity and Equality Action Plan	Emma Popo (Sue Bull)	22	
12	Core20PLUS5 ADULT 2: Severe Mental Illness	SMI Health Checks	Gail Owen	23	
13	Core20PLUS5 ADULT 3: COPD	Spirometry Services	Fiona Smith	24	
		Delivery of Flu and Covid-19 Vaccinations	Emma Pyrah Steve Ellis	25	
14	Core20PLUS5 ADULT 4: Early Cancer Diagnosis	STW Cancer Strategy Early Cancer Diagnosis Objectives	Marie-Claire Wigley	26	
		Early Cancer Diagnosis Improvement Plan	Helen Onions	27	
		PCN Cancer DES	Janet Gittins	28	
		Core20PLUS Connectors (Cancer Champions)	Alex Mace	29	
15	Core20PLUS5 ADULT 5: Hypertension and Lipids	Targeted secondary prevention Lipid Management	Clare Stallard	30	
		InHIP Hypertension Community Case-finding	Edith Macalister	31	
		Hypertension Treatment to Target	Alex Mace	32	
16	Core20PLUS5CYP 1: Asthma	CYP transformation for Asthma	Nicola Siekierski	34	
17	Core20PLUS5CYP 2: Diabetes	Diabetes Transformation for CYP	Fiona Smith	35	
18	Core20PLUS5CYP 3: Epilepsy	CYP Transformation for epilepsy	Nicola Siekierski	36	
19	Core20PLUS5CYP 4: Oral Health	Oral Health workforce training	Kate Taylor-Weetman	37	
		Provision of toothbrushes and toothpaste			
		Supervised toothbrushing for early years			
		Data analysis and audits of current waiting lists			
20	Core20PLUS5 CYP 5: Mental Health	Data analysis and audits of CYP MH access	Brett Toro-Pearce	38	
		National Mental Health Support Teams in Schools			
		Education and awareness of childhood trauma			

Key Notes on Progress

- Of the 37 programmes and projects listed within the plan, 25 programmes of work are on track to deliver planned actions and 12 programmes are experiencing delays or risks of delay.

- When reviewing barriers to progress for programmes considered at risk, four common themes were identified:
  - Capacity challenges across the health system.
  - Incomplete datasets and analysis as a result of limited analytical capacity, technical challenges or I.T. system capabilities.
  - Awareness and understanding of objective areas and their impact on the population i.e. digital exclusion, and consequent limited engagement from healthcare organisations amidst urgent competing priorities.
  - Limited availability of funding.

- Mitigations are in place across all programmes however Alcohol Care Teams and Diabetes for Children and Young People have been highlighted as key risk areas due to significant delays in progress.

- As testament to the successful work taking place across the system, Shropshire, Telford & Wrekin was selected to showcase a number of programmes at the Midlands Health Inequalities Conference in November 2023, as well as feature on the events leadership panel.

KLOEs 1-5:

Restore NHS Services Inclusively
Mitigate Digital Exclusion
Complete and Timely Datasets
Leadership and Accountability

2023/24 OBJECTIVE	KLOE 1: Restore NHS Services Inclusively	Objective Lead/s: Barrie Reis-Seymour

Programme /Project	Planned Actions	Deliverables	Base line	EOY Target	RAG
Elective Recovery Transformation Programme	~~• Completion of EQIA's for all Transformation Programmes.~~ • Undertake EQIAs on elective recovery across all organisations. • Development underway of one fully integrated whole system Elective Transformation & Recovery Inequalities plan including Trust specific SMART actions and milestones, including Elective Transformation Programmes, Trust's elective recovery initiatives and Primary Care recovery plans. • Development of an overarching system EQIA for elective transformation and recovery built upon the inequalities plan. • Planned audits and analysis of outpatient 'did not attend' rates by patient ethnicity and deprivation, and to better understand reasons for missed appointments. • Targeted outreach to patients more likely to not attend appointments. • Regular monitoring of patients with a learning disability on lists prioritising patients by socio-economic factors (in addition to clinical need and time waited). • Development of alternative comms approaches/appointments/reminders etc to better reach	~~• Elective Transformation Programmes EQIA's~~ • Provider Trust Elective Recovery EQIA's • System-wide combined Elective Transformation & Recovery EQIA • NHS Trust and ICB Reports show waiting lists by deprived quintile and ethnicity. • A whole system integrated Elective Transformation & Recovery Inequalities plan, including individual Trust and programme SMART actions. • Written review of available data sources and agreed integrated approach to analysis and action planning. • Written review of outcomes from DNA audits with actions that contribute to the overall Inequalities Plan.	Pending subject to EQIAs	Pending subject to EQIAs	

Latest Progress Updates

Brief Progress Update/ Progress against EOY targets	Key Achievements/Completed Deliverables/ Examples Best Practice and Good News Stories	Activity Planned for the next 3 months
• QIA's and EQIA's for the system transformation programme completed and in place. Any actions that come out of that are built into the work of that programme. • New System IIA template now in place that builds in enhanced screening of inequalities and inequity impact. • Work continues to develop and bolster as system Elective Recovery & Transformation Inequalities Plan that will link to the Elective Recovery work, and feed into the STW Inequalities Plan. • Work is being undertaken by BI Teams to show waiting lists by IMD and ethnicity.	• Outpatients' transformation standard processes now in place to offer traditional appointments where needed and appropriate to mitigate against digital exclusion. • Audits now commencing (SaTH & RJAH) into DNA's/Missed appointments that will inform remedial targeted actions. • Work with Sight Loss Shropshire and outreach groups to help shape improvements to patient communications and pathways. • Short film developed to train others in how to better reach those with limited vision or sight loss – about to be launched.	• Running audit into DNA's and producing action plan. • Launching patient comms Task & Finish Group to address the many inequality and inequity issues around patient communications. • Transformation programmes completing the new IIA that will inform specific inequalities actions and plans. • Providers to complete their plans and actions around recovering elective services inclusively. • Drawing together individual actions into overarching system elective inequalities plan.

Key Risks	Mitigations
Delays to full implementation of any required actions due to the capacity challenge below	Increasing awareness and buy-in of the importance of this work with provider Trusts
Challenges/Barriers to Progress	**Actions/Support Required**
Capacity to give the necessary time and focus to this area of work, particularly for providers.	Increasing awareness and buy-in of the importance of this work with provider Trusts

2023/24 OBJECTIVE	KLOE 2: Mitigate Against Digital Exclusion	Objective Lead/s: Tristi Tanaka			
Work Programme/Projects	**Planned Actions**	**Deliverables**	**Base line**	**EOY Target**	**RAG**
Development of STWs 2023/24 Digital Strategy and incorporation of key objectives to mitigate against digital exclusion	Q1 2023/24 Onwards • Initial drafting and engagement on proposed Digital Strategy document Q2 2023/24 • Consideration of engagement/feedback regarding digital exclusion and how this can be addressed through local actions. • Development of a Digital Strategy Action Plan which includes specific actions to mitigate digital exclusion.	• Published Digital 2023/24 Strategy • Published Digital Strategy Action Plan end of Q4	N/A	N/A	

Latest Progress Updates

Brief Progress Update/ Progress against EOY targets	Key Achievements/Completed Deliverables/ Examples Best Practice and Good News Stories	Activity Planned for the next 3 months
• System Digital Strategy shared with the Integrated Care Board Q3. • Work to be done to develop a detailed roadmap and implementation plan. • System CDIO post now vacant at 1 November 2023 • Input from the Prevention / Health Inequalities Team started • System Engagement team's Big Conversation insights to inform possible mitigations for known digital exclusion and opportunities for stakeholder involvement in action plan • Review opportunities to improve digital inclusion by adopting and adapting the NHSE Digital Inclusion Framework	• Seconded Head of Digital Innovation and Transformation to progress work on the system Digital Strategy roadmap and implementation plan.	• Baseline partner digital portfolios to feed the Digital Strategy roadmap • Identify and agree system principles to guide action planning to enable digital inclusivity/mitigations in each key tranche of the digital lifecycle for digital transformation programmes in the roadmap– Discovery, Design, Delivery and Continuous Improvement • Adopt and adapt the NHSE Digital Inclusion Framework • Draft the detailed roadmap and implementation plan with linked digital inclusion actions/exclusion mitigations

Key Risks	Mitigations
Delays to progress due to local capacity during ICB management of change	Identity 'digital, community and digital clinical' champions to identify opportunities and spread learning

Challenges/Barriers to Progress	Actions/Support Required
Incomplete data and analysis to underpin digital exclusion mitigations	List of existing stakeholder networks especially 'champions' to support discovery
Leadership awareness of digital inclusion as part of design and delivery	Access to related plans and opportunity to inform bid opportunities, commissioning and procurement

2023/24 OBJECTIVE	KLOE 3: Ensure Complete and Timely Datasets	Objective Lead/s: Craig Kynaston and Craig Lovatt			
Work Programme/Projects	**Planned Actions**	**Deliverables**	**Baseline**	**EOY Target**	**RAG**
Improved data-sharing across the system, specifically in terms of General Practice data to enable review of population data at a granular level.	• Engagement with the Local Medical Committee (LMC) to jointly progress facilitation of data access via the EMIS X Analytics tool. Begin governance process between organisation to facilitate the legal basis to extract and flow data from general practice into the CSU hosted DSCRO. • STW to obtain funding required to flow data (timescale will be dictated by governance process and financial agreement, however this will commence immediately following LMC agreement).	Finalised system-wide data-sharing arrangements.	N/A	System-wide data-sharing agreement	

Latest Progress Updates

Brief Progress Update/ Progress against EOY targets	Key Achievements/Completed Deliverables/ Examples Best Practice and Good News Stories	Activity Planned for the next 3 months
• Further engagement with EMIS EXA team for governance clarification sort from LMC. • Awaiting input from Royal college of General Practice on final governance section before feedback can be given to LMC for approval to proceed to PCN/Practice review • Returning to LMC Jan 24 to update and discuss next steps including support from SE Shropshire PCN medical lead	Direct engagement with EMIX EXA team and CSU to process data flows once available Medical lead for SE Shropshire and clinical lead for CVD program of work engaged with access to Patient level Practice data extraction. Happy to support the ICB in the development and feedback at LMC in Jan 24	• Final feedback to LMC providing governance required. • Engage with PCN/Practices to present the EMIS EXA solution utilising LMC approval once gained • Update at LMC in Jan 24 with Support of SE PCN clinical lead

Key Risks	Mitigations
LMC refusal	Working closely with EMIS EXA and LMC to provide full reassurance on information governance.
Potential for STW practices to be looking at new System (Not EMIS)	Primary Care IT lead keeping BI team updated on this development

Challenges/Barriers to Progress	Actions/Support Required
LMC not assured preventing progression	

2023/24 OBJECTIVE	KLOE 3: Ensure Complete and Timely Datasets	Objective Lead/s: Craig Kynaston and Craig Lovatt			
Work Programme/Projects	**Planned Actions**	**Deliverables**	**Baseline**	**EOY Target**	**RAG**
Improved ethnicity recording across the system (and specifically for those with learning disabilities via primary care)	Q1 2023/24 • Confirmation of baseline data Q2 2023/24 • Engagement with Providers to understand barriers to recording ethnicity data • Shared learning with other systems to understand what actions systems with high %s of ethnicity recording have taken • Development of local action plans to improve Q3 onwards • Implementation of new electronic patient record systems where required and ensuring these include the functionality to record key data fields to support analysis of health inequalities. Acute Provide (Apr 24), Specialist Orthopaedic (Spring 2023).	• Reports on baseline ethnicity reporting. • Upgraded electronic patient record systems. • Action plans for each Provider.	6.91% ethnicity recording unavailable 4.28% ethnicity status not stated or refused to be given	Reduced % of ethnicity recording unavailable Reduced % of ethnicity status not stated or refused to be given	

Latest Progress Updates

Brief Progress Update/ Progress against EOY targets	Key Achievements/Completed Deliverables/ Examples Best Practice and Good News Stories	Activity Planned for the next 3 months
• Engagement with two main acute providers to improve data capture – however, both Providers are implementing Electronic Patient Record Systems (EPRs) and are dependent on these programmes. • Engagement with community and mental health Providers to develop national datasets (CSDS and MHSDS) to reconcile to internal EPR recording of key metrics.	Assessment of key Health Inequality data items and engagement on options to improve recording.	Document data quality improvement plans where applicable and will be monitored as part of STW ICS health inequalities dashboard. Further collaboration with Practice across STW to ensure the completeness and accuracy of ethnicity recording.

Key Risks	Mitigations
Delays to the implementation of the electronic patient record systems	

Challenges/Barriers to Progress	Actions/Support Required
Understanding of the CSDS and MHSDS datasets	STW BI team engaged with CSU colleagues to support improved utilisation of CSDS and MHSDS datasets

2023/24 OBJECTIVE	KLOE 3: Ensure Complete and Timely Datasets	Objective Lead/s: Craig Kynaston and Craig Lovatt			
Work Programme/Projects	**Planned Actions**	**Deliverables**	**Baseline**	**EOY Target**	**RAG**
Provision of baseline data and intelligence to support a PHM approach for key improvement programmes in line with HI objectives.	• Recruitment of a dedicated PHM analytical post (Q3) • Utilise available tools (locally and nationally) to monitor performance based inequity relating to ethnicity, age or sex for priority programmes including Cancer, Mental Health, CVD, ECDS Performance and MSK Waiting Lists. • Complete development work for the above programmes and share information with wider audiences across the system. • Creation of local dashboards to capture local need.	• Recruited PHM Analyst. • Ensure resource is linked in with national/local HI forums and has access to relevant tools. • Local dashboards show performance and inequalities for key programmes: Cancer, MH, CVD, ECDS and MSK waiting lists.	National data sources - current Core20 levels	Improvement	

Latest Progress Updates

Brief Progress Update/ Progress against EOY targets	Key Achievements/Completed Deliverables/ Examples Best Practice and Good News Stories	Activity Planned for the next 3 months
• New Analyst has been appointed and has commenced employment with NHS STW and both Local Authority insights/Public health teams, Mid - September. • Introduction of new BI developer role in ICB to support further creation of PHM focused dashboards, development of Power BI system sharing environment and ICS wide data lake. • Current dashboards for Cancer, MH and ED demand, All 3 with a health inequalities lens within them, agreed as base to create dashboards for remaining system clinical priorities and CYP core 20 plus 5. • Initial review completed and subject to final work before being shared with wider Health Inequalities team	• Successful recruitment of dedicated resource (PHM Analyst post) • Development of three dashboard environments based on NHS STW key priorities with Health inequalities lens (Cancer, Mental Health and Emergency). • Introduction of BI technical developer role • 15 people from NHS STW system (including ICB Head of information) now enrolled into national Core 20 Health inequalities ambassador program	• Further development of dashboards in line with STW remaining priorities (including CVD/Hypertension). • Scoping of data quality improvement plans • Implementation of LTC place based dashboard • Addition of dedicated PHM/Health inequality lead analyst development meetings

Key Risks	Mitigations
Limited capacity	Recruitment of a dedicated PHM analyst post

Challenges/Barriers to Progress	Actions/Support Required

2023/24 OBJECTIVE	KLOE 5: Leadership and Accountability	Objective Lead/s: Tracey Jones			
Work Programme/Projects	**Planned Actions**	**Deliverables**	**Baseline**	**EOY Target**	**RAG**
Identification of senior responsible leadership across the system	~~• Confirmation of SROs for each organisation (Q1 2023/24)~~ ~~• SROs (or deputised Trust representation) to be included as members of key forums, including Place-based Boards, Health and Wellbeing Board and the Prevention and Health Inequalities Board.~~	~~• Directory of key lead contacts for tackling health inequalities across STW, including organisation SROs and leads for preventative programmes/Core20PLUS clinical areas.~~	5 SROs confirmed	6 SROs confirmed	
Improved system-level governance.	Q1 2023/24 • All Provider organisations report on health inequalities to internal Boards ~~• Reports to ICB Board to demonstrate how inequalities have been considered as part of decision making, strategies and delivery plans~~ ~~• Development of an updated NHS 2023/24 Health Inequalities Implementation Plan.~~ ~~• Refreshed version of Schedule 2N in Provider Contracts.~~ Q2 2023/24 ~~• Establish a Prevention and Health Inequalities Board to have direct oversight of objectives outlined within the Health Inequalities Implementation Plan.~~ ~~• Improved system-level reporting and monitoring framework.~~	• Health Inequalities Reports to Trust Boards ~~• Health Inequalities Reports to ICB Board~~ ~~• Finalised 2023/24 Implementation Plan~~ ~~• Established Prevention and Health Inequalities Board~~ ~~• Clear process for monitoring progress against objectives.~~ ~~• Updated Schedule 2N agreed with Providers and included in the 2023/24 contract.~~	Early stages of reporting maturity subject to system capabilities.	All organisations to have clear governance for reporting on HI objectives and progress.	

Latest Progress Updates

Brief Progress Update/ Progress against EOY targets	Key Achievements/Completed Deliverables/ Examples Best Practice and Good News Stories	Activity Planned for the next 3 months
• SROs identified across each organisation. • Prevention and Health Inequalities Board in place with a reporting/monitoring framework for process metrics. • Work in progress by BI Teams to develop an outcomes-based performance dashboard aligned to key objectives. • Schedule 2N in place for Trusts and initial round of updates/discussions on health inequalities held via Contract Meetings in October/November. • Workshop in development for 5th December to review current programmes and identify collaborative initiatives.	• New digital leadership: System Head of Digital Transformation appointed with vested interest in health inequalities and mitigating the digital divide. • STW were successful in their expression of interest to present at two workshops at the upcoming Midlands Health inequalities Conference in Birmingham 29th November. Presentations cover CYP Asthma at the Core20PLUS Clinical Areas Workshop and STW Cancer Champions at the Partnerships Workshop. STW have also secured a table and screen for the lunchtime marketplace to showcase our work in community Hypertension case-finding. ICB HI Lead asked to partake in the event panel and meeting with Bola Owolabi, Director for Health Inequalities, NHSE in a closed session.	• Develop Schedule 2N for 2024/25. • Review and refine reporting requirements and internal Trust governance. • Outputs of the Workshop to be put into action, identifying key initiatives and taking these forward.

Key Risks	Mitigations
Reporting on health inequalities not fully ratified system-wide.	Established Prevention and Health Inequalities Board to support oversight/progress where Provider Trusts are working with ICB Leads to improve awareness.
Challenges/Barriers to Progress	**Actions/Support Required**

2023/24 OBJECTIVE	KLOE 5: Leadership and Accountability	Objective Lead/s: Tracey Jones		
Work Programme/Projects	**Planned Actions**	**Deliverables**	**Baseline**	**EOY Target**	**RAG**
Awareness, training and dissemination of key resources system-wide relating to Health Inequalities.	• Development of a central space for HI on the Shro and Tel Intranet (accessible to staff across the entire health and social care system) (Q2) ~~• Identification and upload of key training modules/resources to the Learning Management System (Q2)~~ ~~• Exploration of alternative methods to deliver awareness/training i.e. through webinars, presentations, video etc. (Q2)~~	• Shro and Tel Health Inequalities Page ~~• Shared resources incl. training modules and tools~~ ~~• Delivered webinar to Virtual Huddle~~ • Delivered presentations within Provider organisations	Unknown training/ awareness	Measurable training and awareness	
Standardised approach to undertaking impact assessments.	~~• Standardised and complete IIA process, used system-wide~~ • Development of a HEAT easy use guide and signposted training • Embedded Health Equity Assessment Tool (HEAT)	~~• Ratified process for completing integrated impact assessments (Q1)~~ • HEAT Easy Use Guide (Q4) • HEAT training opportunities and support tools incorporated within key resources comms (Q2)			

Latest Progress Updates

Brief Progress Update/ Progress against EOY targets	Key Achievements/Completed Deliverables/ Examples Best Practice and Good News Stories	Activity Planned for the next 3 months
• Initial content shared with Comms. Team to create Shro and Tel Health Inequalities page. • Relevant and recommended training modules uploaded to the System Learning Management System LMS). • Assessment of current training methods available i.e. modules, webinars, presentations. • PMO Team working with Comms. to develop a local induction video for NHS staff highlighting the problem, our role to address it. • Series of webinars being arranged on key topics such as inclusive recovery and NICE Health Inequalities interface. • Comparison analysis undertaken on STW Integrated Impact Assessment and PHE HEAT Tool to understand tool purposes and outputs. • Plans developing for ICB and Public Health HI Leadership to attend Trust Boards and discuss health inequalities.	• 14 Core20PLUS Ambassadors and 1 Health Inequalities Finance Fellow were successful in their applications to be part of the national programme.	• Official launch the Shro and Tel Health Inequalities page. • Commence videoing for NHS Health Inequalities Induction Video with comms. team. • Promote local training modules and monitor access/uptake. • Review comparison of IIA and HEAT tool and understand how the outputs of HEAT can be achieved through IIA tool. • Develop HEAT tool easy-use guide and promote use of tools available. • Continued awareness sessions introducing HI to NHS staff. • Local peer network meeting with Core20PLUS Ambassadors and HIFF to support them on their journey. • Delivery of Health Inequalities presentation to the Equality, Diversity and Inclusion event in January 2024.

Key Risks	Mitigations
Capacity focused solely on supporting progress/coordination of health inequalities actions	• ICB Prevention and Health Inequalities Team has secured additional funding for a Project Support Officer. • ICB PHI Team are exploring/utilising resources developed by other systems, where suitable.

Challenges/Barriers to Progress	Actions/Support Required

2023/24 OBJECTIVE	KLOE 5: Leadership and Accountability	Objective Lead/s: Mandee Worrall and Alison Lester

Work Programmes	Planned Actions	Deliverables	Baseline	EOY Target	RAG

Improving awareness and understanding of Equality, Diversity and Inclusion (EDI)	**Quarter 1 2023/24**
	• MS Teams Bitesize sessions focused on various subjects (such as challenging hate incidents in the workplace).
	Quarter 2 2023/24
	• Update EDI System-wide Steering Group Terms of Reference to refresh Chair and membership.
	• Revise EDI governance and assurance model
	• Develop an Action Plan to address the following:
	  • NHSE EDI Improvement Plan (includes 6 high impact actions)
	  • Rural racism report recommendations (including ref to international workforce)
	  • Workforce Race Equality Standards (WRES)
	  • Michelle Cox employment tribunal learning
	  • Workforce Race and Equality Inclusion Strategy (WREI)
	Quarter 3 2023/24
	• Deliver a Cultural Diversity awareness workshop
	• Deliver educational leadership sessions for Managers on handling equality workforce issues (clinical and non-clinical)
	• Pause and reset to review EDI Leadership, governance and strategic objectives
	• System wide workshop planning
	• Implement High impact 1 – Board Specific and measurable EDI Objectives
	Quarter 4 2023/24
	• Systemwide EDI workshop (Planned January 2024)
	• Approve EDI governance and assurance model
	• Timely and measurable strategic objectives – including NHSE improvement plan/RR/MC learning
	• Review and approve systemwide STW EDI leadership including SRO and EXEC SRO
		Quarter 1 2023/24
		• Bespoke Bitesize sessions focused on several subjects (such as challenging hate incidents in the workplace).
		Quarter 2 2023/24
		• EDI steering group Chair (Now Provider led and 12 month rolling position)
		• Updated EDI Steering group Terms of Reference
		• EDI Governance and Assurance model
		• Draft EDI project plan – to be approved following outcomes from January workshop
		• Proposed governance and escalating model – awaiting approval
		Quarter 3 2023/24
		• Cultural Diversity awareness workshop – September 23.
		• Rolling educational leadership sessions for Managers on handling equality workforce issues (clinical and non-clinical)
		• Embed NHSE High Impact 1
		• EDI governance and assurance model revised and approved
		• Draft action Plan to address the following: To be implemented following January workshop
		  • NHSE EDI Improvement Plan (includes 6 high impact actions)
		  • Rural racism report recommendations (including ref to international workforce)
		  • Workforce Race Equality Standards (WRES)
		  • Michelle Cox employment tribunal learning
		  • Workforce Race and Equality Inclusion Strategy (WREI)
			n/a	n/a	

Latest Progress Updates

Brief Progress Update/ Progress against EOY targets	Key Achievements/Completed Deliverables/ Examples Best Practice and Good News Stories	Activity Planned for the next 3 months
• The People Team have organised a series of bitesize education sessions over Q1 with NCA delivering, including a focus on challenging hate incidents from patients, staff and visitors. All work complete. • Work is taking place to develop a system-wide action plan to improve EDI, as well as refreshing the Terms of Reference for the EDI Steering Group. A workshop has been planned for 11-1-24 to begin this collaborative process. • Conversations have taken place with Northern Care Alliance to organise a series of leadership sessions from September focused on handling equality workforce issues. Five sessions have been delivered and a meeting is taking place with NCA to review evaluations 12-12-23.	• Utilising the Learning Management System (LMS) as a central tool for training, programmes and events. • Cultural diversity event delivered in September 2023 originating from discussions and planning at the EDI Steering Group • EDI Steering group Provider led chair confirmed • Implemented and improved robust governance and assurance model • Galvanise leaders initiative – successful cohort 1. Cohort 2 started Sep 23. • Acute Trust EDI Midwife appointed • Increased EDI champion roles appointed across STW	• Deliver EDI STW workshop • Implement EDI Themed workstreams • Approve timely and measurable objectives of EDI project plan • NHSE EDI improvement plan • Revise EDI data capture • Improve internal performance board assurance • Further scope of EDI leadership across STW • System to approve Senior Leader role across STW (SRO/Exec Lead) • Robust plan to continue funding source for ICS EDI roles

Key Risks	Mitigations,
Stakeholder engagement to develop and deliver on actions, especially when discussing uncomfortable subjects.	Updated EDI Steering Group with system-wide membership

Challenges/Barriers to Progress	Actions/Support Required

LTP 1 – 3:
Alcohol, Tobacco and Weight Management

2023/24 OBJECTIVE	LTP 1: Alcohol	Objective Lead/s: Edith Macalister			
Work Programme/Project	**Planned Actions**	**Deliverables**	**Baseline**	**EOY Target**	**RAG**
Implementation of Alcohol Care Team(ACT) at the Princess Royal Hospital (PRH)	Optimisation of ACT across all areas of delivery by March 2024.	• **1**. Full ACT team in situ **2.** Clinical lead in post (Consultant) **3**. Delivery of 7- day service **4.** Completed action reviews : self and peer. **5**.Multi agency Steering Group in place. **6.** Data collection and reporting in place to inform and complete business planning process.	No ACT.	Fully established ACT at PRH	

Latest Progress Updates

Brief Progress Update/ Progress against EOY targets	Key Achievements/Completed Deliverables/ Examples Best Practice and Good News Stories	Activity Planned for the next 3 months
1.Full ACT team now in situ following the recruitment and training of two Band 4 Alcohol Practitioners 2. New SaTH Lead (Lead Nurse for Equality Diversion and Inclusion) along with SaTH HI Lead is renewing efforts to identify a lead Consultant 3.7- day a week operation is an aspiration currently with no plan in place to move from current 5 - day delivery 4.Self review has commenced with plans for peer review in place 5.Multiagency Steering Group meeting regularly with excellent LA and Community representation and commitment. 6.SaTH Lead working to address data collection and input issues	The new SaTH Lead with support from the multi - agency Steering Group has been successful in two key areas : a) Appointment of interim Project Manager to map internal and community pathways for completion/ratification by January and to work with NHS STW Project Manager on business planning (process fundamental to business case for an integrated service extending to Shropshire b) Establishing internal reporting mechanism for the team in SaTH and improving the inhouse ownership and leadership of the ACT which is central to success and future effectiveness. A regular update will be taken to the SaTH Quality Oversight Committee (QOC) with the first paper being presented in January 2024.	• Strengthen efforts to identify a Lead Consultant for the ACT from hepatology/ gastro/psychiatry • Multi agency Steering group to provide a brief for the business planning process ensuring that the case is tailored to a number of future funding opportunities e.g. from NHS England, Acute funds, mental health and substance misuse central funds etc. • Intensify progress on self - review to progress to full peer review process and development of the ACT

Key Risks	Mitigations
Failure to identify Lead Consultant Lead	Continue engagement of SaTH Inequalities Lead and other system leads to secure a Consultant Lead for the service.
Full and effective data collection and submission to national ACT system to track progress and outcomes is not yet in place	Continued efforts of SaTH Lead and HI Lead to resolve the data input and access issues.

Challenges/Barriers to Progress	Actions/Support Required
Good progress made within the last two months, but the ACT will have to intensify efforts to develop quickly and consistently to fulfil optimal requirements by March 2024,enabling the case to be made for continuation and expansion.	Continue engagement of SaTH Inequalities Lead and other system leads to secure a Consultant Lead for the service.

2023/24 OBJECTIVE:	LTP 2: Tobacco	Objective Lead/s: Alexandra Mace

Programme/Projects	Planned Actions	Deliverables	Baseline	EOY Target	RAG
Implementation of Tobacco Dependency Teams and treatment offer to all Acute, Maternity and MH Inpatients (integration with Community Pharmacy and Local Authority Smoking Cessation Services)	Q2 2023/24 • ~~Acute Tobacco Dependency Treatment Service Start~~ • ~~Integrated Community Pharmacy Smoking Cessation Service with Acute pathways~~ • ~~Recruit 2 x Tobacco Dependence Advisors within the Acute Trust~~ Q3 2023/24 • ~~Acute Tobacco Dependency Treatment Service fully established~~ • ~~All inpatients identified as smokers are offered tobacco dependency treatment in line with the national model~~	Q2 2022/23 • ~~Confirmed pathway for referring from Acute to Community Pharmacy~~ • ~~Recruited TDAs within Acute Inpatient settings~~ Q3 2023/24 • ~~Fully established Acute TDT service~~ Q4 2023/24 • All Maternity, MH and Acute Inpatient settings to offer tobacco treatment.	2 established TDT teams 14% of adults smoke	3 established TDT teams 'fully delivering' against the mandated TDT model reduced % of adults who smoke	

Latest Progress Updates

Brief Progress Update/ Progress against EOY targets	Key Achievements/Completed Deliverables/ Examples Best Practice and Good News Stories	Activity Planned for the next 3 months
• Recruitment successful for remaining Acute Inpatient team. Staff in place. • Significant work undertaken with region to validate the list of Community Pharmacies who are registered and actively delivering the Smoking Cessation Service. • MPFT are exploring utilisation of Community Pharmacy for post-discharge support.	• 3/3 inpatient services are now fully established (maternity, acute inpatient and mental health) with all inpatients identified as smokers being offered tobacco dependency support. • A patient has been successful referred from Mental Health Inpatient Services into Local Authority Services and has successfully quite smoking. • Public Health grant funding available to support tobacco/smoking. • Increasing no. of referrals for IMD 1 41.1%.	• Work with Community Pharmacies to Review of referral numbers into community service offers. • Subject to referral numbers, encourage Community Pharmacy sign up to the advanced service specification. • Subject to open risks and progress over the coming months, consider scale down of tobacco steering group and transition into business as usual arrangements. • Confirm funding from region for 2024/25 and progress discussions with Providers, specifically revisiting funding gap for maternity.

Key Risks	Mitigations
Difficulties engaging patients to quit smoking in the MH inpatient setting.	Focused efforts on staff education to reiterate messaging around the effects of smoking on MH.
Interim arrangements for MH TDT to discharge patients with the full 12 weeks NRT due to there being no available post-discharge community support offer for complex MH patients which offers both NRT and behavioural support.	Dedicated post-discharge service provision offered by Local Authority services to ensure there is available behavioural support. ICB continue to monitor referral numbers to assess cost. Continued discussions with regional teams re Community Pharmacy will accept complex MH patients in future.
NRT funding concerns and sustainability of the SaTH Healthy Pregnancy Service.	Costs covered for 2023/24 through NHSE funding uplift and holding vacancies.
Lack of Community Pharmacies actively delivering Smoking Cessation Services.	ICB Community Pharmacy Clinical Lead and LPC Chair supporting to work through barriers and promote the service to other Community Pharmacies.
Lack of Community Pharmacy Capacity to actively deliver the service amongst new additional services being rolled out to support Primary Care Access Recovery.	ICB Community Pharmacy Clinical Lead to support CPs alongside LPC Chair. LA services provide an additional option for TDT patients although these do not offer NRT.

Challenges/Barriers to Progress	Actions/Support Required
Nothing to raise.	

2023/24 OBJECTIVE:	LTP 3: Obesity/Weight Management	Objective Lead/s: Alexandra Mace

Programme /Project	Planned Actions	Deliverables	Baseline	EOY Target	RAG
NHS Digital Weight Management Programme 2023/24	Q1 2023/24 • ~~Update and circulate the Tier 2 Weight Management Programme Flow Chart and Weight Management Tiers Flow Chart to clarify service offers and link to LA weight management offers and local social prescribing.~~ • ~~Confirm 2023/24 allocations and share learning between GP Practices for increasing referrals~~ • ~~Identify reasons behind ineligible referrals and introduce mitigations.~~ Q2 2023/24 • ~~Analysis of referrals made by ethnicity, IMD, age and gender to enable targeted referrals to those living within the 20% highest areas of deprivation.~~ • ~~Exploration of reasons behind patients not taking up a digital offer to understand whether there are opportunities to link to digital support offers such as digital literacy training.~~ Q2 - Q4 2023/24 • ~~Quarterly reviews of referrals made to the DWMP and % of those that meet the eligibility criteria.~~ • ~~Quarterly round up of latest information, guidance and resources to share support and learning across GP Practices.~~	• ~~Updated Weight Management Tiers and Tier 2 Services Flow Charts for 2023/24.~~ • ~~Updated guidance and resources shared with GP Practices.~~ • ~~Increase no. (%) of GP Practices referring into DWMP~~ • ~~Increased no. (%) of referrals made the DWMP~~ • ~~Increased no (%) of eligible referrals made to the DWMP~~ • Achievement of eligible referral targets.	87% GP Practices referring 2854 referrals made (eligibility % not known at ICB level). 32% of adults have a BMI of 30+	100% of GP Practices referring (out of those signed up to deliver the service) 1900 eligible referrals Reduced % of adults with a BMI of 30+	

Latest Progress Updates

Brief Progress Update/ Progress against EOY targets	Key Achievements/Completed Deliverables/ Examples Best Practice and Good News Stories	Activity Planned for the next 3 months
• Review undertaken of current data to understand gaps in referrals. • Targeted plans developed by the Prevention and Health Inequalities Project Support Officer and Primary Care Team Project Support Officer to improve referral rates in areas of highest deprivation. • Patient Comms. and Engagement plans developed to link in with Local Authority Healthy Weight Strategy work. • National DWMP Webinar held which announced that a programme outcomes report is in development.	• STW have historically been one of the highest achieving referrers nationally and remain one of the highest performance in the region. • STW has been asked to share learning with other systems and Charlton Medical Practice has been asked to showcase their success at an upcoming DWMP webinar. • 45/52 GP Practices have made 970 eligible referrals made to the DWMP to date (51% of our year-end target).	• Obtain programme outcomes from the regional team. • Continue to promote referrals into the programme, specifically those Practice who have not yet referred or who have more patients living in higher levels of deprivation. • Consider referrals against Practice allocations and adjust to promote increased outcomes in high-referring practices. • Explore the possibility for direct referrals from other clinical settings such as MSK Clinics.

Key Risks	Mitigations
Without consistent GP Practice level data we are unable to make targeted improvements.	GP level data can be requested adhoc from the regional team but this remains limited where numbers are low as they cannot be disclosed.
Primary Care capacity.	Efforts made to simplify/collate weight management information incl. referral flowcharts.

Challenges/Barriers to Progress	Actions/Support Required
Nothing to raise.	

PLUS 1-2:
Learning Disabilities Rurality

2023/24 OBJECTIVE:	PLUS1: Learning Disabilities	Objective Lead/s: Janet Gittins			
Work Programme/Projects	**Planned Actions**	**Deliverables**	**Base line**	**EOY Target**	**RAG**
Provision and improved uptake of annual health checks for people with learning disabilities and focused improvement on quality of LDAHCs.	• Confirmation of baseline data for LDAHCs and ethnicity recording for those on the LD register (Q1 2023/24) • Evaluate and review progress from 2022/23. • Identify areas for improvement. • Development of a 2023/24 LDAHC improvement plan, including actions specifically focused on improving LDAHC quality. • Undertake LDAHC quality audits within GP Practices.	• 2023-24 trajectory agreed to meet target. Monitoring meetings set with NHSE. • LDAHC Improvement Plan in place for 2023-24. • Undertake at least 10 LDAHC quality audits with practices in 2023-24 • Improve ethnicity recording for LD patients.	77% achieved in 2022-23	75%	

Latest Progress Updates

Brief Progress Update/ Progress against EOY targets	Key Achievements/Completed Deliverables/ Examples Best Practice and Good News Stories	Activity Planned for the next 3 months
• All practices are signed up to the LDAHC DES and continue to offer LDAHCs to patients annually. • LDAHC Improvement Plan in place for 2023/24 in line with national priorities. • Plans in place to deliver quality audits and share learning. • Monthly performance activity monitored.	• Practices achieved 77% against the target in 2022/23. We will continue the same process throughout 2023/24 which is to share process, resources and learning quarterly and prompt low-referring PCNs or GP Practices. • Successful GP Practices actively review their LD register and invite eligible patients in for a review when this is due. • The majority of activity takes place during Q3 & Q4. • MPFT are commissioned to support practices with this work including delivering LDAHC to those hard to reach, cleansing the LD register and improving quality. • Information pack on ethnicity recording produced and shared with all practices. • 3 Quality audits completed.	• Continue to review practice data monthly to monitor and offer support to underperforming practices. • Continue to deliver LDAH Improvement Plan. • Practices offered support from MPFT team with underperforming practices targeted. • Quality audits scheduled and learning shared with all practices. • Practice resources and templates updated and relaunched.

Key Risks	Mitigations
Primary Care Capacity	MPFT commissioned to support practices with this work.

Challenges/Barriers to Progress	Actions/Support Required
Majority of activity takes place during Q3 & Q4	NA

2023/24 OBJECTIVE:	PLUS1: Learning Disabilities	Objective Lead/s: Tracey Slater and Jennifer Morris

Programme/ Project	Planned Actions	Deliverables	Base line	EOY Target	RAG
Implementation of actions in the LeDeR Action Plan	• System-wide rollout of the Oliver McGowan Training • Promote Reasonable Adjustments and Hospital Passports – task & finish group in development • Training offered for reasonable adjustments and hospital passports for acute staff. • Ensure all staff working with people with epilepsy have had training commensurate to their role. • Improved training and awareness efforts around Mental Capacity Assessment (MCA) and Deprivation of Liberties (DoLs). • Training and raising awareness for staff to advise and educate on healthy lifestyle and dietary intake reasons for a healthy lifestyle. • Support equity for those with LD from diverse ethnic backgrounds by raising awareness/engaging with parent carers and service users. • NHS trusts, GP practices and independent care providers (specialist hospital and community) should provide training to raise awareness of the issues of diagnostic overshadowing. Health and social care staff should receive additional training on good dietary and fluid intake that reduces constipation. • To raise awareness about the risks of respiratory diseases in people with LD/A • Ongoing cleansing of GP LD registers. • To develop tailored packages of care around individuals' needs. • Local authorities and ICBs to ensure that adult safeguarding processes in place are robust enough to protect people with a learning disability and autism in line with national guidelines.	• Oliver McGowan working group established by the ICS who meet fortnightly. • All organisations undertaken Tier 1 or 2 OM Training • Reasonable adjustments promoted on the "local offer" website. • Training on use and benefits of Hospital Passports available to all (including service users, family and paid carers). • Completed audit of use of Hospital Passports and Passport quality to be audited in SaTH and RJAH. • Most staff within MPFT have received epilepsy awareness training and this continues to be rolled out to all providers. • Improved LD&A training in the acute trust incl. ReSPECT documentation and MCA. • Care homes are being visited to improve understanding of softer signs of illness and to raise early concerns about subtle changes. Managing deterioration pathway being rolled out • Health and social care staff trained in Early Warning Score tools NEWS2 in hospitals and RESTORE2 in social care. • Programme of information and training around pneumonia and constipation. • Have an accurate LD/A practice register that is regularly monitored and up to date.	TBC	Targets are in development via the LeDeR Steering Group priorities action Plan 100% staff undertaken OM training Reduced mortality for those living with learning disabilities	

Latest Progress Updates

Brief Progress Update/ Progress against EOY targets	Key Achievements/Completed Deliverables/ Examples Best Practice and Good News Stories	Activity Planned for the next 3 months
• Oliver McGowan working group established • Communication plan being developed with LeDeR system partners (to include lessons learned from reviews) • Steering group priorities action plan monitored; progress seen in most priorities	Development of 1 minute brief for all stakeholders across STW system Increased membership on Steering group with EbE- Autism	• Completion of Standard Operating Framework (SOF) for LeDeR • Report on outputs from task & finish groups for RA & Hospital passport • Increase frequency of steering group meetings

Key Risks	Mitigations
Performance of completed focused reviews in 6 months and quality of LeDeR reviews.	Increased the frequency of our Governance panel. Increased the number of cases discussed at Governance panel. Contract review meetings reinstated. Robust QA process by LAC(s)

Challenges/Barriers to Progress	Actions/Support Required
Extracting learning from reviews in a timely manner.	Nil to note at present

2023/24 OBJECTIVE:	PLUS 2: People Living in Rural Areas	Objective Lead/s: Berni Lee, Paula Mawson, Rachel Robinson			
Work Programme/Projects	**Planned Actions**	**Deliverables**	**Baseline**	**EOY Target**	**RAG**
Exploration of the impact of rurality on health and social care.	Discussions via a Council scrutiny committee task and finish group to understand the impact of rurality on health. Identify actions which will impact health outcomes for those living in rural areas. Advocacy at regional level for rural health inequalities, to include policy, practice, research and evidence (building, reviewing & sharing), insight & data and interventions.	Established scrutiny task and finish group. Action Plan to improve health outcomes for those living in rural areas. OHID regional network on rurality Links with research and rural institutes	Specific measures are to be determined	Specific measures are to be determined	

Latest Progress Updates

Brief Progress Update/ Progress against EOY targets	Key Achievements/Completed Deliverables/ Examples Best Practice and Good News Stories	Activity Planned for the next 3 months

• Scrutiny T&F Group meetings concluded
• Report including system-wide recommendations developed
• Advocacy for rural health/recognition of HIs taken forward
	• Comprehensive review undertaken with good engagement from system partners
	• Broad range of recommendations developed with implications for all system partners aimed at improving support for rural communities
	• Commitment from ICB to integrate 'rural proofing for health toolkit' into service planning processes
	• Work continues with Regional colleagues - considering 'next steps' with regard to Rural Health network
		• Scrutiny report to be considered by HOSC on November 20th
		• Dependent on HOSC decision Scrutiny report to be considered for adoption by Council Cabinet in January 2024
		• Present findings and report recommendations to ICB and key decision-making groups to consider response to recommendations focusing on key issues that impact on rural communities including
		  • Health and social care travel and transport infrastructure
		  • Formal adoption of the 'rural proofing for health toolkit', including the impact of policy and service change on voluntary organisations working with/on behalf of rural communities
		• Improved communication and engagement by council officers and system partners with elected members to best utilise their knowledge and community connections

Key Risks	Mitigations
Report findings are acknowledged and acted upon by all partners	Timetable discussion of report findings at key strategic groups

Challenges/Barriers to Progress	Actions/Support Required
System capacity/resources to address to the recommendations	To be determined through discussion with strategic groups

Core20 ADULT 1-5:

Maternity
Severe Mental Illness
COPD
Early Cancer Diagnosis
Hypertension and Lipids

2023/24 OBJECTIVE:	ADULT 1: Maternity	Objective Lead/s: Emma Popo			
Work Programme/Projects	**Planned Actions**	**Deliverables**	**Baseline**	**EOY Target**	**RAG**
LMNS Equity and Equality Action Plan	Q1 2023/24 • ~~Finalisation of the LMNS Equity and Equality Action Plan.~~ • Targeted engagement with service users to ensure input is representative of core groups. • Auditing of Birth Preference Cards • Monitoring uptake and feedback of the Cultural Competency Training within our provider trust • Development and delivery of an Antenatal education offer as part of the Start for Life Family Hubs programme (led by Telford and Wrekin Public Health) Q2 2022/23 • 2023/34 Perinatal Equity analysis conducted in partnership with public health colleagues, this work is scheduled to commence in September 2023.	• ~~LMNS Equity and Equality Action Plan (includes engagement plans)~~ • Audit of Birth Preference Cards • Feedback retrieved on Cultural Competency Training • Antenatal Education Offer as part of the Start for Life Family Hubs Programme • Perinatal Equity Analysis and outcomes	n/a	Numerous	

Latest Progress Updates

Brief Progress Update/ Progress against EOY targets	Key Achievements/Completed Deliverables/ Examples Best Practice and Good News Stories	Activity Planned for the next 3 months
• LMNS Equity and Equality plan has been signed off by LMNS programme board. • Regional Data Dashboard project underway – this will incorporate indicators that were planned to be reviewed as part of the 23/24 perinatal equity analysis exercise • Antenatal education specification agreed with trust, project is being finalised. • EDI Midwife recruitment underway at SaTH	• Business case from maternity and neonatal voices partnership (MNVP) has been approved for increase in funding. The new structure of volunteers has been recruited to. • Roll out of the Civility, Respect, Inclusion and Kindness (CRIK) training has commenced across the Trust. • Baby First Aid classes rolled out across Telford and Wrekin - High take up • Baby Friendly Initiative (BFI) Midwife in post funded by LMNS transformation funds to drive progress toward Stage 1 accreditation in SaTH Maternity Unit	• STW LMNS Equity and Equality Action plan to be published on new LMNS website by end of December 2023 • Completed and fully funded MNVP work plan (inc. engagement plan) to be signed off by LMNS programme board. • Seventeen CRIK sessions planned between September 23 and March 24. The dates are currently with Maternity Services leaders for them to decide which dates fit best for them and where/how these will be delivered. The target date for 90% compliance is March 2024. • Development and implementation of the regional dashboard in partnership with CSU. • Antenatal Education project to commence • Audit of Birth Preference cards to commence • BFI Accreditation action plan

Key Risks	Mitigations
Reduced capacity and resilience with the LMNS PMO team due to maternity leave to deliver its objectives.	Alignment to existing LMNS governance and implementation of PM approaches to ensure grip, pace of delivery and early warning signs when delivery is at risk across the plan

Challenges/Barriers to Progress	Actions/Support Required
Inaccurate completion record for initial rollout of Civility, Respect, Inclusion and Kindness (CRIK)	Updated SOP to ensure no completions are missed going forward

2023/24 OBJECTIVE:	ADULT 2: Severe Mental Illness (SMI)	Objective Lead/s: Gail Owen

Programme	Planned Actions	Deliverables	Baseline	EOY Target	RAG
Deliver an improved pathway to ensure adequate provision and improved uptake of annual physical health checks for those living with SMI.	• Ongoing consolidation of GP registers & Secondary care (MPFT) registers (Q1-2) • Ensure data between Primary & Secondary care (RIO) flows to EMIS, including back log data (MPFT led) (Q1-2) and is captured for NHSE reporting • Work closely with local third sector/ vol/private community services Shropshire, ACCI) (Q1-2) • Reduce DNA rates (Q1-2) • Strengthen an outreach service to support patients who are unable to attend clinics(including DNA) (Q1-2) • Explore digital Support / access (Q1-2) • Undertake review (audit) of follow up interventions, and outcomes (Q1-2) • Improve partnership working between Primary care & Secondary care (Q1-2) • MPFT service specification proposal to be implemented (Q3) • Review the quality of the PH checks (Q3)	• SMI register is accurate, eligible patients receive the PH check • Improve accuracy of PH check activity undertaken • To provide healthy lifestyle resources & activities (i.e. pilot with tennis as part of the offer) • To enable SMI PH checks to reach a wider population in community venues ie. calm cafes • Embed NHSE Tech equipment (Afinion2 & Whzan Blue boxes) to improve our digital usage within primary & community services • Audit of follow-up interventions and outcomes. • Reviews and assurance of the quality of completed SMI PH checks	1867 health checks completed (core 6) November 2023 Equivalent 49.6	Trajectory 2,300 health checks STW Target 2879	

Latest Progress Updates

Brief Progress Update/ Progress against EOY targets	Key Achievements/Completed Deliverables/ Examples Best Practice and Good News Stories	Activity Planned for the next 3 months
• Consolidation of GP registers will remain ongoing. • Coding AHC activity from Sec. Care (MPFT) to EMIS: Primary Care to code ongoing & backlog (approx. 343). (April – nov) data to demonstrate it's working. Guide has been produced to support PC with the process. • Service Spec being reviewed & proposal to go to CWG for approval / GP Board review. • Working with Shropshire Public health to address health inequalities primarily aimed at obesity.	• Developing opportunities to engage local 3rd sector/ voluntary/private community services to provide healthy lifestyle resources and activities. Increased engagement with Public Health. • Pilot tennis coaching sessions supported by Shropshire Tennis have been successful and extended for a further year, due to publicity other services/clubs have come forward to offer activities i.e. cricket. • PHSMI System Maturity work feedback (led by NHSE) - overall positive feedback particularly around the system offer, NHSE have requested STW to present at a regional forum • NHSE Tech equipment is in place – secondary care clinics feedback positive.	• To continue to work towards the local system target / the NHSE target by increasing the no. of completed SMI checks including coding of all activity completed in secondary care onto EMIS. • Work is on going to complete all backlog coding in primary care slight decrease in backlog . • Increase the Outreach Service offer – with increased workforce activity this should increase and DNAs should decrease. • MPFT service Specification review completed and new workforce plan approved. • Improving lifestyles - Greater focus on engagement with the third sector to support educational and practical advice on healthy eating, weight management and other lifestyle choices. Greater engagement with Public Health network including joint offer. • Start review quality of SMI Annual Health Checks and follow-up interventions/ outcomes. • Recovery plan will remain in place and be reflective of current position. • Service Spec being reviewed & proposal to go to CWG for approval / GP Board review.

