Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Appendices

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MOU between the ICB and NHSE

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Memorandum of Understanding NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS England

01 September 2022

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1. Introduction

Integrated care systems (ICSs) are partnerships of health and care organisations that come together to plan and deliver joined up services and to improve the health of people who live and work in their area.

The four key aims of an ICS are to:

- improve quality of services and outcomes in population health and healthcare
- tackle inequalities in outcomes, experience, and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

Collaborating as partners in an ICS will help health and care organisations tackle complex challenges, including:

- improving the health of children and young people
- supporting people to stay well and independent
- acting sooner to help those with preventable conditions
- supporting those with long-term conditions or mental health issues
- caring for those with multiple needs as populations age
- getting the best from collective resources so people get care as quickly as possible.

Shropshire, Telford and Wrekin ICS is led by both an Integrated Care Partnership (ICP) and an Integrated Care Board (ICB). The ICP is a statutory joint committee bringing together all system partners to produce the ICSs integrated care strategy. The focus of this MOU is with the ICB as the statutory body with responsibility for NHS functions and budgets.

2. Purpose of this agreement

This MOU is between the NHS Shropshire, Telford and Wrekin Integrated Care Board, and NHS Midlands region, on behalf of NHS England. It is effective as of 01 September 2022. It sets out:

- the principles that underpin how the ICB and NHSE will work together to discharge their duties to ensure that people across the system have access to high quality, equitable health, and care services
- the delivery and governance arrangements across the ICB and its partner organisations
- how NHSE, the ICB and NHS partner (foundation) trusts will work together to implement the requirements set out in the NHS Oversight Framework taking into consideration local delivery and governance arrangements, risks and support needs
- how the ICB and NHSE will work together to address development-specific needs in the ICS and across the region.

This MOU is not a legally binding agreement, and it does not change the statutory roles and responsibilities or functions of either party. NHSE will continue to exercise its statutory role and powers in relation to regulatory action under legislation, including to address individual organisational issues in line with the principles set out in this MOU. The accountabilities of individual NHS organisations also remain unchanged.

In particular, it is noted that:

- this MoU does not delegate functions from NHSE to the ICB or vice versa
- NHSE's oversight delegated functions will take place in accordance with the delegation agreement.
- the MoU does not mean that functions are being exercised jointly by NHSE and the ICB within the meaning of section 65Z5 of the NHS Act 2006 (joint working and delegation arrangements) and
- references to meetings held jointly do not mean that a joint committee has been set up between NHSE and the ICB.

It is acknowledged that the MOU represents a new way of working and there will be a period of transition and bedding in required, and an associated regular review process.

It is also recognised that the ICB has retained governance and oversight arrangements which were developed within the ICS pre-establishment. These remain current for now but following completion of work on the operating model and consequential review of governance arrangements, this MOU will need updating for new arrangements.

3. Ways of working

3.1 Leadership Behaviours to support 'Whole System' Working in the Midlands

To deliver the best for our people and our patients, we are committed to the following leadership behaviours across the Midlands.

Figure 1: Leadership behaviours

3.2 Rules of engagement to support 'Whole System' Working in the Midlands

The following principles will inform how the ICB and NHSE will work together:

1. **First among equals whilst respecting the respective responsibilities and accountabilities.** Ways of working will be non-hierarchical and jointly owned whilst respecting that statutory roles and responsibilities of different parts of the system will still need to be carried out. Despite respective NHSE/ICB roles there are common challenges that affect us all which will require collaborative leadership to resolve.

2. **No decision about me without me.** Structures for regional decisions relating to development and improvement will include systems as part of a whole system approach. This is to ensure that decisions around regional support are informed by the knowledge, skills and experience of those leading and delivering the strategic change/operational improvement.

3. **No surprises.** Arrangements will be transitional and will need to evolve as together we build confidence and trust. Early notice of information and concerns, be open and willing to share intelligence using agreed data sources to avoid different views.

4. **No bypassing.** There will be agreed channels of communication between the organisations, the ICB and NHSE, ensuring that duplication is minimised and that the region and system role is not undermined. There should be no bypassing system or regional leadership. NHSE's primary relationship will be with national directorates and ICBs whereas ICB primary relationships will be with place, organisations and local government.

5. **ICB Oversight will be NHSE led with oversight of NHS organisations led by the ICB - where we need to deviate from this it will be with ICB involvement.** ICBs are accountable for the oversight of NHS performance whilst NHSE remains statutorily responsible. NHSE will work with and through, the ICB to discharge this function. However, where there is a need to respond quickly to unexpected issues or where formal regulatory action is required this will be responsibility of NHSE. In all cases NHSE decisions will include the involvement of the ICB and good relationships and communication should ensure that NHSE is sighted on local issues.

6. **Midlands and NHSE ways of working will be clearly outlined to clarify responsibilities and to avoid undermining or duplicating the role of an ICB.** Jointly agreed arrangements will be set out for Midlands System Leadership. Individual ICB/NHSE ways of working will be outlined in MOUs which are to confirm roles and responsibilities for any NHSE functions discharged or delegated by NHSE and reviewed/updated regularly as arrangements evolve. These will articulate the 'step in rights for NHSE' where required.

7. **Continue to address unwarranted variation whilst upholding the principle of subsidiarity and local flexibility.** Some things will need to be done once for consistency and or where there are benefits to economies of scale. The overriding principle however should be one of decisions being taken as locally as possible to ensure we are meeting the need of populations served.

8. **Together we will strive for excellence and harness the talent we have to improve health and care outcomes, quality and access to care and reduce health inequalities.** Where things go well we will lock in the learning and strive to do better. When things go wrong, we will seek to understand why and learn from our mistakes.

9. **Collaboration.** All ICBs are expected to work together and with NHSE to support effective and timely delivery of care to patients and communities, and performance improvement against regional priorities. We recognise that collaborating and supporting beyond system or organisational boundaries can create additional challenges and risks locally and we will work together to quickly resolve any barriers and ensure that the positive impact of effective collaborative behaviour is duly recognised and celebrated.

4. System priorities and deliverables

4.1 System Priorities

To drive improvement across the Shropshire, Telford and Wrekin system the ICB has committed to delivering ten key pledges as well as five programmes of work and two enablers as system priorities.

Figure 2 below shows alignment of these system priorities and deliverables to the four fundamental purposes of an Integrated Care System

4 ICS Principles	10 STW ICS Pledges	5 Programmes of Work & 2 Enablers
Improve outcomes	Improving safety and quality	Prevention
	Delivering improvements in Mental Health, Learning Disability & Autism provision	
Tackle inequalities	Tackling the problems of ill-health, health inequalities and access to healthcare	Local Care
	Integrating services at Place and Neighbourhood level	
	Workforce	Transforming Clinical Pathways
Improve productivity and Value for Money	Creating system sustainability	
	Governance	Workforce
	Enhanced engagement and accountability	
Help broader social and economic development	Climate change	Value for Money
	Economic regeneration	
Enabler: Infrastructure HTP, Buildings, IT, Environmental & Economic Sustainability		
Enabler: ICS Development, ICB (delivery and Assurance), ICP and Place-based Boards, Commissioning, Community Engagement & Involvement		

The priorities, committed to as a partnership, will be monitored through the ICB governance functions. See *figure 7* – Governance Structure below.

The Shropshire, Telford and Wrekin ICS is currently working to review and restate its purpose, post COVID, as an ICS and how it delivers as individual organisations and as a system partnership. Work is underway to agree a common value set.

4.2 NHSE / ICB Joint Priorities

NHSE and the ICB have a joint commitment to a number of key priority areas for 2022/23.

4.2.1 Delivering a Greener NHS

NHSE and the ICB are committed to address the climate emergency, which is also a health emergency. Unabated it will disrupt care and affect patients and the public at every stage of our lives. With poor environmental health contributing to major diseases, including cardiac problems, asthma and cancer, our efforts must be accelerated.

The ICS and its Providers have Green Plans in place, and NHSE will provide appropriate expertise, investment and focus to enable us to deliver as a region. Sustainability should be implicit in all considerations and decisions made and geared towards delivery of the NHS's net zero targets. This aligns with one of the pledges that the ICS has committed to.

4.2.2 Reducing health inequalities

NHSE and the ICB will work together to support tackling Health Inequalities in outcomes, experience and access.

Health inequalities are the preventable, unfair and unjust differences in health status between groups, populations or individual that arise from the unequal distribution of social, environmental and economic conditions within societies, which determine the risk of people getting ill, their ability to prevent sickness, or opportunities to take action and access treatment when ill health occurs.

There are unfair and avoidable differences in access to and experience of NHS services by different population groups. Additionally, there are healthcare inequities that could be addressed through the provision of needs based, person centred services and systems.

The Health and Care Act 2022 introduces a range of obligations on NHS bodies in relation to action on health inequalities. These new obligations are summarised in Annex A.

4.2.3 Supporting our People

Staff are at the centre of our collective ambition for greater integration and better care and the ICB has a central role to play in delivering the vision for our 'one workforce'.

As NHS leaders and organisations, NHSE and the ICB will work together to deliver 10 outcomes-based functions with our partners in the ICB to make the local area a better place to live and work for its people. We will work together and through the local People Board to meet the following core objectives:

i. Supporting the health and wellbeing of all staff
ii. Growing the workforce for the future and enabling adequate workforce supply
iii. Supporting inclusion and belonging for all, encouraging diversity and creating a great experience for staff
iv. Valuing and supporting leadership at all levels, and lifelong learning
v. Leading workforce transformation and new ways of working
vi. Educating, training, and developing people, and managing talent
vii. Driving and supporting broader social and economic development
viii. Transforming people services and supporting the people profession
ix. Leading coordinated workforce planning using analysis and intelligence

x. Supporting system design and development.

Shropshire, Telford and Wrekin ICS have well-established plans in place to support and strengthen the health and care workforce and future transformational work is planned to enable the system to 'grow its own'. The People Plan has 5 key priorities, underpinned by the wealth of work being undertaken to improve and enhance the experience of the people throughout the system.

One of the key priorities, 'Belonging in STW' has seen a sharper focus on Equality, Diversity, and Inclusion (ED&I), to ensure ED&I is paramount within all aspects of workforce and OD system workstreams.

Figure 3

Looking After Our People	Belonging in Shropshire, Telford & Wrekin	New Ways of Working & Delivering Care	Growing for the Future	Focusing on Nursing

Oversight of this priority area will be through the regional NHSE people board, through bespoke meetings between the ICB and NHSE and at the regular NHSE ICB meetings.

4.2.4 Elective Care

<u>Eradication of elective 104 week waits & 78 weeks, reducing 52-week backlogs</u>

- Work is underway jointly between the ICB and NHSE to identify actions and support wider mutual aid to ensure delivery against the key challenged specialty areas.
- Oversight of progress and support requirements will be through NHSE attending the Elective and Diagnostics Group and at the regular NHSE: ICB meetings.
- The Shropshire and Telford Hospitals NHS Trust, along with the Robert Jones and Agnes Hunt NHS Foundation Trust have been allocated to Tier 2 escalation for elective care recovery, as such there are weekly scheduled meetings with NHSE and system and provider colleagues to address rectification of concerns.

4.2.5 Cancer

<u>Improvement of overall performance position</u>

- Significant work is required by the ICB to reduce the overall cancer backlog position and to meet the March 2023 operational plan ambition. Actions have been identified by the ICB to improve the cancer waiting position and NHSE will work with the system to identify any further support requirements.
- Oversight of progress and support requirements will be through NHSE attending the Cancer Group and at the regular NHSE ICB meetings.

- The Shropshire and Telford Hospitals NHS Trust has been allocated to Tier 2 escalation for cancer recovery, as such there are weekly scheduled meetings with NHSE and system and provider colleagues to address rectification of concerns.

4.2.6 UEC

Eradication of ambulance handover delays

- Key focus areas are handover delays, flow, and discharge.
- There are risks to delivery of the Operating Plan which the system is prioritising to provide mitigation in readiness for what is expected to be a challenging Winter period. The system is fully engaged with NHSE in Winter planning events to ensure the system is focused on this key priority area.
- Oversight of progress and support requirements will be through NHSE attending the UEC Group, system tactical discussions and at the regular NHSE ICB meetings.
- The system has been assessed by national NHSE and placed in the Ambulance Handover Heightened Concerns Programme, this results fortnightly support and oversight conversations with the national team.

4.2.7 Mental Health

Recovery of the Improving Access to Psychological Therapies standard and eradicating Out of Area Placements

- Oversight of progress and support requirements will be through NHSE attending the Shropshire, Telford and Wrekin System Programme Board, the MH checkpoint meeting and at the regular NHSE: ICB meetings.

4.2.8 Learning Disability and Autism

Delivery of the TCP target

- Oversight of progress and support requirements will be through NHSE attending the ICB TCP meetings, with additional discussions as required, as part of the planning cycle and at the regular NHSE ICB meetings.

4.2.9 Finance

Delivering system-level financial balance

- This is a key focus area and there is a significant system wide work programme in place to improve the systems overall position
- The detailed governance arrangements for this priority area is set out in section 6.2 of this MoU
- Oversight of the financial position and support requirements will be through bespoke NHSE: system financial review meetings and at the regular NHSE: ICB meetings.

5. Partnership and place arrangements

5.1 Shropshire, Telford and Wrekin ICB Geography

The ICS footprint covers a population of around half a million people, over a total area of 3,487km2. By 2043 there will be an estimated 0.6 million people in Shropshire, Telford, & Wrekin.

Figure 4

ICSs and their ICB and ICP will have influence over three key geographical footprints, with their own partnership and delivery structures:

System – this covers the whole population of an ICS, for STW this is the whole of Shropshire, Telford & Wrekin.