Key Risks	Mitigations
Number of completed SMI checks remain low	Increasing engagement and strengthening relationships across the system Supporting Primary Care to code completed checks (Secondary Care) which will increase NHSE compliancy
System wide support although improving remains disjointed	
Regionally figures continue to demonstrate high levels of health issues in SMI population ie cancer	Working with NHSE closely and networking with regionally

Challenges/Barriers to Progress	Actions/Support Required
Continued to progress with Primary Care engagement particularly re ongoing /backlog coding of secondary care's completed SMI checks onto EMIS – in order to progress data entry of backlog .	Continues support (when needed) from NHSE and Senior Management

2023/24 OBJECTIVE:	ADULT 3: Chronic Respiratory Disease	Objective Lead/s: Fiona Smith

Work Programme/Projects	Planned Actions	Deliverables	Baseline	EOY Target	RAG
Improved provision of local Spirometry Services	Q2 2023/24 • Analysis of respiratory data by ethnicity, IMD and gender. • Options appraisal for Spirometry which will reference Health Inequalities. • Application for non-recurrent funding to support Spirometry • Scoping opportunities to pilot targeted programmes of work to address spirometry backlogs, specifically in areas of known inequality such as areas of deprivation. • Development of a project/action plan to support General Practice to improve spirometry activity.	• Options Appraisal • Successful bid for additional funding • Improved data intelligence on COPD outcomes	TBC	TBC	

Latest Progress Updates

Brief Progress Update/ Progress against EOY targets	Key Achievements/Completed Deliverables/ Examples Best Practice and Good News Stories	Activity Planned for the next 3 months

• A recent survey has gone out to practices asking them to confirm:
  • The backlog of patients awaiting Spirometry.
  • The current levels of Spirometry activity taking place.
  • Training requirements.
  • Whether the GP Practice has a spirometry machine.
• Benchmarking is taking place around what other systems are currently being paid to do spirometry as well as a costing appraisal from 4 practices around actual cost of spirometry.
• An options appraisal paper is due to go to Commissioning Working Group in September 2023.
• Plan on how to address backlog and how to support practices to be able to undertake spirometry.
• EOI interest has gone into NHSE for £50k towards innovation
	• Undertaken some practice visits to ascertain level of backlog and what is currently being achieved.	• Options appraisal to go to CWG

Key Risks	Mitigations
Significant backlog with spirometry.	Plan to bring in outside provider to support with backlog
Will need investment into the service.	Application for extra funding through an expression of interest
May not see full return on investment for FIP in first year	
Lack of resource within transformation team	

Challenges/Barriers to Progress	Actions/Support Required
Capacity within General Practice	Agreement from ICB around investment and pending outcome of options appraisal to CWG/EOI to NHSE for additional funding.
Lack of appetite from primary care to deliver spirometry.	
Lack of Investment	

2023/24 OBJECTIVE:	ADULT 3: Chronic Respiratory Disease	Objective Lead/s: Emma Pyrah and Steve Ellis

Work Programme/Projects	Planned Actions	Deliverables	Baseline	EOY Target	RAG
Primary Care delivery of Flu and Pneumonia Vaccinations	• Optimising national and local comms. to promote an increase in vaccination uptake. • Integrated MECC approach. • Joint flu and Covid clinics working with the Covid-19 Vaccination Team (SCHT)	• GP Practiced signed up to delivery Flu Enhanced Service • Targeted communications via GP Practices.	TBC	TBC	
Covid Vaccination Service - Autumn/Winter Booster Programme 2023/24 (subject to Joint Committee on Vaccinations (JCVI) and Immunisations advice and Ministerial approval)	• Utilisation of detailed data throughout the Autumn/Winter programme to inform comms. and engagement • Confirm Providers via EOIs signed up to the service. • Specific communications messaging aimed at those with Chronic Respiratory Disease. Direct communication to this cohort from their GP (linked to Flu comms). • Joint flu and Covid clinics working closely with GP Practices and PCNs • Ongoing organisation of vaccination clinics in community and outreach settings such as fire stations, community centres and Public Health's Health and Wellbeing Bus.	• Targeted communications via GP Practices. • Provision of outreach clinics.	57% of those with COPD vaccinated	60% of those with COPD vaccinated	

Latest Progress Updates

Brief Progress Update/ Progress against EOY targets	Key Achievements/Completed Deliverables/ Examples Best Practice and Good News Stories	Activity Planned for the next 3 months
COVID Accelerated A/W vaccination programme began in early September, initially in Care Homes then moving to Local Vaccination Sites and mass programme. Awaiting data on uptake amongst those with Chronic Respiratory Disease **Flu** ES released August 2023, all practices are expected to sign up. Confirmation on delivery of vaccine and payment from 1st September	**COVID** • Comms has been developed and passed to GP practices for targeted Text messages to this cohort • Following end of main programme on 15 December, there is a targeted focus on health inequalities (inc. CRD) until 31 Jan 2024. **Flu** Practices continue to offer vaccination to protect those who are most at risk of serious illness or death should they develop influenza between September 2023 and 31 March 2024.	**COVID** • Delivery through December and January will be more targeted at areas and cohorts with lower uptake. • Delivery will continue through willing PCNs and CPs alongside various pop-up locations delivered by SCHT. Continued targeted communications to those at risk (including Chronic respiratory Disease). • Coadministration where possible **Flu** • Clinics set up from 1st September in Primary Care. • Care Home visits scheduled from 2 October 2023.

Key Risks	Mitigations
COVID: Lack of providers due to reduction in Item of Service fee (£10.06 to £7.54) and workforce capacity issues	Utilisation of increased clinics from SCHT
Vaccine apathy amongst target cohort	Continued comms and engagement, including patient stories

Challenges/Barriers to Progress	Actions/Support Required

2023/24	ADULT 4: Early Cancer Diagnosis (1 diagnostic pathways)	Objective Lead/s: Katy Lewis and Jess Greenwood		

Work Programme/Project	Planned Actions	Deliverables	Base line	EOY Target	RAG
Meet early diagnosis objectives in the Integrated Cancer Strategy for STW 2022-2027	• Development of local Community Diagnostic Centres (Spring 2023) • Restore compliance with the Faster Diagnosis Standard (FDS) across cancer pathways (April 2024) • Improvement to all cancer pathways to ensure compliance with the 7 Rapid Diagnostic Centre (RDC) principles (April 2024) • Establish a diagnostic imaging network • Improved diagnostic innovations for CCE, Cytosponge, FIT and teledermatology	• Established CDCs • Increased no. of cancer sites meeting the FDS • Increased no. of cancer sites meeting RDC principles • Evidence of Diagnostic Imaging Network • Roll out of Colon Capsule Endoscopy in the Lower GI pathway • All lower GI FDS referrals are accompanied by a FIT result • Established teledermatology service	53.1% of cancers diagnosed at stage 1 or 2	75% of cancers diagnosed at stage 1 or 2 Reduced % of under 75 mortality rates Reduced % of under 75 mortality rate from cancer that is considered preventable	

Latest Progress Updates

Brief Progress Update/ Progress against EOY targets	Key Achievements/Completed Deliverables/ Examples Best Practice and Good News Stories	Activity Planned for the next 3 months
• The first part of the Telford CDC opened in Nov 23 • STW remain in NHSE Tier 1 management due to FDS performance currently not meeting trajectory. WMCA funding received to support backlog reduction and improve FDS performance. • FIT compliance maintained, further development of straight to test flexible sigmoidoscopy pathway for FIT negative patients. • Teledermatology hub due to open in the CDC in Feb 2024. Further hubs planned following options appraisal / business case approval by CWG. • Targeted Lung Health Checks (TLHC)– Task & Finish group set up and meeting regularly. Aiming to commence from April 2024. Additional meetings in place and Task & Finish group being set up for fortnightly meetings. An outline options appraisal has been developed for TLHC and data is being utilised to guide discussions with Primary care regarding initial roll out areas.	• TLHC utilising data on smoking rates / lung cancer incidence / deprivation index to identify first area to roll out programme.	• Continue focused work on individual diagnostic pathways. • Data across all diagnostic pathways is due to be analysed to identify key areas of need and enact targeted intervention.

Key Risks	Mitigations
Despite utilisation of FIT testing, the number of referrals to the Urgent Suspected Cancer (2WW) Colorectal pathway has not decreased	Non-Specific symptoms (NSS) pathway due to commence Q4 for FIT negative patients GP education sessions held with Colorectal consultant from Primary care – further session planned in Jan 24 to include use of the NSS pathway
Challenges/Barriers to Progress	**Actions/Support Required**
Capacity of all stakeholders challenged	Increased cancer team in ICB funded by WMCA being recruited to support transformation

2023/24 OBJECTIVE:	ADULT 4: Early Cancer Diagnosis (2 screening)	Objective Lead/s: Helen Onions			
Work Programme/Projects	**Planned Actions**	**Deliverables**	**Base line**	**EOY Target**	**RAG**
Early Cancer Diagnosis Improvement Plan	• Review local datasets - focus on health inequalities • Management of breast screening backlog and round length delivery • Bowel screening age extensions (age 50-60 & >58 year olds) • Implement new IT cervical screening call & recall system • Provider plans for reducing health inequalities in screening via HEA • Breast Screening Health Equity Audit (Q1/Q2) • Apply learning from the Breast Cancer HEA to other screening progs • Targeted Lung Health Checks – develop and roll out new programme (NHS E funding) • GRAIL trial led by CRUK and Kings College Year 2 July & Year 3 commences in September	• Equity profile for each screening programme • All cancer screening services to complete a health equity audit.	**Bowel screening 2021/22** STW 72.3%, Shrops 73.9% T&W 69.4%, 18% gap across GPs **Breast screening 2021/22** STW 58.9%, Shrops 58.5% T&W 64.4% **Cervical Screening 2021/22** **25-49 year olds** STW 73.6%, Shrops 75.2%, T&W 70.8% **50-64 year olds** STW 76.1%, Shrops 76.6%, T&W 74.7%	Improve overall coverage of 3 cancer screening programmes Narrow the gap in coverage across GPs of the three cancer screening programmes	

Latest Progress Updates

Brief Progress Update/ Progress against EOY targets	Key Achievements/Completed Deliverables/ Examples Best Practice and Good News Stories	Activity Planned for the next 3 months
••Breast screening round length now recovered ••Detailed equity intellgience profile being completed ••Working group for TLHC prog development established across partners, options appraisal re model and clinical leads being sought ••GRAIL referrals to SaTH x 5 82% uptake & more are anticipated in next round	••Finalise equity profiling and present to Sept Cancer Strategy Board ••Breast cancer awareness event Telford Ramada hotel, seldom heard voices May 2023, and October 2023 ••SE Telford PCN video to non responders resulting 25% increase in cervical screening uptake amongst 25-year-olds at Stirchley GP	•Review/update Breast Screening Equity Audit and implement actions •Agree cancer screening programme commitments and priorities in the refreshed cancer strategy •Development of targeted social media campaign to improve bowel cancer screening coverage and reduce inequalities in coverage

Key Risks	Mitigations
Potential changes suggested following insights may require additional funding, such as consistency in GP Practice websites and ability to translate to other languages.	If no immediate action can take place, area leads are encouraged to build actions into future plans.
Capacity in SaTH radiology and colonoscopy services. Current reliance on independent sector for colonoscopy puts performance at risk from unexpected changes, introduces inefficiency and is a risk to future programme expansions.	NHS to re-raise with Trust and ICB to seek long term solution: although current performance is in standard, this does mask some risk in the colonoscopy provision

Challenges/Barriers to Progress	Actions/Support Required
None at present.	

2023/24 OBJECTIVE:	ADULT 4: Early Cancer Diagnosis (3 primary care)	Objective Lead/s: Katy Lewis/Janet Gittins

Work Programme/ Projects	Planned Actions/Deliverables	Base line	EOY Target	RAG
General Practice / PCN Cancer DES	• Support the improvement of timely presentations • Support Primary Care, facilitating the delivery of the PCN Early Cancer Diagnosis Network DES • Supporting early cancer diagnosis: - Review referral practice for suspected and recurrent cancers to identify actions, particularly where early diagnosis rates are lower. / Adopt and embed requesting FIT tests for suspected colorectal cancer, - Use tele-dermatology to support skin cancer referrals (where available and appropriate). • Develop and implement a plan for prostate cancer to increase proactive and opportunistic assessments for potential cancer diagnosis in population cohorts where referral rates are not recovered to pre pandemic. • Review non-specific cancer pathways and identify opportunities and actions to increase referral activity. • Development of education and training project in primary care / - Optimisation of primary care contract particularly in relation to improving screening uptake, safety-netting patients and review of incidence (emergency presentations etc); monitoring of referral rates, incidence, conversion rates, to inform improvement plans	53.1% of cancers diagnosed at stage 1 or 2 **2018** Shrops 50.8%. T&W 47.3% **2019** Shrops 53.0%. T&W 50.3% **2020** Shrops 50.3%. T&W 53.6%	75% of cancers diagnosed at stage 1 or 2 Reduced % of under 75 mortality rates Reduced % of under 75 mortality rate from cancer that is considered preventable	

Latest Progress Updates

Brief Progress Update/ Progress against EOY targets	Key Achievements/Completed Deliverables/ Examples Best Practice and Good News Stories	Activity Planned for the next 3 months
• Review of referral practice audits in Primary Care • PCN Cancer leads meeting bi-monthly to share good practice • All 8 PCNS are delivering the PCN DES requirements and developing care coordination as a SPC for cancer patients. Systems and processes being reviewed and improved - escalations and flags. Regular reviews, investigations of late diagnosis cancers and case study peer learning. • FIT testing proforma on F12 and all staff aware. Trialling popup windows on system as reminder. Training provided to GPs. • Discussions on ICS Non-Specific Symptoms pathway in motion. • Telederm models of delivery piloted in Primary Care and survey completed September to inform future model. • New PCN Cancer Care Coordinators in post and training provided on Motivational Interviewing/cancer.	• Excellent work in SE Telford PCN through Care Coordinator – including focus on late stage diagnosis for prostate cancer, targeting men with abnormal PSA/BPH – focus on black men aged 40+ • Macmillan Community Care Pilot Project (MCC) ended May 2023. Work continues within PCNs.	• Telederm future local model agreed with roll out Q4 23/24. • Non specific symptoms pathway to be developed Q4 23/24. • Fit training led by consultant repeated in Q4 2023/24.

Key Risks	Mitigations
Potential changes suggested following insights may require additional funding, such as consistency in GP Practice websites and ability to translate to other languages.	If no immediate action can take place, area leads are encouraged to build actions into future plans.
Capacity in primary care remains an issue	PCN ARRs roles utilised.

Challenges/Barriers to Progress	Actions/Support Required
None at present.	

2023/24 OBJECTIVE:	ADULT 4: Early Cancer Diagnosis (4 community awareness)	Objective Lead/s: Alex Mace			
Work Programme/Projects	**Planned Actions**	**Deliverables**	**Base line**	**EOY Target**	**RAG**
Core20PLUS Connectors (STW Cancer Champions)	~~• Continue engagement with healthcare organisations and local communities. (Q1)~~ ~~• Develop an insight themes report and feedback to action plan to facilitate internal discussions around opportunities for service development. (Q2)~~ ~~• Stakeholder webinar to raise awareness of insights on barriers to access (Q2)~~ ~~• Continued discussions to facilitate connector insights and service development (Q3 onwards).~~	~~• 50 connectors recruited.~~ ~~• Increasing no. of engaged organisations.~~ ~~• Attendance at community events and groups.~~ ~~• August 1 Year on Webinar – sharing insights~~ ~~• Development of a themed insights report.~~ ~~• Delivery Partners/Connectors invited to national/local meetings/discussions to inform change.~~ • Changes made as a result of Connector insights.	53.1% of cancers diagnosed at stage 1 or 2	75% of cancers diagnosed at stage 1 or 2 Reduced % of under 75 mortality rates Reduced % of under 75 mortality rate from cancer that is considered preventable	

Latest Progress Updates

Brief Progress Update/ Progress against EOY targets	Key Achievements/Completed Deliverables/ Examples Best Practice and Good News Stories	Activity Planned for the next 3 months
• Delivery partners continue to network, engage and promote cancer awareness to communities, events, organisations etc. This includes Breast Cancer Awareness Event held by Seldom Heard Voices. • Interim draft themes report on insights developed by Delivery Partners. • Insights and recommendations are being fed into forums at local, regional and national level to prompt actions to reduce barriers. • Recruitment taken place to replace Champion Coordinators. • Podcast with Dr Hilary Jones in development.	• 160+ Cancer Champions recruited (original target of 50), from a range of diverse backgrounds including Ukrainian, Bulgarian, Hong Kong, Chinese, Iranian, Jordanian, Polish and Sikh communities and adults with learning disabilities. • 84 healthcare and community organisations engaged to date. • Project contributes to healthcare staff awareness of healthcare inequalities. • Delivery Partners have been approached by other systems to adopt our volunteer-led and training approaches. • Cancer Champions 1 Year On Webinar held August 23 to share progress, insights and 'what would help' recommendations. Really well received and led to a number of discussions with partners on shared learning and actions to reduce barriers. • Project successful in interest to present at the upcoming Midlands Health Inequalities Conference sharing our partnership approach. • 4 PCNs are interested in piloting use of the cervical screening concerns checklist following our Cancer Champion Survey.	• Record the podcast with Dr Hilary Jones. • Continue sharing insights through forums, webinars and direct discussions with service leads. • Support PCNs to pilot the Jo's Trust cervical screening checklist. • Feed insights into the STW Cancer Strategy Refresh. • Work with our breast screening team and primary care to improve communications for patients. • Link in with national screening team re outcomes of pilots. • Discussions on 2024/25 sustainability.

Key Risks	Mitigations
Potential changes suggested following insights may require additional funding, such as consistency in GP Practice websites and ability to translate to other languages.	If no immediate action can take place, area leads are encouraged to build actions into future plans.
Sustainability of service (part of a short-term, pilot programme funded by NHSE).	Top-up funding has been provided which takes the service to 2024/25. Delivery Partners have volunteer networks which could potentially continue the Cancer Champions legacy.

Challenges/Barriers to Progress	Actions/Support Required
None at present.	

2023/24 OBJECTIVE:	ADULT 5: Hypertension and Lipid Case-finding and Optimal Management	Objective Lead/s: Alex Mace			
Work Programme/Project	**Planned Actions**	**Deliverables**	**Baseline**	**EOY Target**	**RAG**
Hypertension Treatment to Target	~~• Established baseline data and data modelling to understand improvement required (Q1)~~ ~~• Review individual GP Practice-level data to identify outliers, including any showing unwarranted variation and a need for focused efforts on certain populations (Q1)~~ ~~• Development of business case (if required) and options to support GP Practices in improving treatment figures (Q1)~~ ~~• Obtain supporting resources to share with General Practice (Q1)~~ ~~• Roll out of support and improvement initiative with Primary Care (Q2)~~ • Utilisation of locally developed dashboards to monitor progress and improvements (Q2)	~~• Baseline data and modelling~~ • Approved business case (if required) ~~• Established Project Group~~ ~~• Mobilised support within GP Practices~~	59%	77%	

Latest Progress Updates

Brief Progress Update/ Progress against EOY targets	Key Achievements/Completed Deliverables/ Examples Best Practice and Good News Stories	Activity Planned for the next 3 months
• Latest extract of CVDPrevent Data analysed (June 2023). • STW achievement for CVDP007HYP has reduced slightly (in line with national trend) to 63.94% meaning 10,896 people require optimal treatment to achieve the 77% target. Acknowledgement that the number of hypertensive patients requiring optimal treatment is increasing due to significant local case-finding efforts. • CVD Prevention Clinical Lead, PMO, and Medicines Management have scheduled a series of 1:1 face-to-face meetings with outlier GP Practices to share local data, the case for change, recommended resources and UCL frameworks, best practice and support improvements in Hypertension treatment. • A wider educational offer is being worked up to support all GP Practices through GP Forum/PLT events. • BI Teams are producing a local dashboard which will provide a more up-to-date view of progress and better inform targeted action.	• Local team have received direct support offers from numerous regional and national leads including Matt Kearney (Clinical Director UCL Partners) and the West Midlands Health Innovation Network. • 3/4 outlier GP Practices initially approached have responded welcoming support.	• 1:1 meetings with outlier GP Practices to focus on how we can do things 'different' to improve processes and efficiencies through additional roles/digital innovation. • Encourage and promote working with system partners such as community outreach activities and community pharmacies to obtain BP readings for hypertensive patients. • Organise and coordinate educational workshops at GP Forum/PLT for all primary care staff, potentially supported by regional/national leads.

Key Risks	Mitigations
CVD Prevent only provides data up to June 23 (4 months out of date).	Work with BI teams to obtain local, up-to-date, granular data.
Limited capacity within BI Teams to support with developing local data intelligence to inform improvement initiatives.	Utilisation of national dashboards such as CVDPrevent. Triangulating work to reduce duplication across workstreams.
Primary care capacity to undertake medication reviews and limited options for additional funding.	Project focuses on doing things 'different' to identify efficiencies and free up capacity. Support offered by ICB PMO, CVD Prevention Clinical Lead and ICB Medicines Management Team.
Challenges/Barriers to Progress	**Actions/Support Required**

2023/24 OBJECTIVE:	ADULT 5: Hypertension and Lipid Case-finding and Optimal Management	Objective Lead/s: Edith Macalister			
Work Programme/Project	**Planned Actions**	**Deliverables**	**Baseline**	**EOY Target**	**RAG**
Innovation for Health Inequalities (InHIP) Community Hypertension Case-finding Project	• Identify number of volunteers and outreach activities required to achieve outcomes (process complete in Telford and Wrekin but ongoing in Shropshire Q1) • Put in place the use of the Docobo platform and all associated IG processes for collection ,processing and aggregation of data (Q 2) • Progress to stage 2 of the data sharing element of project to agree and implement GP receipt and optimal use, of data • Develop an agreed, systematic evaluation plan with delivery partners, other stakeholders and commence evaluation processes (Q2) • Achieve sustainability – funding, process, opportunities and outcomes (Q3)	• Agreed model for volunteer recruitment working with existing community outreach teams with schedule of activity to reach all target groups throughout rural and urban Shropshire • IG documentation in place for collection, processing and aggregation of data using the Docobo platform • An agreed method is in place for GP's to receive all BP readings from the Docobo platform . (Obtained via close collaboration with GP Board LMS and PCN leads as required) • Systematic local evaluation completed by end of March 2024. • Funding obtained to extend project 2024/5	19.27%	80% by 2029	

Latest Progress Updates

Brief Progress Update/ Progress against EOY targets	Key Achievements/Completed Deliverables/ Examples Best Practice and Good News Stories	Activity Planned for the next 3 months
• Successful plans developed to sustain the project for 2024/5 • In Telford and Wrekin excellent progress has been made to deploy volunteers, implement activities for targeted groups and IMD areas. • In Shropshire a different model has been successfully developed to train "Level 1" volunteers to disseminate information and awareness of risks re high BP and "Level 2" volunteers who take BP readings and direct those with high BP readings for 7- day monitoring via Social Prescribers in GP practices • Local evaluation plan agreed , submitted and accepted by NHS England with no additional requirements.	• £185,000 of national funding to extend the project to 24/25 following regional / national bidding process. • Telford and Wrekin –volunteers trained ,blood pressure checks completed for 600 people and **37** cases of previously undiagnosed high blood pressure identified. In Shropshire 40 Level 1 and Level 2 volunteers trained and BP checks completed for 60 people • Project selected to showcase findings via an interactive market stall event at the West Midlands Regional Health Inequalities conference in Birmingham on 29th November • All IG documentation with Docobo and delivery partners on course for completion and implementation by 6th December	• Enable receipt of data(: individual BP readings) by GP practices • Intensify roll out of targeted activities to all areas of Shropshire • Achieve additional targeting of activities in Telford and Wrekin to all IMD decile 2 areas. • Continue quantitative and qualitative evaluation via delivery partners , users of the service and community / system stakeholders • Revisit opportunities for involvement of Community Pharmacy within project

Key Risks	Mitigations
Process of data sharing with GP's impeded by data sharing obstacles and differing GP/ PCN requirements for data	NHS STW Project Lead and GP Lead for CVD working to proactively address and resolve issues in collaboration with comms/ GP Board/PCN leads /LMC as required

Challenges/Barriers to Progress	Actions/Support Required
None identified	

2023/24 OBJECTIVE:	ADULT 5: Hypertension and Lipid Case-finding and Optimal Management	Objective Lead/s: Clare Stallard			
Work Programme/Project	**Planned Actions**	**Deliverables**	**Baseline**	**EOY Target**	**RAG**
Targeted secondary prevention Lipid Management (integrated Secondary and Primary Care)	• Agree service models and funding arrangements for primary and secondary care- complete STF funding bid awarded (Q1) • Approach practices identified as a priority and identify and engage with a champion for each (Q1) • Complete multidisciplinary education and mentorship sessions with each surgery and each surgery to have held first clinic (Q2) • Establish POC testing in cardiac rehabilitation clinic (Q2) • Hold lipid education event to engage with health care professionals in the region (Q3) • Share learning through abstract/ poster/ article submissions (Q4) • Share learning and outcomes through local mechanisms (Q4) •Service evaluation and collation of data (Q4)	• Individualised cholesterol management plan in place for each patient reviewed addressing barriers and concerns. • Improved lipid levels and reduction of patients within each of the UCL partners cohorts. • Education sessions delivered and clinician attendance. Increased prescribing of evidence-based lipid management medicines	Age >=18 and CVD. Non-HDL > 2.5mmol/L and on optimal statin = 2638	Decreased No. of patients >=18 and CVD. Non-HDL > 2.5mmol/L on an optimal statin	

Latest Progress Updates

Brief Progress Update/ Progress against EOY targets	Key Achievements/Completed Deliverables/ Examples Best Practice and Good News Stories	Activity Planned for the next 3 months
• Reviews ongoing in 4 practices, with named lead/champion for each practice • Ongoing support provided for risk stratification and system searches to support targeted reviews. • Campaign materials completed • Education sessions offered to all participating practices • Secondary care clinics commenced • POC device repurposed from Primary Care. Device application submitted to Trust.	• Campaign posters currently being distributed to GP practices and associated pharmacies. Website section completed with links to resources/social media posts-advertised via PB • Data returns for number patient reviews in practice: 220 (Statin initiated-19; statin dose optimised-13; statin intensity optimised-9; Ezetimibe added-36; bempedoic acid initiated-6; inclisiran initiated-2) • Total inclisiran prescribing in STW primary care (Jan-Sep23)=123 items/79 patients • 69 patients seen in Hospital clinic	• Distribute final campaign materials to participating practices • Undertake education session for practices • Continue with secondary care clinics • Collation of data for payment • Evaluate project findings and outcomes • Prepare for sharing learning at local level and national (poster, article submission etc)

National				
Indicators	Sep-22	Dec-22	Mar-23	Jun-23
CVDP009CHOL	81.39	81.61	82.17	82.35
CVDP007CHOL	24.98	26.24	27.88	28.68

Project Outcomes (Nov 23)

STW ICS				
Indicators	Sep-22	Dec-22	Mar-23	Jun-23
CVDP009CHOL	81.24	81.58	82.01	82.19
CVDP007CHOL	27.25	28.33	30	30.3

Practice 1 – IMD: 59				
Indicators	Sep-22	Dec-22	Mar-23	Jun-23
CVDP009CHOL	81.90	82.59	83.33	83.5
CVDP007CHOL	20.79	21.73	23.53	24.4

Key Risks	Mitigations
High workload and lack of capacity in primary care-GPs have stated this is a significant barrier to undertaking extra work	Risk stratification has been put in place to allow for prioritisation of patients that would most benefit from intervention
Secondary care-not being able to procure POC testing machine and cardiac rehab not up and running	The secondary care clinics are running in isolation and prioritising patients that we know will benefit (ie have bloods on the system). POC device repurposed from Primary Care (due to decommissioning of LCS)
Challenges/Barriers to Progress	**Actions/Support Required**

Core20 CYP 1-5:

Asthma
Mental Health
Epilepsy
Diabetes
Oral Health

2023/24 OBJECTIVE:	CYP 1: Asthma – address overreliance on reliver medications and decrease asthma attacks	Objective Lead/s: Nicola Siekierski

Programme /Project	Planned Actions	Deliverables	Baseline	EOY Target	RAG
CYP Transformation and Personalised Care for CYP with Asthma	• Delivery of asthma education and review of medications via the Childrens Community Nursing Services for CYP living with asthma in areas of deprivation. • Delivery of 48 hour reviews for CYP following admission to SaTH, and development of business case to continue this service. • Driven uptake of schools accredited as Asthma Friendly. • Pilot project for use of risk stratification to identify and support CYP with high risk of asthma attack (September 2023) • Delivery of tier 2-4 Asthma training for clinical staff • Develop an options appraisal around the delivery of diagnosis of asthma in CYP, improved practice and accessibility. • Continued drive to utilise the Asthma App to support self-management. • Working with medicines management on a CYP specific asthma formulary. • Face to face training delivered to colleagues in housing and resources being developed to support families in relation to management of mould and damp; offer of training for housing associations in relation to asthma and opportunity to sign up to STW CYP Asthma Charter. • Working with staff in children's homes to support good asthma care.	• Business Case to continue the delivery of 48hr reviews following admission to SaTH. • Increased % of Asthma Friendly Schools. • Access to Eclipse Tool. • Development of a CYP specific asthma formulary. • Delivered training to housing and resources staff re management of mould and damp.	• 4968 children in Shropshire using an inhaler of which 2,900 are not diagnosed with Asthma • A further 3591 children are using inhalers in Telford and Wrekin of which 2,100 are undiagnosed • 43% of CYP coded with Asthma received an annual asthma review in Shropshire • 36% of CYP coded with Asthma received an annual asthma review in Telford and Wrekin • 8 month backlog for CYP asthma clinics in outpatients • 1,100 ward admissions 2022/23 • 3,200 seen in CAU • 1,112 CYP presented in A&E • 36% of schools in Telford accredited Asthma Friendly • 73% of school in Shropshire accredited Asthma Friendly • 100 children and young people using Asthma App • Level 1 training (as at May 23 = 277 across STW have completed.	• Reduction in the no. of children using an inhaler who are not diagnosed with Asthma. • Additional 320 asthma reviews to be undertaken by March 2024 • Reduction in waiting times for CYP Asthma clinics in secondary care by 1 month as a result of 48hour reviews service by March 2024. • 10% reduction in ward / CAU / A&E admissions for CYP Asthma by March 2024 • 100% schools accredited as Asthma Friendly schools by March 2024 • 300 children using asthma App by March 2024 • 500 to complete level 1 training by end March 2024	

Latest Progress Updates

Brief Progress Update/ Progress against EOY targets	Key Achievements/Completed Deliverables/ Examples Best Practice and Good News Stories	Activity Planned for the next 3 months
• 435 48hr Reviews completed for CYP discharged from inpatient care at SaTH. • 178 annual asthma reviews completed for CYP in 4 practices. • Risk stratification criteria presented at GP Forum. 11 practices opted in to receive practice based training and guidance to identify children at high risk using manual search. • 20 staff from Housing associations from across STW attended face to face asthma training • 10 practice nurses commissioned to undertake Paediatric Spirometry training.	• 70% of all schools in STW accredited as asthma friendly • 200 Early Years staff received face to face training in asthma • Public campaign to reduce reliance on Short-acting beta-agonists (SABAs) (Bronchodilators) - 'Too Much Blue? We need to see you!' • Asthma Children's Community Nursing (CCN) team have completed Nurse Prescribing courses. • ICB Asthma lead presented overview of asthma programme at Health Inequalities conference. • Tiered training added to LMS in Community and Secondary Care services	• School nursing service conducting audit of inhaler use and asthma action plans in schools • Continued development of resources on Healthier Together Website including training videos for Primary Care • Business case for continuation of 48 hour reviews in CCN service to be shared with organisations such as Asthma UK and pharmaceutical companies to try and identify funding.

Key Risks	Mitigations
Loss of Asthma CCN Team and discontinuation of 48 hour reviews end March 2024.	Business Case to support need for future funding

Challenges/Barriers to Progress	Actions/Support Required

2023/24 OBJECTIVE:	CYP 2: Diabetes – increase access to glucose monitors/insulin pumps and Type 2 Diabetes AHCs	Objective Lead/s: Fiona Smith

Work Programme	Planned Actions	Deliverables	Base line	EOY Target	RAG
Diabetes Transformation Programme	Q1 2023/24 • Improved focus on Diabetes Prevention including working with Diabetes UK to visit communities and raise awareness of Diabetes Prevention and the NHS Diabetes Prevention Programme (NDPP). Q2 2023/24 • Requests for patient representatives with lived experience for the Diabetes Transformation Board who will act as Diabetes Health Champions. • Analysis of access to real-time continuous glucose monitors, insulin pumps and CYP Type 2 Diabetes annual health checks to understand gaps in provision. • Exploration of opportunities and funding to support the provision of continuous glucose monitors and insulin pumps for deprived communities.	• Increased NDPP referrals from our most deprived areas and from areas with high levels of BAME. • Diverse patient representatives on the Diabetes Transformation Board. • Approved policy for access to Continuous Glucose Monitors. • Type 1, 2 and foot pathways agreed by the end of Q3 • Prevention, Transition and in patient provision agreed by the end of Q4	TBC	TBC	

Latest Progress Updates

Brief Progress Update/ Progress against EOY targets	Key Achievements/Completed Deliverables/ Examples Best Practice and Good News Stories	Activity Planned for the next 3 months
• Diabetes transformation underway, 6 areas identified (Type 1 Pathway including pump patients, Type 2 Pathway, Foot Pathway, Prevention, Transition, In Patient Provision) • Access to Continuous Glucose Monitoring agreed as per NICE guidance, policy due to be approved. • EOI for patient representation on the Clinical Advisory Group have gone out. • EOI for monies towards providing extra support for under 40's with Type 2 Diabetes. • Process mapping undertaken for transition of patients between Paediatric services and adult services	• Initial work undertaken with Diabetes UK to raise awareness of Diabetes Prevention and the Diabetes Prevention Programme at VCSE networks and community locations (local Gurdwara, Shrewsbury Football Club). • Established Clinical Advisory Group (CAG) to support with and develop clinical pathways.	• Continue with supporting Clinical Advisory Group (CAG) around pathways. • Work with BI Teams to analyse data.

Key Risks	Mitigations
Not being able to move money around system to support a care closer to home model.	Provider Collaborative.
Not being able to move services due to lack of commissioned services/service specifications.	
Diabetes not being recognised by whole system as priority	
Lack of resource within the transformation team to continue prevention awareness work.	Strong links with Diabetes UK

Challenges/Barriers to Progress	Actions/Support Required
Lack of Clinical Leadership from SaTH	SaTH Medical Director trying to identify Diabetes leadership from SaTH
Engagement with Primary Care	Leadership roles needed within Primary Care.

2023/24 OBJECTIVE:	CYP 3: Epilepsy – increasing access to specialist nurses and ensuring access in the first year of care for those LD&A	Objective Lead/s: Nicola Siekierski

Programme /Project	Planned Actions	Deliverables	Baseline	EOY Target	RAG
CYP Transformation for Epilepsy in CYP	• Recruitment of 2 x CYP Epilepsy Nurses in secondary care to support the delivery of the NHSE Care Bundle • Recruitment of band 8A psychologist to support CYP living with epilepsy and their families with mental health • Understanding patient experience through working with children and families. • ASIS pathway mapping and identification of gaps and challenges to provision of quality services • STOMP and STAMP - Working with third sector organisations to identify therapeutic interventions for CYP • STOMP and STAMP - Understanding current pathways in the prescribing of psychotropic medication • Understanding experiences of children and families with Epilepsy and LD	• Recruited CYP Epilepsy Nurses. • Recruited Band8A Psychologist to support CYP living with epilepsy and their families. • Identification and implementation of at least one intervention for children and young people with Epilepsy to support mental health. • Pathway mapping and gap analysis for sharing with ICB • Report in relation to patient experiences • 2 case studies in relation to CYP with Epilepsy and LD to understand patient experience	To be shared on imitation of pathway work	Psychologist to see 100 children and young people with Epilepsy by March 2024 Epilepsy Service to increase support for children and young people with Epilepsy by March 2024	

Latest Progress Updates

Brief Progress Update/ Progress against EOY targets	Key Achievements/Completed Deliverables/ Examples Best Practice and Good News Stories	Activity Planned for the next 3 months
* 2 Epilepsy nurses recruited to the ICB 1 day per week to support the delivery of the new epilepsy care bundle. Posts commenced early November for 12 months. • Psychologist post filled and will commence Feb / Mar 2024. • Currently identifying baseline data to inform the bundle and Epilepsy 12 audit. • Materials being gather for inclusion on Healthier Together Website.	• Small system working group established to support the delivery of the care bundle. • ICB lead attending STOMP / STAMP meetings. • Task and Finish Group in place to progress delivery of epilepsy nurse input into EHCPs for CYP with SEND.	• Development of resources on Healthier Together website • Development of Care Plans for children with Epilepsy • Support and training development for mainstream education. • Pathway mapping for MRI / EEG • Submission of data for Epilepsy 12 audit.

Key Risks	Mitigations
Nursing staff not able to identify children with EHCP already in place as not flagged on care records.	Working with LA to establish process to identify children and input to plans.

Challenges/Barriers to Progress	Actions/Support Required

2023/24 OBJECTIVE:	CYP 4: Oral Health – address backlog in tooth extractions for under 10s	Objective Lead/s: Kate Taylor-weetman

Work Programme/Project	Planned Actions	Deliverables	Baseline	EOY Target	RAG
Oral Health Training for the wider professional workforce	• Universal offer of training to wider professional workforce to support their role in promoting oral health & signposting to dental services	• No. of training sessions delivered	2022 dental epi data: NB 95% CIs wide due to low consent rates to participate in survey. Data is for whole popn. Not available by core 20 popn. at present. Telford and Wrekin LA: %dmft>0 : 19% Shropshire LA: %dmft>0: 15%	TBC	
Provision of toothbrushes & paste by health and social care professionals – Brushing for Life	• Targeted provision of toothbrushes and toothpaste & advice at key contact points for young children - targeted at 30% most deprived by LSOA IMD decile	• No. of packs distributed			
Supervised toothbrushing programmes in early years settings – Brilliant Brushers	• Planned rollout of programmes in nurseries and schools in targeted areas - IMD 1/2, %FSM & supplemented by local knowledge	• No. of nurseries/schools offered supervised brushing programme • No. of nurseries/schools participating in supervised toothbrushing programme			
Audits of current data and waiting list intelligence to identify inequalities.	• Undertake a review of community dental service waiting lists to identify inequalities and prioritise accordingly. • Links to improvements in data quality and reviewing the possibilities to report against the chosen indicators (CYP aged under 10 - current indicators are only available for under 16s).	• Equality Impact Assessment undertaken for dental waiting lists. • Agreed upon indicators for monitoring progress.			

Latest Progress Updates

Brief Progress Update/ Progress against EOY targets	Key Achievements/Completed Deliverables/ Examples Best Practice and Good News Stories	Activity Planned for the next 3 months
• Q2 figures: 16 training sessions delivered v target of 10 • Brushing for Life programme: Ongoing challenges re recording of activity and delivery of activity. Shropshire has improved in part since last Q but Telford less so. • Brilliant Brushers programme - 32 settings taking part – c3200 children brushing their teeth at nursery/school each day. • No progress re waiting list audit. Insufficient capacity in commissioning team, provider team and lack of data to support this due to national dataset requirements not aligning the Core20plus5 metrics.	• Overachieved no. of workforce training sessions • Resources and an action plan to encourage uptake of the national 5 year old dental survey in both Shropshire and Telford & Wrekin have been developed which will support targeting and monitoring of preventive programmes going forward. • Development of social media platform content to raise awareness of programme such as Brilliant Brushers and key oral health messages.	• Continuation of commissioned programmes as per Annual work programme for 2023/4.

Key Risks	Mitigations
Brushing for Life programme – toothbrush and paste distribution	Active involvement and support by LA colleagues and plans to meet with providers to explore barriers and options.

Challenges/Barriers to Progress	Actions/Support Required
Commitment by schools to introduce Brilliant Brushers programme	Active involvement by LAs to encourage uptake of Brilliant Brushers programme.
Staff resources and data for general aesthetic waiting list review re inequalities.	

2023/24 OBJECTIVE:	CYP 5: Mental Health – improving rates of CYP access	Objective Lead/s: Brett Toro-Pearce

Work Programme/Project	Planned Actions	Deliverables	Baseline	EOY Target	RAG
Education and awareness of childhood trauma (adverse childhood experiences ACE)	• Whole STW awareness briefing in CEOs organisation-wide meeting • Roll out of Childhood Trauma training and awareness programme to build on integrating better awareness into operational clinical practice. • Capturing Looked After Children as a standard demographic by service providers (MPFT-BeeU)	• Delivered awareness briefing on childhood trauma • Training sessions held with individual organisations and services. • Incorporation of a routine Looked After Children metric in the Performance Dashboard.	Denominators: Local LAC - 596 Out of Area LAC - 530	TBC subject to local analysis	
Building on the 'Healthier Together' Website to share up to date and useful information, guidance and resources for communities	Expanding information resources aimed towards those at risk of health inequalities	Expanded content aimed towards those at risk of health inequalities	Website 'hits' to relevant pages	Increased No. of website hits	
National Mental Health Support Teams (MHST) in Schools Programme	School selection for inclusion in the project is undertaken in conjunction with LA Public Health colleagues. Deprivation is a major factor in the decision-making process.	• Four schools included in the MHST Programme in STW. • All schools in the programme fully trained. • By 2025 50% of Schools will be covered by MHSTs	No. of CYP u18 accessing NHS Funded mental health with at least one contact: 570 per annum as at Mar 23	No. of CYP u18 accessing NHS Funded mental health with at least one contact: 2,353 per annum by Mar 24	
Analysis of CYP MH access data to determine whether deprivation is a significant driving factor for referrals.	Q3 2023-24 • Undertake analysis of access to CYP MH and identify referral hotspots • Development of a metric to monitor access rates across 'at risk' CYP cohorts	• Report on CYP MH Access analysis • Access rates for 'at risk' CYP cohorts metric • Improved data collection and quality	TBC subject to local analysis	TBC subject to local analysis	

Latest Progress Updates

Brief Progress Update/ Progress against EOY targets	Key Achievements/Completed Deliverables/ Examples Best Practice and Good News Stories	Activity Planned for the next 3 months
• ACE – initial awareness session shared at the ICB Virtual Huddle 18th April 2023 which proposed next steps to work with system leadership and commissioners to embed trauma approaches in commissioning and service delivery. Training plan & resource pack for the 'Miss Kendra' approach rolled out to schools. • Healthier Together website continues to grow in both content and reach. • MHST workforce development continues, with recent focus on training and frontloading service offer for whole school approach. • Analysis of access data – on track for Q3 23/24.	• ACE – Train the Trainer for trauma informed approaches has been provided for VCSE incl. the Director of Brightstar (a boxing academy which supports young people at risk). • Review remains ongoing with strengthened areas in relation to MH Crisis and ND pathways. Strong co-production with stakeholders. • Schools growing in confidence. Where MHST input successful require less input/oversight and operate as business as usual. • Futures-in-mind for whole school approach for Mental Health. • Planning completed and workplan on track.	• Continue to expand content and monitor hits/web traffic for healthier together. • Continue to roll out and focus on workforce retention. Review of success and contacts. • Undertake analysis to identify referral hotspots. Development of a metric to monitor access rates across 'at risk' CYP cohorts. • 9 MHST practitioners on the wave 10 training which starts January 2024. • Plans to develop a self-harm page on the healthier together.

Key Risks	Mitigations
Reduced transformation and commissioning capacity within NHS STW CYP portfolio	Deputy Director MH, LDA, CYP covering until commencement of Head of T&C – CYP in October 2023.
Competing demands within the portfolio	Prioritisation exercise completed to ensure priority actions are progressed.

Challenges/Barriers to Progress	Actions/Support Required
Should mitigations be unsuccessful workforce capacity will be a challenge and potential barrier. This is the case for progressing the roll out of childhood trauma training for healthcare organisations.	None required at present. Mitigations in place regarding capacity.
Biggest challenge demand and capacity	Looking at system level offer, working across I-Thrive model and assessing offer against the model.

Assurance Report
Prevention and Health Inequalities Board

Committee / Group / Meeting, Date	
Prevention and Health Inequalities Board due	Wednesday 24th January 2024

Author:	**Contributors:**
NHS STW Health Inequalities Team	ICB Programme Leads

Report sign-off:
Tracey Jones, Director of Mental Health, Learning Disabilities & Autism, Children & Young People and ICB Lead for LTP Prevention and Health Inequalities

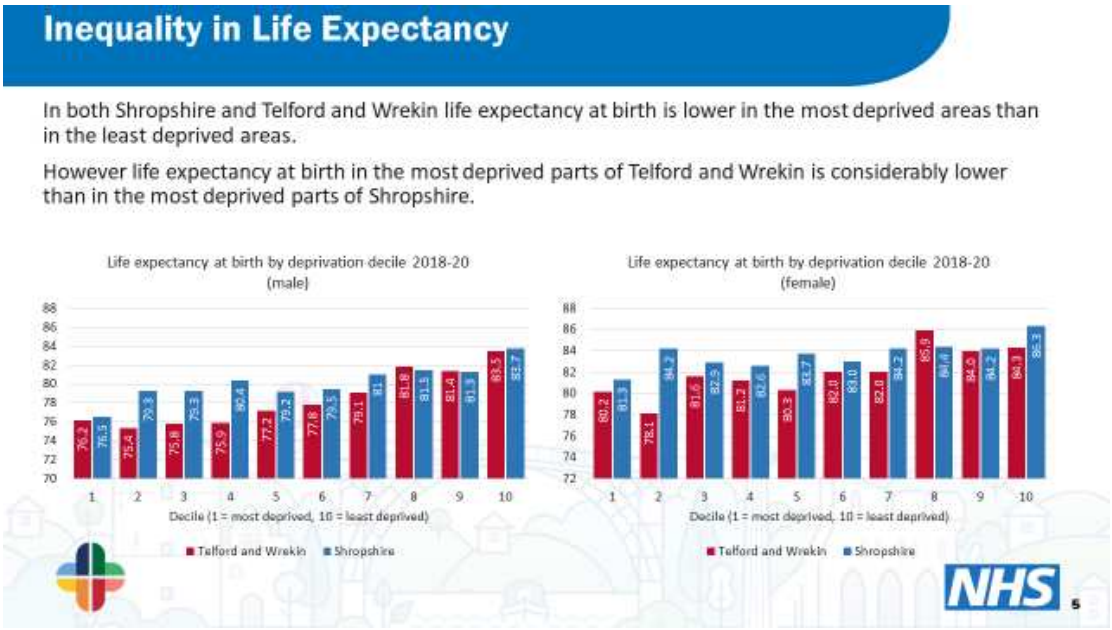
1. Background

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience and people's experience of and access to care.

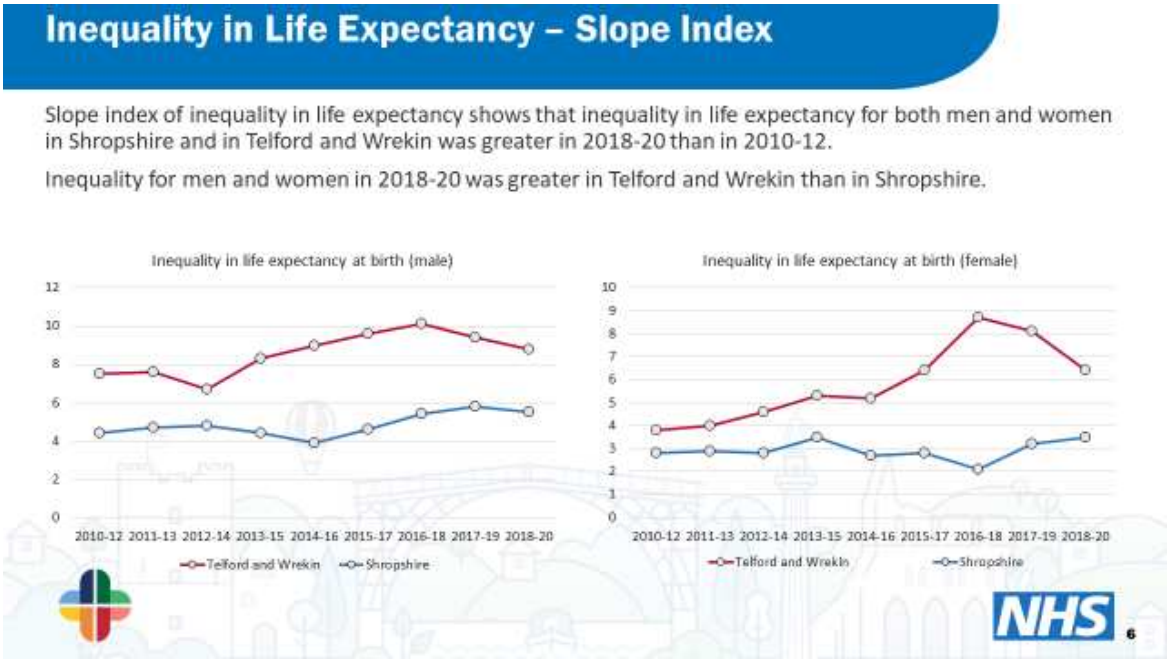
Research shows that people living in areas of high deprivation, those from Black, Asian and minority ethnic communities and those from inclusion health groups, for example the homeless, are most at risk of experiencing health inequalities.

According to the 2021 Census, there are 60,100 people living in the 20% most deprived areas nationally in Shropshire, Telford & Wrekin, of which 45,400 live in Telford & Wrekin and 14,700 live in Shropshire. These areas are those to which the National Core20 approach to target improvements in health and healthcare inequalities is targeted. There are also a range of other excluded groups that we have considered locally as part of this approach, for example, those with Learning Disability and households at risk of rural exclusion.

Life expectancy is lowest in the most deprived 20% of areas (Decile 1 & 2 below) and there is a gradient in life expectancy by deprivation in both Telford & Wrekin and Shropshire.



Inequality in life expectancy is largest in Telford & Wrekin compared to Shropshire. However, both local authorities have smaller gaps compared with their statistical neighbours. Inequalities in life expectancy has been increasing over the last decade but in 2016-18 in Telford & Wrekin started to decrease.



2. Key Requirements in the Joint Forward Plan relating to Operational Planning Guidance

Tackling inequalities in outcomes, experience and access of healthcare services is one of four key purposes of Integrated Care Systems (ICSs) and should be central to everything we do.

The body of the report to the Prevention and Health Inequalities Board relates to the delivery of the following strategic objectives as outlined in the 2023/24 Operational Planning Guidance and National Core20PLUS5 Approach to Reducing Healthcare Inequalities:

i. **Restoring Services Inclusively** – using local data to plan the inclusive restoration of healthcare services, ensuring that waiting list performance reports are delineated by ethnicity and deprivation.

ii. **Mitigating Against Digital Exclusion** – enabling robust data collection to identify which populations are accessing face-to-face, telephone and virtual consultations (broken down by relevant protected characteristic) and ensuring the impact of digital innovation is assessed, considered, and mitigated.

iii. **Ensuring Datasets are Complete and Timely** – to improve the collection and recording of ethnicity data across primary care, outpatients, A&E, mental health, community services and specialised commissioning.

iv. **Accelerating Preventative Programmes** – driving initiatives which focus on the prevention of long-term conditions including those focused on lifestyle-related risk-factors and the clinical areas outlined in the Core20PLUS5 for Adults and Children & Young People.

v. **Strengthening Leadership and Accountability** – ensuring named executive leads are appointed for tackling health inequalities, improving awareness and knowledge of the workforce, and supporting access to relevant training and development.

As a system, there are additional actions undertaken which address the wider determinants of health which are reported and monitored through both Shropshire and Telford and Wrekin Health and Wellbeing Boards and other local authority governance boards. Whilst these are not highlighted in the body of this report, the Board are asked to note that this work is ongoing alongside the specifics of the NHS healthcare requirements in the Operational Planning Guidance.

The report highlights the findings from the monitoring of these programmes to the Prevention and Inequalities Board. The section below outlines the potential implications of those objectives and associated risks.

3. Assurance Report

3.1 Areas of non-compliance/risk; matters to be addressed urgently; or matters requiring escalation to progress

ALERT – The following programmes or projects have been brought to the attention of the **Prevention and Health Inequalities Board**, as they:

- Represent non-compliance with required standards or pose a significant risk to the ability to deliver responsibilities or objectives and therefore require action to address, OR
- Require the approval of the Committee for work to progress.

Strategic objective: Long Term Plan Prevention 1: Alcohol
Programme of work/project: Implementation of Alcohol Care Teams
Reason for escalation: Significant delays in implementation mean the project will not be completed by the anticipated completion date of 31st March 2024. This is the result of changes in staff throughout the lifespan of the project. Mitigations are in place with support from the ICB and T&W Council to drive forward progress with underspent national funding and a dedicated lead at the Trust has been appointed to support implementation.

Strategic objective: CYP 2: Diabetes – access to glucose monitors/insulin pumps and Type 2 AHC's
Programme of work/project: Diabetes Transformation Programme
Reason for escalation: Slow progress in a number of areas due to commissioning and capacity challenges, including:

- The Diabetes Transformation Board seeks to have diverse patient representation but to date, no representatives have been appointed.
- The policy for access to Continuous Glucose Monitors has not yet been approved by the Clinical Assurance Group.

- There are delays in approval of Type 1, 2 and foot pathways which were to be agreed by the end of Q3 2023/24. Whilst the type 2 pathway has been approved, the foot pathway is expected to be approved 19th December and Type 1 pathway in January 2024.
- No progress has been made regarding funding to support the provision of continuous glucose monitors and insulin pumps for deprived communities.

3.2 Areas of on-going monitoring with new developments

ADVISE – The following programmes or projects have been brought to the **Prevention and Health Inequalities Board's** attention as they represent areas for ongoing monitoring, a potentially worsening position, or an emerging risk to the ICS' ability to deliver its responsibilities or objectives:

Strategic objective: Inclusive restoration of NHS services
Programme of work/project: Elective Recovery Transformation Programme
Reason for escalation: Many actions are pending due to system wide capacity challenges.

- EQIA's for the Elective Transformation Programme are complete. Provider Trust Elective Recovery EQIA's and the system-wide combined Elective Transformation & Recovery EQIA are pending.
- Business Intelligence Teams are working to split waiting lists down by ethnicity and deprivation.
- DNA audits have commenced and the outcomes will inform the development of a whole system integrated Elective Transformation & Recovery SMART Inequalities Plan.
- Engagement work has taken place with sight-loss Shropshire to improve patient communication and pathways for those with sight loss.
- Standards are also in place to ensure face to face appointments are offered where needed to mitigate digital exclusion.

Strategic objective: Mitigating against digital exclusion
Programme of work/project: Development of STWs 2023/24 Digital Strategy and incorporation of key objectives to mitigate against digital exclusion.
Reason for escalation: Slow progress due to capacity and recent change in senior leadership for digital innovation and transformation.

- The 2023/24 Digital Strategy has not yet been published, although it has been drafted and influenced by the Prevention and Health Inequalities Team. A new Head of Digital Innovation and Transformation has been appointed and will work closely with the Prevention and Health Inequalities Team to ensure the accompanying Digital Strategy Action Plan (due to be developed in Q4 2023/24) reflects and adopts the actions set out in the NHSE Digital Inclusion Framework. Engagement is taking place to inform mitigations for known digital exclusion and opportunities for stakeholder involvement in action plan development.

Strategic objective: Long Term Plan Prevention 2: Tobacco
Programme of work/project: Implementation of Tobacco Dependency Teams
Reason for escalation: Limitations in available funding for the provision of NHS-funded Nicotine Replacement Therapy (NRT) and community-based smoking cessation support.

- 3/3 Tobacco Dependency Services are fully established including maternity, inpatient acute and mental health.

- Engagement is taking place with community pharmacies to encourage sign-up to the enhanced service specification to bolster the post-discharge support offer across the patch.
- Work is taking place to understand smoking cessation support on offer to those in community hospital beds.

Strategic objective: Adult 2: Severe Mental Illness
Programme of work/project: Deliver an improved pathway to ensure adequate provision and improved uptake of annual physical health checks for those living with Severe Mental Illness.
Reason for escalation: SMI check completion figures are low and system-wide support, although improving, remains disjointed. Regionally figures continue to demonstrate high levels of health issues in the SMI population i.e. Cancer.

- Work continues to consolidate GP registers and improve the coding of health check activity from secondary care (MPFT) to EMIS (primary care). Primary Care will code ongoing health checks and backlog health checks (approximately 343 health checks in total) and a guide has been produced to support the process. A recovery plan will remain in place and be reflective of the current position.
- The annual health check specification is being reviewed and a proposal is due to go to Commissioning Working Group for approval/GP Board review.
- Work is taking place to explore an outreach service offer which should increase activity and reduce DNAs.
- Quality reviews of SMI Annual Health Checks are due to start imminently and programme leads are working with VCSE and Local Authorities to integrate and improve lifestyle factors.

Strategic objective: Adult Clinical Area 3: COPD – a clear focus on COPD and driving uptake of vaccinations to reduce infective exacerbations and emergency hospital admissions.
Programme of work/project: Improved provision of local Spirometry Services
Reason for escalation: Significant backlog with spirometry due to capacity challenges in primary care, engagement challenges and lack of investment.

- Work taking place in primary care to understand spirometry activity, demand, and resource needs. A benchmarking exercise will take place against other systems.
- Non-recurrent funds are required to support, and an EOI for 50k has been submitted to NHSE. Plans to address backlogs include looking to an external provider.

Strategic objective: CYP Clinical Area 3: Epilepsy – increase access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism
Programme of work/project: CYP transformation for epilepsy
Reason for escalation: Delays due to the care bundle being released by NHSE November 2023, behind expected plan schedule.

- A small system working group has been established to support the delivery of the care bundle. Two epilepsy nurses have been recruited 1 day per week to support this work (posts commenced early November for 12 months). A Psychologist post has also been recruited to support and will commence February/March 2024.

- A separate Task and Finish Group is in place to progress delivery of epilepsy nurse input into Educational Health and Care Plans (EHCPs) for children and young people with Special Educational Needs and Disabilities (SEND).
- Work is taking place to identify baseline data to inform the bundle and Epilepsy audit.
- A pathways mapping exercise will take place in the next quarter for neurodevelopmental pathways, Non-Epileptic attack disorder, Tertiary neurology and the Children's Epilepsy Surgery Service.

Strategic objective: CYP Clinical Area 4: Oral Health – addressing the backlog in tooth extractions for under 10s

Reason for escalation: Delivery challenges with brushing for life and lack of progress in undertaking an audit of current waiting lists.

- 16 training sessions have been delivered to local workforce, exceeding the original target of 10.
- Resources and an action plan to encourage uptake of the national 5 year old dental survey across Shropshire, Telford & Wrekin have been developed which will support targeting and monitoring of preventive programmes going forward.
- 32 settings (and an estimated 3,200 children) are taking part in the Brilliant Brushers Programme which teaches supervised toothbrushing in early years settings.
- There are ongoing challenges around the recording of activity and delivery of the Brushing for Life programme which offers free toothbrushes and toothpaste to the community. Shropshire has improved in part since throughout the last quarter but further work is needed in Telford & Wrekin. Meetings are planned with the relevant teams to understand and discuss barriers and plan improvements.
- A social media platform has been developed to raise awareness of oral health programmes and support (such as Brilliant Brushers) and key oral health messages.
- There is a lack of progress in undertaking a waiting list audit. This is due to insufficient capacity in the commissioning team, provider team and lack of data to support this due to the national dataset requirements not aligning the Core20plus5 metrics. This has been raised nationally.

Strategic objective: CYP Clinical Area 5: Mental Health – improving access rates

Reason for escalation: capacity challenges have led to risks of delay. These are mitigated by recruitment of new leads to drive progress and prioritisation exercises to ensure priority actions are progressed.

Programme of work/project: Education and awareness of childhood trauma

- An initial awareness session was shared at the ICB Virtual Huddle 18th April 2023 which proposed next steps to work with system leadership and commissioners to embed trauma approaches in commissioning and service delivery. A training plan and resource pack for the 'Miss Kendra' approach has been rolled out to schools.

Programme of work/project: National Mental Health Support Teams (MHST) in Schools

- There is ongoing MHST workforce development, with a recent focus on training and frontloading a service offer for a whole school approach. 9 MHST practitioners have been secured for training which starts January 2024.

Programme of work/project: Analysis of access to mental health services for CYP

- Analysis will be undertaken in quarter 4 to identify referral hotspots. Further work is taking place to develop a metric which will monitor access rates for 'at risk' cohorts of children and young people.

3.3 Areas of assurance

ASSURE – The following programmes or projects have been brought to the **Prevention and Health Inequalities** Board's attention as they highlight good news stories, positive progress and do not raise any concerns related to the delivery of year-end targets.

Strategic objective: Ensure Complete and Timely Data

Programme of work/project: Improved data-sharing across the system and the provision of baseline data to facilitate population analytics, and PHM approach to improvement programmes.

- BI team continues engagement with the Local Medical Committee (LMC) to jointly progress the facilitation of data access via the EMIS X Analytics tool. Assurance around governance is being provided in January with approval anticipated paving the way for practice-level engagement and implementation. Successful recruitment of PHM Analyst post and new BI developer role secured in ICB to develop PHM-focused intelligence assets and systems.

Programme of work/project: Improve the recording of ethnicity

- Engagement is taking place with main providers to improve the capture of ethnic data and on the implementation of new Electronic Patient Record Systems (EPRs) to support. Work is additionally taking place with community and mental health Providers to develop national datasets (CSDS and MHSDS) to reconcile to internal EPR recording of key metrics.

Strategic objective: Improved Leadership and Accountability

Programme of work/project: Governance and Planning

- Dedicated SROs and Leads have been identified across all system organisations. The System-wide Prevention and Health Inequalities Board was established in Q3 2023/24 with oversight of the health inequalities objectives outlined in the 2023/24 Operational Planning Guidance. A system-wide workshop was held December 2023 to identify key priorities and integrated and targeted initiatives for 2024/25.

Programme of work/project: Awareness, training, and resources

- A variety of methods are in place to support colleagues across the system with developing their understanding of health and healthcare inequalities, e.g., the ICB Health Inequalities Team are developing a space on the Shro and Tel intranet, development sessions are taking place at various Boards/Services and system-wide webinars are being arranged where needs are identified such as Inclusive Restoration. 15 Core20PLUS Ambassadors successfully accepted into the National Ambassador Programme (ranging across the ICB, secondary care and Primary Care Networks).

Programme of work/project: Equality, Diversity, and Inclusion

- Delivery of steering group priorities action plan continues to be monitored and positive progress is being made for most priorities. A dedicated Chair has been

appointed to lead the EDI Steering Group, as well as appointed EDI Leads within organisations and an increased number of EDI Champions.
- The Prevention and Health Inequalities Team will be attending an EDI Stakeholder Workshop in January 2024 to present on Healthcare Inequalities and draw links with EDI priorities.

Strategic objective: Long Term Plan Prevention 3: Obesity and Weight Management
Programme of work/project: NHS Digital Weight Management Programme
- Shropshire, Telford & Wrekin have historically been one of the highest achieving referrers across the nation. 45/52 GP Practices have made 1,200 eligible referrals since April 2023 and in the remaining quarter 3 and 4 will be focused on areas of high deprivation. STW GP Practices have been asked to showcase their success at an upcoming DWMP event.

Strategic objective: PLUS, Group 1: Learning Disability and Autism
Programme of work/project: Improved Uptake of Annual Health Checks
- All practices are signed up to the LDAHC DES and continue to offer LDAHCs to patients annually, performance trajectory is on track against 23/24 improvement plan. Quality audits are scheduled, and learning will be shared with all practices.

Programme of work/project: LeDeR Action Plan
- Positive progress is being made against most priorities within the LeDeR Action Plan and the steering group has increased its membership having been joined by Experts by Experience.
- A separate Oliver McGowan working group has been established to drive progress in training.
- A communication plan is in development with LeDeR system partners (to include lessons learned from reviews).
- The performance of completed focused reviews in 6 months and quality of LeDeR reviews is an area of risk. To mitigate this, the frequency of Governance panels has increased, Contract Review Meetings have been reinstated and the quality review processes strengthened.

Strategic objective: PLUS, Group 2: Rural Exclusion
Programme of work/project: Exploration of the impact of rurality on health
- A comprehensive review has been undertaken with good engagement from system partners. This will inform a report and broad range of recommendations for all partners to improve rural community support. A scrutiny report will be considered for adoption by Council Cabinet in Janunary 2024.
- The Integrated Care Board has agreed to integrate the 'rural proofing for health toolkit' into service planning processes.
- Discussions will continue with Regional Colleagues regarding a Rural Health network.

Strategic objective: Adult Clinical Area 1: Maternity
Programme of work/project: LMNS Equity and Equality Action Plan
- The LMNS Equity and Equality action plan has been signed off by the LMNS programme board and will imminently be published for public review. Progress on actions will be monitored through individual maternity and neonatal workstreams.

- Recruitment is taking place for an EDI Midwife at SaTH and roll out of the Civility, Respect, Inclusion and Kindness (CRIK) training has commenced across the Trust.
- A Business Case from maternity and neonatal voices partnership (MNVP) has been approved for an increase in funding.
- Baby First Aid classes have been rolled out across Telford and Wrekin within areas of significant socio-economic deprivation. These have seen high uptake.
- An Antenatal education specification has been agreed with the Trust. The project is being finalised and is due to commence imminently.

Strategic objective: Adult Clinical Area 3: COPD – a clear focus on COPD and driving uptake of vaccinations to reduce infective exacerbations and emergency hospital admissions.

Programme of work/project: Covid-19 Vaccination Programme

- Accelerated autumn/winter Covid-19 Vaccination Campaign commenced September 2023, initially focusing on care homes but extended to offer increased access for under-served communities through targeted outreach at community bases, fire stations, pop-up locations etc. Vaccination communications are targeted to those who are at risk (specifically those with COPD).

Strategic objective: Adult Clinical Area 4: Early Cancer Diagnosis (diagnostic pathways)

Programme of work/project: Early Cancer Diagnosis Objectives

- The first stage of the Community Diagnostic Centres opened in Telford November 2023.
- FIT compliance has been maintained with further development of a straight-to-test flexible sigmoidoscopy pathway for FIT negative patients.
- GP education sessions were held with the Colorectal consultant from Primary Care – a further session is planned in Jan 24 to include use of the NSS pathway.
- A task and finish group has been set up to begin planning of the Targeted Lung Health Checks. An outline options appraisal has been developed and used to inform initial roll-out areas.
- A Teledermatology hub is due to open in the Community Diagnostic Centre in February 2024. Further hubs are planned following options appraisal/business case approval by Commissioning Working Group.
- Analysis will take place across all diagnostic pathways to identify key areas of need and enact targeted intervention.

Strategic objective: Adult Clinical Area 4: Early Cancer Diagnosis (screening)

Programme of work/project: Early Cancer Diagnosis Improvement Plan

- Breast screening round length is now recovered.
- A detailed equity intelligence profile is in progress and a draft has been presented to the Cancer Strategy Board in September.
- Five GRAIL referrals to SaTH with 82% uptake and more are anticipated in next round.
- A breast cancer awareness event took place in Telford community settings with Seldom Heard Voices in May and October 2023. These were attended by other local projects included Cancer Champions.
- South East Telford PCN have created a video for non-responders resulting a 25% increase in cervical screening uptake amongst 25-year-olds at Stirchley GP Practice.

Strategic objective: Adult Clinical Area 4: Early Cancer Diagnosis (primary care)
Programme of work/project: PCN DES

- All 8 PCNS are delivering the PCN DES requirements and developing care coordination for cancer patients. New PCN Cancer Care Coordinators are in post and trained on Motivational Interviewing/cancer and systems and processes are being reviewed and improved, such as escalations and flags for late diagnosis and the sharing of learning.
- There is a FIT testing proforma on F12 and all staff are aware with a trial for pop-up reminders and training to GPs.
- Teledermatology is being piloted in Primary Care and a survey was completed in September to inform future models.
- A non-specific symptom pathway is being developed in quarter 4.
- Excellent work is taking place in South East Telford PCN through Care Coordination, including a focus on late-stage diagnosis for prostate cancer, focusing on black men aged 40 and above with abnormal PSA/BPH.

Strategic objective: Adult Clinical Area 4: Early Cancer Diagnosis (Community Awareness)
Programme of work/project: Core20PLUS Connectors (STW Cancer Champions)

- Significant progress has been made against all deliverables with over 180 Cancer Champions recruited from a diverse range of backgrounds. The project team are working closely with colleagues across the system to embed changes based on Champion insights, including building these into the refreshed Cancer Strategy. The project was successfully chosen to showcase its successful approach to partnership working at the Midlands Health Inequalities Conference in November 2023.

Strategic objective: Adult Clinical Area 5: Hypertension and Lipid Case-finding/Management
Programme of work/project: Innovation for Healthcare Inequalities (InHIP) Targeted secondary lipid management

- Ongoing support is being provided for risk stratification and system searches to support targeted reviews, with reviews ongoing in 4 practices with a named lead or champion for each practice.
- Campaign materials have been developed and education sessions offered and resources will be shared with all participating practices.
- Secondary care clinics have commenced.
- POC device repurposed from Primary Care. Device application submitted to Trust.

Programme of work/project: Innovation for healthcare inequalities (InHIP) hypertension case-finding

- Shropshire, Telford & Wrekin have been successful in their bid for 185k of national CVD Prevention and Health Inequalities funding to support, sustain and enhance the community hypertension case-finding.
- In Telford and Wrekin excellent progress has been made to deploy volunteers and implement activities for targeted groups and IMD areas. Successful case study where an individual was diagnosed hypertensive, pre-diabetic and encouraged to make lifestyle changes.
- In Shropshire a different model has been successfully developed to train “Level 1” volunteers to disseminate information and awareness of risks re high BP and

"Level 2" volunteers who take BP readings and direct those with high BP readings for 7- day monitoring via Social Prescribers in GP practices.

- The project was showcased at an interactive market stall event at the Regional Health Inequalities conference in Birmingham on 29th November.
- There have been challenges and delays with DPIA documentation and arrangements for sharing blood pressure data obtained in the community with GP Practices but this has now been resolved and is moving forward.
- Developments are ongoing to integrate hypertension case-finding with services offered by Community Pharmacy and Dental Surgeries.

Programme of work/project: Hypertension treatment to target

- A project has been initiated by the system CVD Prevention Clinical Lead and ICB PMO to identify efficiencies in practice and support outlier Practices (those within lowest IMD deciles, high BAME populations or rural areas) to adopt UCL Partners resources and improve optimal treatment. Work is ongoing to align with Health Innovation West Midlands to support GP Practices to increase treatment percentages to 80% and educational workshops with partners via GP Forum and PLT events to support all Practices.

Strategic objective: CYP Clinical Area 1: Asthma

Programme of work/project: CYP transformation and personalised care for asthma

- The programme is making positive progress with 232 Reviews undertaken since April 2023; 200 CYP using the Asthma App. 352 Completions of L1 training and a Reduction average of 20 admissions during 2022/23. 70% of schools across STW are asthma-friendly accredited (43% 2021/22) and Specific, tailored asthma training offered to practice nurses (to carry out paediatric spirometry), early years staff and sessions in planning for housing associations. STWs work improving outcomes for children and young people with asthma was successfully chosen to present at the Midlands Health Inequalities Conference in November 2023.
-

4.0 Conclusion / Recommendation

The Committee is asked to:

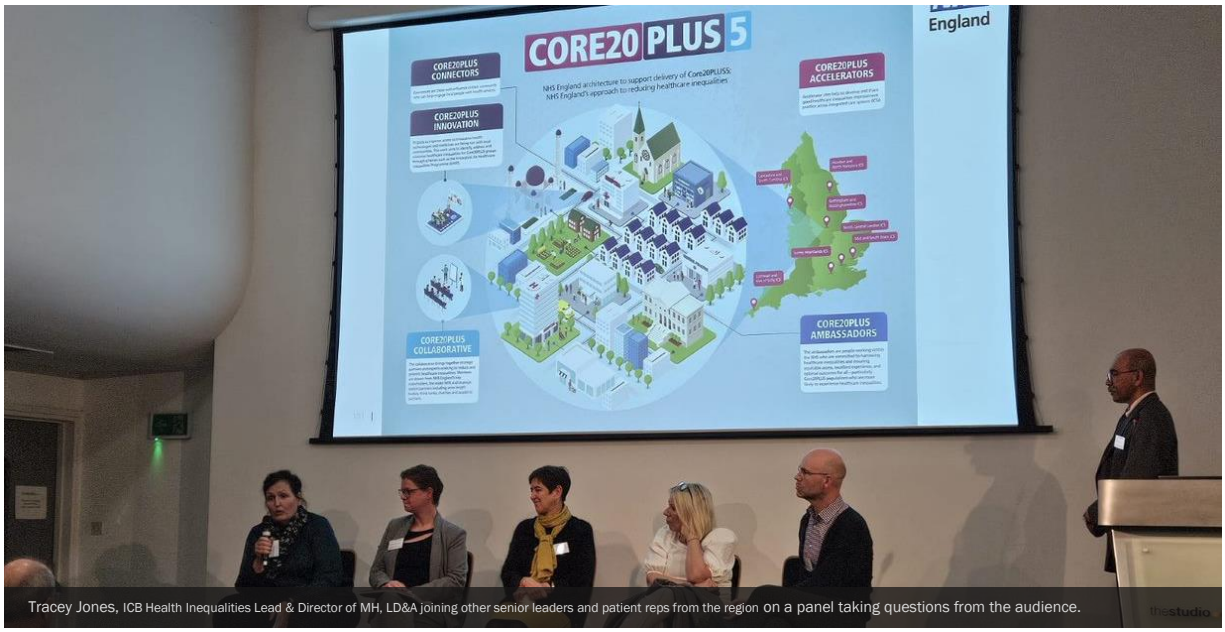
1. CONSIDER the content of section 3.1 and agree next steps where required;
2. NOTE the content of section 3.2 and CONSIDER whether any further action is require; and
3. NOTE the content of section 3.3.

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Taking Action on Health Inequalities

System workshop & Regional Health Inequalities Conference



Tracey Jones, ICB Health Inequalities Lead & Director of MH, LD&A joining other senior leaders and patient reps from the region on a panel taking questions from the audience.

Midlands Conference

On the 29th November 2023, colleagues from across the West Midlands representing healthcare, voluntary sector (VSC) and local authority (LA), packed into the Studio in Birmingham committed to or seeking to be informed about the health inequalities agenda, The event provided unrelenting and inarguable cases for change, inspiring conversations with lived experience speakers and an incredible number of presentations from systems showcasing fantastic work underway across the region. Several representatives from the Shropshire, Telford & Wrekin Integrated Care System (ICS attended, and although we are a small, financially challenged system, we were very prominent on the day, and took pride in showcasing our work.

Shropshire, Telford and Wrekin was selected to showcase at the workshops two fantastic examples of work in addressing inequalities, with a third showcased during a market-place segment of the day. *ICB Health Inequalities Lead & Director of Mental Health, Learning Disability, Autism & Children and Young People*, **Tracey Jones** joined a panel of senior colleagues in answering challenging questions from attendees and was also selected to attend a session with **Bola Owolabi,** Director for Health Inequalities England.

Health inequalities if not addressed result in unjust and unfair health outcomes based predominantly on people's **life chances**, and as an ICS we are committed to understanding health inequalities in all our activities and to take collective action, remembering it is everyone's business, to tackle inequality.

Find out more about the National health inequalities improvement programme.

"The event was well introduced and supported by both regional and national leads. Some very inspirational conversation based around overall inequalities, including the PHM specific sessions I attended."

– ***Craig Lovatt,*** *Head of Information at NHS Shropshire, Telford, and Wrekin*

Showcase: Improving early cancer diagnosis in our underserved communities

Miranda Ashwell, Lingen Davies Cancer Fund and **Alexandra Mace,** STW Health Inequalities Project Manager shared the exemplary work of the core connectors cancer champion's project.

The project aims to increase the uptake of cancer screening invitations through raising awareness in underserved communities, through training volunteer champions from these communities. More information here

160+ Champions

85+ Organisations engaged.

Cancer Champions
www.cancerchampions.co.uk

Showcase: Addressing Health Inequalities in children's asthma

Nicola Siekerski, STW Transformation Partner CYP Asthma / Epilepsy shared the fantastic work she and colleagues are delivering around the Asthma Care Bundle.

A system wide approach to supporting children with asthma across the STW footprint. Targeted intervention and focus on population groups, such as those living in depravity, those who are home-schooled, travelling communities, young people's homes, and young carers.

Partnership working with housing authorities and associations is talk taking place with the development of training, resources, and engagement around policy to improve the standards of housing.

200 Early years staff received asthma training.

200 CYP using the asthma app

232 Asthma reviews since April 2023

70% of STW Schools Asthma Friendly.

#AskAboutAsthma

Marketplace: Targeted community blood pressure conversations and checks delivered by volunteer champions.

660 people checked

37 Undiagnosed Hypertension

Edith McAlister, STW Health Inequalities project manager and **Rachel Threadgold,** Senior Health Improvement Practitioner (Telford Place & Communities) took to the market stand to share the lifesaving work of the community InHip Project.

The offers blood pressure checks in alternative and informal settings, by volunteers, with the aim of identifying previously undiagnosed hypertensive patients and a secondary aim of raising awareness or risk across target populations. **More info for** Telford | Shropshire

High blood pressure is a major cause of heart attack and stroke. Known as the *'silent killer'* because rarely are there any signs or symptoms.

Left to right – Edith McAlister and Rachel Threadgold presenting the InHip project at the conference marketplace.

Insight and reflection from the session with Bola Owolabi, NHSE Health Inequalities Lead

Tracey Jones, *ICB Health Inequalities Lead & Director of MH, LDA & CYP,* was personally invited to join Bola and other senior leaders from the region in a closed session. Key notes and reflection of the conversation include –

Harnessing the power of data and experience to tell the story and show impact. *Our BI team, with support of colleague's system wide, are building a powerful dashboard that will shine greater light on the heath inequalities in our system, support targeted efforts and measure the impact of those efforts.*

System leaders must be resilient, brave, and courageous in advocating for differential investment, and the innovative use of whole budgets to deliver health equity outcomes.

Colleagues conference reflections

The challenge of the health inequities agenda

Edith McAlister – Health Inequalities Project Manager

Edith has spent 4 decades working in health and a large chunk of that time making a difference to health inequalities here and in other parts of Country. Edith reflects on the challenge of work on the health inequalities agenda.

Tackling complex and deep-seated inequalities requires skill, knowledge, resilience, and stamina. Tackling the health inequalities agenda can be tough and sometimes be discouraging, but we all need to remind ourselves that it is much, much tougher for the people in our community who experience inequalities every hour of every day.

Change doesn't happen overnight, but we need to do it at pace, often grasping opportunities as they appear with determinants and ambition and try something which has never been done before!

The complexity in depth and breadth of inequalities means that sometimes it is hard to plan actions which will improve access, treatment, experiences, and outcomes in a meaningful, measurable way. BUT by understanding what the inequality is, identifying causes and addressing barriers with those worse affected**,** you can with sound planning, accurate and timely data, good evaluation, and skilled partnership achieve many fantastic successes and we can make a difference.

A Partnership Perspective to Health Inequalities

Miranda Ashwell – Lingen Davies Cancer Fund

Hearing the latest health inequalities data on life expectancy and healthy life expectancy was both depressing and motivational. Shocking to learn that now the UK is one of only 2 OECD countries where life expectancy is falling, not improving (together with USA, a country without universal health care). Didn't know whether to cry or be angry. This is avoidable and we can all reflect on what are the underlying causes - and causes of the causes and also consider the political leadership responsibilities. I would like to think it firmed the resolve of all present to make reducing health inequalities at the heart of all our work.

Bola was inspirational and is a reminder that all partners, health, social care, voluntary and local authorities, local government etc. need truly inspirational senior leaders championing the imperative of addressing health inequalities in their locality, putting it at the front and centre of decision making.

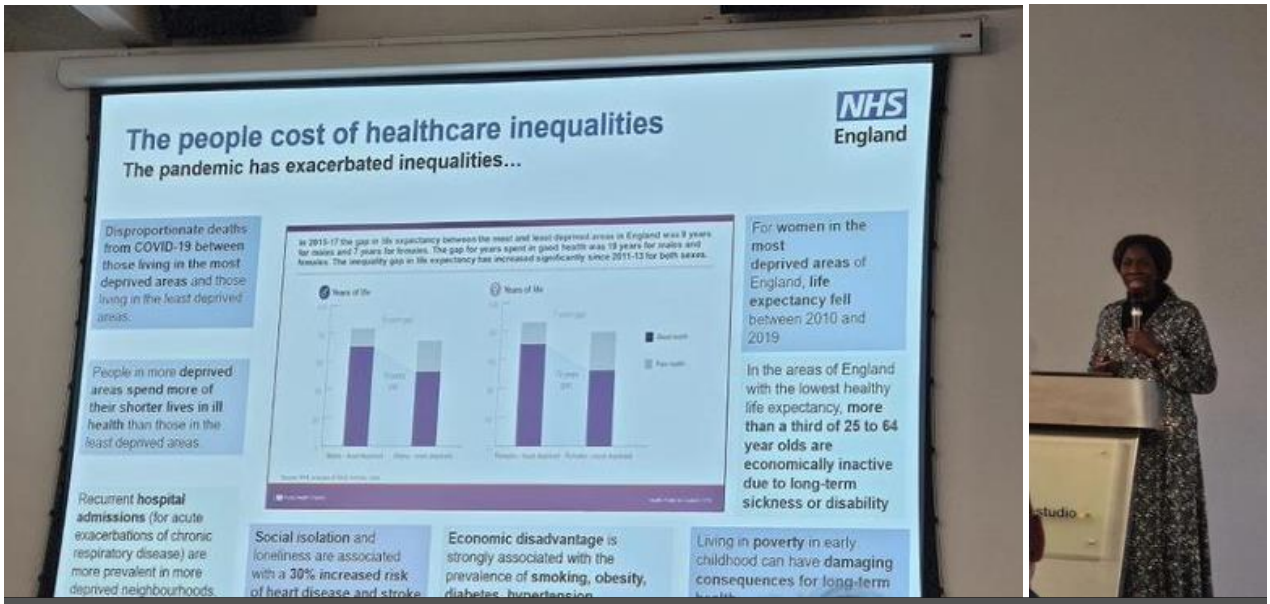
Great to hear examples of good practice from Black Country housing, but particularly interested in Military maternity Voices, as we have been doing work with Armed Forces. Great example of where problems people encountered were not recognised & often had not been articulated until someone took the trouble to ask and listen, giving a safe space for people to open up. Food for thought…

what does health mean to you?