Place – this is broken down into different localities within the system. There are two defined and agreed Places within STW – Telford & Wrekin Integrated Partnership (TWIP) and Shropshire Integrated Partnership (ShIP). Both are co-terminus with the two Local Authority Boundaries

Neighbourhoods – this footprint covers the communities within each Place. There are 8 neighbourhoods, with 4 in each Place. These neighbourhoods include communities such as Ludlow, Shrewsbury and Whitchurch

5.2 The ICB Responsibilities and Functions

The ICB is working to develop the full extent of its operating model and provider collaborative, 2 place-based partnerships, a lead provider for mental health and a primary care collaborative. The ICB will continue to define and refine the role, responsibilities and functions of its Places and Provider Collaboratives. The ICS knows that without thriving Places, systems cannot achieve the ICS quadruple aim.

The proposed role, function and decisions for place-based partnerships are set out below in *figure 5*, below. A table outlining the system partners is attached in annex D.

	Role	Function	Decisions
Place-based partnerships	Place-Based Partnerships are collaborative arrangements formed by the organisations responsible for arranging and delivering health and care services in our communities.	The key functions: A Collectively deliver the outcomes set by the ICS and deliver services within scope B Utilising PHM information and analysing the implications for Place C User and community engagement	Key decisions will include: A Future pathway redesign B Service integration options C efficiency options D Ensuring health inequalities are addressed

5.2.1 Place-based Partnerships (PBP's)

There is already a strong track record of Place-based working and delivery, demonstrated by the work of the two place-based partnerships in operation are: Shropshire Integrated Partnership Board; and Telford and Wrekin Integrated Partnership Board.

They are constituted based on local provider models and, as such, membership and governance reflects this. Despite reflecting the differing needs of the 2 populations that they serve the 2 partnership boards are fairly consistent in their defined scope of services, have defined local priorities based on their respective health and well-being board and other evidential needs and have wide partner representation. An initial scope of Place-based services that may sit best predominantly at Place covers the following areas:

- Population Health Management, prevention, public health, Better Care Fund
- Out of Hospital and Community Services
- Community Mental Health Services and IAPT
- Primary Care

The ICB supports an Action Learning Set that has been established to share learning and agree congruence between PBP's where appropriate.

5.2.2 Provider Collaboratives

There are a number of forming collaboratives with the ICS. Beyond the regional footprint the local geography of the ICS means frequent collaboration with partners outside the system who are not represented in the structure of the ICS but are important to improving population's health outcomes.

i. Maternity Collaborative

SaTH's Maternity Transformation Programme partnering with Sherwood Forest Hospitals NHS Trust, including a safeguarding review and peer review of SaTH's response to the Ockenden Report. There is a robust clinical infrastructure, and governance is being updated to strengthen collaboration across providers.

ii. Cancer services

The ICS also collaborates with the Royal Wolverhampton Trust and University Hospital of North Midlands for provision of Cancer services.

iii. Primary Care Collaborative

The voice and power of Primary Care within the system footprint is essential and integral to the successful functioning of an integrated care system. Primary Care is represented and involved in decision making within key forums of the ICS and there is work underway to develop a more detailed support and development plan for local GP services.

iv Children's Services

The ICS collaborates with Birmingham Children's Hospital to provide Trauma services

5.2.3 Integrated Delivery Committee

An Integrated Delivery Committee has been established within the ICB infrastructure. This committee will focus on delivery via the place based partnerships, the role of provider collaboratives in the delivery of the system priorities and provide assurance to the Board of NHS STW in regards to the delivery of the system wide transformation agenda. The work programme of this committee includes the developmental work, in conjunction with partners, to assess the readiness of both the place based partnership and the provider collaboratives to take on delegated responsibilities from the Board of NHS STW.al responsibilities as required.

5.3 How the ICB and NHSE will work together to strengthen local arrangements, and mechanisms for coordination and information sharing

NHSE will receive assurance of place and provider collaborative developments via the governance and oversight arrangements set out in the next section. NHSE will continue to engage, share learning and information with the Shopshire, Telford and Wrekin system through the regional Provider Collaborative and Place workstreams.

5.3.1 Collaboration across ICBs

- In order for the ICB to effectively discharge its functions it will need to collaborate with other ICBs both within the region and across regional boundaries.
- The NHSE / ICB ways of working will need to evolve to take account of collaborations and agreed governance including the emerging offices of the East / West Midland ICBs. This MOU will be updated to take account of those arrangements when they are clear both in terms of the governance and the activity.
- For some commissioning activity, the preference is to collaborate across the East and West Midlands footprint. During 2022/23 we plan to develop the existing East and West Collaborative Commissioning Boards into formal committees / decision making bodies. This work is being led by NHSE Commissioning Directorate and the Chief Executives from the eleven Midlands ICBs.
    - Shropshire, Telford and Wrekin ICB will participate in the West Midlands Collaborative Commissioning Board for those services agreed to be commissioned at this level.
- Some commissioning functions will be retained by NHSE and these responsibilities will also be recognised within the developing collaborative arrangements noted above.
- The ICBs have formally been delegated responsibility for Primary Medical services. NHSE will operate the support services GMAST under a separate MOU arrangement until all the other Primary Care Services - Pharmacy, Optometry and Dental are formally delegated in April 2023.
    - Shropshire, Telford and Wrekin ICB will work with NHSE on services yet to be delegated so that there is confidence in both the capacity and capability ahead of any delegation.
- NHSE will need to engage directly with providers on specialised and directly commissioned contract arrangements and procurements. However, as per the principles set out in section 3.2 the ICB will be involved as appropriate.
- NHSE Specialised Commissioners have a relationship with mental health provider collaboratives through the NHS Standard form contract, retaining strategic commissioning and oversight and assurance functions. Multi-ICB involvement and

oversight will be on an East/West Midlands basis through collaboration and agreed governance as above.

- Responsibility for complaints will be delegated to the ICB at the same time as functions are delegated but the regional complaints functions will continue to transact pending confirmation of national policy and local implementation.
- Mutual aid arrangements to support the region to meet its elective recovery plans will continue during 2022/23. Where mutual aid is provided between providers and systems, NHSE will recognise and support where an ICB has provided this capacity, this will include taking into account any consequential impact on the local delivery of financial and operational performance targets.
    - The ICB will support the ask on provision of mutual aid and work with NHSE to prioritise areas where it can support whilst ensuring it is not disadvantaging its own population in so doing.

5.3.2 Single point of contact

- The ICB has established a single point of contact distinct from its incident response/EPRR arrangements and request that NHSE use this as a single route in and out of the ICB/ICS.
- The Regional Operations Centre (ROC) will become the single source of access in and out of the NHSE Midlands region for formal and / or routine communications, cascades, commissions and data requests from Regional and National teams. There will be a transitional period to confirm the scope of what is covered by the ROC, and embed the new arrangements.
- The ROC will also assume a point of regional escalation and de-escalation, ensuring the appropriate records management and governance are in place for events such as critical incidents. The ROC will hold a position which considers data at a holistic pan regional level, drawing conclusions and raising alerts where links to delivery are recognised.

6. Governance and Oversight

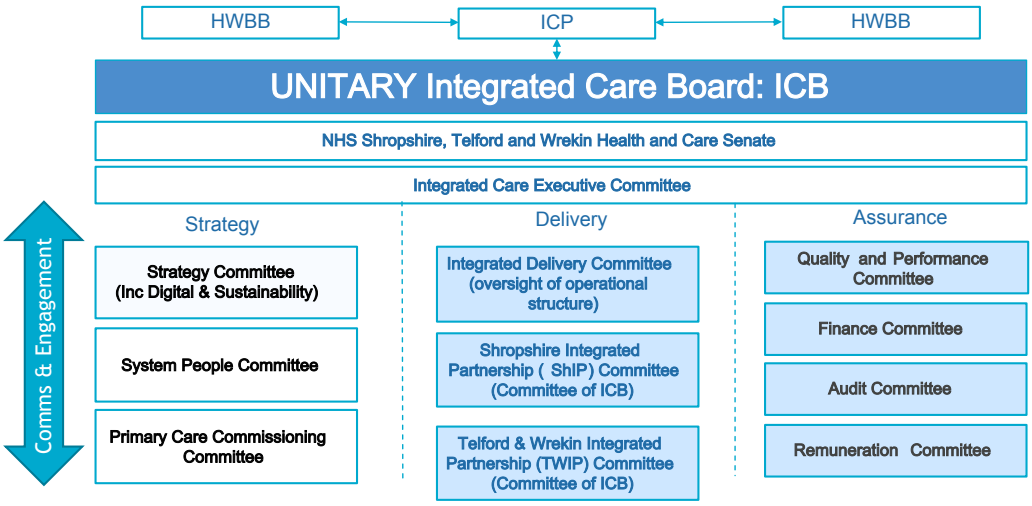
Since its formation on 01 July 2022, the ICS / ICB has established governance arrangements and adopted a functions decision map which are outlined in the diagrams below. The first diagram shows the structures the ICB has in place for proportionate and robust decision and the second diagram the oversight mechanisms across the ICB and its partner organisations.

These reflect local delivery and governance arrangements.

Figure 6 - ICB roles, functions and decisions

Shropshire Telford & Wrekin ICS	Role	Function	Decisions
Integrated Care Board (ICB)	The role of the ICB is to produce a five year plan to meet the health and healthcare needs of our population. The ICB allocates resources to deliver this plan, establishes joint working arrangements to embed collaboration in the plan, establish governance arrangements to support collective accountability and drive joint working.	Statutory key functions: A All Current CCG duties B Agreeing a 5 year Plan for NHS services C Delegated commissioning responsibility for a proportion of specialised services D Delegated responsibility for dental, general ophthalmic and pharmaceutical services	Examples of key decisions: A Scheme of Reservation and Delegation (SoRD) B Allocation of NHS resources C Agreeing the roles of different committees/partnerships/ bodies D Having oversight of delivery of NHS functions and working in collaboration with the 2 local authorities on areas of common work.
Integrated Care Partnership (ICP)	The role of the ICP committee is to bring together multiple system partners to develop an integrated care strategy for our whole population using best available evidence and data, covering health and social care and addressing health inequalities and wider determinants.	The statutory function of the ICP is: A To produce an integrated care strategy B To act as a statutory committee of the ICS C Have regard to relevant mandates and guidance	Key decisions will include: A Priorities for improving system-wide health and care outcomes and experiences B Championing the principle of subsidiarity and empowering local decision making C Highlighting where coordination is needed
Place based partnerships	Place-Based Partnerships are collaborative arrangements formed by the organisations responsible for arranging and delivering health and care services in our communities.	The key functions: A Collectively deliver the outcomes set by the ICS and deliver services within scope B Utilising PHM information and analysing the implications for Place C User and community engagement	Key decisions will include: A Future pathway redesign B Service integration options C efficiency options D Ensuring health inequalities are addressed
Provider collaboratives	Provider collaboratives are partnership arrangements involving at least two trusts working at scale across multiple places, with a shared purpose and effective decision-making arrangements	The key functions of provider collaboratives: A Reducing unwarranted variation and inequality in health outcomes, access and experience B improving resilience C Ensuring specialisation and consolidation occurs where beneficial	Key decisions will include: A Allocation of their resources B Delivery of benefits C Objectives and shared responsibilities
Supra-ICB	There are some functions where ICS NHS bodies will need to work together creating Supra-ICB arrangements, often where relatively small numbers of providers serve large populations.	Depending on the Supra-ICB arrangement, key functions include: A Commissioning more specialised services B Commissioning emergency ambulance services C To work with providers spanning multiple ICSs or clinical networks	Key decisions may include: A Agreeing a shared plan for cancer services B Establishing joint working arrangements across a wide footprint C Implementing effective delegated commissioning responsibilities including specialised commissioning across the W. Midlands

Figure 7 - NHS STW Governance Structure



The terms of reference for these committees of the Board can be found in the ICB's Governance Handbook available on our website:

Our Constitution - NHS Shropshire, Telford and Wrekin (shropshiretelfordandwrekin.nhs.uk)

6.1 NHS Shropshire, Telford and Wrekin Integrated Care Board (NHS STW)

The ICB is a statutory body responsible for the commissioning of healthcare services across the Shropshire, Telford and Wrekin ICS area, bringing the NHS together locally to improve population health and care.

NHS STW is part of the Shropshire, Telford and Wrekin Integrated Care System, a partnership involving the local NHS, Local Government organisations, the third sector and other relevant bodies with an active interest in the health, care and wellbeing of the residents of the Shropshire, Telford and Wrekin. Together they will collaborate to address health and care inequalities, enhance integrated working, ensure optimal use of available resources and contribute to broader societal priorities.

NHS STW is specifically responsible for a range of planning, commissioning, financial and oversight functions which will be discharged with the aims of improving the health of the local population and ensuring the efficient and effective delivery of NHS services.

6.2 Financial governance arrangements

The ICB 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.

To ensure that the ICB fulfils its statutory duty to carry out its functions effectively, efficiently and economically details have been set out in the SFIs. They are part of the ICB's control environment for managing the organisation's financial affairs as they are designed to ensure regularity and propriety of financial transactions.

As a committee of the board the Finance Committee contributes to the overall delivery of the ICB objectives by providing oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable system financial plan, including financial performance of the ICB and NHS organisations within the ICB footprint. The committee is also responsible for overseeing the use of the System's financial framework, including the Intelligent Fixed Payment mechanism that is currently in use.

The Audit Committee is responsible for assurance on Internal Control, Audit arrangements and Governance and Statutory functions.