Rachel Threadgold – Senior Health Improvement Practitioner (Place & Communities) for Telford Council.

There were several speakers whose messages hit home with me: Dr Tamy Boyce Institute of Health Equity and asking the question 'what does health mean to you'. I saw this framed in a New Local webinar and the question was to residents seeking support to improve the way they feel. The question here was' what matters to you', in essence what has brought you here today. Building upon this it is fundamentally about listening to what someone is saying and the reasons for doing what you do, needing what you need. This was later reflected on in one of the workshops where an intervention had provided the opportunity for intimate conversations and how vital these are to help support someone.

My other take home was from Professor Bola Owolabi which was about making a difference and crafting a narrative for our different audiences and how we look at that in terms of projected costs and productivity as this may resonate more if you trying to balance budgets. She talked about Health Care expenditure and the paradox of the CORE20PLUS population – live shorter and cost more. We are often driven by 'ill health' and do not look at the economic impact for example of leaving the workforce earlier resulting in productivity losses and costs involved whilst out of work and enabling people to return to work. She also talked about 'are we doing all we can'. Sometimes we can be working hard but it is the adage, can we work smarter together?



Bola Owolabi, Health Inequalities Director for England presenting at the Midlands Health Inequalities conference.

The Power of Data – A health Inequalities lens

Craig Lovatt – Head of information, STW
Miranda Ashwell – Lingen Davies Cancer Fund

It is clear overall that the impact of Deprivation, impacts most significantly with regards to inequality and impact of healthy life. However, we and colleagues regionally are aware of local impacts that may cause inequality and need to be addressed along with any intelligence/analytics utilised to support Health inequalities and Population health management.

The population health data and dashboards workshop demonstrated the fascinating big picture that data can powerfully evidence. What Nottingham had achieved was particularly impressive. They had gone to national government to gain special permission to combine pseudonymised hospital data set within other data linked to NHS numbers – enabling a much wider picture to be gained linked to health outcomes to inequalities, and the impact/demand on primary and secondary services. If Nottingham was able to do this (overcoming data sharing/ governance issues), what is the potential for other areas to be able to create a similar data set?

What was clear from the three presentations is that there is no set way of reviewing/analysing PHM or Health Inequalities data. With this in mind STW is currently developing products/ tools to serve the STW population for the local delivery program. These tools assure STW that we are in line or ahead of other systems across the country with our approach to HI and PHM. NHS STW have already commenced conversation with our regional Office for Health Improvement and Disparities (OHID) team on how we can drive the use of Local and Regional data platforms.

System Workshop

On Monday 4th December, partners from across the Shropshire Telford and Wrekin footprint gathered to identify areas to join up and collaborate, with a focus on health inequalities, to improve programme value and increase impact for our populations.

Slides were presented throughout the workshop to share an overview of public health intelligence, including Cardiovascular Disease (CVD) outcomes, cancer, avoidable and preventable mortality, obesity, smoking vaccinations, Severe Mental Illness (SMI) outcomes, alcohol-related conditions, and maternity (smoking & obesity).

Partners around the table shared the work their organisations had been doing, aligned to the NHS Must Do's for health inequalities and discussed areas where they felt more value could be added by greater collaborative working.

Key reflections from the workshop include the importance of working at scale efficiently, connecting the existing system wide work on health inequalities and ensuring alignments with the priorities established within the Joint Forward Plan and Integrated Care Strategy. This compels collective energy and peer support, to improve outcomes for our most under-served populations, and unity in supporting all those working in healthcare, to approach service with health inequalities in mind.

Examples of work from our Partners

Shrewsbury & Telford Hospital NHS Trust

Mitigating digital exclusion through outpatient transformation.

Investing in digital systems and improving digital maturity for better data accuracy and recording e.g., ethnicity recording and enabling improved reporting.

Enhanced health inequalities leadership through additional roles and EDI focused posts.

Preventions programmes –

- Cancer faster diagnosis
- CYP Asthma
- Inpatient and maternity smoking cessation
- Tier 3 weight management

Midlands Partnership NHS Foundation Trust

Health improvement advice pilot as part of Patient Knows Best.

Inpatient smoking cessation

Severe Mental Illness physical health checks.

Bespoke housing advice for SMI vial voluntary partner.

Co-located lifestyle advisors from T&W LA with MH Teams

Implementing National Standards for Food and Drink to

Improving BAME access to community perinatal services.

Apprenticeship promotion in diverse settings.

Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Review of DNA's, early results showing alarming rates in Paediatrics.

Single STW MSK service, removing wait time disparity and allowing flexibility move capacity around the system where it is most needed.

Optimising facilities in rural areas.

Work to improve data-sets including ethnicity recording. Working through challenges with IMD analysis due to difference in scores between England and Wales.

The hospital is used as a community hub, particularly for those experience isolation and loneliness as a place for lunch. Charities also utilis Trust spaces i.e., the dining room for Christmas dinners.

Telford & Wrekin Council

Health inequalities is embedded into Health and Wellbeing Strategy.

Mental Health and Lifestyle Advisors have been co-located.

Work with MPFT, LA representation from Leisure and Energize Active Partnership looking at physical activity interventions.

Partnership work with partners and VCSE on Cancer Champions to support recruitment from underrepresented groups.

Blood pressure checks in underserved communities to enhance CVD Prevention awareness and intervention.

Shropshire Community Health NHS Trust

Covid-19 Vaccination Programme is focusing on respiratory disease.

System focus on CYP Asthma to address the over reliance on reliever medications but also preventing these conditions or exacerbations of disease.

Work in local schools supports CYP programmes as teachers know which families/children need more support.

Oral Health - Healthy Smiles Team.

Shropshire Council

Task and finish group looking at Rural Proofing; considering closer to home services and travel support.

Healthy weight strategy

Health checks in farming communities.

Universal health checks working in GP Practices to focus on people with greater inequality and vulnerability.

RESET – MDT wraparound support for rough sleepers with drug and alcohol dependency.

Healthy Lives Service - *smoking cessation and weight management.*

Alcohol strategy

Digital inclusion with support to areas with no access.

First contact services team reach out to vulnerable maternity patients.

Measles MMR Action Plan, inequalities targeting.

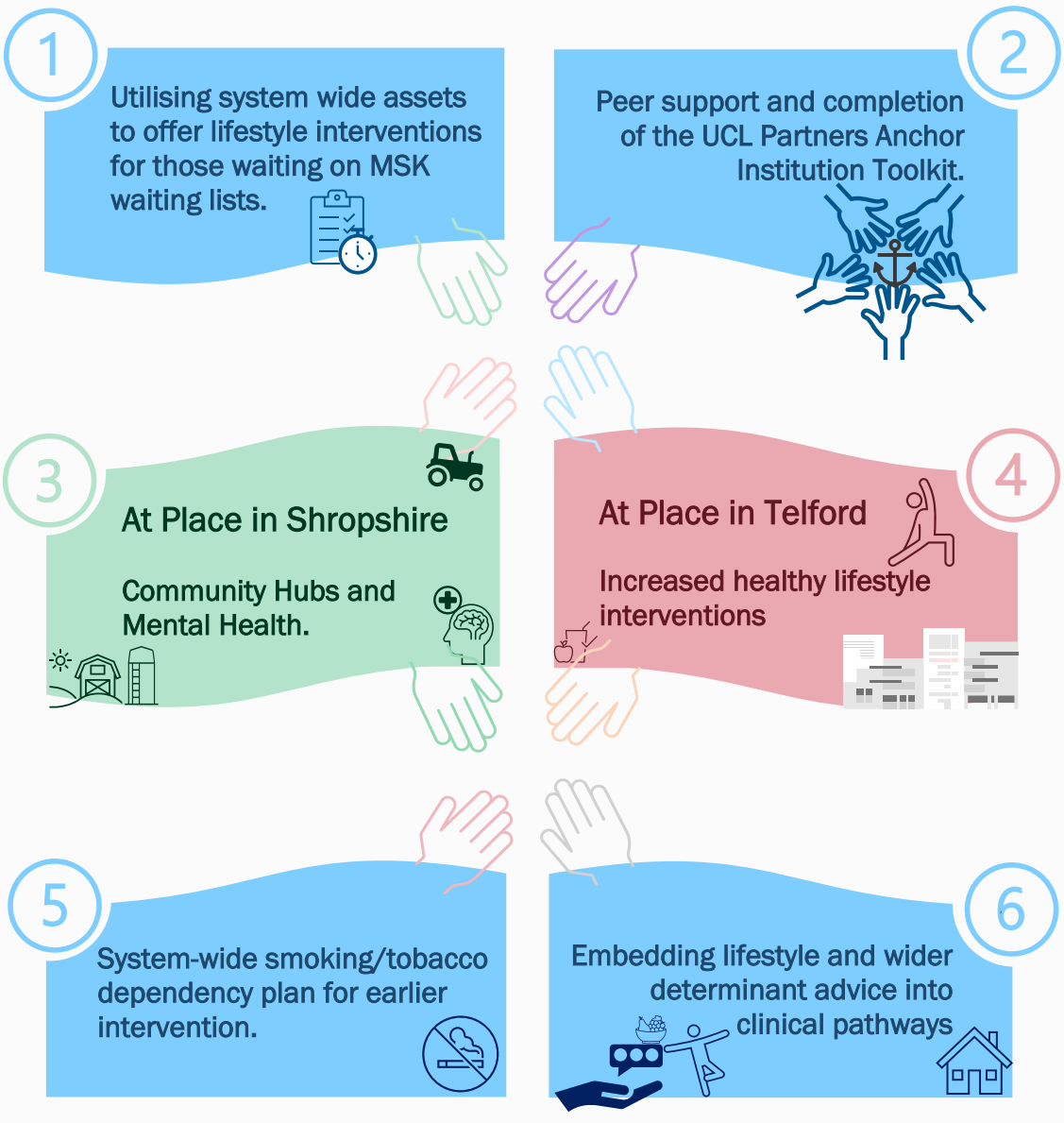
Targeted MDT working for children taken into care age 0-5 and under 1.

Workshop Outputs

Building blocks for collective Health Inequalities Action

Collective intelligence To enable us to fully understand our population.	**Inclusive community engagement** Local intelligence tells us 'what', engagement tells us why.	**Measuring the right impact** To ensure we are making the right difference to people.	**Wider Determinants** Using our role as Anchor Institutions to support people's wider needs, which impact health.
Good governance Tracking our success and challenges to continually improve	**Re-framing the narrative** Through embedded knowledge and awareness and championing the case for change.	**Collaborative Partnerships** Utilising our individual strengths as a collective alliance.	**Connecting Pathways** Understanding and utilising the vast work already taking place across our system.

The opportunities for enhanced collaborative working



What are Health Inequalities?

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society.

These include how long people are likely to live, the health conditions they may experience and the care that is available to them.

The conditions in which we are born, grow, live, work and age can impact our health and wellbeing. These are sometimes referred to as wider determinants of health.

What do Health Inequalities look like?

Learning disability
59
years is the median age at death (compared to 83 and 86 for males and females in England 2016–18)

Homeless
44
years is the mean age at death (compared to 80 and 83 for males and females in England 2016–18)

Asylum seekers
61
per cent are likely to experience serious mental distress, and asylum seekers are five times more likely to have mental health needs than the general population

LGBTIQ+
52
per cent have experienced depression, compared to around 20 per cent in the general population

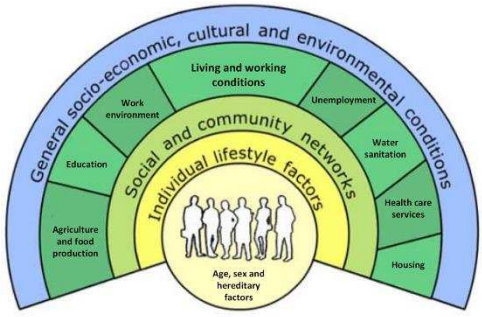
Black men
3
per cent have experienced a psychotic disorder compared to <1 per cent of white men

What are the causes of Health inequality?

The conditions in which we are born, grow, live, work and age can impact our health and wellbeing. These are sometimes referred to as wider determinants of health.

- These factors are often outside of a person's control.
- Wider determinants of health are often interlinked.

  For example, someone who is unemployed may be more likely to live in poorer quality housing with less access to green space and less access to fresh, healthy food.



Equity over Equality

Think 'sameness'

Think 'fairness'

Appendix 3 – Snapshots of the Health Inequalities Outcomes Dashboard (currently draft and in development)

Health Inequalities Dashboard

Home

NHS
Shropshire, Telford and Wrekin

Health Inequalities: Definition

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them.

The Conditions in which we are born, grow, live, work ad age can impact our health and wellbeing. These are sometimes referred to as wider determinants of health.

The below table displays all metrics contained within this dashboard.

Metric Code	Metric Name	Source	Refresh Frequency	Latest Data
HIMT001	Secondary care DNA rates	SUS	Monthly	October 2023
HIMT002	IAPT Recovery Rate	IAPT	Monthly	October 2023
HIMT003	% Hypertension with Age Appropriate BP Recorded (all ages)	RISKSTRAT	Monthly	October 2023
HIMT004	Rate of Avoidable Hospital Admissions	SUS	Monthly	October 2023
HIMT005	Admissions for Alcohol Conditions	SUS	Monthly	October 2023
HIMT006	Obesity Prevalence in Adults	RISKSTRAT	Monthly	October 2023
HIMT007	Rate of Non-Elective Admissions by LTC	RISKSTRAT	Monthly	October 2023
HIMT008	Emergency re-admission to hospital within 30 days of discharge	SUS	Monthly	October 2023
HIMT009	Under 75 Mortality: Cancer	DEATHREG	Monthly	March 2023
HIMT010	Under 75 Mortality: Respiratory	DEATHREG	Monthly	March 2023
HIMT011	Under 75 Mortality: CVD	DEATHREG	Monthly	March 2023

Health Inequalities Dashboard

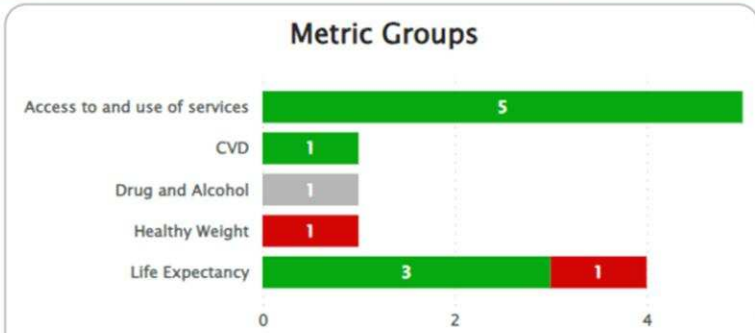
Metric Summary

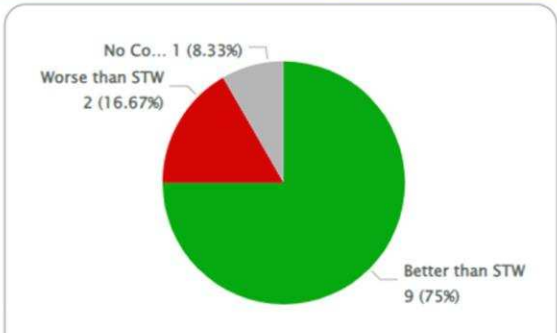
NHS
Shropshire, Telford and Wrekin

Local Authority	MSOA Name	Gender	Age	Age Band	Ethnicity	Ethnicity – Detail	IMD Quintile	Rural / Urban
Telford and Wrekin	All	All	All	All	All	All	All	All

12

Total Metrics





Metric Name	Latest	Cohort	STW	Cohort vs STW	Metric Trend
HIMT001 – Secondary care DNA rates	October 2023	6.9%	7.3%		
HIMT002 – IAPT Recovery Rate	October 2023	48.6%	45.5%		
HIMT003 – % Hypertension with Age Appropriate BP Recorded (all ages)	October 2023	65.2%	62.9%		
HIMT004 – Rate of Avoidable Hospital Admissions	October 2023	343.63	372.88		
HIMT005 – Admissions for Alcohol Conditions	October 2023	48.00	112.00		
HIMT006 – Obesity Prevalence in Adults	October 2023	20,539.39	18,978.22		
HIMT007 – Rate of Non-Elective Admissions by LTC	October 2023	1,248.68	1,322.95		
HIMT008 – Emergency re-admission to hospital within 30 days of discharge	October 2023	400.17	444.37		
HIMT009 – Under 75 Mortality: Cancer	March 2023	114.54	124.92		

Health Inequalities Dashboard

Obesity Prevalence in Adults

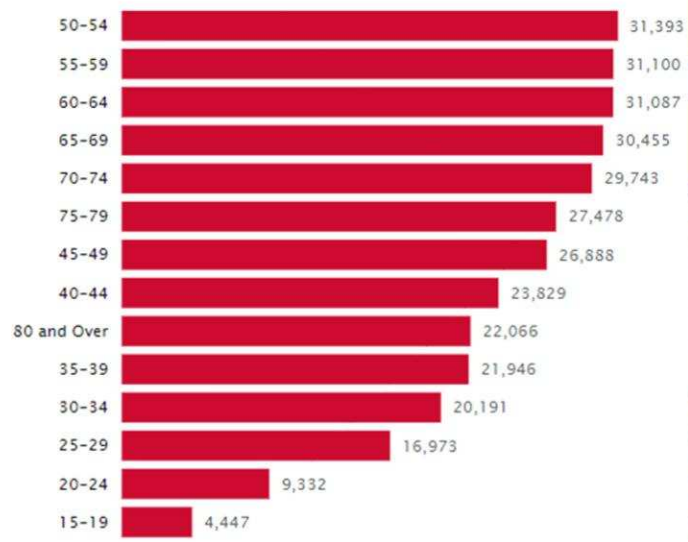
Home

Contents

NHS
Shropshire, Telford and Wrekin

Date Selection		Local Authority	MSOA Name	Gender	Age Band	Ethnicity	IMD Quintile	Rural / Urban
01/10/2023	01/10/2023	All	All	All	All	All	All	All

Obesity Prevalence by Cohort (per 100,000 population)



View Bar Chart by:

Age | Gender | Rurality | MSOA | Ethnicity | IMD | Local Authority | GP Practice

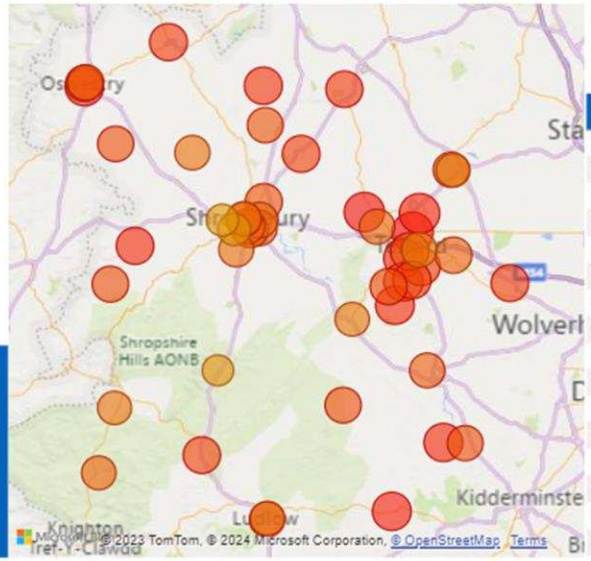
Patients Classified as Obese

100,856

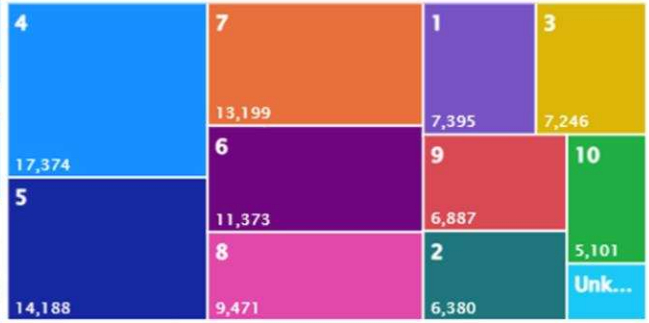
Per 100,000 Population

24,756

Obesity Prevalence by Practice (per 100,000 population)



Obesity by IMD Decile



Gender	Age	Ethnicity	IMD	Denom	Percent
Male	60-64	White - Other	1	7	100.00%
Female	45-49	Black - African	1	7	85.71%
Female	60-64	Mixed - Other	1	7	85.71%
Female	70-74	White - Other	2	10	80.00%
Female	75-79	White - Other	2	15	80.00%
Female	40-44	White - Other	1	9	77.78%
Female	40-44	Mixed - Other	1	9	77.78%
Female	50-54	Asian - Pakistani	1	9	77.78%
Female	35-39	Mixed - Other	1	20	70.00%
Female	50-54	White - Other	1	10	70.00%
Female	30-34	Mixed - Other	1	32	68.75%
Female	25-29	Mixed - Other	1	9	66.67%
Female	65-69	White - Other	2	9	66.67%
Female	40-44	Asian - Pakistani	1	11	63.64%
Female	50-54	Mixed - Other	1	43	62.79%
Male	60-64	Mixed - Other	1	15	60.00%

Health Inequalities Dashboard

Alcohol Related Conditions

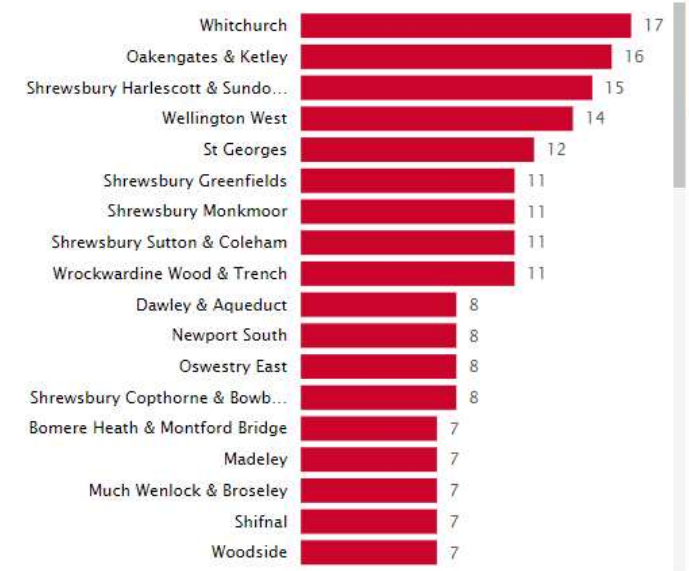
Home

Contents

NHS
Shropshire, Telford and Wrekin

Date Selection	Local Authority	MSOA Name	Gender	Age Band	Ethnicity	IMD Quintile	Rural / Urban
01/08/2023 – 01/10/2023	Multiple selections	All	All	All	All	All	All

Alcohol Related Conditions by Cohort (no. of admissions)



View Bar Chart by:

Age | Gender | Rurality | MSOA

Ethnicity | IMD | Local Authority

Alcohol Related Conditions (no. of admissions)

336

(Date Selection)

Recent Month

100

Previous Year: 69 (+44.93%)

Current FYTD

804

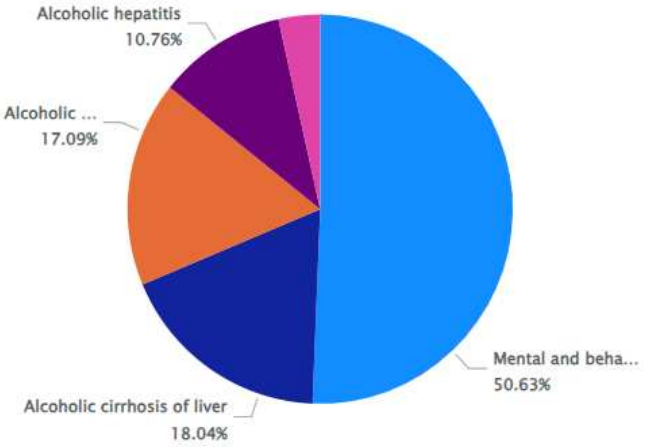
Previous FYTD: 686 (+17.2%)

Rolling 12 Months

1328

Previous Rolling 12 Months: 1217 (+9.12%)

Top 5 Diagnosis for Alcohol Related Conditions



2 Year Trend (no. of admissions)

Agenda Item

ICB 31-01-014

Good Governance Institute (GGI) governance review, and amendments to the Constitution and Governance Handbook

APPENDIX A

Summary of the Good Governance Institute's report on Making Meetings Matter for NHS Shropshire, Telford and Wrekin

December 2024

1. Scope of work:

In March 2023 NHS STW appointed Good Governance Improvement (GGI) to support Shropshire, Telford and Wrekin ICB ("the ICB") on a governance improvement programme, involving:

Phase 1:
• Diagnostic and mapping of the current governance structure
• The co-design of a revised governance structure

Phase 2:
• Implementation of new governance structure "three cycles"

The purpose of the programme is to develop a co-designed, simplified corporate and divisional structure for the ICB, with fewer, more efficient meetings that strengthen assurance, management of processes and board oversight.

This report summarises the GGI's key findings and recommendations from phase 1 as described above.

2. Progress of work completed during phase 1:

2.1 During the course of the GGI's work they:

- reviewed documentation (meeting papers, terms of reference)
- observed meetings (integrated delivery committee, finance committee)
- attended the senior leadership team (SLT) awayday
- interviewed ICB officers, and a wide number of system partners (see appendix I for lists of interviewees)

2.2 As a result of this work the GGI have found the following key issues:

- significant complexity in the current structure, in particular in relation to the integrated delivery committee (IDC)
- in many cases unclear accountability and reporting lines lack of clarity as to purpose
- concerns expressed about poor meeting etiquette (attendance, apologies, arriving and leaving late) and the quality of papers
- 136 meetings were identified, of these 45 terms of reference were received and 95 were not received when requested for the review
- several management groups were reporting into board committees, rather than to the executive leadership team
- attendance at meetings was variable

- basic governance was not in place for all meetings, including terms of reference where some were outdated, inconsistent or missing

2.3 Findings specific to the Integrated Delivery Committee:

In the ICB structure, the integrated delivery committee (IDC) was found to be the most complex. This is a committee of the board, chaired by the chair of one of the system partners who is not a member of the ICB board, although he does attend the ICB board meetings.

The GGI found a number of challenges with the IDC structure:

- The large number of groups in IDC's structure, which are almost all management groups. In the GGI's view it is sub-optimal for management groups to be reporting to board committees, as these are operational groups which should be reporting to ICB management. The number of groups, 16 in total with a further 34 sub groups reporting to IDC creates significant pressures for the meetings.
- There is a group for each of the ICB's six key priority operational programmes for 2023/24. Five of the six groups reported directly to IDC, however one of them (children and young people) reported via another (mental health, learning disability and autism).
- Inconsistencies between terms of reference as to where groups were reporting. For example, the two place groups, Telford and Wrekin Integrated Partnership (TWIP) and Shropshire Integrated Partnership (ShIP) are both reporting to IDC when these are committees of the ICB board. Two groups, people delivery board and estates group, had terms of reference which stated that they reported to IDC but were not referred to in the terms of reference for IDC itself
- Duplication of names and/or groups. For example, the strategy committee has a strategic estates working group reporting into it, and there is also a strategic estates group reporting into the financial improvement group which reports to IDC
- Confusion in terminology. Several groups are called 'board', which are, in reality, management groups and should be called something else to reflect this status.

2.4 Findings from Interviews:

The GGI interviewed ICB directors and officers, and also representatives from the system partners. The list of interviewees is included in Appendix 1. The GGI also attended the ICB'S senior leadership team (SLT) awayday in June 2023. The views of interviewees and SLT were very consistent, and are summarised below.

The GGI noted that it was very positive that all those interviewed showed commitment and enthusiasm for improving the governance structure, which provides a real opportunity for the ICB to move forward in the future.

2.4.1 Board

- Several interviewees shared the view that there is insufficient focus on the core functions of the ICB, in particular health inequalities. Frustration that the ICB is now expected to performance manage providers, which was not intended to be a role for the ICB. This drives the behaviour of executive directors and leads to the board being overly operational and less strategic.
- Board focus is on reporting, and it does not hold difficult conversations. There is good challenge by some NEDs, and the board is maturing. Private sessions are valued. There are too many individuals in attendance at board meetings over and above

voting Board members, and so the overall number attending board meetings is very high
- Insufficient discussion about the accountability of the partners to the ICB and about risk. Not sufficiently sighted on the work of the local authorities.
- Board has not defined what the place partnerships should do, and place partnerships do not report directly to the board
- Relationship between the board and committees needs to be clarified

2.4.2 Committees

- Too many committees, agendas are too long, too many papers, very resource intensive. Most are unclear on purpose. Meetings are not considered a good use of time. Poor attendance. Not working effectively, integrated delivery committee (IDC) in particular
- Lack of discussion of system issues. Tendency for attendees to talk only about their own organisation
- **IDC**: too much going for information, without action. Should not be NED chaired. Could be replaced by strong PMO
- **Quality and Performance committee**: Too much duplication with provider's quality committee meetings
- Insufficient clinical voice at **Strategy committee**. Strategies do not always align.
- **People committee**: impacted by lack of capacity at providers and ICB.

2.4.3 Governance

- There were numerous comments on the complexity of governance. Difficult to negotiate, too many meetings, too bureaucratic, unwieldy. Structure is overly complex and does not work. Multiple layers of reporting, too much duplication
- Balance between operational management and assurance is not working appropriately
- Inter-relationship between ICB/ICS governance and provider governance can be developed to reduce duplication
- Roles of board/committees/groups are unclear. Not clear where decisions are made
- Cycles of business are not established, including interaction with system partners' governance which is a source of assurance for the ICB and timing of committees within the board cycle
- Conflicts of interest are not always recognised and handled appropriately

2.4.4 Place

- Unclear where ideas which come out of place partnerships should be developed

2.4.5 System executive group

- Lack of clarity on membership, purpose and how the group fits in to the rest of the governance structure

2.4 6 Meetings

- There needs to be more consistency, including cover sheets, executive summaries, shorter reports. Need to be clear what the ask is.
- Papers should be taken as read

- Discussion time is not always spent in the right areas
- Quality of minutes needs to be improved

2.4.7 Other matters

- The current ICB governance structure has been informed by the governance structure of the ICS and the CCG without sufficient review
- Changes in people and number of interim staff provide an additional challenge
- Focus is on urgent and emergency care
- Organisational development is not in the system, because it has not been resourced and prioritised

3. Governance challenges facing ICBs nationally

The GGI noted that there has been relatively little mandatory guidance about how ICBs should govern themselves and deliver on the system leadership with which they are charged. The challenges faced by STW ICB are extremely similar to those that GGI has seen across other ICBs. The following are the key points from the GGI's learning nationally:

Strategic focus
- Limited time being spent in public board meetings on strategy items
- Considerable operational detail and reporting
- Agendas have few items that are forward looking or horizon scanning

Systems working
- Preponderance of traditional healthcare items
- Limited consideration of social and economic development or broader determinants

Impact and added value
- Strategic priorities and intended impacts are in development
- Focus on outputs and process
- Ensure that Equality Impact Assessments are considered and developed

Assurance
- Duplication between Board, committees, partnership and management groups and partner organisations
- Board Assurance Frameworks are developing but don't yet drive agendas

Discussion and decision making
- Considerable variation in the way boards are operating, some are demonstrating constructive challenge with informed and evidence-based decisions, others have some way to go.

4. Proposed Structure for the Future

4.1 Overall context

The GGI suggests that this is an ideal opportunity to reset the governance structure at the ICB, now that the Chief Executive Officer (CEO) has been appointed substantively.

The GGI proposes:

- Utilising the momentum of the CEO's first 100 days
- Practical recommendations for effective meetings, accompanied by training and supported by communications

The ICB needs to be both pragmatic and realistic

- Remember that there are key priorities to be delivered now for which the ICB is accountable for
- Changes need to be accompanied by a development programme for SLT and the administrative team

The ICB must acknowledge that the changes will be incremental and evolutionary

- Place and provider collaborative will be important in the future, and the proposed future state needs to be recognised in the current redesign
- The current changes should be designed to enable "lift and shift" into the provider collaborative over time as the system matures

4.2 Points to consider based on GGI observations

The GGI have set out 'ground rules' for board committees and management groups. Following these will address many of the issues noted above. In particular, by putting in place clear terms of reference and reporting there will be increased clarity about the purpose for meetings and so those attending can be more confident about their roles and remit.

This needs to be supported by:

- Strong chairing of meetings, to keep discussions succinct and on-topic
- Commitment by those who are members of meetings groups to attend and to contribute
- High quality papers, including:
    - Papers which are well-written, concise and impactful
    - Reports from each meeting to the group to which it reports, using 3As reporting (see Appendix II for an example)

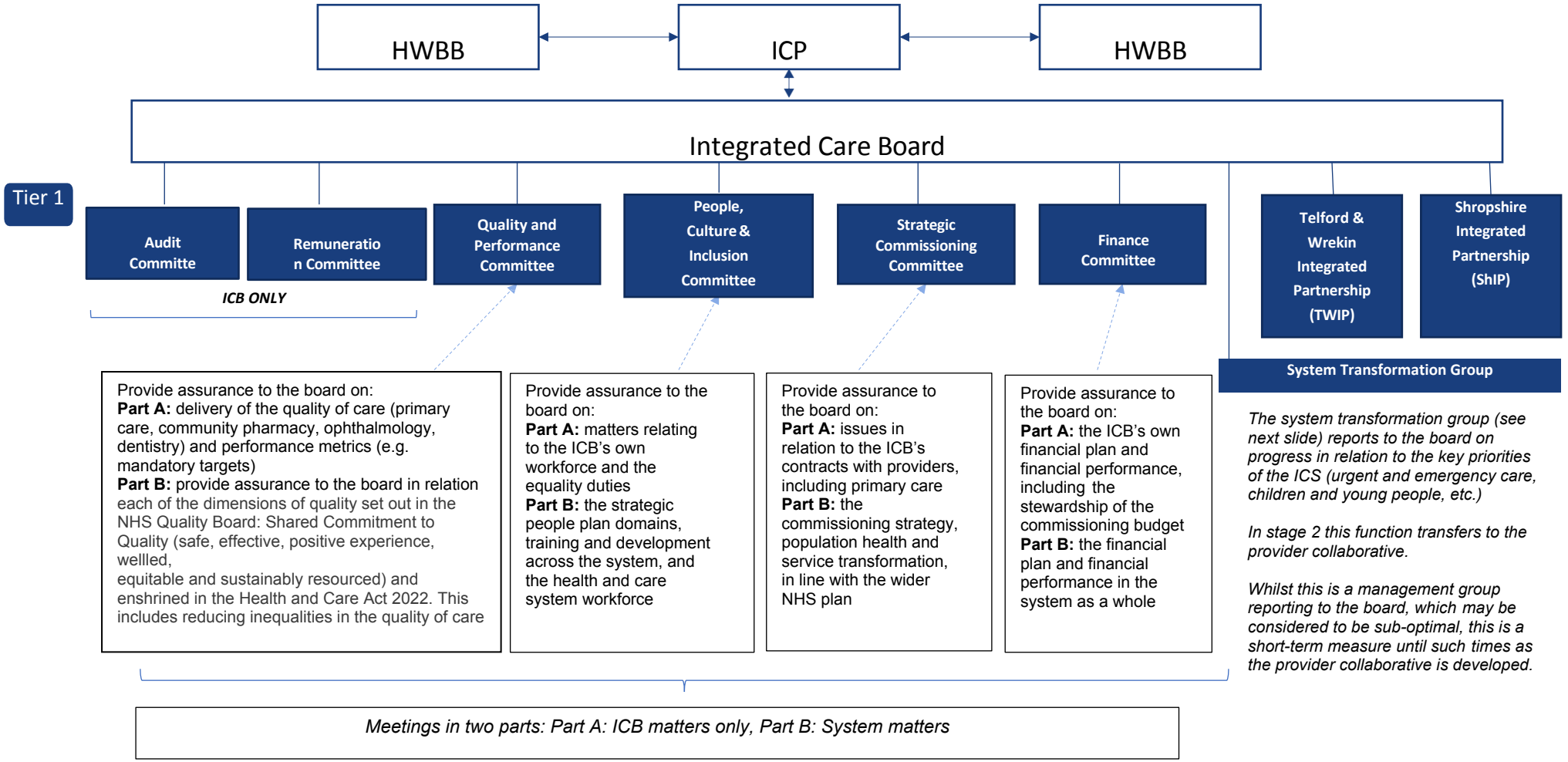
- Clear responsibilities for administrative support for meetings, including:
    - Working with the meeting chair to set the agenda
    - Collecting and distributing papers
    - Taking minutes
    - Updating action logs

4.3 Ground Rules for board committees and management groups

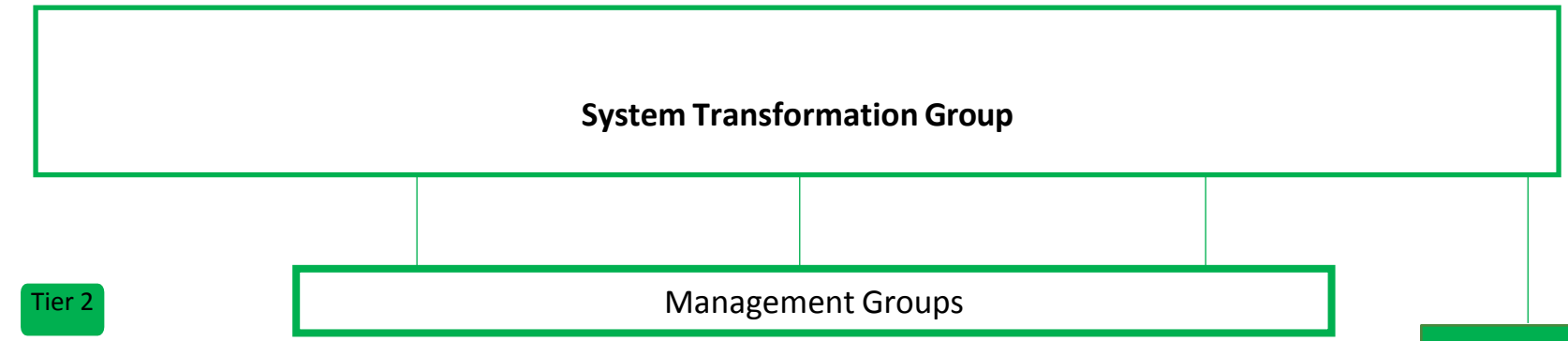
- There is only one board – the board of the ICB. The board has committees, which are chaired by non-executive directors. A group reporting into a committee is a sub-committee
- Management groups should not report directly to the board or its committees:
    - Management groups relating to the business of the ICB report to the ICB executive, and membership will generally consist of ICB officers and will be chaired by executive directors

    - Management groups relating to the system report to the system executive group (SEG). Once the provider collaborative is established these groups are likely to be managed by the collaborative
- All management groups – including task and finish groups - must have a terms of reference which sets out, for the group:
    - The group's purpose
    - Its duties
    - The membership, including chair and vice chair
    - Where it sits within the structure:
        - The group it reports to
        - The names of groups reporting into this group
- Management groups must produce a report after each meeting (3As report – see Appendix II for an example), which is shared with the group to which it reports and is included in the papers for that group.

4.4 Proposed structure for the future, stage 1 ICB board and its committees



4.5 Proposed structure for the future, stage 1 ICS management



The system executive group, membership of which is chief executives of the NHS system, and local authority representatives

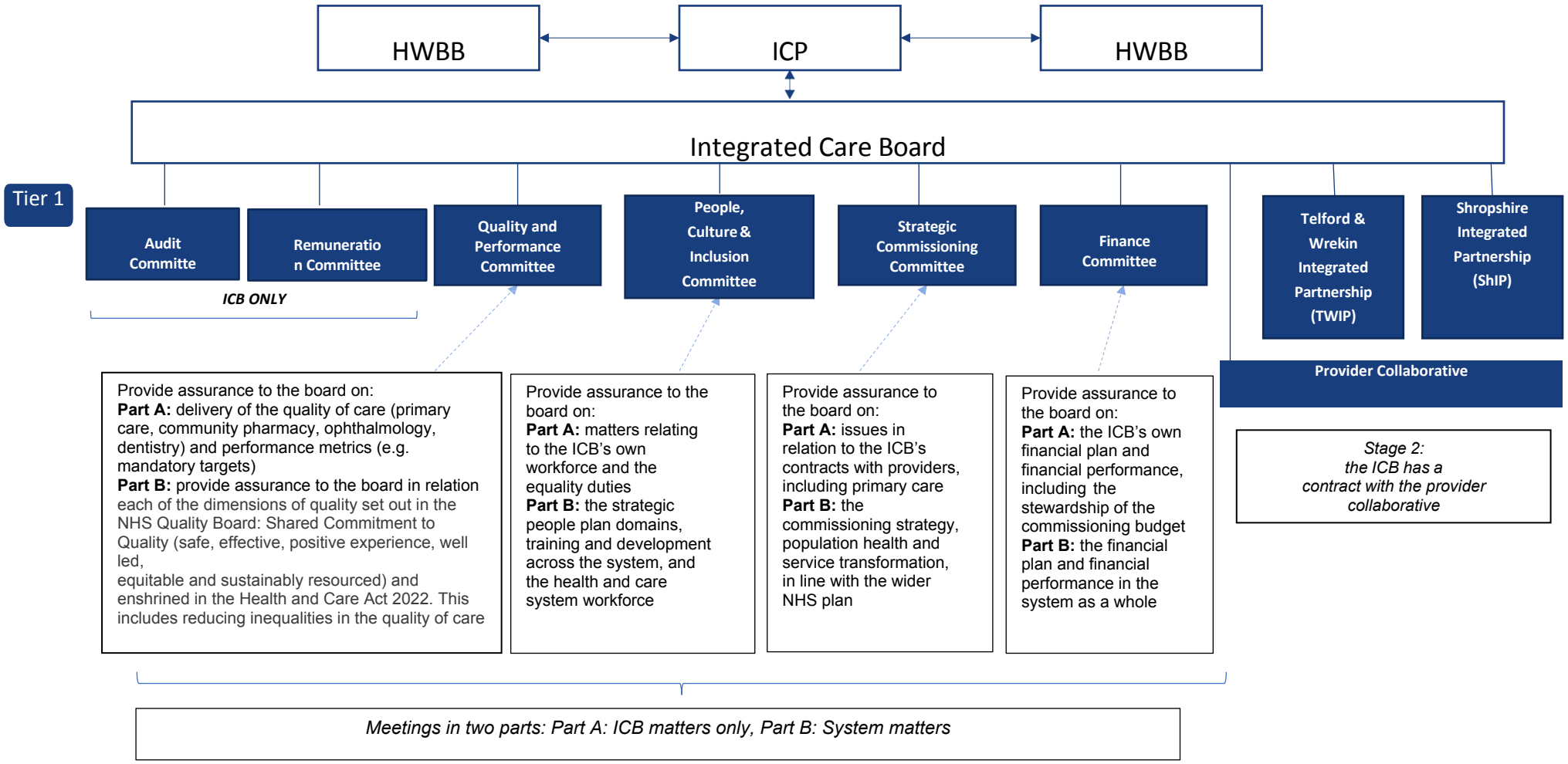
This group would review progress in the priority areas:

- Urgent and emergency care
- Elective care and diagnostics
- Mental health, learning disability and autism
- Children and young people
- Workforce (agency and recruitment)
- Financial improvement
- Local Care Programme

- It is the responsibility of the system executive directors to decide on the management groups, including their purpose and membership, to drive the delivery of the system objectives. There are existing groups which could be used for this purpose.
- Each tier 2 group is chaired by an executive director, who initially is likely to be an ICB executive director, but over time would transfer to a provider executive, in anticipation of the provider collaborative taking on full responsibility for delivery.
- Any tier 3 groups will report into one of the tier 2 groups.
- Tier 4 groups will potentially be required, each of which will report into a tier 3 group. We do not recommend that there are any groups below tier 4, as these groups are then too far removed from the executive group

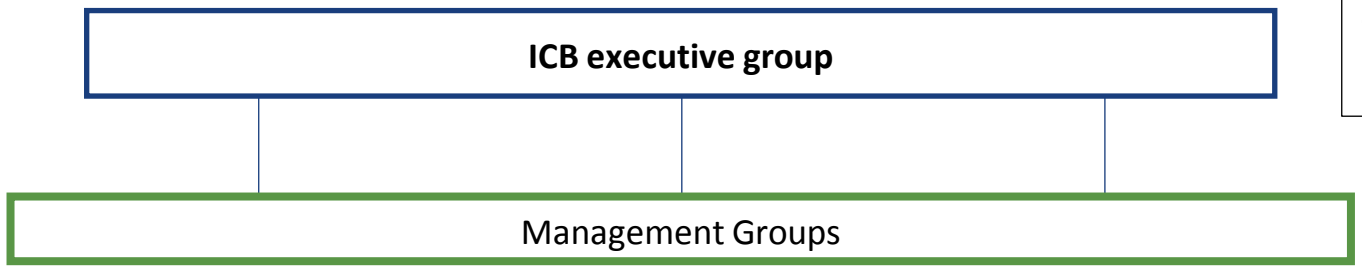
Investment Panel is likely to stay with the ICB

4.6 Proposed structure for the future, stage 2 ICB and it's committees



4.7 Proposed structure for the future, stages 1 and 2 ICB management

This is how the ICB manages itself, and how the ICB Executive Directors deliver on their portfolios



Core membership of this group is the ICB Chief Executive Officer and the ICB executive directors

Tier 2

It is the responsibility of the ICB's executive directors to decide this structure in the light of its operating structure, which is currently being reviewed and revised

All tier 2 groups are chaired by ICB executive directors, and report into the ICB executive group

Any tier 3 groups will report into one of the tier 2 groups.