A third Committee of the Integrated Care Board, the Integrated Delivery Committee, also plays a crucial role in the management of system finance by overseeing delivery of the System's Transformation and Efficiency programmes. This includes use of the 'Triple Lock' Process.

Areas of concern and issues are escalated to the Integrated Care Board through these committees.

The System also has a strong management infrastructure with weekly meetings of the Directors of Finance and the System Chief Finance Officer acting as an advisor to the weekly Chief Executive meeting. The System Chief Finance Officer has regular dialogue with NHSE finance colleagues and also attends QSRM and other appropriate meetings with NHSE (both regional and national teams).

6.3 Quality governance arrangements

As part of the integrated assurance approach of the ICS, it operates a quality and safety infrastructure which makes it possible to rapidly identify and address support requirements

and required interventions. This approach also enables the provision of rapid escalation through the ICB, to providers, place structures and to NHS England

The Quality and Performance Committee (QPC) assures the Board that regulatory elements of quality are being met, that services are safe, effective and caring and that the system of quality governance and internal control that supports the development and delivery of sustainable, high-quality care is working well across the system. Importantly the committee also gives guarantee to the Board that quality risks are recognised, controlled, mitigated and escalated as appropriate.

The System Quality Group reports to the Quality and Performance Committee and is the forum at which partners from across health, social care, public health and wider, within the ICS, work collaboratively to join up around common priorities. They share insight and intelligence, identify opportunities for improvement and concerns/risks to quality, and develop system responses to improve the quality of care and services across the ICS.

Other sub-groups and sub-committees reporting into QPC include:

- System Quality Group
- SOAG (Sath Safety Oversight and Assurance Group)
- LMNS Programme Board
- Health Protection Board (in addition to reporting to Health & Wellbeing Boards)

6.4 Delivery Governance Arrangements

6.4.1 Programme Boards

A number of Programme Boards have been established in the ICB, these include Cancer, UEC, Elective and Diagnostics.

The ICB and NHSE are members of the Programme Boards where oversight of the delivery against national / local priorities is monitored. Formal responsibility for delivery will be via the ICB Integrated Delivery Committee, Finance Committee, and Quality and Performance Committee and ultimately the NHS STW Board.

6.4.2 Place-based governance arrangements:

Place based governance arrangements in terms of decision-making and any joint arrangements for statutory decision-making functions between the NHS and Local Authorities are still an evolving position. The actual process of agreeing delegation to place has currently not been confirmed. See section on Partnership and place arrangements above.

6.4.3 Planning Group

The ICB has established a Planning Group to oversee the development, implementation and oversight of ICB Operational and Strategic plans.

It is led by the ICB Director for Strategy and Integration and membership includes providers and partners from the System, including NHSE.

Whilst not duplicating work of the ICS Programme Boards on performance assurance and rectification, it enables triangulation and understanding of dependencies across workstreams and provides assurance to the ICB Strategy Committee.

6.5 Oversight Arrangements between STW ICS and NHSE

Core objectives

- The Midlands oversight model recognises that effective system governance and oversight arrangements should underpin regional oversight and assurance processes.
- Systems will take a joint and leading role in oversight both at a local level and in the contribution and mutual accountability arrangements for Midlands wide performance, supported as necessary by NHSE, with a commitment to proportionality and minimising administrative burden.
- Oversight arrangements should reflect a balanced approach across the six oversight themes in the NHS oversight framework, including leadership and culture at organisation and system level.
- NHS Midlands role in system-level oversight arrangements will reflect both the performance and relative development of an ICS.
- The oversight process for providers will be led by the ICB and follow an ongoing cycle of monitoring performance and capability against the six themes; identifying the scale and nature of support needs; and coordinating support activity (and where necessary formal intervention) so that it is targeted where it is most needed.
- Business intelligence and data-led approaches will be used to support collective effective decision making, in a dynamic and responsive manner.

NHSE and Shropshire, Telford and Wrekin ICB have agreed the following oversight arrangements in 2022/23:

6.5.1 Quarterly System Review Meeting (led by NHS Midlands RD).

Purpose: formal accountability mechanism for region to assess and assure system performance, what support is required and gather evidence for any change to provider or system segmentation.

6.5.2 **Regional and sub-regional boards** include system SROs / professional leads.

Purpose: mutual oversight and accountability for regional position and agreement of specific support and intervention to address underperformance.

N.B. specific pan-regional oversight arrangements will be discussed and agreed where oversight is required for services which across ICS boundaries. For example, for ambulance providers.

6.5.3 System oversight and assurance structures to include specific system: NHSE: provider oversight and assurance meetings.

Purpose: to discharge respective responsibilities for enhanced or intensive oversight and support. For example, to oversee elective and cancer recovery, quality and financial improvement actions or monitoring progress against provider undertakings.

These have been agreed on a case-by-case basis between NHSE and the system and arranged to minimise the administrative and regulatory burden on challenged organisations.

Annex E references the ICB governance meetings where NHSE is in attendance including the capacity in which they attend.

Where NHSE is part of system governance meetings, the annex makes clear in what capacity this is i.e. a critical friend support and / or to support mutual accountability.

Where NHSE is not part of system governance meetings, the ICB will be responsible for notifying NHSE on any new issues or concerns relevant to statutory duties on a timely basis.

6.5.4 System review / Oversight and Assurance Meeting

Purpose: review performance challenges within the system (which are driving the NHS Oversight Framework (NOF) ratings for the system and organisations, progress made and the effectiveness of interventions and support. Frequency and approach according to table below.

As the ICB is currently in segment 4 of the NOF, monthly Improvement Review Meetings will be held in monthly in addition to the Quarterly System Review Meetings. These meetings are led by NHSE, with the agenda being jointly agreed in advance.

The new National Operating Model and NHS Oversight Framework (NOF) states that an ICS or Trust is eligible to be considered for mandated intensive support (Recovery Support Programme or RSP) and entry to segment 4 if any of the following criteria are met:

- longstanding and/or complex issues that are preventing agreed levels of improvement for ICSs, or trusts in segment 3, or
- a significant underlying deficit and/or a significant actual or forecast gap to the agreed financial plan, or
- a catastrophic failure in leadership or governance that risks damaging the reputation of the NHS, or
- for trusts, a recommendation by the CQC.

STW ICS entered SOF4 and the RSP arrangements in August 2021 due to pre-existing concerns, namely:

- Lack of agreed strategic, long term system sustainability plan
- History of lack of effective system working
- Historical Leadership and governance competency concerns
- Lack of focus around operational planning and delivery
- Continuing quality concerns at SaTH

STW ICS and NHSE have agreed the following criteria for the system to exit from SOF4 and RSP

Development of an agreed 5 Year STW Integrated System Improvement Plan, including longer term sustainability
Evidence of meaningful mobilisation of the Integrated System Improvement Plan over a period of at least 12 months.
System has in place robust system governance structure, processes and mechanisms established and fully functional, including financial governance
Evidence of whole system ownership of quality, operational and financial challenges.
Demonstrable and effective system support to address CQC conditions and undertakings in system providers.

The measures and metrics to assist regional NHSE assessment of progress against the exit criteria are in the final stages of agreement with the ICB. This will enable NHSE to confirm at which point the system has satisfied a given exit criteria. It is expected that these will be confirmed as final draft by latest 31 August 2022 for joint sign off by ICB and NHSE. Future

monitoring arrangements will be structured through monthly meetings (Improvement Review Meetings) commencing September 2022, chaired by regional NHSE, including representation from STW ICB and the national NHSE team. A draft Recovery Support Programme report will be reviewed and agreed by all parties at the monthly IRM. These RSP reports will be circulated to appropriate regional and national NHSE colleagues. The progression or exit from RSP is seen as an improvement journey, at the next stage the system being placed in segment 3 (SOF3) according to the NHS Oversight Framework

The Strategy Committee monitors the ICS's progress against the exit criteria agreed during the mandated intensive support (segment level 4) of the NHS Oversight Framework, holding the relevant committees and partners accountable.

NHSE and the ICB are committed to working together effectively to support performance improvement locally and across the region, and in accordance with the respective roles and responsibilities outlined below.

6.5.5 STW Provider SOF Position

The system SOF oversight arrangement replicates SOF 4 and RSP exit process NHSE have in place with SaTH i.e. monthly calls via SOAG (see Annex E) and RSP reporting. SaTH were placed in SOF 4 and RSP due to service quality and financial issues. RJAH were placed in SOF 3 in 2022 with regard to IPC concerns. The fifth RSP exit criteria for the system clearly references the need to support providers in their exit from SOF 4 for SaTH and SOF 3 for RJAH. This MOU seeks to demonstrate the interrelationship between provider and system SOF ratings and the manner in which system and NHSE work together to address the concerns.

7.Roles and responsibilities in performance improvement

The narrative below describes the roles the ICB and NHSE will undertake, individually and collectively, to address performance challenges within the Shropshire, Telford and Wrekin system.

NHSE and the ICB will use 2022/23 to embed new ways of system working to achieve performance improvement. This will be predominantly by devolving responsibility for performance improvement to segments of the operating model both in 2022/23 and 2023/24.

In practical terms for 2022/23, ICB Board Committees hold formal responsibility for delivery of the constitutional standards and those metrics in the NHS Oversight Framework. The ICB has established a range of sub-committees and working groups with partners. In 2023/24, these responsibilities may transfer to other partners in the system. This will be tested by the readiness assessment to be overseen by the System Development Committee and reported to the ICB Board for any decision on delegation.

The ICB is developing new performance assurance framework that will bring together the key constitutional standards from the NHS Oversight Framework, 2022/23 Operational guidance and other key performance indicators. This single version of the truth of performance across the ICB will be routinely presented to the ICB Executive and Board.

This performance framework extracts the relevant metric for each ICB priority and/or deliverable and assigns it to the strategic board/governance group which has responsibility for its delivery. This is then compiled to produce a standardised report that is tailored with relevant information for each meeting/fora, which drives a conversation about whether performance and delivery is on track, and if not, what corrective actions need to be taken.

NHSE and the ICB are committed to working together effectively to support performance improvement locally and across the region, and in accordance with the respective roles and responsibilities outlined below.

7.1 System

- The ICB is taking a leadership role in driving improvement across the system, this includes ensuring that a quality improvement methodology underpins the approach within the ICS.
- The ICB will co-ordinate NHS support interventions within the Shropshire, Telford and Wrekin system, where appropriate, working in partnership with NHSE, including to jointly review the impact of interventions.
- The ICB is responsible for ensuring that the system develops, monitors and oversees plans to meet the agreed 'exit criteria' for systems and organisations receiving mandated support.
- Common exit criteria:

- Realistic and ambitious recovery/improvement plan developed
- Key trajectories being delivered
- The system has the capacity and capability to deliver the key requirements agreed with NHSE
- The system is proactively taking relevant actions to ensure that deliverables are maintained.

7.2 Region

- Regional support will focus on learning and improvement by:
  - Working with the local system to develop capability and capacity
  - Bringing systems together and/or with experts/peers to share learning and facilitate the adoption of best practice and innovation
  - Embedding colleagues within the system to provide solution focused support, that supports problem solving and sharing of best practice
  - Supporting peer review e.g. of service quality, the model of care, the governance or the approach to quality assurance or improvement etc.
- Regional support will be tailored according to NOF segmentation level or any specific governance / leadership issues for example, Provider Undertakings
- Clinical Professional Leadership (CPL) to be a critical element of leadership to quality and clinical transformation agenda, working with regional leads on system quality groups, supported by quality leads meetings to review progress against improvement plans/quality metrics/SI thematic reviews/learning.
- Support will also be provided via Clinical Network Infrastructure, and we will agree the approach and interfaces with system leadership.
- Support and facilitation to mediate or intervene where there is conflict or a difference of opinion within the ICB or between ICBs.
- Manage the interface and accountability of the region with the national team.
- Conduct the annual performance assessment of the ICB in each financial year and publish a summary of its findings.

7.3 System & Region

- Regular engagement between NHS Midlands SMEs / professional leads and the Shropshire, Telford and Wrekin system counterparts to:
  - Support individuals in their respective roles
  - Understand the current position
  - Assess what support and input would be helpful
  - Contribute to the development and implementation of improvement actions.
- It is important to confirm that this engagement will be delivered in line with the principles set out in section 3.2.

- NHSE will work with the system to identify quality, financial and operational improvement and transformation actions; and design bespoke support as and when mandated, required or requested. This will be linked to NOF and for all domains as necessary.
- NHSE relationship leads are working with the system on the oversight infrastructure providing support/critical friend input into the UEC, elective and diagnostics, cancer, MH and LDA forums.
- NHSE and the system will ensure there is collaboration through regional forum, such as the finance leadership group.
- Where new concerns are identified, rapid risk and review (or escalation) meetings will be used as a consistent approach to understand issues, agree actions and outcomes required. To include what further support is required, future monitoring and co-ordination arrangements.

7.4 Overarching Approach to Risks and Escalation

The approach to the escalation of issues within the ICB or by NHSE with the ICB or provider is dependent on the segmentation of the ICB, current levels of oversight, as well as the specific metrics and qualitative factors.

The 2022/23 NHS Oversight Framework outlines the segmentation approach and key metrics which will be considered by NHSE to assess performance of the system and providers against six key themes or domains. Included in Annex B are some key qualitative indicators, which will influence NHSE's judgement regarding escalation levels and interventions, however, the new framework should be referred to in full for guidance on segmentation and metrics.