Tier 4 groups will potentially be required, each of which will report into a tier 3 group. We do not recommend that there are any groups below tier 4, as these groups are then too far removed from the executive group

4.8 Options for Place

As noted above, TWIP and ShIP currently report into IDC. Going forward there are a number of options which the board could take, including:

Option 1: Committee of the board of the ICB - This is the GGI's recommended option

Option 2: Committee of the Health and Wellbeing Board

Option 3: Committee of both the board of the ICB and HWBB (for example West Yorkshire

This is a decision for the board to take;

- If option 1 is taken, it is for the ICB to decide membership
- Option 2 has the advantage of being integrated with the local authorities' structures and so will have ownership by the local authorities
- With option 2, there should be a place on the health and well-being boards for representatives from the provider collaboratives so as to make this work effectively

There is no guidance for place so any option is acceptable. What is key is that a decision is made by the board.

4.9 Governance options for provider collaboratives

There are two main models for provider collaboratives:

Option 1: Lead trust model

One trust takes on the accountability for commissioning and providing services on behalf of the collaborative, in their contract with the ICB

The lead trust needs to make the explicit decision that it is prepared to take on the risks, but these risks are mitigated by having agreements with the other trusts (which the ICB is not involved in)

Option 2: Joint committee model

A joint committee is set up of all the trusts in the collaborative, which reports to each trust board, and to the ICB. In this model there would need to be an agreement in each of the contracts between the ICB and the trusts as to what is delegated.

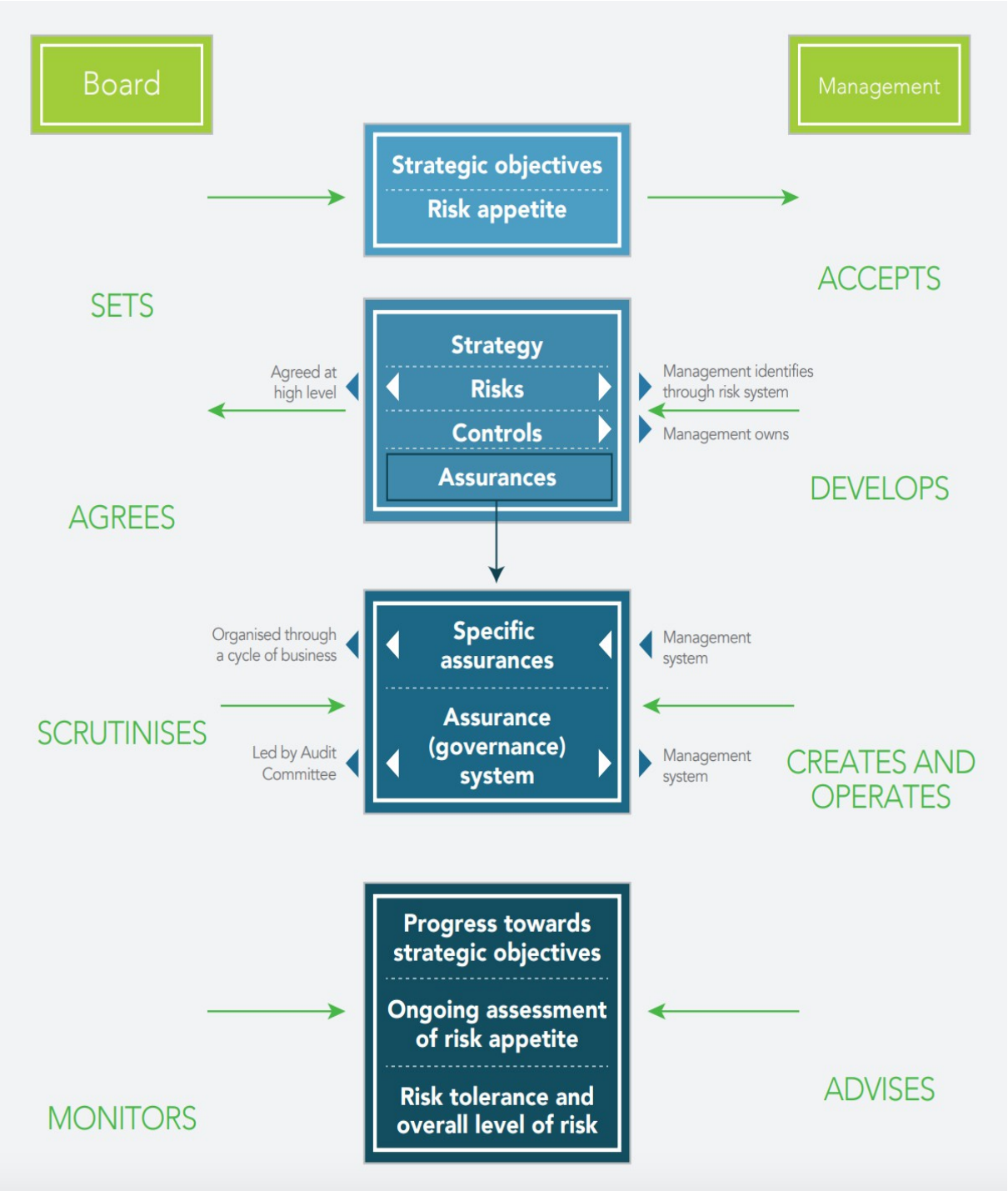
In both of these models, accountability for providing/commissioning services takes place through the contract, and not through the ICB's governance structures. It will be important to be clear from the beginning as to exactly what the ICB is expecting the provider collaborative to do. The provider collaborative should not be developed in isolation of the ICB. As noted in

slide 18 above, we recommend that the provider collaborative is a committee of the board whilst it is in development

4.10 Distinctive roles of the board and management

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

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



5. Recommendations

The GGI's report sets out a proposed structure to be implemented now which can then be revised as the provider collaborative becomes developed, with minimal further changes at that stage. Whilst recognising that these timescales are challenging, then in order to make the most of the opportunity to reset the GGI recommend that:

1. The system CEO's, ICB senior leadership team, and subsequently the ICB board, considers the proposals presented in this report and agrees the stage 1 structures by 31 January 2024

2. The system CEO's, ICB senior leadership team commits to working with GGI to develop terms of reference by 31 January 2024. This includes executive directors identifying the tier 3 groups (and where necessary, tier 4 groups) to support the groups identified in this report, and agreeing the duties and membership of each group, including ensuring that the clinical and professional voice is heard

3. The system CEO's, ICB executive directors, in consultation with the chair of the board and committee chairs, agree the five groups which will be supported by GGI in phase 2, together with timescales for that support

4. The ICS partners commit to identifying and making available staff for training as follows:

    - The chairs of the five groups identified for support, for training in chairing meetings
    - The individuals providing administrative support to the five groups, for training in minute-taking
    - All of the SLT and any other ICS staff who write reports for the board, or for any of the five groups, for training in report writing

5. GGI and ICB officers work together to agree the timings and resources for support for the five groups, over three cycles of business

6. Next Steps

The coming months provide an opportunity to 'reset' the ICB's approach to meetings, as part of a wider reset of the organisation. To support this The GGI propose that they will:

- Provide training in writing reports (one hour on Teams) to all members of the ICB's senior leadership team, and for any other ICB staff who write reports for the board or for the five groups identified for support
- Develop templates for the ICB to use in all meetings:
- Terms of reference in "plain English"
- Report cover sheet and report structure
- 3As report (see appendix II for an example)
- Agenda, minutes, cycle of business, action plan, attendance record
- Provide communications for the ICB to use with staff on the theme of *making meetings matter* to encourage staff to make the best use of time spent in meetings

The core work of phase 2 of the GGI project relates to supporting five meeting groups over three cycles of meetings, details of which are outlined below.

In phase 2 the GGI will support five meetings using the GGI three cycles approach. For each meeting group being supported we will:

- Meet with the chair of each of the 5 meetings to assess current effectiveness and agree aspiration
- Observe meetings
- Survey attendees at the end of the meeting
- Reflect and debrief after each meeting, with the chair

This will be supported by:

- Training
- Meeting chair: chairing meetings effectively
- Meeting administrator: minute taking
- Report writers: boards and how to write for them

Templates

- Terms of reference in "plain English"
- Report cover sheet and report structure
- Assurance report to the group this meeting reports to (3As report)
- Agenda, minutes, cycle of business, action plan, Attendance

Appendix i - Interviews

Over the course of Phase 1, the following people have been interviewed/consulted with as part of the initial diagnosis

Name	Role
Sir Neil McKay	Chair
Simon Whitehouse	Chief Executive
Claire Skidmore	Chief Finance Officer
Gareth Robinson	Executive Director of Delivery and Transformation
Alison Bussey	Chief Nursing Officer
Nick White	Chief Medical Officer
Alex Brett	Chief People Officer
Roger Dunshea	NED, Audit Committee Chair
Meredith Vivian	NED, Quality & Performance Committee Chair
Prof Trevor McMillan	NED, Finance Committee Chair
Dr Julian Povey	Primary Care Partner Member for Shropshire
Cathy Purt	NED, Strategy Committee Chair
Alison Smith	Director of Corporate Affairs
Claire Parker	Director of Partnerships and Place
Tracy Jones	Director of Mental Health, Learning Disability & Autism, and Children & Young People
Nicky O'Connor	Provider Collaborative Structures Lead
Julie Garside	Director of Planning and Performance
Sam Tilley	Director of Collaborative Programmes
Gemma Smith	Director of Strategic Commissioning
Harry Turner	Chair of Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust, Chair of IDC
Louise Barnett	Chief Executive, The Shrewsbury and Telford Hospital NHS Trust
Anna Milanec	Director of Governance and Communications, The Shrewsbury and Telford Hospital NHS Trust
Nigel Lee	Director of Strategy and Partnerships, The Shrewsbury and Telford Hospital NHS Trust
Patricia Davies	Chief Executive, Shropshire Community Health NHS Trust
Shelley Ramtuhul	Director of Governance, Shropshire Community Health NHS Trust
Tanya Miles	Executive Director of People, Shropshire Council
Rachel Robinson	Director of Public Health, Shropshire Council

Cathy Riley	Managing Director, Shropshire, Telford & Wrekin Care Group, Midlands Partnership University NHS Foundation Trust
Simon Froud	Director, Adult Social Care, Telford and Wrekin Council
Liz Noakes	Director of Public Health, Telford and Wrekin Council
Sarah Downes	Integration Programme Manager, Telford and Wrekin Council

Appendix ii – 3A's Report

Board meetings are time-consuming and costly, so organisations have a responsibility to ensure they are well-run and that the discussions and decisions that emerge from them are not wasted. In short: meetings must matter.

One of the many challenges for NHS organisations in ensuring that meetings matter is how effectively they alert, assure and advise management and the board of directors. One of the mechanisms we use to ensure this happens is a report providing alert, assurance and advice – the 3As report for short.

The 3As report provides a simple way for groups and committees to report to their parent group/committee or indeed to the executive group or board of directors. A template can be provided.

As well as listing the name of the meeting and date it was held, the template provides space for information such as:

- whether the meeting was quorate
- the key agenda items discussed
- a review of key risks
- what learning might be shared
- what actions are to be escalated/de-escalated and need consideration by the parent group/ committee.

The body of the report asks for:

- three alerts
- three items of assurance
- three key items for advice discussed at the meeting

This three-of-each approach is intended as a guide and is not prescriptive

The full report should be a maximum of two pages. We suggest that the chair of the meeting takes notes of the 3A items of alert, assure, advise throughout the meeting and agrees them with attendees at the meeting's conclusion for reporting and escalation purposes.

The 3As summary means the report can be quickly escalated to teams and management at the next level, rather than perhaps waiting for several weeks or even months for meeting minutes to be ratified.

In some NHS organisations the GGI have worked with, the 3As report forms the basis for other meetings, such as team meetings, as it helpfully summarises the key points of a meeting. The 3As format can also be used for communication to colleagues.

APPENDIX B

NHS
Shropshire, Telford and Wrekin

GOVERNANCE HANDBOOK

Excerpts from SoRD, SFIs and Financial Scheme of Delegation

NHS Shropshire, Telford and Wrekin - Governance Handbook

Version	Approved by Board	Shared with NHSE/I
1	1st July 2022	7th July 2022
2	30th November 2022	10th January 2023
3	25th January 2023	n/a
4	29th March 2023	n/a
5	28th June 2023	n/a
6	29th November 2023	n/a
7 DRAFT		

Contents

1. Introduction

NHS Shropshire, Telford and Wrekin (NHS STW) Governance Handbook brings together a range of documents which support the Constitution and good governance. It particularly outlines the Scheme of Reservation and Delegation and Standing Financial Instructions that NHS STW adheres to and outlines in detail the decision-making structure and processes of NHS STW as outlined in the functions and decisions map.

Members of the public can influence the decision making of NHS STW through a number of different mechanisms;

- Feeding in your views of current services to help redesign them to make them more effective – the Framework and Principles for Public Involvement and Engagement outlines our strategy to involving people in their healthcare.
- Ask questions of the ICB by submitting questions – information on how to do this is contained on our website.
- Send in a petition – our Petitions Policy is included.
- Submitting complaints and compliments - information on how to do this is contained on our website.
- Submitting Freedom of Interest Requests information on how to do this is contained on our website.
- Contacting your local Healthwatch:
    - Healthwatch Shropshire - Healthwatch Shropshire | Your spotlight on health and social care services
    - Healthwatch Telford and Wrekin - Healthwatch Telford and Wrekin | Live Well Telford

Understanding who is making decisions and what decisions they are making is supported on our website by information on our Board composition and the publication of our agendas and papers in advance of our Board meetings. We also publish our Board members interests and our Conflicts of Interest Policy.

Amendments to the documents that make up the Governance Handbook are approved by NHS Shropshire, Telford and Wrekin.

2. Scheme of Reservation and Delegation (SoRD)

Key:

CEO – Chief Executive
CFO – Chief Finance Officer
CMO – Chief Medical Officer
CNO – Chief Nurse Officer
EDD&T – Executive Director of Delivery & Transformation
DS&I – Director of Strategy & Integration

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

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

Recommend the overall strategic direction of the ICS to the Board		Strategy Committee						
Approval of the consultation arrangements for the commissioning plan.		Strategy Committee						
Approve the commissioning plan.	✓							
Recommend the commissioning plan to the board		Strategy Committee						
Approve any revisions to Commissioning plans		Strategy Committee						
Approval of the ICS operating structure.	✓							
Approval of key strategies	✓							
Agree a plan to meet the health and healthcare needs of the population, having regard to the Partnership integrated care strategy and place health and wellbeing strategies.	✓							
Agree a plan to meet the health and healthcare needs of the population within each place, having regard to the Partnership integrated care strategy and place health and wellbeing strategies		Integrated Delivery Committee						

Recommend allocation of strategic resources to deliver the plan across the system determining what resources should be available to meet population need in each place and setting principles for how they should be allocated across services and providers (both revenue and capital)		Finance Committee						
Allocate resources to deliver the plan across the system determining what resources should be available to meet population need in each place and setting principles for how they should be allocated across services and providers (both revenue and capital)	✓							
Allocate resources to deliver the plan in each place, determining what resources should be available to meet population need and setting principles for how they should be allocated across services and providers (both revenue and capital)		Integrated Delivery Committee						
Arrange for the provision of health services in line with the allocated resources across the ICS	✓							
2. CONSTITUTION AND GOVERNANCE								
Establish and approve terms of reference and membership for ICB Committees	✓							
Approve NHS STW scheme of reservation and delegation (SoRD) which sets out those decisions reserved to the Board, committees and sub-committees, individuals or specified persons	✓							

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

Approve the arrangements for discharging NHS STW's functions in relation to Information law					D S&I			
Approve the arrangements for discharging NHS STW's functions under the Civil Contingencies Act 2004				✓				
Approve the arrangements for discharging NHS STW's functions to secure improvement in quality of services					CNO			
Approve system-level arrangements to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes					CMO			
Approve the arrangements for discharging NHS STW's functions to reduce inequalities					ED D&T			
Approve the arrangements for discharging NHS STW's functions to obtain appropriate advice from Directors of Public Health					D S&I			
Approve the arrangements for discharging NHS STW's functions to regard to effect of decisions	✓							
Approve the arrangements for discharging NHS STW's functions relating to Public involvement and consultation					D S&I			
Approve the arrangements for discharging NHS STW's functions to have regard to assessments and strategies					ED D&T			
Approve arrangements for complying with the NHS Provider Selection Regime	✓							
Agree implementation in place of the arrangements for complying with the NHS Provider Selection Regime.		Integrated Delivery Committee						
Approval of the annual report and annual accounts.	✓							

Recommend the annual report and accounts for approval to the Board		Audit Committee						
Approve the arrangements for discharging the statutory financial duties					CFO			
Approve the arrangements for discharging the statutory health and safety duties as an employer.					System People Lead			
Preparation of proposed amendments to the constitution and standing orders				✓				
Approval to submit proposed amendments to the constitution and standing orders to NHS England for final approval	✓							
Preparation of proposed amendments to the Governance Handbook					D S&I			
Approval of proposed amendments to the Governance Handbook	✓							
Approval of the arrangements, policies and procedures, for the management of conflicts of interest (contained in the Governance Handbook)	✓							
Propose changes to terms of reference for the committees		All Committees as required				All, as required		

Propose changes to terms of reference for the sub-committees		All Sub committees as required				All, as required		
Approve the appointment of the Deputy Chair of NHS STW from amongst the Non Executive Directors except for the Audit Committee Chair.	✓							
Approve changes to terms of reference for committees	✓							
Approve changes to terms of reference for sub committees		Parent Committee						
Approve membership of committees			✓					
Approve membership of sub committees			✓					
Approve arrangements and appointments of Board membership			✓					
Prepare the scheme of reservation and delegation contained in the Governance Handbook					D S&I			
Discharge an urgent decision where a meeting of NHS STW cannot be convened consulting with as many members as possible given the circumstances			✓	✓				
Approve (including any changes) the scheme of reservation and delegation contained in the Governance Handbook	✓							
Execute a document by signature/use of seal			✓	✓	CFO			

Approval of changes to the provision or delivery of audit assurance services to the Board	✓							
Propose changes to the provision or delivery of audit assurance services to the Board		Auditor Panel						
Approve proposals for action on litigation against or on behalf of the Board				✓	CFO, CNO, CMO, ED D&T , D S&I			
Responsibility for overseeing discharge of statutory responsibilities in relation to safeguarding		Quality and Performance Committee						
Receive and approve annual internal and external audit plans		Audit Committee						
Receive and approve internal and external audit reports and recommendations		Audit Committee						
Approve NHS STW's policy management arrangements and oversight, including the policy on the management of policies, supporting plans, policies and procedures.		Audit Committee						

3. FINANCE. CONTRACTING AND PROCUREMENT								
Preparation of Finance policies and Procedures					CFO			
Approval of Finance Policies and Procedures		Finance Committee						
Development of Standing financial instructions					CFO			
Approval of Standing Financial Instructions as part of the Governance Handbook	✓							
Determine the strategic financial framework of NHS STW and monitor performance against		Finance Committee						
Develop an approach to distribute the resource allocation through commissioning and direct allocation to drive agreed change based on NHS STW strategy		Finance Committee						
Approve an approach to distribute the resource allocation through commissioning and direct allocation to drive agreed change based on NHS STW strategy	✓							
Develop a medium- and long-term financial plan for recommendation to the Board which demonstrates ongoing value and recovery		Finance Committee						
Approve a medium- and long-term financial plan	✓							

Oversee the management of the system financial target and NHS STW 's own financial targets against the Finance Plan		Finance Committee						
Develop a system finance staff development strategy					CFO			
Approve a system finance staff development strategy		Finance Committee						
Monitor arrangements for risk sharing and or risk pooling with other organisations (for example arrangements for pooled funds with other Group's or pooled budget arrangements under section 75 of the NHS Act 2006).		Finance Committee						
Approve arrangements for managing exceptional funding requests.		Integrated Delivery Committee						
Approve exceptional individual funding requests		Individual Funding Request Panel						
Determine whether proper process has been followed by the Individual Funding Panel when considering an individual funding request.		Individual Funding Request Appeal Panel						
Approval of the banking arrangements					CFO			
Approve the counter fraud and security management arrangements, including supporting plans, policies and procedures		Audit Committee						

Approval of contracts/contract variations for any healthcare services within approved budgets *With the exception of GMS, PMS and APMS – see separate delegation*		Integrated Delivery Committee						
Approval of non-healthcare contracts outside approved budgets.				✓	Or CFO			
Approval of non-healthcare contracts within approved budgets.		As per budget holder delegation outlined in the Standing Financial Instructions						
Recommend approval of healthcare contracts outside approved budgets.		Finance Committee						
Approval of healthcare contracts outside approved budgets.	✓							
To approve, that NHS STW proceeds to procurement for healthcare services which will include the approval of the timeline for procurement, the proposal for procurement and the service specification.		Integrated Delivery Committee						
To approve the award of healthcare services procurement.		Integrated Delivery Committee						
To approve the extension of a non-healthcare contract, where provision for an extension has been made within the contract terms.				✓	or one of: CFO, CMO, CNO,			

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

Developing a plan to meet the health and healthcare needs of the population (all ages) within NHS STW area having regard to the partnerships strategy		Strategy Committee						
Establishing joint working arrangements with partners that embed collaboration as the basis for delivery within the plan.		ShIP and TWIP, Integrated Delivery Committee						
Arranging for the provision of health services in line with allocated resources across the ICS by putting contracts and agreements in place to secure delivery of its plan by providers		Integrated Delivery Committee						
Arranging for the provision of health services in line with allocated resources across the ICS by convening and supporting providers (working both at scale and at place) to lead major service transformation programmes to achieve agreed outcomes		ShIP and TWIP, Integrated Delivery Committee						
Arranging for the provision of health services in line with allocated resources across the ICS by supporting the development of primary care networks (PCNs) as the foundations of out of hospital care and building blocks of place based partnerships including through investment in PCN management support, data and digital capabilities, workforce development and estates		Primary Care Commissioning Committee						

Arranging for the provision of health services in line with allocated resources across the ICS by working with local authority and voluntary, community and social enterprise (VCSE) sector partners to put in place personalised care for people, including assessment and provision of continuing healthcare and funded nursing care and agreeing personal health budgets and direct payments for care.		ShIP and TWIP, Integrated Delivery Committee						
Leading system wide action on data and digital: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services to put the citizen at the centre of their care		Strategy Committee						
Using joined up data and digital capabilities to understand local priorities, track delivery of plans, monitor and address unwarranted variation, health inequalities and drive continuous improvement in performance and outcomes		Strategy Committee						
Through joint working between health, social care and other partners including police, housing, safeguarding partnerships, employment and welfare services, ensuring that the NHS plays a full part in achieving wider goals of social and economic development and environmental sustainability	✓							
Driving joint work on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support wider goals of development and sustainability.		Strategy Committee						

Planning for, responding to and leading recovery from incidents (EPRR) to ensure the NHS and partner organisations are joined up at times of greatest need, including taking on incident co-ordination responsibilities as delegated by NHS England and NHS Improvement				✓				
Approval of delegated responsibilities by NHS England in relation to specialised commissioning						Joint West Midlands NHS Delegated Commissioning Committee		
Preparing a performance assurance framework (PAF)		Quality and Performance Committee						
Approving a performance assurance framework (PAF)	✓							

5. PEOPLE							
Develop ICS System People Plan		ICS People, Culture and Inclusion Committee					
Approval of ICS System People Plan	✓						
Leading system implementation of people priorities including delivery of people plan and People Promise by aligning partners across the ICS to develop and support "one workforce" including through closer collaboration across the health and care sector with local government the voluntary and community sector and volunteers.		ICS People, Culture and Inclusion Committee					
Approval of arrangements to discharge the ICB's People /HR and Equality, Diversity and Inclusion responsibilities as an employer;				ICB Executive Group			
Approval of arrangements to discharge the ICB's Equality, Diversity and Inclusion responsibilities as an employer				ICB Executive Group			
Approval of arrangements to discharge the ICB's Health and Safety responsibilities as an employer;				ICB Executive Group			
Preparation of HR systems, policies and procedures to support the arrangements for discharging the statutory duties of NHS STW as an employer.				System People Lead			

Preparation of Equality, Diversity and Inclusion systems, policies and procedures to support the arrangements for discharging the statutory duties of NHS STW as an employer.					System People Lead			
Preparation of Health and Safety systems, policies and procedures to support the arrangements for discharging the statutory duties of NHS STW as an employer.					CEO			
Approve the policies and procedures to support the arrangements for discharging the statutory duties of NHS STW as an employer to include but not limited to: • HR/People Equality, • Diversity and Inclusion and • Health and Safety.					ICB Executive Group			
Approve the annual evidence submissions on behalf of the Board for: • Equality Delivery System 2 (EDS2) • Workforce Race Equality Standard (WRES) • Workforce Disability Equality Standard (WDES)					ICB Executive Group			
Recommend the terms and conditions, remuneration and travelling or other allowances, including pensions and gratuities of staff on agenda for change.				✓	System People Lead			
Approve the terms and conditions, remuneration and travelling or other allowances, including pensions and gratuities of staff on agenda for change.		Remuneration Committee						

Recommend pensions, remuneration, fees and allowances payable to employees and to other persons providing services to NHS STW not covered by Agenda for Change.			✓	✓	System People Lead			
Approve pensions, remuneration, fees and allowances payable to employees and to other persons providing services to NHS STW not covered by Agenda for Change.		Remuneration Committee						
Recommend the financial arrangements for termination of employment, including the terms of any compensation packages and other contractual terms, excluding ill health and normal retirement, for all employees			✓	✓	System People Lead			
Approve the financial arrangements for termination of employment, including the terms of any compensation packages and other contractual terms, excluding ill health and normal retirement, for all employees		Remuneration Committee						
Recommend the business cases for staff who wish to retire and then return to employment that have been considered and recommended by the Executive team.				✓	System People Lead			
Approve business cases for staff who wish to retire and return to employment		Remuneration Committee						
Recommend disciplinary arrangements for employees, including the Executive Officers and for other persons working on behalf of NHS STW				✓	System People Lead			

Approve disciplinary arrangements for employees, including the Executive Officers and for other persons working on behalf of NHS STW	✓							
6. QUALITY AND SAFETY								
Approve arrangements, including supporting strategies and plans, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.		Quality and Performance Committee						
Approve arrangements for supporting NHS England/Improvement in discharging its responsibilities in relation to securing continuous improvement in the quality of general medical services.		Primary Care Commissioning Committee						
Preparation the Quality Strategy		Quality and Performance Committee						
Approve the policies and procedures to support the arrangements for discharging the statutory duties associated with and including, but not limited to; quality, safety, safeguarding and IPC		Quality and Performance Committee						
Approval of the Quality Strategy	✓							

Oversee the implementation of the Quality Strategy		Quality and Performance Committee						
Oversee the effective reporting and learning from safety incidents		Quality and Performance Committee						
Monitor feedback from compliments and complaints and provide assurance to the Board regarding their timely management		Quality and Performance Committee						
7. RISK MANAGEMENT								
Prepare the arrangements, policies and procedures in relation to risk management					D S&I			
Approve the arrangements, policies and procedures in relation to risk management		Audit Committee						
Approval of the risk appetite of the ICS/ICB	✓							
Approve arrangements for risk sharing and or risk pooling with other organisations (for example arrangements for pooled funds with other Group's or pooled budget arrangements under section 75 of the NHS Act 2006).	✓							
Approve a comprehensive system of internal control, including budgetary control, which underpins the effective, efficient and economic operation of the ICS		Audit Committee						
Approve the arrangements, including supporting plans, policies and procedures for business continuity and EPRR.		Audit Committee						

Approve the use of resources out of hours for exceptional circumstances and limited to situations of necessity					Director on Call			

8. INFORMATION GOVERNANCE								
Develop arrangements, including supporting policies and procedures, for handling Freedom of Information requests.					D S&I			
Approve arrangements, including supporting policies and procedures, for handling Freedom of Information requests.		Audit Committee						
Recommend arrangements, including supporting policies and procedures for ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data.					D S&I			
Approval of arrangements, including supporting policies and procedures for ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data.		Audit Committee						
Oversee the management of IG breaches and the reporting of IG Breaches, where appropriate, to the ICO					CFO (as SIRO)			
9. PARTNERSHIP WORKING								
To the extent permitted by law, authority to enter into arrangements with one or more relevant Local Authority in respect of: • delegating specified commissioning functions to the Local Authority; • exercising specified commissioning functions jointly with the Local Authority; • exercising any specified health-related functions on behalf of the Local Authority.	✓							

Agree formal and legal arrangements to make payments to, or receive payments from, a Local Authority or pool funds for the purpose of joint commissioning.	✓							
For the purposes of collaborative commissioning arrangements with a Local Authority, make the services of its employees or any other resources available to the Local Authority; and receive the services of the employees or the resources from the Local Authority.	✓							
For the purposes of joint commissioning arrangements with other ICSs, to • delegate any of the ICSs commissioning functions to another ICS • exercise any of the Commissioning Functions of another ICS; or • exercise jointly the Commissioning Functions of the ICS and another ICS; and for the purposes of the above; to: • make payments to, or receive payments from, another ICS; or • make the services of its employees or any other resources available to another ICS; or • receive the services of the employees or the resources available to another ICS.	✓							
For the purposes of joint commissioning arrangements with other ICSs, to establish and maintain a pooled fund made up of contributions by all of the ICSs working together jointly.	✓							

Approve decisions that individual members or employees participating in joint arrangements can take. Such delegated decisions must be disclosed in this scheme of reservation and delegation.	✓							
Authority to enter into strategic or other transformation discussions with its partner organisations	✓							
10. DELEGATED FUNCTIONS RELATED TO THE COMMISSIONING OF PRIMARY MEDICAL SERVICES UNDER SECTION 83 OF THE NHS ACT								
Discharge of the delegated commissioning by NHS England of primary care commissioning in accordance with section 65Z5 of the NHS Act and as outlined in the NHSE delegation agreement dated March 2023.								
Decisions in relation to the commissioning and management of Primary Medical Services;		Primary Care Commissioning Committee						
Planning Primary Medical Care Services in the Area, including carrying out needs assessments;		Primary Care Commissioning Committee						
Undertaking reviews of Primary Medical Care Services in respect of the Area;		Primary Care Commissioning Committee						
Management of the Delegated Funds in the Area;		Primary Care Commissioning Committee						
Co-ordinating a common approach to the commissioning and delivery of Primary Medical Care Services with other health and social care bodies in respect of the Area where appropriate; and		Primary Care Commissioning Committee						

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

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

• Management of the Delegated Funds in the Area; • Co-ordinating a common approach to the commissioning and delivery of Primary Prescribed Community Pharmaceutical Services with other health and social care bodies in respect of the Area where appropriate; and • Such other ancillary activities that are necessary in order to exercise the Delegated Functions.								
Primary Ophthalmic Services • Decisions in relation to the commissioning and management of Primary Ophthalmic Services; • Planning Primary Ophthalmic Services in the Area, including carrying out needs assessments; • Undertaking reviews of Primary Ophthalmic Services in respect of the Area; • Management of the Delegated Funds in the Area; • Co-ordinating a common approach to the commissioning and delivery of Primary Ophthalmic Care Services with other health and social care bodies in respect of the Area where appropriate; and • Such other ancillary activities that are necessary in order to exercise the Delegated Functions.		The West Midlands ICBs Joint Committee						
Provision of a forum for collective discussion, agreement and decisions by the constituent members of the committee that is consistent with the delegated limits of each ICB's standing financial orders. So enabling the ICBs to collaborate on areas of work and opportunities that arise.		The West Midlands ICBs Joint Committee						

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

3. Standing Financial Instructions

Contents

1. Purpose and Statutory Framework

1.1 In accordance with the Act as amended, NHS England is mandated to publish guidance for ICBs, to which each ICB must have regard, in order to discharge their duties.

1.2 The purpose of this governance document is to ensure that NHS Shropshire, Telford and Wrekin (NHS STW) fulfils its statutory duty to carry out its functions effectively, efficiently and economically. The SFIs are part of NHS STW's control environment for managing the organisation's financial affairs as they are designed to ensure regularity and propriety of financial transactions.

1.3 SFIs define the purpose, responsibilities, legal framework and operating environment of NHS STW. They enable sound administration, lessen the risk of irregularities and support commissioning and delivery of effective, efficient and economical services.

1.4 NHS STW is established under Chapter A3 of Part 2 of the National Health Service Act 2006, as inserted by the Health and Care Act 2022 and has the general function of arranging for the provision of services for the purposes of the health services in England in accordance with the Act.

1.5 Each ICB is to be established by order made by NHS England for an area within England, the order establishing an ICB makes provision for the constitution of NHS STW.

1.6 All members of NHS STW (its board) and all other Officers should be aware of the existence of these documents and be familiar with their detailed provisions. NHS STW SFIs will be made available to all Officers on the intranet and internet website for each statutory body.

1.7 Should any difficulties arise regarding the interpretation or application of any of these SFIs, the advice of the Accountable Officer or the Chief Finance Officer must be sought before acting.

1.8 Failure to comply with the SFIs may result in disciplinary action in accordance with NHS STWs applicable disciplinary policy and procedure in operation at that time.

1.9 Any changes to the SFIs will require the approval of NHS STW's Board.

2. Scope

2.1 All officers of NHS STW, without exception, are within the scope of the SFIs without limitation. The term officer includes permanent employees, secondees and contract workers.

2.2 Within this document, words imparting any gender include any other gender. Words in the singular include the plural and words in the plural include the singular.

2.3 Any reference to an enactment is a reference to that enactment as amended.

2.4 Unless a contrary intention is evident, or the context requires otherwise, words or expressions contained in this document, will have the same meaning as set out in the applicable Act.

3. Roles and Responsibilities

3.1 Staff

3.1.1 All ICB Officers are severally and collectively, responsible to their respective employer(s) for:

- abiding by all conditions of any delegated authority;
- the security of the statutory organisations property and avoiding all forms of loss;
- ensuring integrity, accuracy, probity and value for money in the use of resources; and
- conforming to the requirements of these SFIs

3.2 Accountable Officer

3.2.1 NHS STW constitution provides for the appointment of the Chief Executive Officer by the NHS STW chair. The Chief Executive Officer is the Accountable Officer for NHS STW and is personally accountable to NHS England for the stewardship of ICBs allocated resources.

3.2.2 The Chief Finance Officer reports directly to NHS STW Accountable Officer and is professionally accountable to the NHS England regional finance director

3.2.3 The Accountable Officer will delegate to the Chief Finance Officer the following responsibilities in relation to NHS STW:

- preparation and audit of annual accounts;
- adherence to the directions from NHS England in relation to accounts preparation;
- ensuring that the allocated annual revenue and capital resource limits are not exceeded, jointly, with system partners;
- ensuring that there is an effective financial control framework in place to support accurate financial reporting, safeguard assets and minimise risk of financial loss;
- meeting statutory requirements relating to taxation;
- ensuring that there are suitable financial systems in place (see Section 6)
- meets the financial targets set for it by NHS England;
- use of incidental powers such as management of ICB assets, entering commercial agreements;
- the Governance statement and annual accounts and reports are signed;
- planned budgets are approved by the relevant Board; developing the funding strategy for NHS STW to support the board in achieving ICB objectives, including consideration of place-based budgets;
- making use of benchmarking to make sure that funds are deployed as effectively as possible;
- executive members (partner members and non-executive members) and other officers are notified of and understand their responsibilities within the SFIs;
- specific responsibilities and delegation of authority to specific job titles are confirmed;
- financial leadership and financial performance of NHS STW;
- identification of key financial risks and issues relating to robust financial performance and leadership and working with relevant providers and partners to enable solutions; and

- the Chief Finance Officer will support a strong culture of public accountability, probity, and governance, ensuring that appropriate and compliant structures, systems, and process are in place to minimise risk.

3.3 Audit Committee

3.3.1 The board and accountable officer should be supported by an Audit Committee, which should provide proactive support to the board in advising on:

- the management of key risks
- the strategic processes for risk;
- the operation of internal controls;
- control and governance and the governance statement;
- the accounting policies, the accounts, and the annual report of NHS STW;
- the process for reviewing of the accounts prior to submission for audit, management's letter of representation to the external auditors; and the planned activity and results of both internal and external audit.

4. Management accounting and business management

4.1 The Chief Finance Officer is responsible for maintaining policies and processes relating to the control, management and use of resources across NHS STW.

4.2 The Chief Finance Officer will delegate the budgetary control responsibilities to budget holders through a formal documented process.

4.3 The Chief Finance Officer will ensure:

- the promotion of compliance to the SFIs through an assurance certification process;
- the promotion of long term financial heath for the NHS system (including ICS);
- budget holders are accountable for obtaining the necessary approvals and oversight of all expenditure incurred on the cost centres they are responsible for;

- the improvement of financial literacy of budget holders with the appropriate level of expertise and systems training;
- that the budget holders are supported in proportion to the operational risk; and
- the implementation of financial and resources plans that support the NHS Long term plan objectives.

4.4 In addition, the Chief Finance Officer should have financial leadership responsibility for the following statutory duties:

- NHS STW, in conjunction with its partner NHS trusts and NHS foundation trusts, to exercise its functions with a view to ensuring that, in respect of each financial year;
    - local capital resource use does not exceed the limit specified in a direction by NHS England;
    - local revenue resource use does not exceed the limit specified in a direction by NHS England;
    - the duty of NHS STW to perform its functions as to secure that its expenditure does not exceed the aggregate of its allotment from NHS England and its other income; and
    - the duty of NHS STW, in conjunction with its partner trusts, to seek to achieve any joint financial objectives set by NHS England for NHS STW and its partner trusts.

4.5 The Chief Finance Officer and *any senior officer responsible* for finance within NHS STW should also promote a culture where budget holders and decision makers consult their finance business partners in key strategic decisions that carry a financial impact.

5. Income, banking arrangements and debt recovery

5.1 Income

5.1.1 An ICB has power to do anything specified in section 7(2)(a), (b) and (e) to (h) of the Health and Medicines Act 1988 for the purpose of making additional income available for improving the health service.

5.1.2 The Chief Finance Officer is responsible for:

- ensuring order to cash practices are designed and operated to support efficient, accurate and timely invoicing and receipting of cash. The processes and procedures should be standardised and harmonised across the NHS System by working cooperatively with the Shared Services provider; and

- ensuring the debt management strategy reflects the debt management objectives of NHS STW and the prevailing risks;

5.2 Banking

5.2.1 The Chief Finance Officer is responsible for ensuring NHS STW complies with any directions issued by the Secretary of State with regards to the use of specified banking facilities for any specified purposes.

5.2.2 The Chief Finance Officer will ensure that for each account there is an up to date schedule of those persons authorised to release funds from the account and that copies of such schedules are held by the bank and any third parties providing relevant financial services to NHS STW.

5.2.3 The Chief Finance Officer will ensure that:

- NHS STW holds the minimum number of bank accounts required to run the organisation effectively. These should be raised through the government banking services contract; and

- NHS STW has effective cash management policies and procedures in place. payments made do not exceed the amount credited to an account;

- NHS STW complies with any mandatory requirements or guidance as regards the level of account balances;

- NHS STW meets any mandatory requirement or guidance as regards the level of cash to be used within any specified period.

5.3 Debt management

5.3.1 The Chief Finance Officer is responsible for NHS STW debt management strategy. This includes:

- a debt management strategy that covers end-to-end debt management from debt creation to collection or write-off in accordance with the losses and special payment procedures;
- ensuring the debt management strategy covers a minimum period of 3 years and must be reviewed and endorsed by NHS STW board every 12 months to ensure relevance and provide assurance;
- accountability to NHS STW board that debt is being managed effectively;
- accountabilities and responsibilities are defined with regards to debt management to budget holders; and
- responsibility to appoint a senior officer responsible for day to day management of debt.

6. Financial systems and processes

6.1 Provision of finance systems

6.1.1 The Chief Finance Officer is responsible for ensuring systems and processes are designed and maintained for the recording and verification of finance transactions such as payments and receivables for NHS STW.

6.1.2 The systems and processes will ensure, inter alia, that payment for goods and services is made in accordance with the provisions of these SFIs, related procurement guidance and prompt payment practice.

6.1.3 As part of the contractual arrangements for ICBs officers will be granted access where appropriate to the Integrated Single Financial Environment ("ISFE"). This is the required accounting system for use by ICBs. Access is based on single access log on to enable users to perform core accounting functions such as to transacting and coding of expenditure/income in fulfilment of their roles.

6.1.4 The Chief Finance Officer will, in relation to financial systems:

- promote awareness and understanding of financial systems, value for money and commercial issues;
- ensure that transacting is carried out efficiently in line with current best practice – e.g. e-invoicing
- ensure that NHS STW meets the required financial and governance reporting requirements as a statutory body by the effective use of finance systems;
- enable the prevention and the detection of inaccuracies and fraud, and the reconstitution of any lost records;
- ensure that the financial transactions of the authority are recorded as soon as, and as accurately as, reasonably practicable;
- ensure publication and implementation of all ICB business rules and ensure that the internal finance team is appropriately resourced to deliver all statutory functions of NHS STW;
- ensure that risk is appropriately managed;
- ensure identification of the duties of officers dealing with financial transactions and division of responsibilities of those officers;
- ensure NHS STW has suitable financial and other software to enable it to comply with these policies and any consolidation requirements of NHS STW;
- ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes; and

  where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

7. Procurement and purchasing

7.1 Principles

7.1.1 The Chief Finance Officer will take a lead role on behalf of NHS STW to ensure that there are appropriate and effective financial, contracting, monitoring and performance arrangements in place to ensure the delivery of effective health services.

7.1.2 NHS STW must ensure that procurement activity is in accordance with the Public Contracts Regulations 2015 (PCR) for non-healthcare services and the Healthcare Services (Provider Selection Regime (PRS) Regulation 2023 for all healthcare services and associated statutory requirements whilst securing value for money and sustainability.