For individual providers, NHSE and the ICB will together discuss segmentation and any support required. However, NHSE will be responsible for making the final segmentation decision and taking any necessary formal enforcement action. Where there is a deterioration in segment NHSE and the ICB will agree exit criteria which will need to be met to exit mandated support and move to a lower segment.

The ICB will ensure there is a robust approach to managing risks and escalations arising from delivery and transformation through its Board Assurance Framework. This will routinely review system risks through a clear governance framework, which will be reported via the Integrated Delivery Committee, Place Based Committees, Finance Committee and Quality and Performance Committee and ICB Board. Together, this will create strong awareness of the issues and enable the system to work together to resolve these. The ICB will also work collaboratively with NHSE in relation to the specific support available.

Annex C outlines the overarching principles we will adopt in relation to escalation of issues.

8 ICS development

- Systems will continue to produce a system development plan (SDP) which will evolve in response to system priorities and national policy development.
- NHSE will provide an allocation of funding (figure TBC) for system development and system participation in the co-design of policy related to the long-term ambition and vision for ICSs.
- NHSE will continue to broker regional and national support in relation to needs identified in system development plans.
- NHSE will work collaboratively with systems to support the interpretation and implementation of national policy and share learning and good practice in relation to ICS development.

Figure 8: Key components of the ICS in April 2023

What could the key components of the ICS look like in April 2023

Integrated Care Partnership	The ICP is established and brings together many different partners collaboratively, with strong working relationships and appropriate processes and decisions. The ICP has a strong relationship with places and plays a distinct role in the system. An impactful ICS Strategy which is owned by all organisations which speaks to our priorities as a system and acts as a strong guide for the wider system.
Integrated Care Board	The ICB is established and meets its statutory duties. We are working in new ways in support of the broader formation of the system (e.g. Place x 2, provider collaboratives, 6 big ticket transformation programmes). The ICB and its committees are fully resourced and have agreed and implemented practicable governance and management arrangements. The NHS 5- year plan is signed off and informed by the ICP strategy.
2 Place Partnerships	The 2 Places (TWIPP and SHIPP) have agreed their remits (delegation of powers) and how they link with the other components of the ICS, clarity of current financial flows and financial delegation arrangements will be agreed. The Lead for Place is agreed as are the managerial resources between ICB, LAs and others. The relationship with the Local Care Programmes clear to ensure delivery via the Place partnerships.
Provider Collaboratives	Provider collaboratives have developed further, with the remits and responsibilities of the collaboratives agreed and non-contradictory to Place and other ICS components. Their focus is to provide effective care, reduce unwarranted variation, provide mutual aid to one another to improve system resilience.
Transformation Programmes (6 big tickets)	Further develop the system of oversight and assurance t ensure delivery of change and sustainability. Resources are allocated systematically to the most effective service transformation initiatives and aligned to ICS strategy. There is robust benefit realisation and evaluation to create a continuous improvement cycle and culture for the system.

9 Reviewing, amending, and monitoring of the MOU

This MOU relates to an ongoing relationship between the ICB and NHSE and will be formally reviewed and renewed on an annual basis. The ICB and NHSE agree to review the agreement every 3 months to assess whether it is still accurate and fit for purpose, as an output of the Quarterly System Review Meeting and taking account of any changes in NOF segmentation.

Changes to the MOU required outside of the proposed review period can occur at any time, if agreed by both parties.

10 Signatures

The ICB and NHSE, as represented by the below officers, agree to honour the aspirations and commitments made in this MOU.

Simon Whitehouse
Interim Chief Executive
NHS Shropshire, Telford and Wrekin ICB

Fran Steele
Director of Strategic Transformation
NHS England Midlands

01 September 2022

Annex A: Obligations on Health Inequalities

New ICB obligations on health inequalities

- A new duty on health inequalities for ICBs: 'Each integrated care board must, in the exercise of its functions, have regard to the need to— (a) reduce inequalities between persons with respect to their **ability to access health services**, and (b) reduce inequalities between patients with respect to the **outcomes achieved for them by the provision of health services**.'
- A new **quality of service** duty on ICBs which includes addressing health inequalities.
- A duty to **promote integration** where this would reduce inequalities in access to services or outcomes achieved.
- Duties on ICBs in relation to several other areas which require consideration of health inequalities – in making wider decisions, **planning, performance reporting**, publishing certain reports and plans, **annual reports and forward planning.**
- In addition, each ICB will be subject to an **annual assessment** of its performance by NHS England, which will assess how well the ICB has discharged its functions in relation to a range of matters including reducing health inequalities, improving quality of service, and public involvement and consultation.

New requirements to publish inequalities data for ICBs, Trusts and Foundation Trusts

- NHS England must publish a statement about use of information on inequalities in access and outcomes, setting out the powers available to bodies to collect, analyse and publish such information, and views about how the powers should be exercised.
- NHS bodies should publish annual reports describing the extent to which NHS England steers on inequalities information have been addressed

Annex B: Key factors in NHSE escalation and intervention decisions

NHS Oversight Framework

The 2022/23 NHS Oversight Framework outlines the key metrics which will be considered by NHSE to assess performance of the system and providers against 6 key domains.

Key qualitative factors

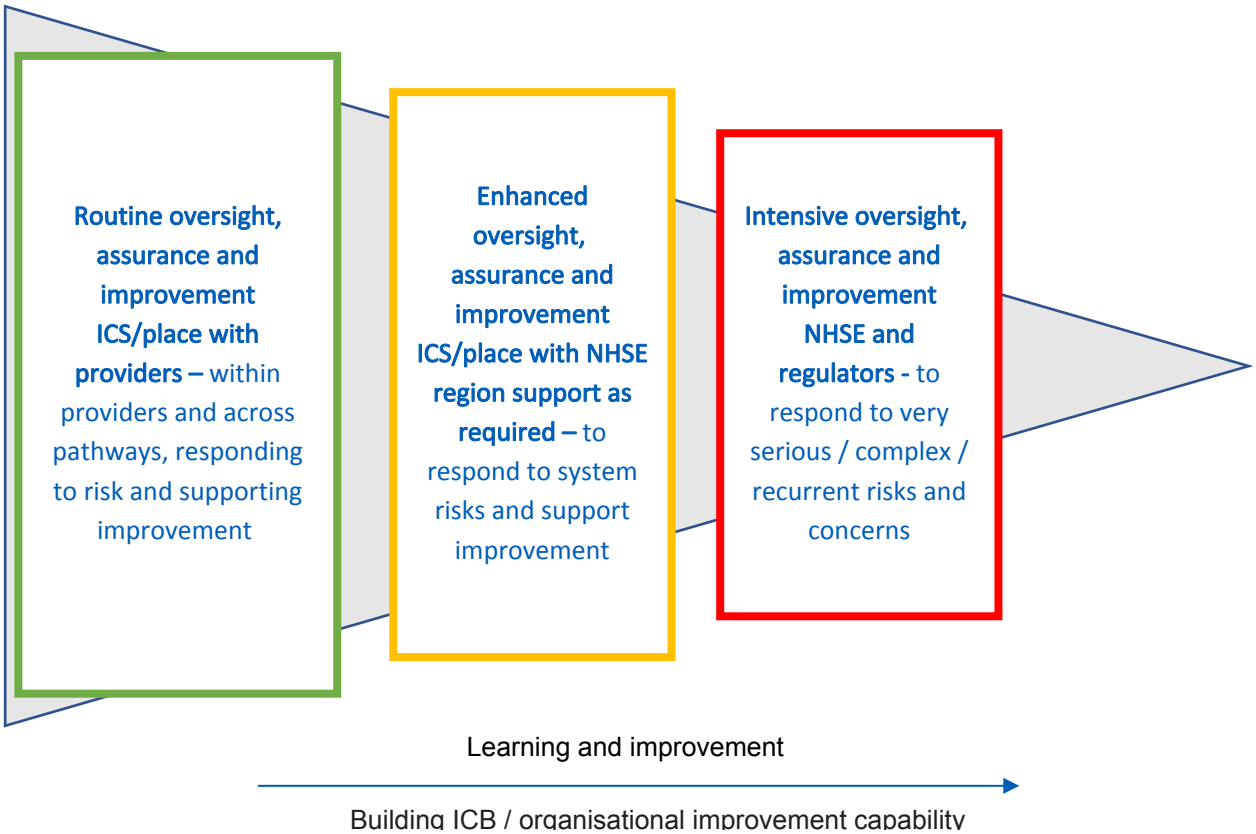
which will influence NHSE's judgement regarding segmentation decisions and if regulatory intervention is required (as a last resort):

- Lack of assurance that the issue/ concern is being addressed or managed in a timely and effective manner by the ICB
- System tensions or conflicts of interest, e.g. a whistleblowing report about an ICB exec lead
- Poor engagement with regional teams
- Lack of effective system collaboration to drive improvements
- Lack of robust governance and oversight arrangements within the ICS or within a provider
- Material concerns regarding the structure, leadership, and culture of an ICB
- Evidence that the ICB or a provider lacks the capacity and capability to effectively address the issue

Instances where NHSE might by-pass the system

- Evidence of a conflict of interest
- A need to act rapidly to protect patients or staff (but we would notify the ICB at the earliest opportunity).
- Evidence of a failure of system governance to identify the issue
- Whistleblowing issues raised with NHSE

Annex C: Escalation approach



The different escalation levels are as follows:

- Routine oversight, assurance and improvement:
  - Day-to-day activity when there are no risks or minor risks which are being addressed effectively
  - Includes standard monitoring and reporting, due diligence and contract management.
- Enhanced oversight, assurance and improvement:
  - Undertaken when there are system risks that are serious, complex and/ or recurrent and require action/ improvement plans and support.
- Intensive oversight, assurance and improvement:
  - When there are very serious, complex or recurrent risks, which require intensive support, including mandated support from NHS England for recovery and improvement.

Annex D: Additional information

Table 1: Healthcare providers across the two places in Shropshire, Telford and Wrekin

Provider Type	Organisation	Summary
Acute	Shrewsbury & Telford Hospital NHS Trust (SaTH)	The main provider of district general hospital services for nearly half a million people in Shropshire, Telford & Wrekin, and mid Wales. Main service locations are the Princess Royal Hospital in Telford and the Royal Shrewsbury Hospital in Shrewsbury.
Specialist Orthopaedic	The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH)	A single site hospital based in Oswestry, close to the border with Wales, serving patients locally, regionally, and nationally. A leading orthopaedic centre of excellence providing a comprehensive range of musculoskeletal surgical, medical and rehabilitation services.
Community Health	Shropshire Community Health NHS Trust (ShropCom)	The Trust provides a range of high quality, innovative community-based health services for adults and children in Shropshire, Telford & Wrekin, and some services to people in surrounding areas.
Mental Health	Midlands Partnership NHS Foundation Trust (MPFT)	An integrated organisation providing physical and mental health, learning disabilities and adult social care services. Most services are delivered in Staffordshire, Stoke-on-Trent, Shropshire, Telford & Wrekin, however some specialist care is provided nationally.
Ambulance	West Midlands Ambulance Service Foundation Trust (WMAS)	The Trust is the region's emergency ambulance service and covers a population of 5.6 million people across the areas of Shropshire, Herefordshire, Worcestershire, Staffordshire, Warwickshire, Coventry, Birmingham, and the Black Country conurbation.

Table 2: Local Authorities across the two places in Shropshire, Telford and Wrekin

Place	Local Authority	
Shropshire	Shropshire Council	There are two Local Authorities in our ICS: Telford & Wrekin Council, and Shropshire Council. Both councils have unitary authority respectively, thereby holding the powers of a non-metropolitan county and district council combined. Both councils work in partnership with the ICS to find ways to improve the health outcomes of our local population.
Telford and Wrekin	Telford and Wrekin Council	

Table 3: PCNs across the two places in Shropshire, Telford and Wrekin

We have eight PCNs in our ICS, with four mapped to each Place. Each PCN has a PCN Clinical Director. The numbers of member practices in each PCN varies, with the smallest PCN having 2 member practices and the largest having 16. Overall, within our eight PCNs there are a total of 51 independent General Practices serving varied population sizes. Collectively our practices deliver most of the health and care to the communities in our system.

Place	PCN	List Size
Shropshire	Shrewsbury	127,734
	South West Shropshire	36,389
	South East Shropshire	58,989
	North Shropshire	90,391
Telford and Wrekin	Teldoc	61,621
	Newport and Central Telford	57,904
	Wrekin	31,387
	South East Telford	37,895

Annex E: ICB / NHSE Meeting Structure

Name of meeting	Frequency	Lead	NHSE attendance	Purpose of NHSE involvement*
QSRM	Quarterly	Regional Director-NHSE	ESM's	Regulatory/Statutory
STW Improvement Review Meetings	Monthly	S&T – NHSE	S&T, IST,	Assurance / Oversight
Corporate Governance Meetings				
ICB meetings	Bi Monthly	ICB Chair	S&T	Observer role
Audit Committee	Quarterly	ICB NED & ICB CFO	x	
Remuneration Committee	As required	ICB NED & ICB SPL	x	
Finance Committee	Monthly	ICB NED & ICB CFO	x	
System People Committee	Bi Monthly	Provider Trust Chair & ICB SPL	x	
Integrated Delivery Committee	Bi Monthly	Provider Trust Chair & ICB Exec Director D&T	x	
Quality and Performance Committee	Monthly	ICB NED & ICB CNO/CMO	x	
Strategy Committee	Bi-Monthly	Provider Trust Chair & ICB Director S&I	x	
Primary Care Commissioning Committee	Bi monthly	ICB NED & ICB CMO	x	
Shropshire Integrated Partnership Committee	Bi-monthly	LA Director and Community Trust CEO	x	
Telford and Wrekin Integrated Partnership Committee	Bi-monthly	LA Director	x	
Functional meetings				
System Quality Group	Monthly	ICB CNO	Nursing and Quality	Assurance Oversight/support
SaTH Safety Oversight and Assurance Group	Monthly	ICB CEO	Medical, Nursing and Quality, S&T, IST	Assurance Oversight/support
RJAH Improvement Review Meetings	Monthly	S&T - NHSE	S&T, IST	Assurance Oversight/support
Cancer and Elective Care Recovery Ops Group	Monthly	ICB Director P&P	S&T	Oversight/support/ info
Planned Care Operational Board	Monthly	CEO RJAH	S&T	Oversight/support/ info

Cancer Strategy Board	Monthly	ICB Director P&P	Cancer Alliance	Oversight/support/ info
UEC Board	Monthly	ICB CEO	S&T	Oversight/support/ info
UEC Ops Group	Monthly	ICB Director UEC	S&T/UEC	Oversight/support/ info
Mental Health and LDA Partnership Board	Monthly	ICB Director P	S&T, MH	Operational oversight & support
System Planning and Performance Group	Monthly	ICB Director P&P	S&T	Oversight/support/ info
System escalation calls UEC	As required	ICB Director on Call	S&T/UEC	Oversight/support/ info
Investment Panel	Monthly	ICB CMO	X	

National oversight framework including exit criteria

Agenda item 28-09.020

RSP (Recovery Support Programme) Draft Exit Criteria	Exit Criteria Ref	Required Priority Areas - DRAFT (To be agreed with ICB)	Proposed new metrics - DRAFT (To be agreed with ICB)
Development of an agreed 5 Year STW Integrated System Improvement Plan, including longer term sustainability	1	Clinical Strategy & 5 enabling frameworks which could include: Quality People Estates Finance Digital	1. Robust plan in place that triangulates finance, performance and quality. a) Plan is backed up by clinical strategy to be developed by and agreed between ICB and NHSE b) The plan contains detailed milestones for delivery in Yr1 and Yr2 c) The plan delivers measurable quality improvements for the system's population d) Executive leads identified as SROs for each of the plan workstreams 2. Cyclic review is in place that links in with ICB governance. Clear process for monitoring delivery of the plan and review in line with annual planning cycle. This will include assurance that the plan places no significant risk to maintaining quality, and robust internal governance processes are in place to identify any worsening of the system's position 3. Plan signed off by ICB and NHSE
Evidence of meaningful mobilisation of the Integrated System Improvement Plan over a period of at least 12 months.	2	Collaboratives or joint working to facilitate effective and sustainable delivery of the improvement plan	1. Delivery of agreed milestones within the ISIP. 2. Delivery of quantified performance improvements. This will focus on improvements against agreed trajectories rather than delivery of specific constitutional standards. 3. Mitigation in place where milestones cannot be delivered for reasons outside system control. 4. Evidence of sustained ISIP delivery (at least 6 months) with sign off by ICB 5. Evidence in the Integrated Performance Report that actions have had a demonstrable positive effective on performance improvement in the areas of quality, workforce, operational efficiency and Finance
System has in place robust system governance structure, processes and mechanisms established and fully functional, including financial governance	3	ICB & Subcommittee structure implemented	1. Subcommittee Structure and Governance Handbook in place 2. Evidence of regular and meaningful monitoring of Delivery in line with ICB Governance Handbook 3. Executive team in place and ICB established 1st July. Executive portfolios agreed with clear ownership key programmes 4. ICB/NHS England MOU reflects ICB role and responsibility in solving the system quality and financial challenges 5. Evidence that the Integrated Plan is discussed and implemented at PLACE as sub-committees of STW ICB 6. Delivery and Assurance arrangements in place for the Implementation Plans

Evidence of whole system ownership of quality, operational and financial challenges.	4	Links to the ICB & Subcommittee structure (no. 3).	1. Visible evidence that following collective behaviours across the system are embedded and valued within system leadership a) Collective decision making b) Sharing quality, operational and financial risk 2. ICB/ PLACE & Trust Board Minutes/Papers are explicit in addressing quality & financial issues (to include ToRs, membership etc) 3. Evidence of system sign off for key strategies and plans including ISIP, Annual Plan, Clinical Strategy and progression of HTP 4. Evidence of shared approach to risk management in the system 5. Evidence of Clinical and Professional Leadership and work of clinical advisory groups
Demonstrable and effective system support to address CQC conditions and undertakings in system providers.	5	5 conditions, linked to MH, UEC and Maternity. Therefore support to be supported by the Collaboratives	1. Through ICB Quality Governance structures evidence of decisions which support SaTH to address CQC conditions. 2. Evidence of ICB leading changes through UEC Delivery Board which deliver a) services which promote improved UEC and discharge performance to support SaTHs delivery of safe care e.g. reduction of MMFDs b) Demonstrable and effective system support for resolving Undertakings for UEC at SaTH 3. Resolution of the CQC condition regarding CYP with mental health issues and no physical issues within SaTH a) Development and approval of a clear strategy for MH&CYP b) Development of a newly commissioned service model and supporting transformation plan 4. Resolution of the CQC conditions and completion of Ockenden report 1 (10-Dec-20) actions regarding Maternity services 5. Demonstrable and effective system support for resolving Undertakings for IPC at RJAH 6. Evidence of Clinical and Professional Leadership and work of clinical advisory groups

ICB delegation to sign off the SaTH submission of the 10 Maternity Safety Actions of the Clinical Negligence Scheme for Trusts (CNST) reporting to NHS Resolution.

Agenda item 28-09.021

LMNS Programme Board / ICS Board
23 September 2022 / 28 September 2022

The Shrewsbury and Telford Hospital NHS Trust

Agenda item	/21			
Report	CNST MIS Year 4 Progress Update – as at August 2022			
Executive Lead	Director of Nursing			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people	√	Effective	√
	Our service delivery	√	Caring	√
	Our partners	√	Responsive	√
	Our governance	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√	BAF 1, BAF 2 BAF 3, BAF 4 BAF 7, BAF 8	
	For decision / approval	√	**Link to risk register:**	
	For review / discussion	√	CRR 15	
	For noting	√		
	For information	√		
	For consent	√		
Presented to:	23.08.2022 SaTH Women and Children's Divisional Committee 31.08.2022 SaTH Quality and Safety Assurance Committee			
Dependent upon	n/a			
Executive summary:	SaTH is a participant in year 4 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS), which is operated by NHS Resolution (NHSR) and supports the delivery of safer maternity care. This paper sets out SaTH's progress to date in demonstrating compliance with the actions in their current format and plans for the remainder of the reporting period. It also includes information to evidence the closure or partial completion of several Safety Actions, which the committee is asked to receive on behalf of the Trust's Board of Directors.			
Appendices:	There are 12 appendices to this report; all are set out, with reason for inclusion, in section 1.0 (introduction) and referenced individually in the corresponding paragraphs.			
		Hayley Flavell Director of Nursing The Shrewsbury & Telford Hospital NHS Trust 30 August 2022		

1.0 Introduction

1.1 SaTH is a member of the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme (CNST MIS), which is regulated by NHS Resolution (NHSR) and is designed to support the delivery of safer maternity care.

1.2 The scheme incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved all ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

1.3 The purpose of this paper is to provide the Local Maternity and Neonatal System and Integrated Care Board with:

1.3.1 Assurance that SaTH is compliant with the standards it is obligated to have attained by now.

1.3.2 Details of the standards that must be evidenced between now and the reporting deadline of 5 January 2023.

1.4 This paper comprises several appendices (too many to set out on the cover page). Each one is fully explained during the relevant Safety Action paragraph, with a note as to what action is requested of the LMNS / ICS relating to each one. These actions are summarised in the final section of this paper. The appendices are as follows:

1.4.1 **CNST reporting timeline** (for information).
1.4.2 **CNST sign-off process for SaTH and the ICS** (for approval)
1.4.3 **Digital Strategy – Maternity** (Safety Action 2 – for approval)
1.4.4 **1Q2022-23 Transitional Care Audit** (Safety Action 3; for assurance).
1.4.5 **1Q2022-23 ATAIN audit** (Safety Action 3; for assurance).
1.4.6 **Obstetric medical workforce paper – review of compliance** (Safety Action 4; for assurance)
1.4.7 **Updated midwifery workforce paper** (Safety Action 5; already approved by the Board of Directors but provided in this bundle for completeness).
1.4.8 **1Q2022-23 Locally Agreed Safety Intelligence Dashboard** (Safety Action 9; for assurance and with a request to share directly to the Board of Directors).

2.0 Overall Progress Status

2.1 The below chart shows a CNST completion rate as at August 2022 (including compliance with the standards and accrual of supporting evidence) of 39% 'Evidenced and Assured', 38% 'Delivered, Not Yet Evidenced' and 23% 'Not Yet Delivered'.

2.2 This status supersedes the most recently reported position to QSAC and the LMNS (April 2022) which displayed 32% Evidenced and Assured, 21% Delivered, Not Yet Evidenced and 47% Not Yet Delivered.

2.3 The plan is on track for delivery within the deadline of noon on Thursday 5 January 2023, (QSAC have accepted a sign-off procedure plan on behalf of the Board of Directors; this is attached for approval of the ICS at Appendix 2). Nonetheless, some risks to delivery do still exist, and these are highlighted below in section 10.

3.0 Safety Action 1: "Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?"

3.1 SaTH is compliant to date with reporting to the MBRRACE-UK website.

3.2 The Board of Directors (BoD) has received a report each quarter since August 2021 that includes details of the deaths reviewed and the consequent action plans. This must continue up to the deadline of 5 January 2023.

3.3 The most recent report (Quarter 1, 2022-23) was presented by the Director of Midwifery (DoM) to the BoD's Meeting in Private in August 2022. CNST does not require the PMRT report to be shared directly with the LMNS / ICS, however, it can be provided on request.

3.4 **Progress Status: On Track**

4.0 Safety Action 2: "Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?"

4.1 The revised requirement for Safety Action 2, standard 1 is that Trusts have an up-to-date digital strategy for their maternity services which aligns with the wider Trust Digital Strategy and reflects the 7 success measures within the What Good Looks Like Framework[1].

4.1.1 Maternity, Fertility and Neonatal Services and divisional leadership, partnering with the Trust's Digital Leadership team (including the Digital Transformation Officer and Chief Information Officer) have produced this strategy, which has been designed to complement the wider Trust strategy.

4.1.2 This proposed Maternity Digital Strategy is attached at **Appendix 3**. The strategy has been approved by the Women's and Children's Divisional Committee and the QSAC, and will be formally presented for accepted to the SaTH Board of Directors' meeting in October 2022. The Integrated Care Board is requested to **approve** this.

4.2 Regarding standards 2-7: The April 2022 updates to the Divisional Committee, QSAC and other forums noted that SaTH was experiencing issues with data upload to the Maternity Services Data Set (MSDS).

4.2.1 Fortunately, this position has been much improved through ongoing staff training (thereby improving quality of data entered) and resolution of configuration issues. Based on the Trust's own assessment of its data upload for July 2022, the following points should be noted:

4.2.1.1 All 11 Clinical Quality Improvement Metrics (CQIM's) appear to have been uploaded to the requisite standard

4.2.1.2 Body Mass Index, Complex Social Factor and Personalised Care Plans have all been uploaded for over the pass mark of 90% of all women.

4.2.1.3 However, the ethnicity data (standard 6 – a new requirement from the May 2022 CNST update) was only recorded for around 87% of bookings; short of the 90% pass mark.

[1] https://transform.england.nhs.uk/digitise-connect-transform/what-good-looks-like/what-good-looks-like-publication/

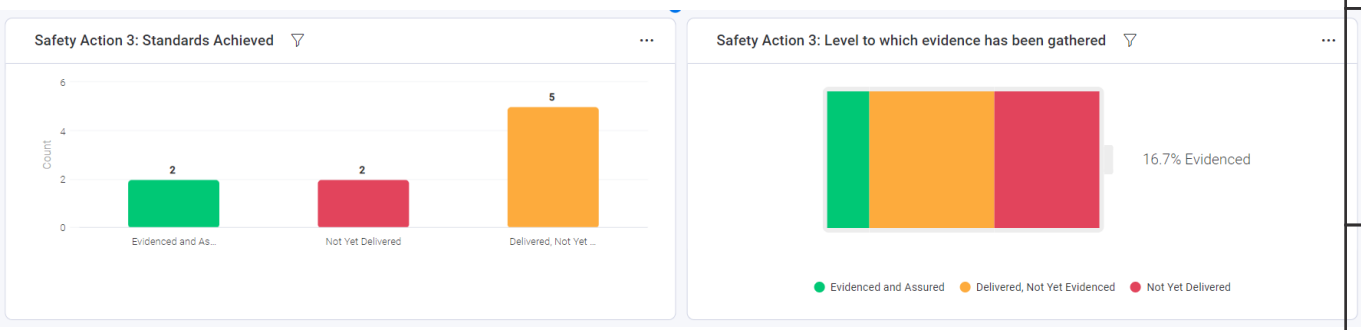
4.2.1.4 A retrospective data gathering exercise, led by the Deputy Director of Midwifery for Quality and Safety, is underway, and it is likely this pass mark will be achieved before the data upload.

4.2.2 Therefore, it is likely this Safety Action will be achieved. However, until this is confirmed, the status must remain 'at risk'. Confirmation will be reported to the LMNS / ICS as soon as it is available.

4.2.3 It should also be noted that data that Trusts upload to the MSDS is not published by NHS Digital for at least two months pending receipt, hence it will not be possible to confirm definitively whether this safety action has been attained until October 2022 at the earliest.