7.1.3 NHS STW must consider, as appropriate, any applicable NHS England guidance that does not conflict with the above.

7.1.4 NHS STW must have a Procurement Policy which sets out all of the legislative requirements.

7.1.5 All revenue and non-pay expenditure must be approved, in accordance with these SFIs, prior to an agreement being made with a third party that enters a commitment to future expenditure.

7.1.6 All officers must ensure that any conflicts of interest are identified, declared and appropriately mitigated or resolved in accordance with NHS STW standards of business conduct policy.

7.1.7 Budget holders are accountable for obtaining the necessary approvals and oversight of all expenditure incurred on the cost centres they are responsible for. This includes obtaining the necessary internal and external approvals which vary based on the type of spend, prior to procuring the goods, services or works.

7.1.8 Undertake any contract variations or extensions in accordance with PCR 2015 (non-healthcare) and PSR (healthcare) and NHS STW procurement policy.

7.1.9 Retrospective expenditure approval should not be permitted. Any such retrospective breaches require approval from any committee responsible for approvals before the liability is settled. Such breaches must be reported to the Audit Committee.

7.2 Tendering & Contracting

7.2.1 Quotations: Competitive and Non-Competitive

Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed, £25,000 (this figure to be reviewed periodically).

7.2.1.1 Competitive Quotations

a) Competitive quotations must be obtained in line with the limits stated in NHS STW's financial scheme of delegation.

b) Quotations should be in writing unless it is impractical to do so in which case they may be obtained by telephone or electronically. Confirmation of telephone or electronic quotations should be obtained in writing without delay, and the reasons why the non-written quotation was obtained should be set out in a permanent record.

c) All quotations should be treated as confidential and should be retained for inspection.

d) The quotations should be evaluated and the one selected should provide the best value for money. If this is not the lowest quotation, then the choice made and the reasons why should be recorded in a permanent record, and pre-approved by the Chief Finance Officer.

7.2.1.2 Non- competitive Quotations

Non-competitive quotations in writing (i.e. from a limited range of providers) may be obtained in the following circumstances:

a) The supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not possible or desirable to obtain competitive quotations;

b) The supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts.

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by NHS STW and which is not in accordance with SFIs except with the authorisation of the Chief Finance Officer.

7.2.2 Formal Competitive Tendering

NHS STW shall ensure that competitive tenders are invited for:

- The supply of goods and materials;
- The rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH); for special arrangements governing the engagement of management consultants;
- For the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens).

7.2.2.1 Healthcare Services

Where NHS STW elects to invite tenders for the supply of healthcare services, these SFIs shall apply as far as they are applicable to the tendering procedure and must follow the principles of the PSR. There are no financial threshold restrictions~~.~~

7.2.2.2 Exceptions and Instances where Formal Tendering need not be applied

Formal tendering procedures need not be applied (only applies to non-healthcare services)~~where~~:

a) The estimated expenditure or income does not, or is not reasonably expected to exceed £75,000 for the life of the contract. (this figure to be reviewed periodically); or

b) Where the supply is proposed under special arrangements negotiated by the DH in which event the said special arrangements must be complied with.

7.2.2.3 Formal tendering procedures may be waived in the following circumstances:

a) In exceptional circumstances where the Accountable Officer decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate ICB record;

b) Where the requirement is covered by an existing contract;

c) Where Crown Commercial Services framework agreements (or alternative framework agreements) are in place;
d) Where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;
e) Where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;
f) Where specialist expertise is required and is available from only one source;
g) When the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;
h) There is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of continuity must outweigh any potential financial advantage to be gained by competitive tendering;
i) For the provision of legal advice and services providing that any legal firm or partnership commissioned by NHS STW is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council or England and Wales in relation to the obtaining of Counsel's opinion) and is generally recognised as having sufficient expertise in the area of work for which they are commissioned. The Chief Finance Officer shall ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work;

The waiving of competitive quotations or tendering procedures must not be used to avoid competition, nor for administrative convenience, nor simply to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided that competitive quotations or tendering is not applicable and may be waived, the fact of the waiver and the reasons, should be documented and recorded in an appropriate ICB record which must receive prior authorisation from the Accountable Officer or Chief Finance Officer. All waivers will be reported to the Audit Committee and will be subject to scrutiny

7.2.3 Fair and Open Competition

NHS STW shall ensure that it complies with the Procurement Regulations which are based on the principles of fairness, equal treatment, non-

discrimination, and transparency. Tenders will be advertised in line with these principles to ensure fair and open competition.

7.2.4 List of Approved Firms

The Accountable Officer or Chief Finance Officer shall ensure that normally the firms/ individuals invited to tender (and where appropriate, quote) are among those on approved lists. Where, in the opinion of the Chief Finance Officer, it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Accountable Officer.

7.2.5 Items which subsequently breach thresholds after original approval

Items estimated to be below the limits set in these SFIs for which formal tendering procedures are not used, but which subsequently prove to have a value above such limits, shall be reported to the Accountable Officer and must be considered in line with the Public Contract Regulations, Reg 72. Modifications which could be deemed a substantial change are required to be re-tendered.

7.2.6 Confidentiality of information received

NHS STW has policies and procedures in place to meet its information governance, data security and protection obligations and to enable NHS STW to fulfil its information governance responsibilities. These policies provide a framework to bring together all of the requirements, standards and best practice that apply to the handling of confidential, business sensitive and personal information and include; Data Protection; Data Quality; Records Management; Access to Information; Freedom of Information and IT/Network Security.

7.2.7 Invitation to Tender

a) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders;

b) In line with Public Contract Regulations, Reg 22, all tenders must be conducted through the eTendering System unless there are exceptional circumstances, (e.g.: risk of breach of security). The opening and recording of these tenders will be managed by the authorised user and retained on the portal as a fully auditable record.

c) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable. Every tenderer must give a written undertaking not to engage in collusive tendering or other restrictive practice.

7.2.7.1 Receipt of Safe Custody Tenders

Formal competitive tenders are date and time stamped at the point of submission via the eTendering System and cannot be accessed until the closing date has passed. An electronic process for the acceptance/rejection of tenders is undertaken by the Procurement Lead in liaison with the Commissioner.

7.2.7.2 Accessing Tenders

After the stated closure date the Procurement Lead accesses the tenders via the eTendering System. The Procurement Lead must remain impartial throughout the tender process and any issues that may occur, (e.g.: a late tender), must be discussed with the Commissioner and escalated to the identified SRO for decision making.

7.2.7.3 Admissibility

a) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Accountable Officer.

b) Where only one tender is sought and/ or received, the Chief Finance Officer shall be advised and, as far practicable, he/she shall ensure that the price to be paid is fair and reasonable and will ensure value for money for NHS STW.

c) Where examination of tenders reveals errors which would affect the tender price, the tenderer is to be given details of the errors and afforded the opportunity of confirming or withdrawing the offer.

7.2.7.4 Late Tenders

a) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Accountable Officer or his/her nominated officer decides that there are clear exceptional circumstances i.e. delayed through no fault of the tenderer. In these circumstances the Procurement Lead and ICB's SRO should escalate the matter to the Accountable Officer prior to releasing the tenders for evaluation.

b) The Accountable Officer or nominated officer shall decide whether such tenders are admissible or whether re- tendering is desirable. Re-tendering may be limited to those tenders reasonably in the field of consideration in the original competition.

c) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration and while re-tenders are being obtained, the tender documents shall be kept securely on the eTendering System and not accessed until a decision has been made.

7.2.7.5 Acceptance of Formal Tenders

a) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender. Information provided by a tenderer under these circumstances shall not be acted upon by NHS STW until it has been confirmed in writing by the tenderer.

b) Tenders must be evaluated on the basis of Most Economically Advantages Solution (MEAT) and not awarded solely on the lowest price, (in accordance with PCR15 Regulation 67).

c) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by NHS STW and which is not in accordance with these SFIs except with the authorisation of the Accountable Officer.

d) The use of these procedures must demonstrate that the award of the contract:

- Was not in excess of the going market rate/ price current at the time the contract was awarded;
- Achieved the best value for money.

e) All tenders shall be treated as confidential and shall be retained for inspection.

7.2.7.6 Exceptions of Using Approved Contractors

If, in the opinion of the Accountable Officer and the Chief Finance Officer, it is impractical to use a potential contractor from the list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Accountable Officer should be satisfied that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

7.2.7.7 Authorisation of Tenders and Competitive Quotations

Providing all the conditions and circumstances set out in these SFIs have been fully complied with, and the intended expenditures or income falls within the relevant budget, formal authorisation and awarding of a contract may be made within the limits laid down in NHS STW's Financial Scheme of Delegation. A list will be maintained of Board members/employees able to authorise invoices and their delegated limits. The Scheme of Delegation is attached at Appendix 1.

Signing and, where appropriate, sealing of contracts and other documents shall be in accordance with the section in the Standing Orders.

7.2.7.8 Instances where Formal Competitive Tendering and Competitive Quotation is not required

Where competitive tendering or a competitive quotation is not required, NHS STW shall use an external procurement service for procurement of all goods and services unless the Accountable Officer or Chief Finance Officer deem it inappropriate, in which case the Chief Finance Officer shall determine an alternative procurement process. The decision to use alternative sources must be documented and reported to the Audit Committee.

7.2.7.9 Compliance Requirements for All Contracts

The Board may only enter into contracts on behalf of NHS STW within the statutory powers delegated to it by the Secretary of State and shall comply with:

a) The ICB~~CCG~~'s Constitution and SFIs;

~~a)~~b) Public Contract Regulations 2015 or ~~The Heath Care Services (~~Provider Selection Regime Principles and other statutory provisions;

c) The CCG's Constitution and SFIs;

d) Public Contract Regulations 2015 and other statutory provisions;

e) Any relevant directions including specific DH guidance, and guidance on the Procurement and Management of Consultants;

f) The NHS Standard Contract Conditions as are applicable;

g) Contracts with Foundation Trusts which must be in a form compliant with appropriate NHS guidance;

h) Where appropriate, contracts which shall be in, or embody, the same terms and conditions of contract as was the bases on which tenders or quotations were invited;

i) Contracts made by NHS STW, and where, within all, the Board shall endeavour to obtain best value for money by use of all systems in place. The Accountable Officer shall nominate an officer who shall oversee and manage each contract on behalf of NHS STW.

j) Payments should not be made to suppliers in advance of the service/product being delivered. In exceptional circumstances, and where a special case can be made to issue a prepayment, this must be approved in advance by the Accountable Officer and Chief Finance Officer.
k) The contract will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way NHS STW can jointly manage risk with all interested parties.

7.2.7.10 Adoption of the Tendering Process Conducted by another Organisation

NHS STW may, on the express approval of the Accountable Officer or the Chief Finance Officer, adopt the tendering process of another organisation provided that organisation is either:
a) NHSE/I, CCG, FT or other NHS Trust; or
b) LIFT Company;
c) A partner organisation where the basis of partnership is a Section 75 agreement and provided specifically that:

I. Such process has not proceeded to contract stage; and
II. The process would satisfy NHS STW's own Constitution and SFIs with regard to procedure and competition; and
III. The ICB~~CCG~~'s authorisation limits for acceptance of tenders and letting of contracts are observed.

In all such instances, the Board shall be informed by formal report at its next scheduled meeting.

7 Staff costs and staff related non pay expenditure

8.1 Chief People Officer

8.1.1 The Chief People Officer (CPO), or the person assuming these responsibilities in NHS STW, will lead the development and delivery of the long-term people strategy of NHS STW ensuring this reflects and integrates the strategies of all relevant partner organisations within the ICS.

8.1.2 Operationally the CPO will be responsible for;

- defining and delivering the organisation's overall human resources strategy and objectives; and
- overseeing delivery of human resource services to ICB employees.

8.1.3 The CPO will ensure that the payroll system has adequate internal controls and suitable arrangements for processing deductions and exceptional payments.

8.1.4 Where a third-party payroll provider is engaged, the CPO shall closely manage this supplier through effective contract management.

8.1.5 The CPO is responsible for management and governance frameworks that support NHS STW employees' life cycle.

8.1.6 Any remuneration, fees and allowances paid to ICB members will be in accordance with decisions taken by NHS STW's Remuneration Committee, having received written recommendations from NHS STW's CPO.

8.1.7 Decisions regarding remuneration, fees and allowances for employees and individuals providing services to NHS STW other than ICB members will be taken by the Remuneration Committee.

8.1.8 All appointments of staff including the engagement of agency workers or contractors, must be done so in line with the detailed scheme of delegation and in line with NHS STW's Establishment Control Policy.

8.1.9 Nobody will re-band any posts, either on a permanent or temporary basis, or implement changes to any aspect of employees' remuneration or reimbursement unless they have been specifically authorised to do so under

the detailed scheme of delegation and in line with NHS STW's Establishment Control Policy.

8.1.10 The remuneration of any and all individuals providing services to NHS STW will be via the payroll system unless other arrangements have been explicitly authorised by the Chief Finance Officer.

8.1.11 The Chief Finance Officer has overall responsibility for

- specifying timetables for the submission of properly authorised time records and expense claims;
- payments being made on agreed dates;
- maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;
- checks to be applied to completed payroll before and after payment.

8.1.12 Budget holders are responsible for submitting properly authorised time records and expense claims in line with the agreed timetables and submitting termination forms immediately upon knowing the effective leaving date of an employee. If an employee or individual providing services to NHS STW behaves in any manner suggesting that they have left without notice, the Chief Finance Officer must be informed immediately.

8.1.13 The CPO will ensure that the payroll system has adequate internal controls and suitable arrangements for processing deductions and exceptional payments.

8.1.14 The Chief Finance Officer will implement a system to ensure the recovery from those leaving the employment of NHS STW of any sums due or property belonging to NHS STW.

8 Non Pay Expenditure

9.1 Official Orders

9.1.1 Official Orders must:

a) Be consecutively numbered;

b) Use the form provided by SBS;

c) Be in a form approved by the Chief Finance Officer;

d) State NHS STW's terms and conditions of trade;

e) Only be issued to, and used by, those duly authorised by the Accountable Officer

9.2 Duties of Officers and Managers

9.2.1 Officers and Managers must ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer and that:

a) All contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Finance Officer in advance of any commitment being made;

b) Contracts above specified thresholds are advertised and awarded in accordance with rules on public procurement;

c) Where consultancy advice is being obtained, the procurement of such advice must be in accordance with DH guidance;

d) No order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or members of staff other than:

I. Isolated gifts of a modest nature or inexpensive seasonal gifts, such as calendars;

II. Conventional hospitality, such as lunches in the course of working visits, (reference should always be made to NHS STW's Declaration of Gifts, Hospitality and Sponsorship - Anti-Bribery Policy before accepting such items).

e) No requisition/ order is placed for any items for which there is no budget provision unless authorised by the Chief Finance Officer on behalf of the Accountable Officer;

f) All goods, services, or works are ordered on an official order except works and services executed in accordance with a contract, purchases from petty cash, and goods or services purchased via NHS STW's approved purchasing card scheme, (see Payment Card policy);

g) Other than for purchases made via NHS STW's approved purchasing card scheme, verbal orders must only be issued in cases of emergency or urgent need, by a member of staff designated by the Accountable Officer, and only in cases of genuine emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

h) Orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

i) Goods are not taken on trial or loan in circumstances that could commit NHS STW to future uncompetitive purchase or other liability;

j) Changes to the list of officers authorised to certify invoices are notified to the Chief Finance Officer;
k) Purchases from petty cash and/or NHS STW's payment card are restricted in value and by type of purchase in accordance with instructions issued by the Chief Finance Officer;
l) Petty cash and payment card records are maintained in a form as determined by the Chief Finance Officer.

9.3 Joint Finance Arrangements with Local Authorities and Voluntary Bodies

9.3.1 Payments to Local Authorities and Voluntary Organisations made under the powers of Sections 256 and 257 of the NHS Act 2006, shall comply with procedures laid down by the Chief Finance Officer which shall be in accordance with these Acts and the 2000 Directions of the Secretary of State.

9.3.2 The Better Care Fund (BCF), is a pooled budget with the local authority which falls under these Acts and the regulations within them. In addition, all payments in respect of the pooled budget shall be in accordance with NHS STW's SFIs and the Scheme of Delegation.

9 Annual reporting and Accounts

10.1.1 The Chief Finance Officer will ensure, on behalf of the Accountable Officer and ICB board, that:

- NHS STW is in a position to produce its required monthly reporting, annual report, and accounts, as part of the setup of the new organisation; and
- NHS STW, in each financial year, prepares a report on how it has discharged its functions in the previous financial year;
- an annual report must, in particular, explain how NHS STW has:
    - discharged its duties in relating to improving quality of services, reducing inequalities, the triple aim and public involvement;
    - review the extent to which the board has exercised its functions in accordance with its published 5 year forward plan and capital resource use plan; and

- review any steps that the board has taken to implement any joint local health and wellbeing strategy.

10.1.2 NHS England may give directions to NHS STW as to the form and content of an annual report.

10.1.3 NHS STW must give a copy of its annual report to NHS England by the date specified by NHS England in a direction and publish the report.

10.2 Internal audit

10.2.1 The Accountable Officer is responsible for ensuring there is appropriate internal audit provision in NHS STW. For operational purposes, this responsibility is delegated to the Chief Finance Officer to ensure that:

- all internal audit services provided under arrangements proposed by the Chief Finance Officer are approved by the Audit Committee, on behalf of NHS STW board;
- NHS STW must have an internal audit charter. The internal audit charter must be prepared in accordance with the Public Sector Internal Audit Standards (PSIAS);
- NHS STW internal audit charter and annual audit plan, must be endorsed by NHS STW Accountable Officer, Audit Committee and Board;
- the Head of Internal Audit must provide an annual opinion on the overall adequacy and effectiveness of NHS STW Board's framework of governance, risk management and internal control as they operated during the year, based on a systematic review and evaluation;
- the Head of Internal Audit should attend Audit Committee meetings and have a right of access to all Audit Committee members, the Chair and Accountable Officer of NHS STW.
- the appropriate and effective financial control arrangements are in place for NHS STW and that accepted internal and external audit recommendations are actioned in a timely manner.

10.3 External Audit

10.3.1 The Chief Finance Officer is responsible for:

- liaising with external audit colleagues to ensure timely delivery of financial statements for audit and publication in accordance with statutory, regulatory requirements;

- ensuring that NHS STW appoints an auditor in accordance with the Local Audit and Accountability Act 2014; in particular, NHS STW must appoint a local auditor to audit its accounts for a financial year not later than 31 December in the preceding financial year; NHS STW must appoint a local auditor at least once every 5 years (ICBs will be informed of the transitional arrangements at a later date); and

- ensuring that the appropriate and effective financial control arrangements are in place for NHS STW and that accepted external audit recommendations are actioned in a timely manner.

10 Losses and special payments

11.1 HM Treasury approval is required if a transaction exceeds the delegated authority, or if transactions will set a precedent, are novel, contentious or could cause repercussions elsewhere in the public sector.

11.2 All cases relating to ICB losses and special payments must be submitted to NHS England for approval if the proposed transaction values exceed the delegated limits that are detailed below or satisfy the conditions in section 11.1.1:

EXPENDITURE TYPE	DELEGATED LIMIT
All losses	Up to £300k
Special Payments including Extra Contractual/ Statutory/ regulatory/ compensation & Ex gratia	Up to £95k
Special severance & Retention payments	£0
Consolatory payments	£500

11.3 The Chief Finance Officer will support a strong culture of public accountability, probity, and governance, ensuring that appropriate and compliant structures, systems, and process are in place to minimise risks from losses and special payments.

11.4 NHS England has the statutory power to require an integrated care board to provide NHS England with information. The information is not limited to losses and special payments, must be provided in such form, and at such time or within such period, as NHS England may require.

11.5 As part of the new compliance and control procedures, ICBs must submit an annual assurance statement confirming the following:

- details of all exit packages (including special severance payments) that have been agreed and/or made during the year;

- that NHS England and HMT[2] approvals have been obtained (in relation to non-contractual pay elements or amounts that exceed NHS STW delegated limits), before any offers, whether verbally or in writing, are made; and
- adherence to the special severance payments guidance as published by NHS England.

11.6 NHS STW Chief Financial Officer is responsible for ensuring that processes and procedures that facilitate the capturing and reporting of losses and special payments are in place and ensure that a losses and special payments register is maintained.

11.7 All losses and special payments must be recorded in the register and reviewed as part of the internal controls process.

11.7.1 All losses and special payments (including special severance payments), must be reported to NHS STW Audit Committee.

11.7.2 For detailed operational guidance on losses and special payments, please refer to NHS STW losses and special payment guide.

2 This is only applicable to elements of the exit packages that are classified as non contractual

12. Fraud, bribery and corruption (Economic crime)

12.1 NHS STW is committed to identifying, investigating and preventing economic crime.

12.2 NHS STW Chief Finance Officer is responsible for ensuring appropriate arrangements are in place to provide adequate counter fraud provision which should include reporting requirements to the board and audit committee, and defined roles and accountabilities for those involved as part of the process of providing assurance to the board. These arrangements should comply with the NHS Requirements the Government Functional Standard 013 Counter Fraud as issued by NHS Counter Fraud Authority and any guidance issued by NHS England and NHS Improvement.

12.3 Unfortunately fraud, bribery and corruption, as well as theft, does occur throughout the NHS. All employees have a duty to ensure that public funds are protected. NHS STW requires all staff to always act honestly and with integrity to safeguard the public resources they are responsible for. There will be many subject areas contained within these DFPs where fraud, bribery and corruption could occur and all staff need to be aware of their responsibility to report any suspicions of economic crime if suspected. NHS STW will not tolerate any fraud perpetrated against it and will actively recover any loss suffered.

12.4 If an employee or manager suspects that there has been a potential act of fraud, bribery or corruption against NHS STW or the wider NHS, or has seen any suspicious acts or events, they must report the matter to NHS STW's Counter Fraud Team (contact details can be found on NHS STW's public website and/or intranet) or report the matter to the NHS Fraud and Corruption Reporting Line on 0800 028 4060.

12.5 Alternatively, reports can be made through the online reporting tool at https://cfa.nhs.uk/reportfraud. Further advice on counter fraud issues is available from the Chief Finance Officer, deputy Chief Finance Officer/Fraud Champion and the CCG's Counter Fraud Team.

12.6 Security Management - All members of NHS STW and employees (including its contractors), are responsible for the security of the property of NHS STW; avoiding loss; exercising economy and efficiency in the use of resources; and conforming with the requirements of the Constitution, Standing Orders, Scheme of Delegation and Standing Financial Instructions. In line with their responsibilities, the Audit Committee will monitor and ensure compliance with NHS security management standards. NHS STW shall nominate a suitable person to carry out the duties of the Security Management Specialist.

13. Capital Investments & security of assets and Grants

13.1.1 The Chief Finance Officer is responsible for:

- ensuring that at the commencement of each financial year, NHS STW and its partner NHS trusts and NHS foundation trusts prepare a plan setting out their planned capital resource use;

- ensuring that NHS STW and its partner NHS trusts and NHS foundation trusts exercise their functions with a view to ensuring that, in respect of each financial year local capital resource use does not exceed the limit specified in a direction by NHS England;

- ensuring NHS STW has a documented property transfer scheme for the transfer of property, rights or liabilities from ICB's predecessor clinical commissioning group(s);

- ensuring that there is an effective appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

- ensuring that there are processes in place for the management of all stages of capital schemes, that will ensure that schemes are delivered on time and to cost;

- ensuring that capital investment is not authorised without evidence of availability of resources to finance all revenue consequences; and

- for every capital expenditure proposal, the Chief Finance Officer is responsible for ensuring there are processes in place to ensure that a business case is produced.

13.1.2 Capital commitments typically cover land, buildings, equipment, capital grants to third parties and IT, including:

- authority to spend capital or make a capital grant;

- authority to enter into leasing arrangements.

13.1.3 Advice should be sought from the Chief Finance Officer or nominated officer if there is any doubt as to whether any proposal is a capital commitment requiring formal approval.

13.1.4 For operational purposes, NHS STW shall have nominated senior officers accountable for ICB property assets and for managing property.

13.1.5 ICBs shall have a defined and established property governance and management framework, which should:

- ensure NHS STW asset portfolio supports its business objectives; and
- comply with NHS England policies and directives and with this standard

13.1.6 Disposals of surplus assets should be made in accordance with published guidance and should be supported by a business case which should contain an appraisal of the options and benefits of the disposal in the context of the wider public sector and to secure value for money.

13.2 Asset Register

13.2.1 NHS STW shall maintain an asset register recording fixed assets.

13.2.2 The Accountable Officer is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer concerning the form of any register, and the method of updating and arranging for a physical check of assets against the asset register, to be conducted once a year.

13.2.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

a) Properly authorised and approved agreements, architects certificates, supplier invoices and other documentary evidence in respect of purchases from third parties;
b) Requisitions and records for own materials and labour including appropriate overheads;
c) Lease agreements in respect of assets held under a finance lease and capitalised.

13.2.4 The Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

13.2.5 The value of each asset shall be indexed to current values in accordance with methods specified in the Government Financial Reporting Manual (FReM).

13.2.6 The value of each asset shall be depreciated using methods and rates as specified in the FReM.

13.2.7 The Chief Finance Officer shall calculate and charge depreciation as specified in the FReM.

13.3 Security of Assets

13.3.1 The overall control of fixed assets is the responsibility of the Accountable Officer. Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Finance Officer. This procedure shall make provision for:

a) Recording managerial responsibility for each asset;

b) Identification of additions and disposals;

c) Identification of all repairs and maintenance expenses;

d) Physical security of assets;

e) Periodic verification of the existence of, condition of, and title to, assets recorded;

f) Identification and reporting of all costs associated with the retention of an asset; reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

13.4 Grants

13.4.1 The Chief Finance Officer is responsible for providing robust management, governance and assurance to NHS STW with regards to the use of specific powers under which it can make capital or revenue grants available to;

- any of its partner NHS trusts or NHS foundation trusts; and
- to a voluntary organisation, by way of a grant or loan.

13.4.2 All revenue grant applications should be regarded as competed as a default position, unless, there are justifiable reasons why the classification should be amended to non-competed.

14. Legal and insurance

14.1 This section applies to any legal cases threatened or instituted by or against NHS STW. NHS STW should have policies and procedures detailing:

- engagement of solicitors / legal advisors;
- approval and signing of documents which will be necessary in legal proceedings; and
- Officers who can commit or spend ICB revenue resources in relation to settling legal matters.

14.2 ICBs are advised not to buy commercial insurance to protect against risk unless it is part of a risk management strategy that is approved by the accountable officer.

15. Appendix 1 – Financial Scheme of Delegation

The Financial Scheme of Delegation sets out the levels of financial authority that are delegated to different levels of staff within NHS Shropshire, Telford and Wrekin (NHS STW). Staff may only operate within the authority levels delegated to them and any breaches must be reported immediately to the Chief Finance Officer or Deputy Chief Finance Officer. Breaches will also be reported to the Audit Committee.

The Financial Scheme of Delegation is reviewed and amended from time to time. It is the responsibility of the Chief Executive to communicate current policy to staff.

The Financial Scheme of Delegation must be read in conjunction with other relevant financial and other policies of NHS STW, including NHS STW's policies in relation to Conflicts of Interest.

Key:

CEO – Chief Executive Officer
CFO – Chief Finance Officer
CMO – Chief Medical Officer
CNO – Chief Nurse Officer
EDDT – Executive Director of Delivery & Transformation
DSI – Director of Strategy & Integration
Other Dir - Director other than CFO, CMO,CNO, DDT or DSI
Equiv – equivalent staff member (who may be fulfilling work of similar nature or at an equivalent level of seniority relevant and appropriate for the authority level, to be determined by a more senior line manager)

Notes:

1. An authorised individual may appoint another to formally deputise (e.g. during leave). In that case, the deputy has the authority of the individual that has assigned it. Such appointment must be in writing and clear as to the scope and terms of the assignment.

Delegated matter	Authority							Notes
	Board and chair (if delegated)	Committee	Chief Executive Officer	ICB Directors	Heads of Service (Band 8c & above)	Budget Manager (Bands 8b & 8a)	Resource Manager (Band 6 & above)	
Signing of Healthcare Commissioning Annual Contracts & SLAs and Pooled Budgets	n/a	n/a	No Limit	CFO (No Limit) CMO (No Limit) CNO (No Limit) EDDT (No Limit) DSI (No Limit)	No	No	No	If within budget agreed by Board
Authorisation of monthly block payment for agreed contract value to NHS bodies	n/a	n/a	No Limit	CFO (No Limit)	Head of Contracts (No Limit)	No	No	If within signed annual contract value
Variations to healthcare and non-healthcare contracts	n/a	n/a	No Limit	CFO (No Limit) CMO (No Limit) CNO (No Limit) EDDT (No Limit) DSI (No Limit)	No	No	No	If within budget agreed by Board

Delegated matter	**Authority**							**Notes**
	Board and chair (if delegated)	**Committee**	**Chief Executive Officer**	**ICB Directors**	**Heads of Service (Band 8c & above)**	**Budget Manager (Bands 8b &8a)**	**Resource Manager (Band 6 & above)**	
Continuing Healthcare - Authorisation of Continuing Healthcare contracts and related weekly cost packages.	n/a	n/a	No Limit	CFO (No Limit) CNO (No Limit) CMO (No Limit) EDDT (No Limit)	Up to £5,000	Up to £3000	Up to £1500	If supported by contract/tendering and quotation approval and within budget. Limits relate to anticipated total weekly package costs
Authorisation of requisitions (or certification of invoices when no requisition/order was raised).	n/a	n/a	No Limit	CFO (No Limit) CMO (No Limit) CNO (No Limit) EDDT (No Limit) DSI (No Limit)	Up to £250,000	Up to £100,000	Up to £1,000	All ICB Staff
Pharmaceutical, Opthalmic and Dental Primary Care Delegation (NHSE Staff): Authorisation of requisitions (or certification of invoices when no	n/a	n/a	No Limit	CFO (No Limit) CMO (No Limit) CNO (No Limit) EDDT (No Limit) DSI (No Limit)	Up to £250,000	Up to £100,000	Band 5: Up to £5,000 Band 6: Up to £10,000 Band 7: Up to £30,000	NHSE Staff as part of the delegation of Pharmaceutical, Opthalmic and Dental Primary Care functions

requisition/order was raised)/ Contract Variations								
Delegated matter	**Authority**							**Notes**
	Board and chair (if delegated)	**Committee**	**Chief Executive Officer**	**ICB Directors**	**Heads of Service (Band 8c & above)**	**Budget Manager (Bands 8b & 8a)**	**Resource Manager (Band 6 & above)**	
Authority to waive tenders or quotations, or to accept a tender or quotation which is not the lowest.	n/a	n/a	No Limit	CFO (No Limit)	No	No	No	All instances to be reported to the Audit Committee
Approve Special Payments	< £95,001	No	No	No	No	No	No	All cases above £95,000 must be submitted to NHSE for approval
Approve losses, including invoice write-offs	> £50,000 and < £300,001	n/a	Up to £50,000 (in conjunction with CFO)	CFO Up to £1,000 and up to £50,000 (in conjunction with AO)	No	No	No	All instances to be reported to the Audit Committee. All cases above £300,000 must be submitted to NHSE for approval

Approve Consolatory Payments	< £501	No	No	No	No	No	No	All cases above £500 must be submitted to NHSE for approval
Delegated matter	**Authority**							**Notes**
	Board and chair (if delegated)	**Committee**	**Chief Executive Officer**	**ICB Directors**	**Heads of Service (Band 8c & above)**	**Budget Manager (Bands 8b & 8a)**	**Resource Manager (Band 6 & above)**	
Tenancy agreements/ Licences	n/a	n/a	No Limit in conjunction with CFO	CFO - No Limit in conjunction with AO	No	No	No	
Virements between budgets	n/a	n/a	No Limit (capital & revenue)	All Dirs (No Limit) (capital & revenue)	(No Limit) (capital & revenue)	No	No	Must be in accordance with ***Budgetary Control Policy***
Banking arrangements	n/a	n/a	As specified on bank mandate	CFO as specified on bank mandate	Deputy CFO as specified on bank mandate	No	No	In accordance with mandated Government Banking Service arrangements
Payroll forms (starters/changes/ leavers & expense claims)	n/a	n/a	No Limit	All Dirs (No Limit)	(No Limit)	(No Limit)	(No Limit)	In accordance with approval hierarchy in EASY

QUOTATION & TENDERING LIMITS

Value for money should be demonstrated by all staff regardless of the levels of expenditure involved. However, the following limits apply to all expenditure in excess of £25,000:

Value of Expenditure (inclusive of irrecoverable VAT)	Requirement
£25,001-£50,000	2 written quotes
£50,001-£75,000	3 written quotes
>£75,000	Tender

Where the Health Care Services (Provider Selection Regime (PSR) Regulations 2023 applies, no expenditure threshold applies. PSR should be applied to all Healthcare Services.

Additional points to note for the inclusion of POD staff:

- The inclusion of lower band staff for the POD team is minimal risk as they are not material values and the staff are still subject to the same policies which is not a fundamental variation;
- The implication of not agreeing this amendment is that the default would be for all POD invoices to require sign off by ICB staff. There is no capacity to resource this within the ICB as the existing resource sits with the POD team.

APPENDIX C **NHS Shropshire, Telford and Wrekin**

ICB Executive Group

Terms of Reference

1. Constitution

1.1 The ICB Executive Group (the Group) is created specifically to oversee the discharge of the ICB's people and workforce related responsibilities as an employer.

1.2 The Group is responsible to the Board of the ICB in accordance with the Constitution of NHS Shropshire, Telford & Wrekin.

1.3 These terms of reference set out the membership, the remit, responsibilities and reporting arrangements of the Group and may only be changed with the approval of the ICB Board.

1.4 Members of the ICB Executive Group are bound by the Standing Orders and other policies of NHS STW.

2. Authority

2.1 The ICB Executive Group is authorised by the ICB Board to:

- Investigate any activity within its terms of reference;
- Seek any information it requires within its remit, from any employee or member of NHS STW (who are directed to co-operate with any request made by the group) within its remit as outlined in these terms of reference;
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Group must follow any procedures put in place by NHS STW for obtaining legal or professional advice;
- Create task and finish groups or working groups as required.

2.2 For the avoidance of doubt, in the event of any conflict, NHS STW Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference.

3. Purpose

3.1 The Group is established to reflect the ICB's commitment to partnership with its staff in developing, monitoring, improving employment practice, enhancing the working environment, support the operating model of the ICB, health and wellbeing, and improving outcomes and provide solutions.

3.2 The Group will ensure that the ICB discharges its statutory responsibilities and duties as an employer, which will include but not limited to:

- Human Resources

- Health and Safety
- Equality and Inclusion
- Supporting the operating model of the ICB
- Health and Wellbeing

3.3 The Group will discharge the following delegated responsibilities as set out in the Scheme of Reservation and Delegation on behalf of the Board:

- approval of people/HR related policies and procedures;
- approval of arrangements to discharge the People /HR responsibilities as an employer;
- approval of health and safety policies and procedures;
- approval of arrangements to discharge Health and Safety responsibilities as an employer;
- approval of equality, diversity andiInclusion policies and procedures;
- approval of arrangements to discharge equality, diversity and inclusion responsibilities as an employer;
- and
- approval of the following annual evidence submissions on behalf of the Board for:
    - Equality Delivery System 2 (EDS2)
    - Workforce Race Equality Standard (WRES)
    - Workforce Disability Equality Standard (WDES)

3.4 The Group has no executive powers, other than those delegated in the Scheme of Reservation and Delegation and specified in these terms of reference.

4. Membership and attendance

4.1 Membership

4.1.1 The Group members shall be appointed by the ICB Board in accordance with NHS STW Constitution.

4.1.2 The Board will appoint members of the ICB Executive Leadership Team to the Group.

4.1.3 Members are expected to attend 75% of meetings held each calendar year.

4.1.4 The core membership of The Group will be:

- Chief Executive Officer (Chair)
- Chief Finance Officer (Vice Chair)
- Chief Medical Officer
- Chief Nursing Officer
- Executive Director of Delivery and Transformation

4.2 Chair and Vice Chair

4.2.1 The Group will be chaired by an ICB Chief Executive Officer.

4.2.2 In the event of the Chair being unable to attend, the Chief Finance Officer will chair the meeting as the Vice Chair.

4.2.3 In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number to Chair the meeting.

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

4.3 Attendees

4.3.1 Only members of The Group have the right to attend Sub-Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of The Group.

4.3.2 Meetings of The Group may also be attended by the following individuals who are not members of The Group for all or part of a meeting as and when appropriate. Such attendees will not be eligible to vote:

Attendees

- Executive Director of Strategy and Integration (or interim)
- Chief People Officer (or Deputy/ or interim)
- CSU Senior HR Business Partner or their representative

4.3.3 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of matters.

5. Meetings Quoracy and Decisions

5.1 Meetings

5.1.1 The Group will meet on a monthly basis and arrangements and notice for calling meetings are set out in the Standing Orders 4.1. Additional meetings may take place as required.

5.2.1 The Board, Chair or Chief Executive may ask the Group to convene further meetings to discuss particular issues on which they want The Group's advice.

5.3.1 In accordance with the Standing Orders, The Group may meet virtually or face to face.

5.2 Quorum

5.2.1 For a meeting to be quorate their must be at least three of members present.

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

5.2.3 If the quorum has not been reached, then the meeting either may be postponed until the meeting can be quorate or the meeting may proceed if those attending agree, but no decisions may be taken.

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

Where this happens the decision made in this way must be reported to the next meeting to ensure it is captured in the minutes.

5.3 Decision Making and Voting

5.3.1 Decisions will be taken in accordance with the Standing Orders. The Group will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

5.3.2 Only members of The Group may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

5.3.3 Where there is a split vote, with no clear majority, the Chair of The Group will hold the casting vote.

6. Reporting Procedures

6.1 The Chair of The Group is the conduit for reporting to and receiving updates and requests from the Board.

6.2 The Chair's report of The Group will be shared with the ICB Senior Leadership Team and may be shared with Board to provide updates on activity and risks.

7. Responsibilities of The Group

7.1 The Group's duties can be categorised as:

7.1.1 HR/People

- Provide assurance to the Board on all aspects of employment and employment experience with the ICB as an employer, including, but not limited to:
    - provide assurance that legal and regulatory requirements related to employment of staff are fulfilled;
    - terms and conditions,
    - policy development and approval
    - recruitment,
    - health and wellbeing,
    - statutory and mandatory training,
    - education and learning,
    - apprenticeships,
    - career development,
    - talent management,
    - equality diversity and inclusion,
    - organisational development,
    - people management,
    - employee benefits and reward,
    - work-life balance,
    - workforce planning,
    - workforce performance information, and
    - employee voice

- oversight of delivery against action plans

7.1.2 Health and Safety

- Provide assurance to the Board on all aspects of health and safety, including but not limited to:
  - Provide assurance that all legal and regulatory requirements related to Health and Safety are fulfilled
  - Policy development and policy approval
  - Incident reporting/ trend analysis
  - Approve Annual work Plan
  - Approve Annual Health and Safety Report
  - Oversight of delivery against action plans

7.1.3 ICB Operating Model

- Provide oversight of the development of the ICB's operating model
- Support continuous review and improvement of the operating model
- Agree strategic action to enhance ICB culture, behaviours and ways of working

7.1.4 Risk Management

- Review and provide assurance on those elements of the Board Assurance Framework and Strategic Risk Register delegated by the ICB, seeking where necessary further action/ assurance.

8. Conflicts of Interest

8.1 The Group will maintain a standing register, as per any other corporate decision-making body. In advance of any meeting of The Group, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals.

8.2 At the beginning of each meeting of The Group, members and attendees will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declaration will be formally recorded in the minutes for the meeting. Members must ensure that they continue to comply with relevant organisational policies / guidance.

8.3 The Chair of The Group will determine how declared interests should be managed, which is likely to involve one the following actions:

a) Requiring the individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to The Group decision-making arrangements.

b) Allowing the individual to participate in the discussion, but not the decision-making process.

c) Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to The Group decision-making arrangements.

9. Secretariat

9.1 The Group will be supported by the CSU Business Partner and serviced by the Chief Executive's PA or deputy and will operate using the following principles:

- Agenda items will be sought from the members of The Group 14 days prior to the meeting.
- The Chair will agree the final agenda.
- Papers will be circulated 5 working days before each meeting.
- Additional items for the agenda will be taken by exception with the knowledge and agreement of the Chair in advance of the meeting commencing.
- The minutes of each meeting will be circulated within 10 working days of the meeting being held and will be ratified at the following meeting.

9.2 A Chair's report will be created from the minutes.

Created December 2023

Agenda Item

ICB 31-01-015.1

Quality and Performance Committee minutes for meeting held on 26 October 2023

NHS Shropshire Telford and Wrekin
ICS Quality & Performance Committee Meeting

Thursday, 26th October 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
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
Sue Bull	LMNS Programme Manager, NHS STW
Sharon Fletcher	Senior Quality Lead/Patient Safety Specialist, NHS STW
Rosi Edwards	Non-Executive Director, SaTH
Hayley Flavell	Executive Director of Nursing, SaTH
Mahadeva Ganesh	Medical Director, SCHT
Jill Barker	Associate Non-Executive Director, SCHT
Sara Ellis-Anderson	Deputy Director of Nursing and Quality, SCHT
Sam Young	Deputy Chief Nurse, RJAH
Sara Reeve	Deputy Director of Quality, MPFT
Anne MacLachlan	Clinical and Care Director, MPFT
Lynn Cawley	Chief Officer, Healthwatch Shropshire

Attendees:

Deborah Millington	Senior Quality Lead, NHS STW (Observer)
Brett Toro-Pearce	Deputy Director Mental Health, Learning Disabilities & Autism, NHS STW
Sylvia Barnes	Quality Team Administrator, Note Taker, NHS STW

1.0 Minute No. QPC-23-10.138 – 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:

- Paul Kavanagh-Fields RJAH – Sam Young representing.
- Liz Noakes Telford and Wrekin LA
- Clair Hobbs SCHT – Sara Ellis-Anderson representing.
- Simon Fogell Healthwatch Telford
- Simmy Akhtar MPFT
- Ruth Longfellow RJAH.

- Liz Lockett MPFT – Sara Reeve representing.

2.0 QPC-23-10.139 - Members' Declarations of Interests

2.1 There were no declarations or conflicts of interest noted.

3.0 Minute No. QPC-23-10.140- Minutes of Meeting held on 28th September 2023

3.1 The minutes of the meeting held on 28th September 2023 were reviewed and accepted as an accurate record with the exception of the following:
Sara Reeves asked that MPUFT is changed to MFPT.

Action: Sylvia Barnes to amend all instances of MPUFT to MPFT.

3.2 Item 16.1 – Lynn Cawley asked that domestic care reports be amended to complaints reports.

Action: Sylvia Barnes to amend minutes.

4.0 QPC-23-10.141 - Matters Arising and Action Log

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

4.2 QPC-23-09.130 - *discuss issues regarding diabetes transformation with Simon Whitehouse and feedback to the next meeting:* Email communication made to Simon Whitehouse. Gemma Smith, Director of Strategic Commissioning is coordinating a response from Directors and is now the identified SRO.

4.3 QPC-23.09.131 – *Discharge issues:* Vanessa Whatley advised the Discharge Alliance is where all actions have been brought together and covers all trusts, local authorities, voluntary sectors and with assistance from NHSE. Ian Betts, NHSE, has shared the first draft of a new discharge plan with Vanessa Whatley, the final version will be shared with Committee members once agreed. The document includes a range of quality improvement projects at SaTH through to reviewing frameworks around how care in the community is procured. Meeting frequency has been increased to every two or three weeks to gain traction.

4.4 QPC-23-07-108 – *Ascertain why practices are not achieving the diabetes target:* Julie Garside has requested primary care colleagues confirm why practices are not achieving diabetes targets. A point of contact is being identified for primary care due the head of primary care being on leave. This issue will be escalated to Gareth Robinson next week to ensure this information is obtained and an update will be provided before the next meeting.