4.3 **Progress Status: At Risk**

5.0 Safety Action 3: "Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?"



5.1 The Trust operates an effective Transitional Care service and associated pathway and continues to meet and often exceed the national target of Avoiding Term Admission into the Neonatal Unit (ATAIN).

5.2 A new standard was introduced in the May 2022 update to the effect that a data recording process (electronic and/or paper based for capturing all term babies transferred to the neonatal unit, regardless of the length of stay, is in place. This was implemented within the mandatory deadline of 16 June 2022.

5.3 Standard b) requires there to be a monthly audit of transitional care; the report for Quarter 1 2022-23 is provided **Appendix 4**. The paper also evidences compliance with standards d) (confirmation that a database exists in which all transitional care activity is recorded) and standard e) commissioner returns are available for ICS scrutiny upon request.

5.3.1 The LMNS / ICS are requested to **take assurance** that transitional care is correctly implemented within the maternity and neonatal services, and **approve** the evidence for standards d) and e) as complete.

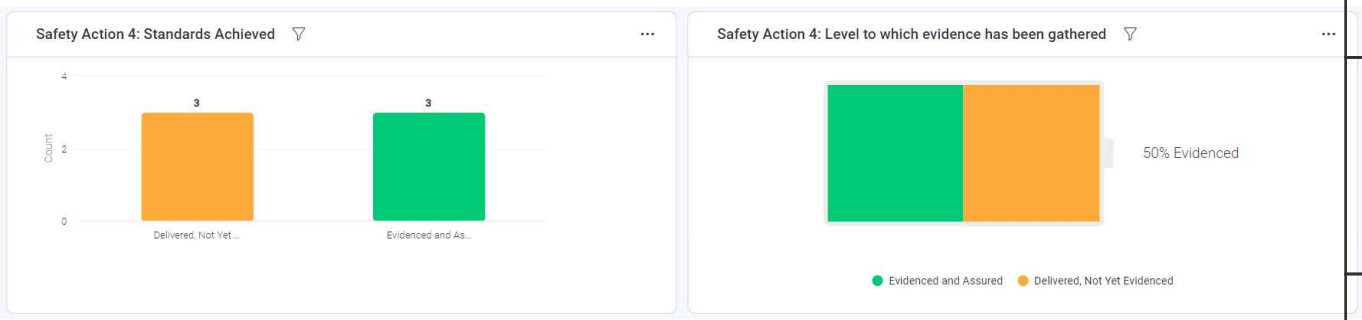
5.3.2 Standard b) must continue to be evidenced each quarter; for CNST purposes Quarter 2 2022-23 (July-September 2022) is the last that must be signed off for this reporting period.

5.4 Similarly, Standard f) requires a quarterly audit of 'Avoiding Term Admission into the Neonatal Unit' (ATAIN) to be conducted – the report for Quarter 1 2022-23 is given at **Appendix 5**.

5.4.1 The LMNS / ICS are asked to **take assurance** from the fact that SaTH continue to exceed the national target of below 6% of term babies being admitted to the neonatal unit, achieving 5.7% for this period. Again, once the quarter 2 audit report has been received, this Safety Action can be considered closed.

5.5 **Progress Status: On Track**

6.0 Safety Action 4: "Can you demonstrate an effective system of clinical workforce planning to the required standard?"



6.1 **Standard a**). The Obstetrics workforce paper was delivered to QSAC on behalf of the Board of Directors at their February 2022 meeting, and the associated audit of consultant attendance where required has been conducted and found to be compliant; this completed Standard a) Part 1.

6.1.1 The May 2022 updated requires standard a) Part 1 to be reviewed at least once since the re-launch and reported to the Board of Directors (via QSAC) and to the LMNS.

6.1.2 The Clinical Director for Obstetrics has reviewed the paper and confirmed that it stands, with no need for amendment. Detail to support this finding is provided in a summary paper at **Appendix 6**.

6.1.3 LMNS / ICS are requested to **take assurance** that this closes out Standard a) part 1.

6.1.4 As regards Standard a) Part 2 ("*Units should monitor their compliance of consultant attendance for the clinical situations listed in this document [RCOG Roles and Responsibilities of a Consultant] when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement should be shared with the Trust board, the board-level safety champions as well as LMNS*"):

6.1.4.1 This was subject to the Ockenden Case Notes audit in October 2021 and has been accepted as a standing audit as part of the revised Maternity Forward Audit and Assurance Plan, from which assurance will be taken.

6.1.4.2 In the meantime, the Consultant Lead for Investigating Incidents monitors compliance of this attendance and this is noted at the Neonatal and Obstetric Incident Review Meetings. There have been no breaches or near misses to date.

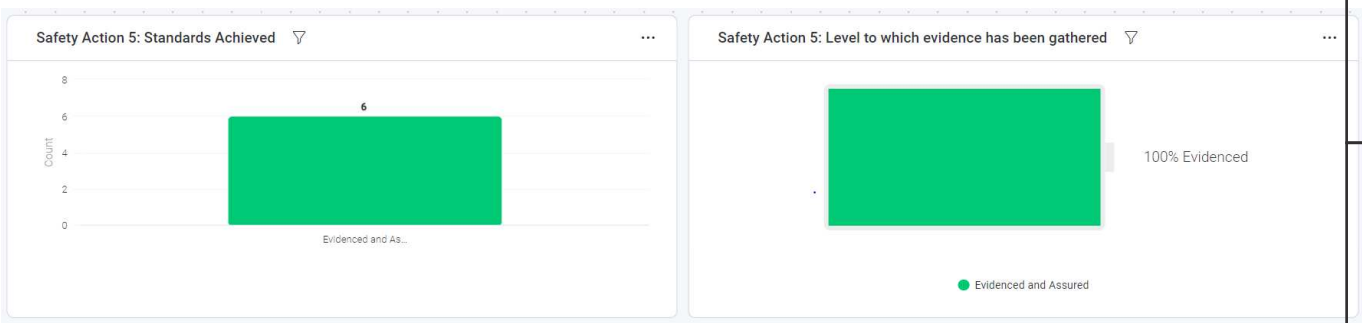
6.2 **Standard b).** Evidence of achieving ACSA Standard 1.7.2.1 was provided to QSAC on behalf of the Board of Directors in the April 2022 update in the form of anaesthetics consultant on-call rotas up to December 2021. The May 2022 re-launch requires this data to be provided for six consecutive months up to and including January 2022. This has been done, and the standard remains compliant, hence this part of the action has been closed out. The rotas prove that, throughout this period, there was a dedicated anaesthetist to labour ward (no other duties outside of maternity) 24/7 every day of the year. These can be shared on request. There is a consultant that can be called every day/ night.

6.3 **Standard c)**. The evidence to show that SaTH has a BAPM-compliant Neonatal Medical Workforce has already been provided to QSAC on behalf of the Board of Directors in April 2022. There has been no change to this standard in the May 2022 re-launch hence it remains complete. The original paper can be shared with LMNS / ICS on request.

6.4 **Standard d)** A separate paper outlining the level of compliance with Safety Action 4 standard d) (Neonatal Nursing Workforce) is being drawn up and will be delivered to QSAC, the LMNS (and ICS, if desired) no later than November 2022.

6.5 **Progress Status: On Track**

7.0 Safety Action 5: "Can you demonstrate an effective system of midwifery workforce planning to the required standard?"



7.1 This action requires two papers covering midwifery staffing to be provided to the Board of Directors during the course of the reporting year; the first was provided in November and the second was included in the previously mentioned "Ockenden Review into

Maternity Services – 1 year on" paper which was received by the Board of Directors in February 2022.

7.2 This action had been completed at the time of the April 2022 QSAC update. However, the May 2022 re-launch has an additional standard (b), which requires the Board of Directors to evidence that the midwifery staffing budget reflects establishment as calculated in a systematic, evidence-based process to calculate midwifery staffing establishment.

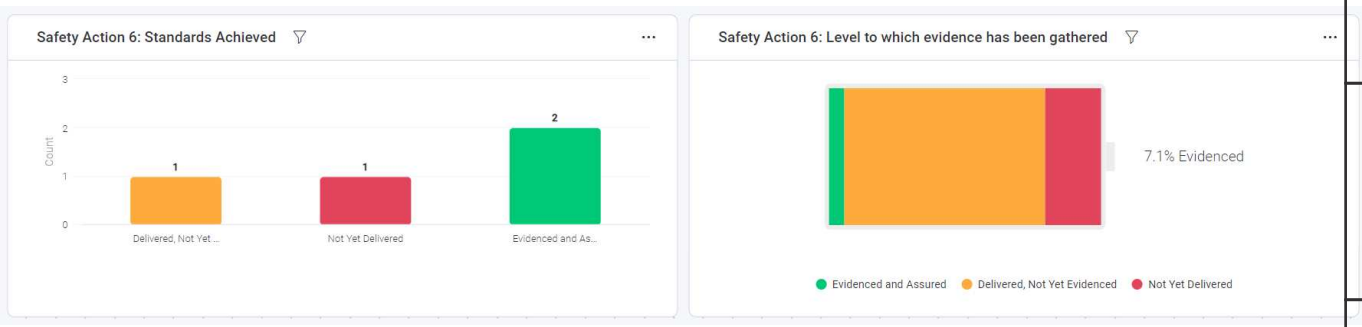
7.3 The latest update, dated 14 July 2022 and covering Quarter 4 of 2021-22 was produced by the Director of Midwifery, and has also been received by the Board of Directors and QSAC. This paper is re-attached **for information** at **Appendix 7**. A further paper covering Quarter 1 2022-2023 (April to June 2022) has been produced by the DoM and will be shared with QSAC and the LMNS / ICS at their September and October 2022 meetings, respectively.

7.4 SaTH implements the process referenced here by commissioning the Birthrate Plus™ tool. In the light of Immediate and Essential Action 2.4 from the final Ockenden Report, the Director of Midwifery has decided to re-commission this assessment, which is expected to be have been completed by October 2022.

7.5 In compliance with Standard b), the Birthrate Plus report most recent was received by the Board of Directors on 10 June 2021 and approval to fund the posts accordingly was given. This standard has therefore already been satisfied, notwithstanding point 7.4 above.

7.6 **Progress Status: Complete**

8.0 Safety Action 6: "Can you demonstrate compliance with all five elements of the Saving Babies' Lives (SBL) care bundle version two?"



8.1 This is one of the largest and most complex of all the Safety Actions because it comprises the five elements of SBL:

8.1.1 Reducing smoking in pregnancy.
8.1.2 Risk assessment, prevention and surveillance of pregnancies at risk of foetal growth restriction (FGR)
8.1.3 Raising awareness of reduced foetal movement (RFM)

8.1.4 Effective fetal monitoring during labour.

8.1.5 Reducing preterm birth.

8.2 Pertaining to Element 1, and as highlighted in the April 2022 update to QSAC, the Trust is still experiencing difficulty in achieving the standard required of >80% women receiving CO monitoring at 36 weeks

8.2.1 Encouragingly, CO monitoring booking is now routinely being monitored to for above 80% of women (i.e. the target has been attained for the last four consecutive months), and in July 2022 this target was also reached for the 36 week appointment.

8.2.2 In order to achieve compliance with this standard, SaTH must achieved >80% on both metrics for four consecutive months before the end of the reporting period in January 2023. Therefore, whilst the trajectory is positive, this action must still be considered 'at risk'.

8.3 In accordance with the requirements of Elements 2 and 5, the quarterly audits have been completed and can be shared with the LMNS / ICS on request.

8.3.1 The LMNS / ICS is asked to take assurance that smoking rates in pregnancy are falling in our local communities, and that, at SaTH, detection and management of babies less than the 3rd centile remains better than the Perinatal Institutes national GAP user average.

8.3.2 However, detection and management of babies born between the 10th and 3rd centile is below the Perinatal Institutes national GAP user average. This is a concern, hence is a focus for 2022/2023.

8.4 Finally, the ICS / LMNS is asked to **note** that, in compliance with standard 5 e. SaTH:

8.4.1 Has have a dedicated Lead Consultant Obstetrician with demonstrated experience to focus on and champion best practice in preterm birth prevention (Mr Guy Calcott – job plan available on request).

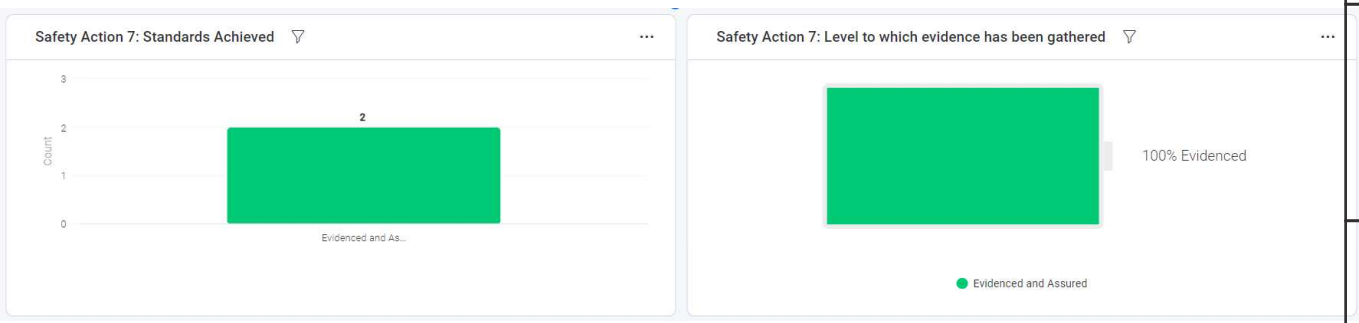
8.4.2 Provides for Women at high risk of preterm birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided (preterm clinic plans and description available on request).

8.4.3 An audit of 40 consecutive cases of women booking for antenatal care has been completed to measure the percentage of women who are assessed at booking for the risk of preterm birth and stratified to low, intermediate and high risk pathways, and that this complies with NICE guidance (audit available on request).

8.5 The LMNS / ICS is asked to **take assurance** from these attestations that Standard 5 e has been satisfied, **note** that this assurance, with supporting evidence was accepted by QSAC on behalf of the Trust Board of Directors, at their August 2022 meeting (the Board of Directors must explicitly state that each of these sub-items have been achieved, at their October 2022 meeting).

8.6 **Progress Status: At Risk (due to the above-mentioned risk relating to CO testing targets for mothers at 36 weeks; all other actions are 'on track').**

9.0 Safety Action 7: "Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?"



9.1 The productive partnership between SaTH and the Maternity Voices Partnership continues to yield important outcomes for service users and staff alike

9.2 All of the evidence requirements for Safety Action 7 has now been secured, with the receipt of the following two items:

9.2.1 Written confirmation from the MVP service user chair that they and other service user members of the MVP committee are able to claim out of pocket expenses, including childcare costs in a timely way, and that the Chair receives remuneration in line with Trust processes and reflective of the commitment. This letter can be shared with LMNS / ICS on request, provided the chair consents to this.

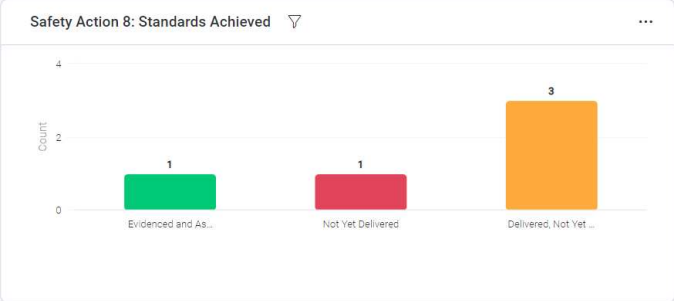
9.2.2 Evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality.

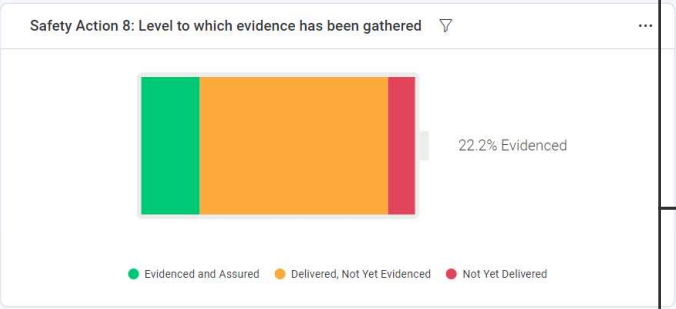
9.2.2.1 The MVP Development Co-Ordinator has authored a paper titled '*Engagement with Seldom Heard Groups, including the Black, Asian and Minoritised Ethnic communities*.' This paper included a number of proactive proposals for LMNS consideration.

9.2.2.2 The plan has already been shared with the LMNS, presented by the MVP service user chair and development co-ordinator.

9.3 **Progress Status: Complete**

10.0 **Safety Action 8: "Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum foetal surveillance and new-born life support, starting from the launch of MIS year 4?**





10.1 It was reported in the April 2022 QSAC update that this action was at risk. Due to successful mitigation since this report and the extended CNST deadline announced in the May 2022 update, the action is back on track, and most groups are compliant to at least the 90% level. However, due to new starters and expiry, some groups have fallen back in compliance with some training; this is being remediated on priority.

10.2 There is a requirement that 90% of each relevant maternity unit staff group have attended an 'in-house' one day multi-professional training day, to include maternity emergencies starting from the launch of MIS year four in August 2021. As of 31 July 2022, SaTH has achieved the following statuses, and is on track to reach the 90%:

10.2.1 Midwives: 95%
10.2.2 Obstetrics Consultants: 100%
10.2.3 Other doctors: 100%
10.2.4 Obstetrics anaesthetists: 100%
10.2.5 Healthcare assistances / midwifery service assistants: 90%

10.3 The training must also include antenatal and intrapartum foetal monitoring and surveillance, starting from the launch of MIS year four in August 2021. As above, statuses as of 31 July 2022 are:

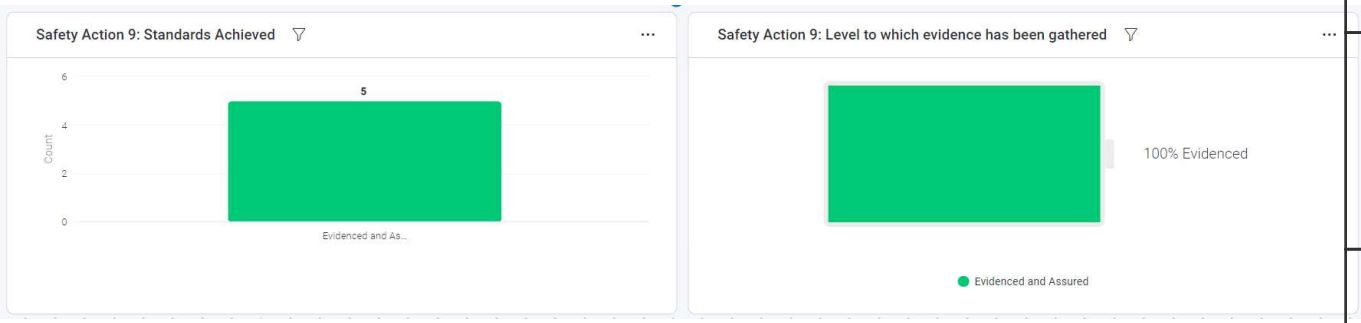
10.3.1 Midwives: 95%
10.3.2 Obstetric Consultants: 100%
10.3.3 Other Doctors: 78% (training underway to bring this back to above 90%)

10.4 Neonatal Life Support (NLS) training rates have also all exceeded the 90% minimum limit for Neonatal Nurses and Doctors at this time, but has fallen to 79% for in-scope midwives. A plan to bring this back to above 90% is underway.

10.5 A full report, to include line-by-line evidence, will be provided to QSAC no later than November 2022 and a summarised version provided to the inform Board of Directors at their seminar session on 1 December, to inform final declaration.

10.6 **Progress Status: At Risk**

11.0 Safety Action 9: "Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?"



11.1 This action has now been fully evidenced, with the group having been apprised with all necessary CNST documentation and reporting to date.

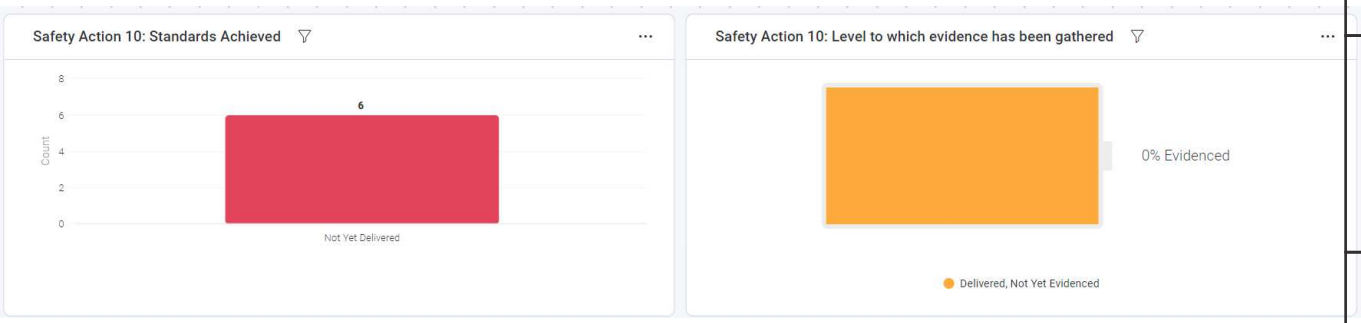
11.2 The Group continue to meet on a monthly basis, with a 'walkabout' of a clinical area conducted at least every second month.

11.3 The group now benefits from the inclusion of a new Non-Executive Director Safety Champion, Professor Julie Green.

11.4 The most recent 'Locally Agreed Safety Intelligence Dashboard' as produced by the Safety Champions, is provided at **Appendix 8** for **information** and **consent**.

11.5 **Progress Status: Complete (quarterly dashboard to continue to be provided to QSAC and the Board of Directors).**

12.0 Safety Action 10: "Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22?



12.1 This Safety Action relates principally to the work of the Divisional Quality Governance Team, supported by the Assistant Director of Nursing, Quality Governance. As with Safety Action 1, the need to report appropriately to the (HSIB) and the NHS Resolution Early Notification Scheme (ENS) is ongoing, hence this action is never 'completed'.

12.2 Notwithstanding this, the action was presented as having been closed out in the April 2022 report to QSAC, there having been evidence of compliance with HSIB and ENS reporting and Duty of Candour for the period concerned, namely financial year 2021-22.

12.3 The reporting period has been extended to December 2022 under the terms of the May 2022 update. Accordingly, a refreshed paper evidencing compliance will be brought to QSAC in November 2022, with a summary of this being provided to the Board of

Directors and LMNS / ICS to inform final declaration at the Board Seminar Session on 1 December 2022.

12.4 **Progress Status: On Track**

13.0 Ongoing Risks to Delivery

There is a risk that…	The risk is caused by…	The potential impact of the risk is…	The mitigation in place is…
The Maternity Services Data Set may be incomplete (SA2), with one quality metric currently not achieved	Insufficient number of data sets collected for service user ethnicity on booking	A failed data set for the month of July causing failure of Safety Action 2	1. All 11 Clinical Quality Improvement Metrics appear to have been hit 2. The sub-metric for ethnicity is being re-gathered as a retrospective exercise; >87% had been reached and the remaining ~3% is feasible.
Trust may miss SBL CO testing targets for mothers for the 36-week CO monitoring). (SA6)	Configuration issues between the Badgernet and Medway EPRs; a shortage of breathing tubes in Spring 2022.	If we don't achieve a minimum of 80% compliance over a 6 month for the 36-week CO monitoring the Trust will fail Safety Action 6.	1. CO testing at booking now achieved routinely 2. In June 2022, CO monitoring target was also achieved for 36- week point. 3. If this trajectory or level continues for a further 3 months, standard will be achieved.
Trust may miss 90% target for Neonatal Life Support training for midwives and for fetal monitoring for 'other doctors'.	Training having expired for some colleagues within these groups	Failure of Safety Action 8	1. Training scheduled for these colleagues within deadlines 2. SaTH expect to achieve this Safety Action, but cannot guarantee this at this time.

14.0 Summary

14.1 SaTH is mostly on track to achieve CNST MIS Year 4 in its latest format, though some risk to delivery for Safety Actions 2, 6 and 8 remains.

14.2 In the April update to QSAC, under the October 2021 guidance, SaTH was able to evidence that three of the of the ten actions had been completed, four were on track, and three at risk (mitigation in place).

14.3 The latest status (die to amended standards and revised deadlines, with associated requirement to evidence for a longer period of time), the Trust can report that eight actions are 'on track' (of which three are nearly complete), and two are 'at risk'.

15.0 Summary of Safety Action completion Statuses:

Safety Action #	Completion Status
1	On Track
2	At Risk
3	On Track
4	On Track
5	Complete
6	At Risk
7	Complete
8	At Risk
9	Complete
10	On Track

16.0 Actions Requested of QSAC:

16.1 **Review and discuss** this paper and advise the Women's and Children's divisional leadership team of any further detail required.

16.2 **Take information** from Appendix 1 as to the remaining evidence which must be shared with the LMNS (and where applicable, the ICS) up to and including the deadline on 5 January 2023.

16.3 **Note** the ongoing risks to delivery but **take assurance** that the likelihood of these occurring has further reduced since the last report in June 2021.

16.4 Be prepared to **support** the Board Seminar session on 1 December 2022 at which the CD for Obstetrics and DoM will be required to provide a summary of CNST evidence in its entirety to guide Board of Directors sign-off and nominate and make available an accountable officer as set out in the sign-off process at **Appendix 2**.