4.5 QPC-23-07-109 – *National guidance advises therapists should be upgraded, no funding has been allocated in MPFT or ICB budget-lines:* This was escalated straight to ICB Board however should have gone via Mental Health and LD&A Board first, Julie Garside will pick this up separately with Cathy Riley. Funding requested by MPFT to cover this uplift will be considered from the 2024/25 MIS growth once system priorities and risks are identified and agreed. Julie Garside wished to assure colleagues the potential risk identified regarding the loss of therapy staff has not come to fruition. Julie Garside suggested this item be closed and brought back to this meeting and if not resolved when 2024/25 monies are prioritised.

4.6 QPC-23-07.113 - *If SaTH do not obtain Nicotine Replacement Therapy funding, they will not achieve Clinical Negligence Scheme for Trusts, currently being provided at financial risk:* Sue Bull advised this was not covered in her report and SaTH continue to fund NRT until the issue is resolved. Hayley Flavell advised this is a cost pressure and was discussed at Quality Safety and Assurance Committee that smoking at the time of delivery is variable. This needs to be correlated with low gestational weight at birth as these go hand in hand and it is imperative that NRT support continues. Rosi

Edwards added that this is a cost pressure for SaTH who are currently under scrutiny for financial deficit. Meredith Vivian advised carried costs were discussed at the ICB development session along with the public health effect of priorities over health or financial deficits and decisions that are needed. Every part of the system are covering costs that are not funded. Meredith Vivian asked the actual cost of NRT therapy. Sue Bull advised the current model is £36, 000. Sharon Fletcher met with Sue Bull and Naomi Roache earlier this week to see if there is supportive work that can be done to connect social prescribing and health coaching alongside the healthy pregnancy and healthy families work streams. Early discussions have been held with John Costello and Sharon Fletcher asked members to advise if anyone else needs to be part of this small working group. Meredith Vivian suggested Sharon Fletcher link in with Nick White as he was leading the discussion at the ICB development session.

4.7 *Include user feedback on experience of care and effects caused by its collection in the next report:* Sue Bull advised MNVP have their own report which Committee members would find interesting and suggested this be included as a separate item in her future updates. Sue Bull was unaware of this item on the action log and asked to be included when meeting papers are distributed.

Action: Sylvia Barnes to include Sue Bull in this Committee distribution list to receive all future meeting papers.

4.8 QPC-23-06-94 - *MPFT to present a report explaining their data collection from services and the work being undertaken to ensure it is accurate:* Vanessa Whatley advised the report has been circulated with meeting papers for information and the author is happy to present the paper at a future date if Committee members wished. Julie Garside suggested any comments are sent for her to coordinate which can then be raised at MPFT contract review meetings where data quality is discussed.

5.0 Minute No. QPC-23-10.142 - 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 Vanessa Whatley advised there has been movement on quite a lot of risks including the acute paediatric pathway. SaTH provided a presentation at SOAG, regarding the pathway and actions which was helpful. PTAC has started to progress, a lot of actions are mapped, graded and reviewed. Meredith Vivian commented it was clear this report has been updated and refreshed.

5.2 Hayley Flavell advised a Deep Dive presentation on C diff figures was presented at SaTH Quality and Safety Assurance Committee yesterday, which Hayley Flavell was happy to share with Vanessa Whatley. SaTH currently reporting around 44 cases against 2023/24 trajectory of 32 cases. Increased C diff cases are being seen, however minimal outbreaks and organisational challenges remain a lack of side rooms and overcrowded ED. Hayley Flavell commented that transmission may be taking place in ED and suggested the Deep Dive be shared at the ICS IPC and AMR Group. Vanessa Whatley welcomed this advising SaTH IPC team and microbiology are always represented at the meeting.

Action: Hayley Flavell to share C diff Deep Dive with Vanessa Whatley for discussion at ICS IPC and AMR Group.

5.3 Sam Young advised a system C diff Action Plan is currently under review by IPC teams across the system and would be keen to also receive the Deep Dive presentation to see if any learning can be shared.

5.4 System Strategic Operational Risk Register – Vanessa Whatley advised Alison Smith has asked this is circulated to all Committees of the ICB Board for information, so they are aware of any responsibility of risks. Some Committees are more active in having

risk registers than others since the ICB was brought into development. The second tab details a Quality Performance Committee risk around continuing healthcare which is not on our risk register, Vanessa Whatley has raised this with Tracey Jones.

5.5 Merdith Vivian advised palliative and end of life care is on the system risk register as deescalated from the Quality and Performance risk register, so should this be removed. Vanessa Whatley agreed. Vanessa Whatley added that Alison Smith is currently working on a central electronic risk register which is something the CCG or current ICB have not have previously, which is progress.

5.6 Meredith Vivian noted that finance department capacity was detailed as a serious risk, which does not feel right. Alison Bussey commented we have a system risk within the People Committee around workforce availability and is something that requires discussions with the executive team in the first instance to unpick further.

Action: Alison Bussey to discuss finance team capacity being detailed on the System Strategic Risk Register with executive colleagues.

5.7 Vanessa Whatley asked this is brought to future meetings for information and issues can be discussed if required. Meredith Vivian asked this is tabled every six months for information.

The Committee:

- Discussed the risks for ongoing progress/action.

6.0 Minute No QPC-23-10.143 – Performance Exception Report – Julie Garside

The report was taken as read; key points of discussion were:

6.1 Julie Garside wished to highlight that assurance against the delivery of a refreshed improvement plan for urgent and emergency care (and associated recovery trajectories) could not be provided. Julie Garside was fully supportive of the approach that feedback/recommendations from all various recent visits would be consolidated into one overarching updated improvement plan, however, performance continues to be off track since July, especially around patients waiting over 12 hours in the department and the four-hour position. Some assurance was provided at the UEC Board that work is continuing on the updated plan.

6.2 Meredith Vivian asked if the concern is a plan is not in place. Julie Garside advised an old plan is still being worked on, however a new updated plan has not been received so unable to provide an indicative timescale for recovery.

6.3 Vanessa Whatley noted SMI physical health checks and LD health checks are below the national target. Julie Garside shared the concerns however has soft intelligence that the picture is being under-reported and is trying to obtain the correct information. Sam Cook commented SMI health check information is included in the deep dive paper later on this agenda.

6.4 Tracey Slater advised LD annual health checks are currently just under 20% but has met with Priya George and Janet Gittins this morning. Communications are planned to primary care colleagues to share findings from the LeDeR reviews. Anne MacLaughlan added that checks are being carried out however there is an issue with how these are coded.

6.5 Meredith Vivian asked for progress regarding GP electronic referrals to the care coordination centre (CCC), what does the engagement look like and with whom. Julie Garside advised work has been undertaken by PCNs and GP Board encouraging practices to use the single point of access with CCC.

6.6 Meredith Vivan noted the improvement trajectory for four-hour waits has been escalated to UEC Board and QPC and asked is this because of risk of harm . Julie Garside advised the underlying concerns around quality of care when targets are

missed but also the links to the lack of delivery for both SaTH and the ICB being in segment 4. SaTH colleagues are working incredibly hard to minimise this. There is a quality risk, but as an ICB one of priorities is to work towards exiting from NOF segment 4 and failure to show improvement in our delivery of UEC is directly affecting this. Depending on the feedback obtained from UEC Board next week, we will ascertain if further action is required by this Committee.

6.7 Hayley Flavell confirmed targets are not being met and the ED department is extremely overcrowded. Patients are being held in escalation areas that are not clinical areas such as corridors within and outside the ED area and in the main corridor at PRH. The risk is high in terms of overcrowding, privacy + dignity and delays in ED which could cause concerns regarding deconditioning. Hayley Flavell added this impacts on the community as ambulances can wait up to 8 hours to offload, however mitigations are in place to ensure the risk to patients is minimised.

6.8 Meredith Vivian queried the contradiction on the availability of psychiatric intensive care beds. Julie Garside is working closely with MPFT colleagues regarding the timeline for a review of beds in conjunction with NHSE, originally requested in June 2023. Out of area providers such as the Priory are used and we need to understand the system requirements, it is then our collective responsibility to commission the necessary capacity. Sam Cook advised that the issue is our female patients do not fit the current criteria for beds commissioned at The Priory by MPFT on behalf of the ICB, so we are paying for resources that are not being used. Julie Garside added the review is required to understand the full scope of the demand and need from our population , so appropriate services can be commissioned.

6.9 Meredith Vivian asked for information around fast-track assessments delays, which can be very upsetting and difficult.. The individualised commissioning team are aware, and this also impacts on SaTH when patients stay in hospital a lot longer than necessary. We need to keep a careful eye on this to ensure it is going in the right direction as the quality implications on families and people are significant.

Action: Julie Garside to discuss with Brett Toro-Pearce how fast-track delays can be improved.

The Committee:

- Noted the content of the report.

7.0 Minute No. QPC-23-10.144 – System Quality Metrics – Vanessa Whatley

The report was taken as read; a discussion took place with the following key points highlighted:

7.1 Vanessa Whatley apologised the incorrect report had been submitted and will circulate the correct version directly after the meeting.

7.2 Mixed-sex accommodation and risks around the diabetes pathway, spoken about frequently continue to see slow movement.

7.3 Meredith Vivan asked what the policy is around mixed-sex accommodation. Vanessa Whatley advised this tends to be patients being stepped down from intensive care and need to go onto a ward, the clock starts ticking. Rosi Edwards advised this is regarding patients who are being held overnight and the overlap when day patients come in. This is due to overspill and escalation, and places being used for beds that are not really suitable or have other functions.

The Committee:

- Considered the quality metrics with performance metrics and system risks.

8.0 Minute No. QPC-23-10.145 - Exception Report - System Quality Group Chairs Update – Vanessa Whatley

The report was taken as read.

8.1 Vanessa Whatley advised the Child Death Overview Panel 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 is quite old-fashioned, it 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.

9.0 Minute No QPC-23-10.146 - Health Protection Board Update – Liz Noakes

The item has been deferred to the November meeting at the request of Liz Noakes

9.1 Liz Noake's apologies received for this meeting.
9.2 Meredith Vivian asked this item is submitted for information to the November meeting.

Action: Sylvia Barnes to move to November agenda for information.

10.0 Minute No. QPC-23-10.147 – Deep Dive Mental Health & Learning Disabilities and Autism – Brett Toro-Pearce

The report was taken as read.

10.1 Brett Toro-Pearce advised the deep dive has been split into three areas; dementia, physical health checks for those with a serious mental illness and Learning Disability and Autism.

10.2 Although not meeting the national target, there has been huge progress in developing the dementia function, particularly Dementia Diagnosis Rates (DDR) where incremental improvements can be seen each month.

10.3 Meredith Vivian noted the tremendous ongoing work with dementia and asked what is stopping us achieving the DDR national target. Brett Toro-Pearce advised it is difficult to identify if this is a data issue or whether some diagnoses are given but are not filtering through in the correct way. Looking at workforce, rates should be higher.

10.4 Meredith Vivian asked if the voluntary community sector, with close relationships with people who may be eligible for diagnosis, are informed and aware. Brett Toro-Pearce advised the sector are informed and the connections are there, however more can always be done.

Action: Brett Toro-Pearce to discuss with the Dementia Lead if anything more can be done to gain assurance people are aware of how to access dementia services.

10.5 Rosi Edwards questioned if we are not diagnosing enough or whether people are being diagnosed and found not to have dementia. Clarification requested regarding the national target that two out of three people would receive a diagnosis of dementia, is this two out of three people over the age of 65.

Action: Brett Toro-Pearce to clarify number of people being assessed for dementia and number diagnosed with dementia. Also, if the national target is two out of every three people over the age of 65 would receive a dementia diagnosis.

10.6 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. Vanessa Whatley advised Stoke in SSOT seem to be doing really well in the figures

presented and asked if discussions have been held to compare work streams. Brett Toro-Pearce confirmed that discussions have been held, and there had been adoption of processes. Numbers are focussed on and not necessarily all of the brilliant work actually taking place and the engagement work with those that have a diagnosis and the people supporting those with dementia.

10.7 Brett Toro-Pearce explained the Navigator Role is integral to get the diagnosis rates and supporting the population. Option three was the preferred option; Implement through existing resources using social prescribers / care co-ordinators. Explore Additional Reimbursement Roles (ARRS). Brett Toro Pearce has passed this work onto Helen Rowney and did not have a progress update since the report was written, however offered to provide Meredith Vivian with an update outside of this Committee.

Action: Brett Toro-Pearce to provide Meredith Vivian with an update on Options for the Navigator Function outside of this Committee.

10.8 Brett Toro-Pearce discussed the issue of recording completion of physical health checks and ensuring this information is recorded in primary care records. A deep dive is taking place as we are confident we are closer to the figure required. IT professionals are looking at how we can make sure the information being received by primary care system is accurate. One issue has already been identified, the two systems do not speak to one another, records currently need to be updated manually. There are a large number of partially completed health checks and a drive is taking place to ensure the person gets the required health check and that piece of work can be completed. Outreach services are being reviewed and early discussions held with primary care colleagues for the use of clinical rooms or premises in the community to allow easier access.

10.9 Brett Toro-Pearce advised that although we are not reaching the national target of no more than one person under the age of 18 are cared for in an in-patient unit, this is a success story. Since the paper was submitted, further meetings have been held with NHSE who advised that some oversight meetings will be stepped down due to performance and progress made, meeting trajectory and on plan to achieve trajectory by the end of the year.

10.10 Brett Toro-Pearce advised the management of this cohort of patients was previously referred to as Transforming Care Programme. This terminology is not currently in use and the appropriate terminology is Assuring Transformation cohort of individuals. Work is being undertaken with local authorities regarding housing to enable discharge planning to commence earlier.

10.11 Meredith Vivian commented housing issues have been under discussion for many years and asked if there is anything different that can be done. Julie Garside agreed but wished to note the success made over the recent years and good work with local authorities. Although the national ambition is zero, we have to do what is right for the individual and this is not always the right option for the individual.

10.12 Meredith Vivian noted the ICB Oversight Panels, meeting quarterly, recommend anonymised reports are tabled at this Committee. Brett Toro-Pearce advised this is just renaming something that already exists regarding the oversight of Care and Treatment Reviews and Care and Education Treatment Reviews, which are really important and function very well at present. The Committee will be appraised.

10.13 Vanessa Whatley advised a mother attended the last Board meeting and discussed her son's disastrous journey after Winterbourne View discharge, he ended up in a variety of unsuitable housing which were private placements with a private nursing workforce. The mother advised that MPFT had actually saved her son's life and received praise for addressing this. Vanessa Whatley asked how we can ensure this does not happen again and that the housing provided is suitable. Brett Toro-Pearce advised the statutory requirement for inpatient beds is an eight-week QA review which is not the same for patients in the community, however this does not mean that processes can be put in place. The majority of patients will be section 117 or CHC

eligible and there is a requirement to complete a review and for section 117 be assured. Making sure we work together as a system, gain assurance and communicate effectively is key. For example, if the local authority meets with the person, can we obtain a system assurance rather than everyone working in isolation, making sure we are collective and ensuring the patient's needs are met. Clinical and commissioning need to be linked in for clinical assurance and the quality of placement assurance as these may be currently worked in isolation, especially where the local authority commissions the contract.

10.14 Meredith Vivan asked if the transcript of the mother's story is available and suggested this be disseminated to Brett Toro-Pearce's team. Vanessa Whatley advised the video is included in one of the presentations, is very powerful and explains what the family had been through. Vanessa Whatley added that we do not have a lot of inpatient facilities, however we do have housing and it is about ensuring the quality of placements and that people are being treated in the best way for their requirements.

Action: Vanessa Whatley to send the patient story presented at the Board to Brett Toro-Pearce.

10.15 Talking Therapies Update – Anne MacLaughlan advised the briefing details an update on the project progress and provide assurance on actions being taken in relation to the fall in the access to treatment numbers. NHS talking therapies, previously named Improving Access to Psychological Therapies (IAPT) is a national programme commissioned to deliver evidence based psychological therapies to treat people with depression and specific anxiety disorders. The project has four distinct delivery components to have a clear clinical pathway:

- To have one clear clinical pathway and clear eligibility into the service, providing a robust referral management system.
- To ensure that the 2 teams are recording on the same instance of IAPTus (not currently doing so) to ensure there is a robust data governance framework and improve clinical decision making.
- To implement the Chatbot solution which will support increased patient access and support/help move the service towards target compliance.
- To procure an external provider to assist in clearing the waiting list backlog.

10.15 The waiting list in Shropshire was significant at over 1200 patients, and SI reviews identified this as a contributing factor in unexpected deaths of self-harm.

10.16 Recruitment of a project clinical lead, data quality analysts, operational lead for combined services, team managers and clinical lead for specialism was noted. There are no eighteen week plus waits for Step 2 and Step 3 waits have been greatly reduced. Shropshire's Step 3 waiting list has reduced from 999 in January 2023 to 226 currently.

10.17 One ICB treatment coding is not recognised nationally so further work is needed. A decision was made, with approval of the national team, that a data cleanse was required, however this has caused a time lag.

10.18 Feedback received from primary care is that due to long-waits, faith has been lost for referring into the system due to delays and work is ongoing to win back trust and advise that waits have been reduced to a meaningful period for people who require high-level therapeutic intervention for a significant mental health problem.

10.19 Meredith Vivian thanked Anne MacLaughlan for the helpful overview and was confident we understand the overall picture has been a nightmare however, sure that figures coming through are valid and reliable and things are beginning to improve.

10.20 Vanessa Whatley asked why the initiative was just for Shropshire. Anne MacLaughlan advised there were two services, one in Shropshire and one in Telford & Wrekin which were commissioned very differently. Telford and Wrekin were commissioned as the core IAPT service and there were issues with how Shropshire was commissioned and funded. The Shropshire workforce, GP counsellors, did not want to work with the IAPT model of counsellors being taken from their practices and into the IAPT services. The

model of counselling used does not fit with the IAPT service and some residual workforce are advising they do not wish to work in this way. It takes time to recruit people who are trained properly to deliver NICE evidence based talking therapies. Anne MacLaughlan confirmed the Shropshire and Telford and Wrekin services are being merged.

10.21 Alison Bussey added it has taken many years to reach this point and congratulated Anne MacLaughlan. Alison Bussey endorsed that the different commissioning arrangements of Shropshire and Telford and Wrekin has not helped and continues to be unhelpful. Anne MacLaughlan has confidence in the great leaders now in place as they are working incredibly hard to turn this around.

10.22 Meredith Vivian asked if a progress report can be tabled at a future meeting. Julie Garside advised the trajectory will be received shortly and asked if this could be reviewed to ascertain when an improvement will be seen to decide when an update should be tabled.

The Committee:

- Noted the report contents.

11.0 Minute No. QPC-23-10.148 - LMNS Programme Board Update – Sue Bull

11.1 Sue Bull advised this report was originally for the September meeting, some things have moved on and wished to highlight the positive increase in the amount of Ockenden recommendations that have been closed.

11.2 The saving babies lives version three care bundle, stipulates the provision of NRT to reduce smoking rates during pregnancy.

11.3 The NHSE three-year delivery plan is the LMNS focus. Positive strides have been made with mapping everything currently in place across the system to avoid duplication and demonstrate how this delivery plan is being met. The LMNS Equity and Equality Delivery Plan has been included, which is a vital piece of work and should not sit in silo.

11.4 Workstreams have been identified and progress will be reported directly into the LMNS Programme Board. This will be managed centrally by the LMNS PMO team, working closely with SaTH, public health teams and all MVP will contribute.

11.5 A regional data dashboard is another positive piece of work and making good strides. MLCSU have been commissioned to develop the dashboard containing all the metrics that system partners have requested be included. Sue Bull added that this is a system-wide database that overlays our population and public health metrics. For example, with smoking in pregnancy, this will show the areas of need such are the area with the highest smoking rates. This will allow us to benchmark and Birmingham and Black Country and Staffordshire and Stoke LMNS wish to be part of this, and data sharing arrangements and agreements are being worked through. It is anticipated this will be up and running by March 2024.

11.6 Rosi Edwards asked how much data will be received regarding poverty and destitution as there could be cases of malnutrition in pregnant ladies and this would enable a review of how poverty leads to poor outcomes such as small for gestational age babies. Sue Bull advised conversations are taking place with public health partners and both local councils to get the metrics agreed and what can be provided. This will allow mapping and profiling our population and the intention to turn this into a health inequalities dashboard as time goes on. Discussions are taking place with Leicester and Rutland ICBs who are currently developing their own health inequalities database.

11.7 Meredith Vivan asked if we will be able to do anything with the information that mapping reveals. Sue Bull advised the data will be real-time and interactive so public health teams will be able to see what information they are interested in and how they can

map that. This will then be reviewed by the system to identify gaps or transformation projects required.

11.8 Meredith Vivan asked if the dashboard will be able to measure effect. Sue Bull confirmed the dashboard will monitor trends.

11.9 Sue Bull clarified NHSE have advised all ICB pilot sites that Independent Senior Advocates are unable to commence any work with families until green light criteria guidance is issued by the national team. Monthly meetings are held to try and progress this issue.

12.0 Minute No. QPC-23-10.149 – Healthwatch Update – Lynn Cawley

The report was noted.

12.1 Apologies were received from Simon Fogell.

12.2 Lynn Cawley advised the Healthwatch complaints report has been recently published which details people are not satisfied with their experiences when making a formal complaint. Having provided the independent health complaints advocacy service, Healthwatch Shropshire feel people using the NHS complaints process require something different, such as in some instances bereavement support and counselling to deal with their experiences. This ties in with work across the system, trauma informed approaches to care personalisation and timely conversation with people so that they understand what is happening.

12.3 Lynn Cawley added the report is not to bash people who work in this challenging field, it is to highlight other ways our system can support these people. The report will be tabled at the System Quality Group, and if members present wish to see the report it is available on Healthwatch Shropshire website.

12.4 Lynn Cawley advised a diabetes report is due to be published and is aware of the work being undertaken around diabetes transformation so wanted to provide people with the opportunity to have their voice heard as these changes and improvements are being made.

12.5 Lynn Cawley added it would be useful to be advised as early as possible when transformation work is planned, so the public can be asked how they are finding the current service and what can be improved, so they feel that changes are the ones they would like to see. Both Shropshire and Telford and Wrekin Healthwatch need to be working together in a lot of these pieces of work, there are various reasons why difficulties are being encountered, however it would be helpful to hear from both Shropshire and Telford and Wrekin residents. It would be easier if the system contacted both Healthwatch teams with the 'ask' to enable joint pieces of work be undertaken, to gain a picture from the whole of the County.

12.6 Work on gaining people's experience of domiciliary care is planned as these are the most seldom heard and hard to reach. Discussions will be held with carer's groups and others to find out what it is like to receive care and hoping this will inform the local care transformation being discussed across the ICS and local authorities' transformation. Early discussions show the public are reluctant to access domiciliary care until they are in crisis. A potential outcome of this work may be for the system to educate the public on what early level help looks like and how this can build as their needs increase.

12.7 Julie Garside suggested a regular agenda item for Healthwatch requests could be placed on Commissioning Working Group meetings. Lynn Cawley thanked Julie Garside and advised it would be really helpful to be advised of any project as early as possible so it can be factored into Healthwatch plans.

Action: Julie Garside to place 'Healthwatch requests' on Commissioning Working Group agendas.

13.0 Minute No. QPC-23-10.150 – Terms of Reference – Vanessa Whatley

13.1 Meredith Vivian asked members to send any observations, suggestions or comments on the Terms of Reference to Vanessa Whatley. Vanessa Whatley requested these be sent within the next three weeks, so they are ready for the November Committee meeting.

Action: All to review the Terms of Reference and forward any observations, suggestions or comments to Vanessa Whatley by 16th November 2023.

13.2 Vanessa Whatley advised the Terms of Reference may need a further refresh once the ICB completes management of change.

14.0 Minute No. QPC-23-10.151– Evaluation of Meeting

14.1 Meredith Vivian encouraged members to feedback comments and/or observations they may have about the meeting or any improvements they wish to see. Please send comments to sylviabarnes@nhs.net

15.0 Minute No. QPC-23-10.152 – Items for Escalation/Referral to Other Board Committees

15.1 No items were identified for escalation or referral to other Board Committees.

16.0 Minute No. QPC-23-10.153 – Any Other Business

NHSE Chief Delivery Officer Letter Regarding Sexual Safety

16.1 Alison Bussey advised all providers received a letter from NHSE Chief Delivery Officer regarding sexual safety in the NHS. As well as the need to safeguard patients, there is significant focus on the impact of sexual harassment and abuse for the workforce, which includes from other staff they may be working with. This is following an investigation by the Guardian, BBC and BMJ. All organisations have been asked to sign up to a Charter, specifically regarding workforce.

16.2 Alison Bussey advised the ICB has signed up to the Charter to implement and take action on the ten pledges, and was aware that MPFT has, and that RJAH and SCHT are currently in the process of doing so.

16.3 The ten pledges include policies, raising awareness, and national training that will become available for staff. The ICB Board will be informed this work is underway.

Date and Time of Next Meeting

Thursday 30th November 2023 at 2.00pm to 4.00pm via Microsoft Teams.

SIGNED …….. DATE ……

Agenda Item

ICB 31-01-015.3

Finance Committee minutes for meetings held on 26 October and 30 Novmber 2023

NHS Shropshire,Telford, and Wrekin
ICB Finance Committee (Section 1) Meeting
Thursday 26th October 2023 at 2.00pm
Via Microsoft Teams

Present:

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

Attendees:

Gareth Robinson	Directory of Delivery and Transformation NHS STW
Laura Clare	Deputy Director of Finance NHS STW
Cynthia Fearon	Corporate PA NHS STW (Note taker).

Apologies:

David Bennett	Non-Executive NHS STW

Minute No. SFC-23-10.001 – Introduction and Apologies

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

Minute No. SFC-23-10.002 – Declarations of Interests

2.1 No declarations of interest were noted.

Minute No. SFC-23-10.003 – Minutes from the Previous Meeting held on: 3rd October 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-23-10.004 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-23-10.005 - ICB M6 Finance Overview

Report received as read.

5.1 LC highlighted that the ICB has at month 6 a £13.8m deficit which set against a planned £7.3m gives a £6.5m variance to the plan.

LC stated there is an £0.6m overspend on acute due to prior year and independent sector activity overperformance and a reduced assumption in anticipated additional ERF income. Also, a £4.7m overspend on individual commissioning budgets which appears to be predominantly due to price increases above the levels funded.

LC highlighted that there is a £0.6m overspend on primary care predominantly due to the overspend on in-year prescribing offset with a prior year benefit. **LC** added that prescribing has seen monthly increases compared to previous year ranging from 7-18% in the first few months of the year. NCSO and Cat M pricing issues continue to hit as well as volume increases.

LC mentioned that there is a £1.3m overspend on 'other' due to Welsh ERF income not materialising in line with planning assumptions.

LC noted the £1.1m year-to-date hit to the position due to unidentified efficiency, Adverse variances are offset with £1.8m of underspends across community, running costs and POD (Pharmacy, Optometry, Dental).

LC stated that we are still currently showing that we will hit the plan target in the reported forecast. If you add the month 6 position to the level of unmitigated risk reported alongside it, this would amount to approximately £39m deficit by the end of the year if no further action is taken.

LC mentioned that forecast outturn scenarios are being scrutinised with the Executive and Senior Leadership teams. **LC** added, ahead of month 7, the ICB finance team are doing a lot of work with budget holders to ensure that all departments are clear about their position and owning their forecasts.

CS made reference to the work to reduce the FOT. A reforecast has not been formalised with NHSE at this stage. **CS** stated that since submitting the month 6 position, a reworked forecast was now a £35.7m a deficit with work ongoing to confirm further mitigations.

GR asked about the Dental underspend as he was not sighted on that. **CS** responded that this has been picked up through the finance route but expected his team to be sighted on it. **CS** added that at this point there is a risk that the underspend could be clawed back by NHSE though ICBS are assuming it in their positions.

***Action: LC** to share with **GR** information on the dental underspend so **GR** can link in with the POD team accordingly.*

TMcM queried the arrangements around ERF baseline figure. **CS** explained anything that is achieves over the 101% baseline figure, will attract additional funding.

TMcM queried about additional Welsh funding. **CS** explained that the rules for the Welsh funding are different to England and that it was very unlikely that Welsh funding would be received within the STW system. The national team continue to look into this.

TMcM queried whether the same principles that was applied to the ICB forecasting, was also applied to the provider organisations. **CS** explained that we have asked provider organisations to give a best-case and worse-case scenario, the same as for the ICB. **CS** added that provider organisations have been encouraged to work towards the best-case scenario in line with the actions being taken by the ICB.

The System Finance Committee noted:

- The M6 headlines for the ICB financial position (£13.8m YTD deficit, £6.5m adverse position to plan, forecasting delivery of plan but with significant risk)
- The key drivers of the risk presented and actions to reduce or mitigate those risks.
- The level of unmitigated financial risk currently reported alongside the forecast position (£27.1m).
- That if the current unmitigated risk was added to the reported FOT this would give a position of a £39m deficit for the ICB for the year.

Minute No. SFC-23-10.006 – Efficiency Update

Report received as read.

6.1 **GR** highlighted that at Month 6 year-to-date, the IDC has delivered £10.5m of savings against a plan of £10.8m which provides an adverse Year-To-date variance of -£391k.

GR stated, the key thing to identify is the significant movement between month 5 and month 6, where we have reduced the unidentified stretch from £4.1m to £2.56m. Significant progress has been made to date in the identification of further plans to bridge the unidentified gap which totalled £8m at the start of the year. The unidentified gap has now reduced to £2.56m with 90% of plans now 'identified and in delivery' which meets the requirements set by NHSE. The remaining unidentified gap (£2.56m) is a challenge and presents a risk to the overall delivery of the plan.

GR stated that there are a much smaller range of pipeline opportunities that we continue to work on that are more transactional rather than transformational but will land as work progresses.

GR noted that the year-to-date variance against plan is due to a delayed start in the Optum programme within the Medicines Management team, non-delivery of the VBC Challenges to date and a delay in the delivery of unidentified efficiencies which were phased to deliver from Month 4 onwards.

Mitigations are in place for each of these areas and it is expected that for both the Medicines Management and VBC Challenges, delivery will catch up in the following months of the year and forecasts will be met. **GR** added each of the programmes are monitored carefully within their respective teams with clear action plans in place and updates are provided to the Sustainability Working Group on a regular basis.

GR stated that weekly 1-1 meetings within the Delivery and Transformation team continue to be held with a set of actions and pipeline opportunities being pursued. A detailed review of budget spend by department will also be undertaken and updates will be reported through to the Sustainability Working Group.

CS stated, when they originally set the plan for efficiency, including the stretch targets. We were careful with the stretch as at the time we did not have any idea as to how it would be delivered. That is the reason why the stretch targets were put in as non- recurring. **CS** highlighted that we are currently forecasting to meet the recurrent target.

The System Finance Committee noted:

- Month 6 efficiency delivery and progress made since May 2023 towards bridging the gap in the unidentified savings plans.

- The actions that are in place to reduce the unidentified savings further and risk associated with the remaining gap.

Minute No. SFC-23-10.007 – Any Other Business

There was no other business for discussion under this agenda item.

Meeting closed at 14.56pm.

Date And Time of Next Meeting

Thursday 30th November 2023, 1.00pm via Teams.

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

NHS Shropshire, Telford and Wrekin
Integrated Care System Finance Committee (Section 2) Meeting
Thursday 26th October 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
Jonathan Gould (for Sarah Lloyd)	Deputy Director of Finance Shropshire Community Health NHS Trust
Peter Featherstone	Non-Executive Shropshire Community Health NHS Trust
Helen Troalen	Director of Finance Shrewsbury and Telford Hospitals NHS Trust
Craig MacBeth	Chief Finance Officer - RJAH
Glenn Head (for Chris Sands)	Head of Financial Management - MPFT

Attendees:

Gareth Robinson	Director of Delivery and Transformation NHS STW
Laura Clare	Deputy Chief Finance Officer NHS STW
Cynthia Fearon	Corporate PA NHS STW (Note Taker)

Apologies:

Chris Sands	Chief Finance Officer - MPFT
David Bennett	Non-Executive Director NHS STW
Sarah Lloyd	Chief Finance Officer Shropshire Community Health NHS Trust
Clair Young	Deputy Director of Finance - SATH
Ben Jay	Assistant Director of Finance – Shropshire LA
Sarfraz Narwaz	Non-Executive - RJAH

1.0 Minute No. SFC-23-10.001 Introductions and Apologies

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

TMcM made reference to the email that was circulated by **CS,** to encourage representation at System Finance Committees from system partner organisation NEDS. Also, for the sharing of finance committee minutes. This is to support a more balanced discussion at System Finance Committee meetings and aid the Committees role in seeking assurance on financial strategy and management.

2.0 Minute No. SFC-23-10.002 Members' Declarations of Interests

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

3.0 Minute No. SFC-23.10.003 Minutes of the Previous Meeting held on: 3rd October 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-23.10.004 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-23.10.005 - ICS M6 Finance Overview

5.1 **Report received as read.**

CS highlighted at Month 6 the ICS has a deficit of £74.5m, which is £33.9m adverse to plan, with a variation from in-month plan of £10.8m in Month 6.

CS stated that the main area of overspend continues to be in SATH and relates to the key drivers around escalation costs, elective activity costs and staffing issues. The ICB also continues to see a year-to-date variance to plan which is, in the main, attributable to expenditure in Prescribing and Individual Commissioning, particularly price increases outstripping plan assumptions. **CS** added that the system is reporting a forecast break-even position against the financial plan submitted but cannot currently provide assurance that this will be achieved. This is reflected in the fact that the total unmitigated risk reported at M6 is £101.5m.

CS highlighted the main areas of concern are escalation capacity (and cost) not reducing in line with plan; potential for unavoidable discharge costs to support SATH not becoming overwhelmed; under delivery of efficiency plans; significant pricing increases in prescribing and individual commissioning (CHC). In addition, at Month 6 the capital programme is underspending by £6.5m Year-To-Date but with a forecast to meet the plan by year end.

CS mentioned that there have been two rounds of discussions with CEOs, supported by task and finish groups and workshops to seek to reduce the forecast. Also, partner organisations have been refining their numbers with their respective committees. **CS** noted that the starting 'most likely' position of £157m had fallen so far to £149m. **CS** stated that work continues to get to the best position possible.

TMcM queried about ERF, **CS** responded that at the moment £2m of planned system income is at risk.

CS stated that the most likely position for the ICB was currently £35.7m though work is ongoing to map a route to a best-case scenario. She invited the other CFOs to share their position.

CM asked if we could enhance our reported numbers by splitting recurring and non-recurring spend and separating categories for income and expenditure. This was agreed as a helpful approach which **LC** agreed to pick up to enact with the other deputies.

***Action: LC** to pick up with deputies the suggested reformatting of reports.*

JG stated that the most likely position has been discussed at SCHT Finance Committee. their unmitigated risk was previously at £3.7m deficit but has since reduced to around £2.9m deficit. **JG** added, that through focus on agency and CIP, there was an aim to move to £1m deficit.

HT reminded the committee that there could be a potential knock-on impact on SATH if SCHT reduces or restricts the use of agency for services such as virtual ward or IDT.

PF stated that SCHT have a commitment to reducing agency spend and noted that this issue is a system wide issue.

GR flagged the need to see the recruitment plan and associated timeline for the Sub Acute wards as this is needed for the bed modelling. **JG** agreed to share outside of the meeting.

***Action: JG** to share with **GR** the recruitment plan and timeline for the sub-acute wards*

CM stated that there are continued pressures for RJAH, and they are currently adrift off their plan by £5.7m. The majority of the pressures are income driven. The majority of that is due to industrial action. **CM** added that there has also been a great impact of inflation on materials, services, and consumables.

TMcM queried whether they would be any potential funding to assist organisations. **CS** responded that there was an announcement some time ago for funds to support provider organisations over periods when there is industrial action and with inflation cost. But nothing has been confirmed nationally or from the region yet in terms of allocations.

HT stated SATH are currently forecasting between £105 - £115m deficit. This is predominantly due to the cost of escalation capacity and the cost of providing elective activity. **HT** added that SATH are currently working to reduce agency cost. It was noted that the priority was to reduce 'no criteria to reside' numbers and improve patient flow.

HT stated that she was confident in the recurrent position moving into next year, referencing for example the fact that all nursing vacancies are planned to be filled by February 2024.

PF queried whether work has been done currently for financial recovery for 24/25 and 25/26 for the financial recovery for the system. **CS** responded that work is being undertaken at a system level. PA consulting have been involved in that work. **CS** added that she intends to bring a paper to the next System Finance Committee (November meeting) on that area of work.

***Action: CS** to bring paper to the next meeting on Demand and Capacity Modelling.*

PF asked what happens to the deficit and what the future year recovery trajectory will look like. **CS** confirmed that the deficit incurred will need to be re-paid in future years as part of the recovery plan.

System Finance Committee noted the following:

- The M6 headlines for the system financial position (£74.5m Year-To-Date deficit, £33.9m adverse to Year-To-Date plan).
- That the system is reporting forecast delivery of the plan but with significant unmitigated risk of £101.5m. This is the subject of discussion with NHSE.
- That all organisations are working hard to develop phased plans to reduce or mitigate as much of the current risk as possible.

6.0 Minute No. SFC-23-10 .006 ICS Efficiency Update

Report received as read.

6.1 **GR** highlighted that the system efficiency plan was submitted as part of the financial plan on 4th May and has an overall target of £70m.

GR stated £18.7m of savings have been delivered against a year-to-date plan of £24.2m and therefore the system is reporting an adverse variance to plan of £5.5m. **GR** added that the main underperformance sits within SaTH (-£5.1m) and the majority of that slippage (£3.3m) directly relates to escalation costs.

GR emphasized in order to recover from this, actions are in place regarding accelerated discharge pathway, IDT Expansion and other core flow interventions which are being monitored weekly by system partners and overseen through the UEC Delivery group.

GR stated significant progress has been made to date towards meeting the unidentified stretch target and from the original £15m gap, £6.5m remains. 90.1% of total plans are now in delivery which meets the requirements set by NHSE. Work continues to identify further areas of cost savings to meet the unidentified stretch target and weekly meetings continue to take place to review every area of opportunity with additional savings being regularly captured into the forecast.

GR highlighted for SATH that system wide work to close the unidentified system stretch target of £3.5m was proposed mainly to focus on pharmacy savings. **HT** stated that SATH does not recognise a £3.5m additional for SATH, expecting the System to have delivered this and that SATH are focusing on delivering their internal CIP.

GR higjlighted further savings have been identified through medicines management and PBJC programmes this month, which have helped to reduce the unidentified in the ICB to £2.6 million.

The System Finance Committee noted:

- Month 6 efficiency delivery and progress made since May 2023 towards bridging the gap in the unidentified savings plans.
- The actions that are in place to reduce the unidentified savings further and risk associated with the remaining gap.

7.0 Minute No. SFC-23.10.007 ICS System BAF update

Report received as read.

7.1 **AS** stated that members of the System Finance Committee would have previously seen work on the Board Assurance Framework (BAF). Also, to note, the development of what we are calling the Strategic Operational Risk Register (SORR) which used to be called a corporate risk register.

Due to limited time at today's System Finance Committee, **AS** added that if anyone has any questions, she can pick them up off-line.

Action: *Questions/comments on the BAF/SORR to be sent to* ***AS***

The System Finance Committee:

a) Reviewed the current system BAF and SORR for system and ICB and consider if, for those risks falling within its remit:
   - any additional assurances are necessary that the risks to the strategic objectives, are being properly managed.
   - any additional risks or amendment to risks are required following discussions in the Committee meeting.

b) Will provide assurance to the Board for the risks that fall within the Committee's remit, that the principal risks of the ICS/ICB of not achieving the strategic and operational priorities have been accurately identified and actions taken to manage them.

8.0 Minute No. SFC-23.10.008 Any Other Business

8.1 There were no items raised as AOB. Meeting closed at 16.33.

Date and Time of Next Meeting

Thursday 30th November 2023, 2.15pm via teams via Teams.

NHS Shropshire,Telford, and Wrekin
ICB Finance Committee (Section 1) Meeting
Thursday 30th November 2023 at 1.00pm
Via Microsoft Teams

Present:

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

Attendees:

Laura Clare	Deputy Director of Finance NHS STW
Kate Owen	Head of PMO NHS STW
Cynthia Fearon	Corporate PA NHS STW (Note taker).

Apologies:

David Bennett	Non-Executive NHS STW
Gareth Robinson	Directory of Delivery and Transformation NHS STW

Minute No. SFC-23-11.001 – Introduction and Apologies

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

Minute No. SFC-23-11.002 – Declarations of Interests

2.1 No declarations of interest were noted.

Minute No. SFC-23-11.003 – Minutes from the Previous Meeting held on: 26th October 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-23-11.004 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-23-10.005 - ICB M7 Finance Overview

Report received as read.

5.1 LC highlighted that the month 7 year to date position is now a £16.4m deficit,

£8.5m adverse to plan. Issues reported in this position are similar to what has been reported all year

LC flagged that discharge spend with the LA above allocation is not factored into the ledger position but is reported as a significant risk for months 8-12. **LC** added discussions continue with the LAs regarding contributions to the funding gap.

LC highlighted that at Month 7 the elective recovery position has been reconciled with providers and local information demonstrates an overall 102% delivery year to date.

LC stated that the ICB is delivering its internal efficiency target but at month 7 reported that £2.2m of the original £5.5m non-recurrent system stretch target remained unidentified. Things have moved on since then and this will be reported in the efficiency section of the meeting.

LC added that the ICB reported £24m unmitigated risk to delivery of the financial plan at month 7 and continues to pursue additional mitigations. **LC** emphasised without further mitigations the current ICB forecast would be a £35.8m deficit for the year. Recent discussions have been had with Execs. and they are now estimating a revised best-case deficit of £25m.

CS mentioned that a weekly meeting has been set up with the ICB senior leadership team to specifically oversee delivery of the actions to bring the £35.8m most likely deficit down to £25m.

TMcM queried the impact of inflation on spend for the ICB. **LC** responded that the impact with inflation has been predominantly with CHC and prescribing. Other inflationary risk sits mainly with the provider organisations.

CS stated that detailed discussions around FOT 23/24 will be picked up in the confidential section of the System Finance Committee – Section One.

Action: LC to provide update on FOT 23/24 in the confidential section of the System Finance Committee – Section One.

The System Finance Committee noted:

- The M7 headlines for the ICB financial position (£16.4m YTD deficit, £8.5m adverse position to plan, forecasting delivery of plan but with significant risk)
- The key drivers of the risk presented and actions to reduce or mitigate those risks
- The level of unmitigated financial risk currently reported alongside the forecast position (£24m).
- That if the current unmitigated risk was added to the reported FOT this would give a position of a £35.8m deficit for the ICB for the year.

Minute No. SFC-23-11.006 – Efficiency Update

Report received as read.

6.1 **KO** mentioned that since the paper for this meeting was written, a further £1.3m schemes had been released from the pipeline into the ICB forecast. **KO** highlighted that significant progress has been made in reducing the unidentified gap which totalled £8m at the start of the year, The unidentified gap has now reduced to £2.1m and 92% of plans are 'identified and in delivery' which meets the requirements set by NHSE. However there remains a risk in meeting the outstanding total of unidentified plans. **KO** added that further pipeline plans are in development and have the potential to release an additional £1.8m of efficiencies in the remaining months of the year.

KO highlighted that at month 7 year to date, the ICB has delivered £13m of savings against a plan of £13.5m which provides an adverse variance of -£536k.

KO stated the variance against plan is due to a delayed start in the Optum programme within the Medicines Management team, non-delivery of savings so far through Value Based Commissioning (VBC) contract challenges and a delay in the delivery of unidentified efficiencies which were phased to deliver from Month 4 onwards.

KO added that mitigations are in place for each of these areas and it is expected that for both the Medicines Management and VBC challenges, delivery will catch up in the remaining months of the year. Each of the programmes are monitored carefully within their respective teams and updates are provided to the Sustainability Working Group on a regular basis.

KO stated that by month 12, it is hoped that the target position will be met.

CS stated that the stretch target was non-recurring in the plan for savings and the ICB are currently do better than anticipated in recurrent terms. Recurrent savings have been found to address some of the non-recurrent savings which will help the underlying run rate into next financial year.

TMcM queried whether any of the risks flagged, could potentially go backwards? **KO** responded that she couldn't currently see that happening. However, **KO** stated that there is a risk regarding meeting the running cost savings in-year though we are managing to report non-recurrent benefits.

TMcM flagged his uneasiness at the scale of risk in the ICB's financial position though recognised the hard work to mitigate issues in areas of concerns. He also noted that the other ICB non- executives were also well sighted on the FOT and the challenges to its delivery.

The System Finance Committee noted:

- Month 7 efficiency delivery and progress made since May 2023 towards bridging the gap in the unidentified savings plans.
- The actions that are in place to reduce the unidentified savings further and risk associated with the remaining gap.

Minute No. SFC-23-10.007 – Any Other Business

There was no other business for discussion under this agenda item.

Meeting closed at 13.26.

Date And Time of Next Meeting
Tuesday 23rd January 2024, 2.00pm via Teams.

NHS Shropshire, Telford and Wrekin
Integrated Care System Finance Committee (Section 2) Meeting
Thursday 30th November 2023 at 2.15pm
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
Chris Sands	Chief Finance Officer – MPFT
Sarfraz Nawaz	Non-Executive - RJAH
Mark Salisbury (Deputising for CM)	Operational Director of Finance – RJAH
Richard Miner	Non-Executive – SATH
Adam Winstanley (Deputising for HT)	Deputy Director of Finance, Operational - SATH

Attendees:

Laura Clare	Deputy Chief Finance Officer NHS STW
Kate Owen	Head of PMO NHS STW
Cynthia Fearon	Corporate PA NHS STW (Note Taker)
Chris Green	PA Consulting (part of meeting only)

Apologies:

David Bennett	Non-Executive Director NHS STW
Clair Young	Deputy Director of Finance - SATH
Ben Jay	Assistant Director of Finance – Shropshire LA
Peter Featherstone	Non-Executive SCHT
Helen Troalen	Director of Finance SATH
Craig MacBeth	Chief Finance Officer – RJAH
Gareth Robinson	Director of Delivery and Transformation NHS STW

1.0 Minute No. SFC-23-11.001 Introductions and Apologies

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

2.0 Minute No. SFC-23-11.002 Members' Declarations of Interests

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

3.0 Minute No. SFC-23.11.003 Minutes of the Previous Meeting held on: 26th October 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-23.11.004 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-23.11.005 - ICS M7 Finance Overview

5.1 **Report received as read.**

CS highlighted that at Month 7 the ICS has a deficit of £89m, which is £44.5m adverse to plan, a variation from in-month plan of £10.5m in M07.

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

CS highlighted that the system is reporting a forecast break-even position against the financial plan submitted but cannot currently provide assurance that this will be achieved. The total unmitigated risk reported at M7 is £91.7m. The main areas of concern are escalation capacity (and cost) not reducing in line with plan; potential for unavoidable discharge costs to avoid SATH becoming overwhelmed; under delivery of efficiency plans; significant pricing increases in prescribing and individual commissioning (CHC).

CS explained the System Chief Executives are overseeing work to describe the likely forecast position with delivery of actions being overseen with support from the system financial improvement director. **CS** added that a number of actions are being pursued to narrow the forecast range so that a position can be agreed with NHSE. All partners are pursuing additional mitigations to reduce the forecast to the lowest variance to plan possible.

CS stated that the System had received a recent letter from NHSE asking all systems to review FOT positions for a national submission on 22nd November and this is now currently being worked through at a system level. **CS** stated that the potential FOT for 23/24 will be discussed in the confidential section 2 of the System Finance Committee.

CS highlighted that at M7 the overall system capital position is £7.8m under planned expenditure (before any impact of IFRS16).

SN queried what was his role at this committee in his capacity as a non-executive director (NED). **CS** replied that she was happy to arrange for an induction meeting with both **SN** and **RM** after explaining that NEDs from our providers can play an important role in helping to provide assurance to the System Board. She also agreed to arrange to circulate the current governance structure and Terms of Reference for Information.

***Action: CS** to send terms of reference and headlines from the governance structure to **RM** and **SN**. **SN** and **RM** to request a 1:1 with **CS** if that would be of use.*

The System Finance Committee noted the following:

- The M7 headlines for the system financial position (£89m YTD deficit, £44.5m adverse to YTD plan).
- That the system is reporting forecast delivery of the plan but with significant unmitigated risk of £91.7m.
- That all organisations are working hard to develop phased mitigation plans to mitigate as much of the current risk as possible and agree a forecast position with NHSE.

6.0 Minute No. SFC-23-11.006 ICS Efficiency Update

Report received as read.

6.1 **KO** explained that the efficiency target for this financial year is £70m which is made up of a core CIP target of £47 million, a reduction in escalation costs of £10.5 million, and a system stretch target of £12.5 million.

KO stated that significant progress has been made in meeting the System Stretch target. and that currently, £90% of our plans are identified and currently in delivery, which was a requirement set by NHS England. **KO** added that at month 7 we are showing an adverse variance to plan of £ 7.7 million. Mainly due to the undelivered target from SATH. The main underperformance is within SaTH (-£7.1m) and the majority of slippage directly relates to escalation costs which have been previously reported. **KO** stated that RJAH are forecasting a position which is -£130k short of plan by the end of the year.

KO stated that £22.8m of savings have been delivered against a year-to-date plan of £30.5m. **KO** added that development of the pipeline of opportunities continues.

KO explained that actions are in place regarding accelerated discharge pathway, IDT Expansion and other core flow interventions which are being monitored weekly by system partners and overseen through the UEC Delivery group. **KO** added that each partner organisation oversees its own risk of business as usual (BAU) CIP delivery and updates are managed through local sustainability working groups. Monthly reporting is sent through to the financial improvement programme group where further actions are agreed if necessary.

AW stated for SATH, for their internal target, they are off target by £1.5 million off plan year to date. SATH currently have plans in place to address that. Regarding the System Stretch target for SATH, of £5.3 million, SATH have currently identified £1.7 million. **AW** added if there is anything else identified through the forecast outturn, they will include in the plan, to reduce the run rate.

RM asked if there was anything working well within other systems nationally that we could review so lessons can be taken for STW. **CS** stated that we do look at good practice and use the data to drive where to look for opportunities to become more efficient, effective, and drive costs out.

KO mentioned that she currently uses an online tool called 'Model Opportunities' to compare where we are at as a system to other systems. Any opportunities identified will be brought into our system wide group to set out how we can best work through those opportunities. **KO** stated that she was happy to go into more detail with **RM** outside of this meeting.

SN queried the percentage for BAU CIP. **KO** explained, the BAU CIP was initially at 2.2%**.** But as the scale of the financial challenge grew, it was increased to 3%. Plus, a stretch target was added on top of that. **CS** noted the combined value of that as 6.1% in total.

The System Finance Committee noted:

- Month 7 efficiency delivery and progress made since May 2023 towards bridging the gap in the unidentified savings plans.
- The actions that are in place to reduce the unidentified savings further and risk associated with the remaining gap.
- Efficiency forecasts are currently being reviewed by all partners in line with recent requirements from NHSE.

7.0 Minute No. SFC-23.11.007 Medium term finance and activity modelling

Report received as read.

[Chris Green from PA Consulting joined the meeting]

7.1 **CS** highlighted that full financial recovery for STW will require a multi-year programme to which we need to turn our focus urgently. **CS** reminded the Committee that at its meeting in October, a briefing paper was presented that outlined the work to be done on updating a system medium term financial plan that would interface with a demand and capacity model.

CS stated that it was agreed that the work on finance will be most robust when set alongside similar trajectories for activity and workforce. Therefore, PA consultancy group were engaged by the system to develop a robust demand and capacity model that links to workforce and finances and pulls in the Hospital Transformation Programme (HTP) modelling alongside the Local Care Programme.

This work is now nearing completion and is now in the handover stage.

A weekly group consisting of BI and finance leads across the system has been engaged with the external consultants throughout the process to co-design the modelling.

CG stated that the first cut model shows that there would be a £226m deficit by 2028/29 in a 'do nothing' scenario. A 2.2% BAU efficiency has been built into the model and the financial impact of known system interventions equating to approximately £144m across the 5 years, leaving a £122m gap that needs to be addressed through further transformational schemes. These figures are based on a start point of 23/24 plan and applying the system assumptions agreed for the August submission to NHSE. Next steps will be to update the model for:

- Agreed 23/24 forecast outturn positions with clear underlying position identified
- Review of all assumptions based on latest information, guidance and benchmarking available.
- Update of all cost pressures/investments for consideration
- Update of all efficiency and system intervention plans
- Development of additional transformation plans across the system to address the gap.

24/25 planning guidance has not yet been received and is expected at the end of the calendar year. The model will also need to be updated for the implications of that guidance.

RM queried how this model is validated against other systems and are there any particular features of our system that make us different to others. **CG** described the fact that this model is adaptable to local factors for example the hospital transformation work that is currently taking place.

SN asked what assurances can be given regarding the modelling work being a success, given the current track record of the challenges the STW are currently undergoing. **SN** added that he is keen to see how the work with PA consulting plays out but recognise at this stage - it is early days. **CG** responded that the model may not be able to give all the answers, but it will be a useful tool to explore some of the issues in a structured way.

ChrisS stated that there needs to be focus on the outputs (the 'so what') rather than the assumptions. He added that there is a danger, we still be in the same place in five years' time if we focus all attention on assumptions rather than actions.

CS stated that a strategic view needs to be taken when discussing the model, as it will take some time for things to play out. i.e.at least two to three years. We cannot put all attention into only looking at next year.

TMcM queried regarding the deficit position of the STW. What happens to it? **CS** replied that it would be part of the recovery plan to assume to pay it back as current rules do not allow for write off.

The System Finance Committee noted:

- The development of the model by PA Consulting Group
- The headline financial output of the model with all caveats and next planning steps identified.

8.0 Minute No. SFC-23.11.008 Any Other Business

8.1 There were no items raised as AOB. Meeting closed at 15.10.

Date and Time of Next Meeting

Tuesday 23rd January 2024, 3.15pm via teams via Teams.

Agenda Item

ICB 31-01-015.5

Strategy Committee minutes for meeting held on 8 November 2023

NHS Shropshire Telford and Wrekin
Strategy Committee

Wednesday 8 November 2023 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

In Attendance:

Dr Ian Chan	Clinical Director of TELDOC PCN
Julie Garside	ICB Director for Planning and Performance NHS STW
Edna Boampong	ICB Director of Communications and Engagement NHS STW
Gemma Smith	ICB Director of Strategic Commissioning NHS STW
Ben Rogers	Director of Psychological Services, MPFT
Jonathan Gould	Deputising for Sara Lloyd Director of Finance Shropshire Community Health Trust
Phil Morgan	Primary Care Workforce Lead Primary Care Workforce & Training Hub
Dr Ganesh Mahadeva	Interim Medical Director Shropshire Community Health Trust
Chris Green	PA Consulting
Jayne Knott	Corporate PA and Minute taker NHS STW

Minute No. SC-08-11.71 Introduction and Apologies:

71.1 The Chair opened the meeting of the STW Strategy Committee and welcomed everyone.

The following apologies were noted:

Nick White	ICB Chief Medical Officer NHS STW
Prof. Paul Kingston	Non-Executive Director, Robert Jones Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Liz Noakes	Director Health & Wellbeing Telford & Wrekin Council
Craig MacBeth	Finance Director Robert Jones Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Sarah Lloyd	Director of Finance Shropshire Community Health Trust
Claire Skidmore	ICB Director of Finance NHS STW
Claire Parker	ICB Director of Partnerships and Place NHS STW

Minute No. SC-08-11.72 PA Consulting – System Capacity and Demand

72.1 The Chair introduced Mr Chris Green from PA Consulting to the Committee members and asked him to give some background.

72.2 PA is supporting the system to develop an integrated financial and demand and capacity model to inform strategic planning.

72.3 Mrs Julie Garside commented that this was the first attempt at trying to join up in an integrated way our first step in our demand and capacity modelling.

72.4 The model will provide a unique opportunity:

- An MTFM that is underpinned by System assumptions including a System view on Demand & Capacity modelling.
- A flexible model that allows changes in requirements and assumptions and can run sensitivities to model the impact of uncertainty.
- The ability to isolate the impact of your planned interventions in a clear and concise way ensuring no double count.
- A recurrent baseline position recognised by providers.
- Produce outputs in a way that are recognisable and supported by System partners.
- Allow integration with further modelling at a System and Provider level.

72.5 Ultimately it will feed into strategic priorities:

- Align key programmes and schemes across the system e.g. HTP and LCTP
- Lay the foundation for establishing the financial gap and planning solutions to this.
- Support as a system, to make the difficult decisions required to deliver a financially balanced medium-term plan.
- Support to exit NOF 4

72.6 The Chair asked if PCNs had been involved in the modelling?

72.7 Mrs Garside stated that the work was just being undertaken with acute and community with primary care being one of the phases in the future.

72.8 Mr Peter Featherstone commented that this piece of work was welcomed, and asked Mrs Garside to clarify the scope in terms of the activity modelling going forward i.e. 2-5 years or ask PA Consulting to go up to 10 years?

72.9 Mrs Garside commented that it was the medium term that was being focussed on, but this could be expanded on.

72.10 Dr Ian Chan stated that there was a need to map out demand and capacity within general practice.

72.11 Mrs Garside said that primary care was not in a position where we can model demand and capacity yet, but there was commitment to add this to the model.

72.12 Mr Nigel Lee commented that as this system model builds on the version, that is in place for HTP, and would agree that having a system-owned, flexible model that allows us to add in several assumptions that gives maximum value.

72.13 Mr Lee also added that he had concerns around social care- pathway 1, 2 and 3 and to make sure that the community-based capacity is counted not just the bed-based capacity.

72.14 **Next steps**
As we move forward for the initial plan draft PA Consulting will work us as a system to.

- Ensure clear links between Activity and Finance, co-ordinated through Demand & Capacity and Technical Model working groups.
- Capture specific efficiency overlays, through liaising with named owners, facilitating the production of first cut model outputs (including the size of the financial gap).
- Set out areas of focus for future phases that will add most value.

72.15 Mr Lee commented that this was a vital component of our Joint Forward Plan as a system and underpins the of work that is being done across the range of different objectives.

72.16 The Chair stated that 90% of patient contact the NHS is through GPs, who only spend 10% of the budget. The Chair said it was important that as part of this work we need to ensure that primary care and PCNs who are close to place really feature.

72.17 The Chair wanted asked for clarification around this piece of work and was to be an enabler of the six clinical priorities or is it a stand-alone piece of work and said that primary care should be a major factor in this.

72.18 Mrs Garside said that we need primary care to work with us as there is a huge amount of preparatory work needed with both PCNs and at practice level.

72.19 Dr Chan commented that general practice capacity is not visible in the system and must be one of the main focuses of this piece of work.

72.20 Ms Rachel Robinson commented that this piece of work was supported and critical to build population health into it.

72.21 Mrs Garside confirmed that population projection was built into the plan.

Minute No. SC-08.11.73 Minutes and action list from the meeting held on 11 October 2023

73.1 Minutes were approved as an accurate record with the exception that Mr David Brown had sent his apologies, and these had not been noted in the minutes.

73.2 Actions List
All actions noted as on-going or closed.

Minute No. SC-08-11.74 Declarations of Interest:

74.1 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.

There were no further conflicts of interest declared.

The Register of Board Members Interests can be found at: Register of Interests - NHS Shropshire Telford and Wrekin (shropshiretelfordandwrekin.nhs.net)

Minute No. SC-08-11.75 STW General Practitioner (GP) Strategy 2023/24

75.1 Mr Phil Morgan presented the item and highlighted the following:

75.2 In July 2022 the STW Primary Care Commissioning Committee approved the first version of the STW ICS GP Strategy. This Strategy was developed in response to the continuing pressures on the STW GP workforce and the need to focus on the recruitment and retention of GPs across the local system.

75.3 Since the first version of this Strategy was published in 2022 three developments have led to the need for a refreshed version:

- The publication of the NHSE Long Term Workforce Plan
- The completion of a series of surveys to inform the refresh of this Strategy covering: Medical Students, Foundation Year Doctors, GP Trainees, Qualified GPs and Practices as Employers of GPs
- The recruitment by STW ICS of a Team of GP Leads

75.4 An Action Plan has been developed designed to ensure implementation of the GP Strategy. The Action Plan contains a series of Actions, grouped around the six themes above. For each Action, the Plan identifies:

- which of the Intervention Stages the action is addressing
- the Priority of the action
- which person or organisation has overall Responsibility for delivering the action
- the ideal Timescale for the action to be delivered.
- how success in delivering the action is to be Measured

75.5 Based on the findings of the surveys, and subsequent consultation with key stakeholders, the ICB Primary Care Team is confident that the Strategy addresses the key issues and challenges facing the STW GP cohort.

75.6 The Action Plan is ambitious in scope and timescale, but the Primary Care Team is confident that, by working with the GP Leads Team, it is possible to make significant progress against the actions set out in the plan.

75.7 Mitigating against this are the capacity constraints within the Primary Care Team and the non-recurrent nature of the funding for the GP leads.

The Strategy Committee is asked to.

Approve the STW ICS GP Strategy and to receive updates on progress against the Action Plan.

The Strategy Committee were happy to approve the GP Strategy 2023/24 on the condition that there is a risk log attached to the joint forward plan.

Action: Mr Phil Morgan to develop a risk log for the GP Strategy and cross reference against the key aspects of the joint forward plan.

Minute No. SC-08-11.76 Outputs from the Big Conversation

76.1 Mrs Edna Boampong introduced the presentation and highlighted key points.

76.2 In February 2023 the Big Health and Wellbeing Conversation was launched to help us understand what is affecting health and wellbeing and what would help us to improve the experiences of local health and care services.

76.3 To gather the views of the local community and stakeholders, a series of public events, focus groups, stakeholder events and an engagement survey.

76.4 Public were concerned about accessing services, appointment availability, and awareness of services.

76.5 Key themes from the targeted events:

- Consider the need to support patients while they are on waiting lists.
- Consider the need for easier access to information about patients' own health.
- Consider focusing more on mental health services.
- Concerns over the lack of provision of services locally
- Face-to-face care is required for better diagnosis of certain conditions.
- Consider improving communications between services.
- Concerns over the difficulty of getting appointments with GPs.

76.6 Improvements are required around staff retention and collaboration between providers and accessing health services.

76.7 Out of all primary care services, GP services users have the most varied experiences.

76.8 Proportionally more respondents rated their experience of Royal Shrewsbury Hospital and Princess Royal Hospital negatively.

76.9 Reasons for negative rating:

- Concerns over appointment waiting times.
- Poor quality of care
- Concerns over the recruitment and retention of staff, and their attitude towards patients
- Lack of car parking availability
- Concerns over poor communication

76.10 Most community services are rated positively. Reasons for negative rating.

- Difficulties getting appointments and long waiting times.
- Poor quality of care

- Concerns around staff attitude and quality of service (e.g. attending appointments late)
- Concerns around the lack of home visits
- Lack of community screening services
- Concerns around limited grants for wheelchair services

76.11 Opinions are split on the use of technology to access health and care services.

76.12 GPs are considered the best people to provide advice and guidance on self-care and how to make lifestyle changes.

Action: The Chair suggested Mrs Boampong bring this item back to the Committee meeting in January for further discussion.

Minute No. SC-08-11.77 MCAP updates

77.1 Mrs Julie Garside updated the Committee on the following.

77.2 There are two stands of work taking place, one is the individual work with providers and working with ShropComm to validate the opportunity for the virtual ward and using the findings of MCAP to help quantify that, but more help is needed from the Clinical Advisory Group to make a decision on that cohort.

Action: Mrs Garside to give fuller update in January.

77.3 **Items for the agenda on 10 January 2024**

- Digital Strategy progress update
- Strategic Commissioning intentions
- Local Care and Transformation Programme and PCN mapping
- Follow-up from the Big Conversation

77.4 It was agreed to have Mental Health on the agenda on 14 February 2024

Minute No. SC-08-11.78 Any Other Business

78.1

Date and time of next meeting: Thursday 10 January 2024 at 2.00pm

Agenda Item

ICB 31-01-015.7

Primary Care Commissioning Committee minutes for meeting held on 6 October 2023

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

NHS Shropshire, Telford and Wrekin
Primary Care Commissioning Committee Part 1 Meeting

Friday 6 October 2023 at 9.30 a.m.
Via Microsoft Teams

Present:

Mrs Niti Pall	**Non-Executive Director (Chair)**
Mrs Claire Skidmore	**Chief Finance Officer**
Mr Gareth Robinson	**Executive Director of Delivery & Transformation**
Mr Roger Dunshea	**Non-Executive Director (Acting Chair)**

Attendees:

Ms Emma Pyrah	**Associate Director of Primary Care**
Dr Ian Chan	**Primary Care Partner Member**
Mrs Janet Gittins	**Partnership Manager**
Mr Alec Gandy	**Partnership Manager**
Ms Jane Sullivan	**Senior Quality Lead**
Ms Sara Edwards	**Lead & Programme Manager, Training Hub**
Mrs Bernadette Williams	**Primary Care Lead for Contracting & Delegated Commissioning**
Mrs Vanessa Barrett	**Chair, Healthwatch Shropshire**
Mr Simon Fogell	**Healthwatch Telford & Wrekin**
Mrs Chris Billingham	**Corporate PA; Minute Taker**

Apologies:

Mr Simon Whitehouse	**Interim Chief Executive Officer, NHS STW**
Mr Nick White	**Chief Medical Officer (Deputy Chair)**
Dr Julian Povey	**Primary Care Partner Member**
Mrs Julie Garside	**Director of Planning & Performance**
Ms Claire Parker	**Director of Partnerships & Place**
Ms Angharad Jones	**Finance Business Partner**

Minute No. PCCC 23-10.52- Apologies for Absence

1.1 Apologies received were as noted above.

1.2 Dr Pall had intimated that she would be late joining the meeting. Mr Dunshea had agreed to Chair the meeting.

Minute No. PCCC 23-10.53 – Members' Declarations of Interests

2.1 Members had previously declared their interests, which were listed on the ICB's Register of Interests and were available to view on the website at:

Register of Interests - NHS Shropshire, Telford and Wrekin (shropshiretelfordandwrekin.nhs.uk)

Minute No. PCCC 23-10.54 – Minutes of Meeting held on 4 August 2023

3.1 The minutes of the meeting held on 4 August 2023 were approved as a true and accurate record of the meeting.

Minute No. PCCC 23-10.55 – Actions Raised from Previous Meetings and Matters Arising

4.1 The Action Tracker was reviewed and updated as appropriate.

Minute No. PCCC 23-10.56 – Changes to Primary Care Commissioning Governance

5.1 Mr Dunshea advised that this topic is part of the wider governance review being undertaken by the Good Governance Institute (GGI). Work is also being carried out within the Executive team. He suggested that the paper presented to the Committee should be for comment only at this stage. Any explanatory information would be helpful, but no firm decisions can be taken until the findings of the GGI review and the Committee structures going forward are known.

5.2 Mr Robinson summarised the history of this topic, which dated back to October last year, and was led by Mr White. The GGI work took place in parallel with this, rather than this being contained within it. He and Mr White prepared a paper in conjunction with Dr Pall. As a consequence, a range of questions were raised, particularly by Dr Povey. In the absence of Dr Povey and Dr Pall at today's meeting Mr Robinson suggested that this was an opportunity to discuss rather than approve.

There is an opportunity for this to accelerate before the GGI findings because some of the actions to be taken don't necessarily need to wait for the over-arching governance review. However, as part of this discussion, we can ensure that Mr White aligns with the GGI to ensure that none of our decisions conflict with any recommendations they may make.

5.3 Mrs Barrett expressed concern that the patient voice was not included in these important debates, particularly within the Part 2 Agenda relating to transformation and development discussions. She had placed in the Chat a link to the report on access to dentistry undertaken by Healthwatch several years previously. Healthwatch also receive many comments about community pharmacy, and she believed that it would be useful for the ICB to formalise having the patient voice in those discussions going forward.

5.4 Mr Robinson advised that the background to this topic is primarily about making sure that we do have the voice of Primary Care with its delegated arrangements for pharmacy, optometry and dentistry and making sure that that voice is clearly heard by the Board.

However, he and Mr White had concerns that because of performance pressures and the way the governance structure of the system has been set up, the focus of the Board may be directed towards other areas.

In parallel with that, the focus nationally around the Primary Care access recovery programme could mean that, if governance of that programme of work lies within the PCCC, the impact of that could have been diluted given the breadth of scope that this Committee covers. As a consequence, Mr White, Ms Pyrah and I designed the structure outlined within Appendix 1 on Page 4 that effectively breaks down the component parts of the Primary Care commissioning agenda and work plan into three areas.

- A new Board - the Primary Care Improvement & Transformation Board - which would absorb the GP Access Recovery Plan, wider transformation, and oversight of Pharmacy, Optometry and Dentistry.
- Core commissioning and contractual decisions which are PCCC statutory obligations would be delegated to the ICB Commissioning Working Group which would then be consistent with commissioning arrangements for areas outside of Primary Care across the broader ICB.
- Strategic developments and plans would sit under the ICS Strategy Committee and give them a much clearer voice within the strategic direction of the ICB.

5.5 The Primary Care Improvement & Transformation Board is a new Board that echoes the national programmes of work and has beneath it the seven work programmes that sit within the national plan. That would then report into both the Regional Primary Care Board and the Integrated Delivery Committee on the same level of focus and direction as the Urgent & Emergency Care and Elective Care financial improvement programmes and set the Primary Care improvement agenda at Board level oversight and scrutiny.

5.6 The Primary Care Improvement & Transformation Board would oversee the delivery, improvement and transformation work and provide direct insight into the Integrated Delivery Committee which provides transparency to the Board; Primary Care contractual and commissioning decisions would be made by the Commissioning Working Group; and strategic development and planning would sit within the ICS Strategy Committee which would allow better alignment with the Joint Forward Plan and the medium term Financial Plan.

5.7 Mrs Skidmore expressed concern as to whether the document had been socialised prior to submission to the Committee and made the following points: -

- Had the proposals been discussed with Alison Smith, ICB Governance Lead? It is very important that we look at this from the viewpoint of Primary Care, but it must fit with the bigger picture in terms of overall governance. If we are proposing to change what is currently a sub-Committee of our Board, that has to have Board sign off and ultimately it also has to be agreed by NHS England.

- The proposal places a reliance on the Commissioning Working Group that it does not have at the moment and requires a fundamental change to that group. It is no longer a working group and that has been part of the discussions with GGI.

It needs to be more than that when we consider the burden being placed upon it in terms of accountability and sign-off, not just for Primary Care but for other areas. We cannot make the change to this part of the governance here in this Committee without making sure that the rest of the governance around it is ready to receive it.

- In relation to the Transformation and Improvement Board, the sub-structure underneath it contains a subset for Gemma Smith around self-referral pathways which I am not sure she is aware of. My suggestion would be that each of the subgroups should be tested. We must make sure that the correct information is being fed into the decision making.

- In relation to testing the proposals, I could not see any reflection in this paper about whether that generates any additional work in terms of administering the meetings, report writing, etc. I think that is particularly important given our move into ICB 3.

5.8 Dr Chan queried how the GP Board would fit into the governance structure. He also queried how, with information feeding into different Committees, those Committees would communicate with each other.

5.9 Mr Robinson provided the Committee with Dr Povey's comments as follows: -

- Dr Povey was broadly supportive of the principle behind the proposals within the paper but was concerned that despite the aim around this being to increase the presence of Primary Care on the Board agenda, this might actually dilute it.

- He was concerned that this would weaken the non-Executive members' oversight of Primary Care.

- He was concerned that there is a risk that the transformation reporting into the IDC gives a signal that we are trying to manage our way out of transformation as we deal with our providers rather than actually allowing Primary Care to lead transformation.

5.10 Mr Robinson believed that the paper had been submitted to PCCC too soon. It clearly had not been socialised enough because a range of issues had been raised that had not been fully thought through.

ACTION: Mr Robinson and Mr White to review feedback received and work on socialisation of the paper.

5.11 Mr Robinson made further points: -

- He did not believe that a conclusion had been reached as to where the GP Board structure sits within governance other than a sub-committee of the Local Medical Committee (LMC) and that discussion must take place before the role of the GP Board within this structure is established.

- Resourcing is an issue. Whatever structure is chosen for ICB 3 more resource and focus is required within Primary Care to deliver the huge agenda and to bring it onto a par with Urgent and Emergency Care and Elective Care.

- Mr Robinson was mindful of Dr Povey's question as to whether this dilutes the voice of Primary Care and the Board, as opposed to enhancing it, which is the ultimate purpose.

ACTION: Mr Robinson to review Dr Povey's feedback with Mr White and Ms Pyrah.

5.12 Mr Fogell echoed Mrs Barrett's comments regarding patient voice and questioned what responsibility and accountability there will be when so many different areas of care and decision-making report to different places. He believed that they should all report into one place.

5.13 Mr Dunshea summed up the discussion as follows: -

- This is clearly work in progress.
- Further consideration needs to be given to delivery and the role of Primary Care as to how that profile is managed and taken forward bearing in mind that Podiatry, Optometry and Dentistry (POD) professionals are joining in that process. Community services and social services are also part of Primary Care and that should also be an important aspect of this. As part of that, those integration pathways are hugely important to Primary Care because Primary Care clinicians cannot work in isolation - they have to work in partnership with other professions.
- The points raised about patient voice is also part of that process to make sure the input is there to meet the needs of the community.
- This is a hugely complex area upon which progress is required, but we must also ensure that the governance arrangements are in place.

5.14 Mr Dunshea asked Mr Robinson and his colleagues to advise the Committee as to the future plan for the development of this approach on Primary Care.

Minute No. PCCC-23.10.57 – GP Occupational Health Service – Direct Award of Contract

6.1 Nuala Woodman from the Office of the West Midlands advised the Committee of updates which were subsequent to preparation of her paper.

6.2 There is currently no occupational health service in place. Discussions are taking place with a provider although it is proving more difficult than anticipated.

6.3 The situation had arisen for two reasons.

The interim provider – the Royal Wolverhampton Trust - has unilaterally ceased providing services. This situation does not just affect Shropshire, but also Staffordshire.

The joint commissioning group for pharmacy, optometry and dentistry were not prepared to pay for the element relating to Medical Directorate responsibilities.

Clarification has been received from the national team that responsibilities relating to the performers list (mainly the GPs and dentists but also some opthalmic performers) are the responsibility of the ICB. Work is being carried out with the national team to rewrite the specification.

6.4 The potential provider is Optima Health or TP Health which is known as Team Prevent. They currently provide services to some of the health community in Staffordshire and have a site in Stoke-on-Trent. The possibility of a site in Shrewsbury is being investigated but there may be additional costs related to this. There is an element that we are responsible for funding which is predominantly the provision of health services to the performers on the performers list. However, responsibility for paying for most of the personnel who are employed through Primary Care sits with the Practices. We are responsible for commissioning a service that they can use.

6.5 All of the providers consulted with were unwilling to invoice the contractors direct. They have now agreed that there could be a facility to do that but there would be a significant additional cost. The possibility of invoicing contractors internally has been investigated but there is currently no capacity to do that. It would mean employing someone to administer re-charging to Practices.

6.6 It has been established that, should agreement be reached, this new provider could mobilise services fully from 1 December 2023.

6.7 We are still in discussion with another private provider.

6.8 Shropcom, who used to provide the service, disbanded their team.

6.9 The Chair observed that as an ICS we should have one central occupational health contract for the whole organisation – GPs, hospitals, community services, etc. - and recommended that, if possible, we should be seeking an ICS-wide contract.

Ms Woodman left the meeting.

Minute No. PCCC-23.10.58 – Asylum Seeker Update

7.1 Mrs Williams highlighted key points of her report: -

- There are approximately 350 asylum seekers in Shropshire Telford & Wrekin who all have access to General Practice in their local area and are now registered patients. It is a national requirement that an initial health check is provided for asylum seekers.

- One of the key areas is around screening for tuberculosis as there is a high prevalence rate in countries from where they originate.

- The ICB receives funding for the health checks. A service specification is in place, and £150 is paid per health check. However, due to changes in the way in which that funding is allocated by NHS England, there is going to be a cost pressure. However, that will not be known until details of our allocation are received in October.

- Our local T.B. service is not adequately resourced to deal with that additional demand.

7.2 Mrs Williams invited questions.

7.3 Mr Dunshea referred to the long-term cost implications in terms of funding streams, asking if they were fully understood.

7.4 Mrs Skidmore confirmed that there was a long-term implication because often when people arrive in this country, they have health and social care needs which go far beyond a health check. Once they are registered and part of our population, that would be built into our cost base.

7.5 The point regarding TB services is an important one because we have historically had quite low prevalence, which is increasing. The Finance team are currently mapping our priorities and TB is one of those priorities.

7.6 Mr Dunshea referred to the prognosis of an overspend occurring in this particular area and requested clarification of the intended course of action.

7.7 Ms Pyrah advised that we must await the allocation which is based on the number of asylum seekers. Primary Care colleagues will then work with the Finance team to try to find an unallocated source of funding in another area of the Primary Care budget.

Minute No. PCCC-23.10.59 – Prioritisation Process for PCN Estates Strategy Capital Programme

8.1 Ms Pyrah advised that she and her team are coming towards the end of a piece of work which was commissioned and funded nationally to work with the PCNs to develop a Workforce and Estates Strategy. This is now near completion and, once finished, the information will be collated into a Primary Care ICB Estates Strategy which would then feed into the ultimate ICS Estates & Infrastructure Strategy.

8.2 The ICB currently has no access to any NHS capital. However, the requirement within those PCN estates strategies for capital investment will be significant therefore as a committee we will require some form of prioritisation process in order to inform our decision making and communicate that rationale to other providers, other Practices, and our public as we will not be able to fulfil all the requirements at the same time.

This is a proposed process for which we are seeking Committee's approval.

8.3 Mrs Skidmore referred to the prioritisation matrix contained within the paper and queried whether it meets the requirements of Practices, aligns with the strategic intent of the system, and supports us in delivering those areas of our clinical and strategic ambitions. She believed that more consideration needs to be given as to how it fits in that broader process and decision making.

She also suggested discussing the process at Senior Leadership Team (SLT) as Dr Garside had been working on the prioritisation framework.

8.4 Ms Pyrah voiced her agreement with that suggestion which needed to be linked into the work that Mr Robinson was commissioning to inform the infrastructure for the ICB / ICS.

Dr Pall joined the meeting at 10.25 a.m. Mr Dunshea continued to Chair the Committee.

8.5 Discussion took place regarding the link with the broader strategy. Mr Robinson advised that development of the ICS Estates Strategy is now commencing and must be completed by March 2024. He intended to create a formal working group which includes all of the Estates Leads for each of the providers. The Estates Strategy must drive the Joint Forward Plan and our longer-term clinical strategies into what we need from our Primary Care.

8.6 Mr Dunshea made the following observations and suggestions: -

- To try several previously approved projects as they can reveal interesting learning points.
- Whether there is an option in the criteria around integration with other services - GP surgeries as an example - and whether that thinking was possible with regard to either community NHS services or social services.
- This now needs to go forward to the next stage.

Minute No. PCCC-23.10.60 – Practice Patient Participation Group Audit and Improvement Action Plan

9.1 Mr Gandy highlighted key points within his report.

- 14 Practices have been identified that currently do not have a PPG. As a consequence, a review was carried out of all 51 Practices.
- Support will be provided to the 14 that do not have a PPG. Some of the reasons for that have been identified.
- 5 Practices are either struggling or are not getting a suitable experience from membership of a PPG therefore the next workstream is to work with those Practices to avoid the PPG being disbanded.
- A pack was sent to all of the Practices to support and encourage PPGs.

9.2 Discussion took place regarding the difficulties of running PPGs.

Managing the correct mix of patient is very difficult. Most of the time only a very few patients are interested, and the majority are from the older population. Younger patients are less interested in engaging. It needs to be recognised that PPGs are difficult for GPs to run - particularly after the pandemic - and that needs to be factored into the plans to improve the uptake rate.

9.3 Mr Dunshea thanked Mr Gandy for the good progress achieved so far and looked forward to the next update.

Minute No. PCCC-23.10.61 – Finance Report

10.1 The Finance report described the position at Month 5.

10.2 Delegated figures both for GP Primary Care but also pharmacy, opthalmology and dental services are as expected, and are forecast to be as expected at the end of the year.

However, increasing pressures are being seen on prescribing budgets and the Finance team have been working with Mrs Walker and the Prescribing team to try to understand what is driving the forecast to increase in the way it has, particularly into the Month 5 numbers.

10.3 There are very common numbers to all systems in terms of growth, particularly between last year and this year. However, Month 6 information is now being received which includes new data. Whereas at Month 5 the position seemed to be increasing quite significantly, there are now factors in more recent information that would suggest that that forecast line may be suppressed. A level of overspend is still anticipated on prescribing, particularly attributable to some of the national issues around cheaper stock alternatives and category M pricing, but the pattern of expenditure seems to be settling.

10.4 Additional information has been provided within the report on that prescribing issue which hopefully addresses some of our actions to provide more activity data.

10.5 The delegated budget is currently on track and there are no material issues to flag.

10.6 The Chair invited questions.

10.7 Dr Pall referred to the prescribing issues and would like the Committee to see the mitigation around that. She also wished to see how Practice Pharmacists or Primary Care Pharmacy is working alongside these prescribing issues.

10.8 Mr Robinson reported that the Primary Care team and Medicines Management team have successfully driven financial improvement values. He believed that more could be done, but the constraints are two-fold.

The availability of analytical resource to provide data, and stronger links between the Medicines Management team and the direct relationship with our GPs. We have recently asked for Mrs Walker to be a member of the LMC and the GP Board to increase that dialogue between both as that data is very important.

ACTION: Mr Robinson and Mrs Walker to consider how prescribing information can be reflected into this Committee.

10.9 Dr Pall referred to practical implementation. Her past experience was that it required implementation of practical steps at a Practice level to influence consulting decisions and prescribing costs, such as low-cost medicines and changing from one brand to another. The PPGs were also included in how those large-scale changes were made and how they were conveyed.

10.10 Mr Robinson will ask Mrs Walker to brief Dr Pall regarding Medicines Management and current arrangements that are in place.

ACTION: Mr Robinson to ask Mrs Walker to brief Dr Pall regarding current arrangements around improving prescribing costs in place within the Medicines Management team.

10.11 Dr Chan believed that there are a number of steps that can still be taken to improve the position and suggested that Medicines Management should also look at data around de-prescribing.

Minute No. PCCC-23.10.62 – Workforce & Training Hub Report

11.1 Mrs Edwards' report was taken as read. The report was written to provide an overview of the workforce figures and activities supporting Primary Care workforce and the slight changes in workforce data, highlighting the change in the landscape in the last 8 years. There are now a lower number of GPs, and the change in landscape means that we have other professions increasing in place.

11.2 Mr Dunshea asked the role of a Physician Associate and Nurse Associate within General Practice.

11.3 Mrs Edwards advised that a Nurse Associate is between a Healthcare Assistant and a fully registered nurse. A two-year course of study is undertaken to become a registered professional. They can perform many activities of a General Practice nurse and can then go on to become a Registered Nurse.

11.4 Dr Chan advised that Physician Associates are individuals who must have a First degree in a science subject before they can apply for a post graduate course at Master level to become a Physician Associate thus enabling them to consult with patients and make diagnosis.

The role is recognised by the Royal College of Medicine, but currently it is not fully regulated. There is currently no regulatory body as such, but it is planned that they will be fully regulated under the GMC.

Physician Associates are supervised by a GP. They currently do not have prescribing rights, nor do they have any rights to request imaging but that will also be changing soon. Physician Associates also work in hospitals.

Minute No. PCCC-23.10.63 – GP Access

Recovery Plan

12.1 Ms Pyrah's report provided an update as to how the team working with the PCNs and Practices are co-ordinating all of the elements required for a system GP Access Improvement Plan to be submitted to Board in November.

12.2 In the report, three areas were highlighted where the Rag Rating is Amber. That relates to self-referral where the asks in the Long-Term Plan around the six or seven pathways being delivered by September will not be achieved. Gemma Smith, the Lead for self-referral pathways, has provided a schedule of when those dates will be achieved. It is likely be 2024 rather than this financial year.

12.3 One of the major challenges is for Practices and PCNs to engage with the local and national improvement support offers because of the huge capacity resource required for them to be released from front line services in order to participate in 13 or 26 weeks of national support. The numbers currently on the programme are quite small but it is anticipated that those numbers will improve over time.

12.4 The draft plan will be socialised this month and taken to GP Board, TWiPP and SHiPP to give wider stakeholder partners an opportunity to input before the final version is taken to Board at the end of November.

12.5 One key area outstanding that requires more work is the trajectories on improvement and how that will be measured. That is a piece of information that is still outstanding from the PCNs and Practices.

They must also advise the Primary Care team what they intend to spend their funding on as there is a requirement nationally that the ICB is assured that the trajectories are achievable, measurable, and that the money is being used for the purpose it is given. Consequently, as part of the audit of PCNs and how they spend their funding, they have been asked for a line-by-line schedule of expenditure to enable the Primary Care team to cross-check - when there are multiple funding streams - that PCNs are only receiving funding for one area rather than for multiple resources.

The capacity in the Primary Care team to do anything more in-depth and the capacity of the PCNs to accommodate that is the limiting factor on the degree of audit possible.

12.6 Variations exist between the PCN plans. The larger PCNs have used their funding to explore carrying out pilots. For example, Shrewsbury PCN are piloting what they call a Winter Illness Service which covers illnesses that do not need continuity of care. Others are focussing very much on digital elements and communication.

12.7 The meeting discussed the role of the GP Board. Ms Pyrah advised that they do not have a role in terms of actual oversight of delivery but are involved by having the opportunity to input to the draft plan before it is taken to the November Board.

ACTION: Ms Pyrah to circulate the TOR of the GP Board to members of the Committee.

Performance Data

12.8 Mr Gandy advised that the performance report and the performance data will look very different in future.

12.9 The data is very much focused on Covid. We now need to start reviewing the actual performance of Primary Care going forward on a month-by-month basis.

12.10 The main points of the report were: -

- Appointments are still increasing.

- Pharmacy service referrals are also increasing. They were slightly less than in previous months but over the last 12/15 months, referrals to Pharmacies are very good.

- In the future we will drill down into Primary Care and Practice performance.

12.11 Discussion took place regarding the large variance between the number of GP appointments per month compared to the number of appointments carried out by the community pharmacy consultation service and the reason why the number of community pharmacy appointments were so small. Mr Gandy advised that the Primary Care team is trying to engage with Practices to improve the referral rate to that service.

12.12 Patients' perception can be an issue. Many patients want to see a GP and do not want to be referred to the Community Pharmacy service.

12.13 Dr Chan believed that the referral rate was affected by a number of factors, including the lack of pharmacists in local pharmacies.

Minute No. PCCC-23.10.64 – Risk Register

13.1 Ms Pyrah's report was provided for information.

13.2 The report highlighted a new risk that General Practice will not receive any winter monies for additional same day appointments this year. Only a very small amount of money was available to the system – just over £600k – and £3.7 million provider bids were received.

Minute No. PCCC-23.10.65 – Primary Care Team: Work Programme Progress Report

14.1 Mr Dunshea suggested that this report should be discussed as part of the main Agenda as it contained certain themes which could be highlighted for concern and discussion and could warrant being heard by the Committee in a more formal way as opposed to purely for information. If concerns exist relating to performances below the required level, the Committee must have a discussion around those concerns to provide assurance and actions to mitigate them.

Ms Pyrah confirmed that if the Committee wished to receive deep dive reports into specific areas, that information could be included in the report.

Minute No. PCCC-23.10.66 – Any Other Business

15.1 There was no other business. However, Dr Pall asked Mr Dunshea to Chair the Part 2 meeting as she was not in an appropriate location to Chair the meeting.

15.2 Mr Fogell asked whether Healthwatch were usually admitted to the Part 2 meeting. Mr Dunshea advised him that they were expected to leave as Part 2 was predominantly commercial discussions and limited to non-Executive Directors and ICB officers.

The Part 1 meeting closed at 11.05 a.m.