END OF MAIN PAPER

Appendix 1: Proposed CNST reporting schedule July-December 2022, for the awareness of the Board of Directors and ICB[2]

Safety Action	Description of Report / Document	Month of Receipt	MNSCG	QSAC	LMNS & ICS	Board of Directors (summary)
1	Quarterly PMRT report	Jul 2022 Oct 2022	✔	✔		✔ (Private)
2	Maternity Digital Strategy	Oct 2022	✔	✔	✔	✔
	Confirmation of MSDS CQIM Compliance	Nov 2022		✔		
3	Transitional Care Quarterly Audit	Jul 2022 Oct 2022	✔	✔	✔	✔
	ATAIN Quarterly Audit	Jul 2022 Oct 2022	✔	✔	✔	✔
4	Confirmation that a review of SA1 Standard a) 1 has been conducted since May 2022	Jul 2022	✔	✔	✔	
	Neonatal Nursing Workforce Staffing Paper (Std d))	Nov 2022	✔	✔	✔	
	Confirmation that Standard a) 2 has been checked each month from May 2022-Nov 2022	Dec 2022		✔		
5	Refreshed midwifery workforce paper and MCoC paper	Oct 2022	✔	✔	✔	✔
6	Quarterly survey and audit reports (FGR, RFM, Smoking Cessation)	Jul 2022 Oct 2022		✔		
7	Confirmation of appropriate remuneration / expenses for Chair and volunteers	Sep 2022		✔		
	Confirmation that the MVP are prioritising the voices of women from BAME backgrounds and women from areas of high levels of deprivation	Sep 2022		✔		
8	Evidence of a local training plan and 90% compliance for relevant groups	Dec 2022		✔		
9	Quarterly Locally Agreed Safety Intelligence Dashboard	Jul 2022 Oct 2022	(Produced by this group)	✔	✔	✔
10	Refreshed evidence of compliance with HSIB and EN notifications, family involvement and Duty of Candour from May 2022-Dec 2022	Dec 2022		✔	✔	
Summary presentation	Presentation of compliance with all 10 Safety Actions from DoM and CD Obstetrics. ICB accountable officer to be present.	1 Dec 2022				✔ (Seminar)
Authorisation to sign	Board of Directors discusses the presentation received on 1 Dec and confirms position on 10 SA's. Votes authority to sign declaration to CEO (ICB votes same for AO)	8 Dec 2022			(✔)	✔
Final Briefing	W&C division to brief on compliance of actions that have to be evidenced right up to CNST deadline. ICB rep present.	28 Dec 2022		✔		
Declaration	CEO (on behalf of SaTH BoD) and AO (on behalf of ICB) sign the declaration form and submit to NHSR.	29 Dec 2022 or 4 Jan 2023 (sugg.)			✔ (AO)	✔ (CEO)

[2] All reports will be presented to Maternity and / or Neonatal Governance and Women and Children's Divisional Committee for ratification before publishing

CNST Year 4 declaration process – planned timeline

Proposal to QSAC, July 2022

Prepared by: Tom Baker, Deputy Director of Ops, Women's & Children's Division, on behalf of Hayley Flavell, Director of Nursing and Executive Sponsor, Maternity Transformation.

Date: 20 July 2022

1. MoU purpose
2. National oversight
3. ICB delegati
4. West Midlands
5. West Midlands
6. ICS Performa
7. Winter Plan
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Situation, Background, Assessment and Recommendations

Situation

- SaTH's Board of Directors must sign the Trust's self-declaration form for CNST no later than noon on Thursday 5 January 2023 (and no earlier than Thursday 29 December 2022).
- The declaration form must be signed by the CEO (as authorised by the Board of Directors) and an accountable officer from the Integrated Care Board.
- The declaration form requires the Trust to state whether it is compliant with each of the ten Safety Actions that comprise CNST. To support this, CNST mandates that the Director of Midwifery and Clinical Director of Obstetrics deliver a presentation showing the Trust's position against each safety action summarising the evidence to support this.
- The declaration form will be available on the MIS webpage at a date yet to be confirmed.
- The purpose of this presentation is to set out a proposal for when and how this process can be implemented.

Background

- SaTH is engaged in Year 4 of the Clinical Negligence Scheme for Trusts - Maternity Incentive Scheme*, which is administered by NHS Resolution and designed to support the delivery of safer maternity and neonatal care.
- CNST comprises 10 Safety Actions. If successful in delivering all of these, the Trust will receive a 10% rebate of its maternity premium.
- As part of the process, the Board of Directors must authorise the CEO to sign the CNST self-declaration form. The CEO must also ensure that the form is counter-signed by an accountable officer from the Integrated Care Board (ICB).

*https://resolution.nhs.uk/wp-content/uploads/2022/05/MIS-year-4-relaunch-guidance-May-2022-converted.pdf

Assessment and Recommendation

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- Most of the Safety Actions should be fully evidenced before **December 2022.**
- Therefore, it is feasible to provide the evidence presentation to the Board Seminar scheduled for **1 December 2022**, with a formal report of the outcome to be presented to the Board of Directors' Meeting on **8 December 2022**. The ICB accountable officer should be nominated beforehand and should be present at both events.
- However, some of the safety actions which focus on external reporting (SA 1 and SA 10) must be evidenced up to **5 December 2022**, and others must be evidenced as at **5 January 2023** (SA 2, SA 7 and SA 8), though in practice these can be satisfactorily evidenced up to a week before.
- Therefore, the Board of Directors will require a brief, final assurance update as close as practicable to 5 January 2023. It is proposed that the QSAC meeting scheduled for **28 December 2022** can be used for this. Declaration can be made from the following day (**29 December**) up until the deadline of noon on Thursday 5 January 2029.
- Therefore, a suitable date between **29 December 2022 and 4 January 2023** for the CEO and ICB accountable officer to meet and sign the declaration, with suitable admin support and a representative from Women's and Children's Division, **needs to be identified**.
- In the unlikely event that any change to the declaration between it being signed and the final deadline of 12 noon on Thursday 5 January 2023, it would incumbent on Women's and Children's Division to alert the Board of Directors and support any consequent notification to NHS Resolution.

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Timeframes

Timeline

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Date	Event	Action required
1 December 2022	Board Seminar	• DoM and CD to deliver a presentation detailing level of CNST compliance with supporting evidence.
8 December 2022	Board of Directors' Meeting in Public	• Board of Directors to receive summary of discussion from the Development Session • Board of Directors to grant authority for CEO to sign the declaration (ICB Accountable Officer must also be duly authorised) • Board of Directors to authorise QSAC to validate any remaining evidence between this date and 5 January 2023.
28 December 2022	QSAC Meeting	• QSAC to receive assurance that any remaining evidence requirements have been satisfied.
Suitable date between 29 December 2022 and 4 January 2023	CEO and ICB Accountable Officer meet to sign self-declaration	• Women and Children's Deputy Director of Ops to prepare the document in advance • Any final administration, assurance and confirmation provided to CEO and ICB Accountable Officer • Sign the self-declaration, submit to NHSR and archive a copy.

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Actions requested of the ICB

ICB are requested to:

1. Approve this plan and associated timeline from ICS perspective.
2. Confirm this to the Trust Board of Directors in order for Corporate Secretariat to make the necessary arrangements.
3. Arrange for an ICS accountable officer to join the sessions on 1 December 2022, 8 December 2022 and the final sign-off meeting (date to be confirmed, between 29 December 2022 and 4 January 2023) in order to receive information to support declaration and to counter-sign the declaration form.
4. Communicate available dates for this colleague per step 3 above.

Appendix 3 to LMNS / ICS CNST Update - Sep 2022

The Shrewsbury and Telford Hospital NHS Trust

Our Digital Strategy supports the Maternity Transformation Programme

This Trust has embarked on a Maternity Transformation Programme. This aims to achieve sustainable improvements within maternity services, whilst focussing on implementing and embedding all actions outlined in the findings of the Ockenden Report in March 2022.

This Digital Strategy aims to promote safe and effective care across the Trust, whilst supporting the objectives of the Maternity Transformation Programme (MTP). We will continue to build upon the successful introduction of core solutions such as Viewpoint and BadgerNet, and will respond to opportunities to use digital to enable the implementation of actions within the Ockenden Report. Our future delivery means giving our service users greater access to their records through the Patient Portal and putting in information screens in the maternity department as well as throughout the hospital sites. We will continue to work with our Maternity Voices Partnership to ensure we have digital inclusion, our solutions are designed with our service users' needs first and we continue to report our progress through tools such as Monday.com. Our aim is to use digital to support clinicians, midwives and service users to have a safe and positive experience of our care.

Maternity planned deliverables

Viewpoint

Ultrasound reporting and image management solution.

BadgerNet

Total continuity of maternity care across settings beyond the hospital and out into the community using a fully-inclusive solution, which captures and records information for women antenatally and postnatally, as well as during the intrapartum period.

ImproveWell App

Enhancing staff engagement and boosting morale, using the innovative idea hub, push notifications, pulse surveys and sentiment tracker features within the platform.

Maternity Whiteboard

Introducing screens to share key information with clinicians 'at a glance' to improve service user flow, reduce errors and releasing staff time to provide care.

Fertility Viewpoint scanners

System and scanners to support fertility management.

Digital transformation will improve our maternity care

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Project	Objective(s)	How this will deliver excellent care for service users	How this will provide an environment that our staff can thrive in	How this will make us more effective and efficient as an organisation and partner
Ultrasound reporting and image management *(Viewpoint)*	Provision of a secure, accessible image management platform.	Best possible interpretation of images; user-friendly solution	Efficient access to images with minimal non-value-adding processes	Where applicable / appropriate, easily facilitated image sharing with partners.
Maternity records system *(BadgerNet)*	Electronic Patient Record system for end-to-end maternity care.	Mobile app encourages engagement of the service-user with access to appointment information and pregnancy advice.	Improved handover of care between ward areas. Consistent approach to maternity documentation.	Efficient and comprehensive transfer of service user documentation between neighbouring trusts.
Neonatal records system *(BadgerNet)*	Implementation of full Badgernet EPR for neonatal care.	Integrated systems encompassing maternal and neonatal notes.	All information integrated into one system.	Ability for whole team to access all information. Reduction in current duplication across several systems.
Maternity Whiteboard	Replace handwritten handover board with an integrated, contemporaneous and editable interface to the EPR system.	Reassurance that all staff have timely access to the service-user's situation to better respond to their needs.	Clear and consistent presentation of the service-user's situation and needs to make handovers, and the reaction to acute events, as efficient as possible.	Improve timeliness of interventions through visibility and standardisation of service-user details.
Maternity and Neonatal Dashboard Maturity	Ensure accurate data is provided of quality and performance indicators in maternity.	Demonstrate safety metrics and benchmark against national metrics.	Allow staff to have the knowledge of our performance and feel pride in the job they are doing.	Provide assurance to our system partners of quality and safety indicators.
Patient Information Screens	Provide quality information to staff and service users.	Patients will have information that supports informed consent.	Staff will feel pride in seeing improved metrics and a greater sense of ownership.	Aligns with recommendation from recent CQC visit.
ImproveWell App	Harness staff insight to deliver the safest, kindest care and enhance staff engagement.	Use staff's deep knowledge of processes and estate to target improvements.	Staff have a greater voice are more empowered and able to influence service development.	SaTH will be able to give more accurate feedback to partners to focus investment to best effect.
Fertility Viewpoint scanners	Deliver updated systems.	Further enhanced image quality supports excellent care.	Empowered to give best possible care.	Fully compatible systems.

Maternity

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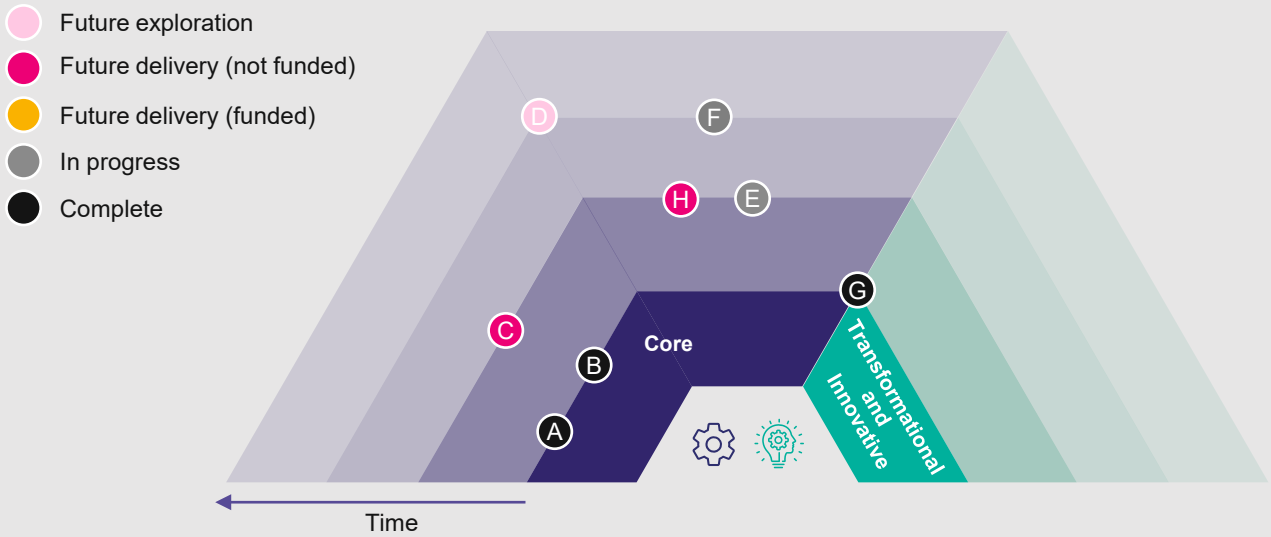
The digital transformation within maternity services aligns to our Trust's Digital Strategy

As set out in the over-arching Trust Strategy, the maternity services' plan and reflects the 7 success measures within the What Good Looks Like Framework[1].

Improved maternity dashboard data will allow divisional and service leadership to concentrate managerial support in the right areas and drive associated improvement.

Overall data quality will improve, enabling better peer-to-peer and national learning. Use of digital information screens will reduce paper waste and laminating, thereby driving environmental efficiencies. The platforms selected have market-leading cyber security features, thereby protecting patient data.

Many of these initiatives will make it easier for staff to voice there ideas and opinions, and enable managers to provide timely and well-structured feedback. Service users will have maximal access to information to empower them to make informed decisions about their care.



	What we will implement	What this will achieve	How this aligns to our Trust Digital Strategy
A	Ultrasound reporting and image management *(Viewpoint)*	Simplifying ultrasound image management, reporting and data gathering.	Records Management
B	Maternity records system *(BadgerNet)*	Giving mothers greater access to and more control of their pregnancy records or care notes through paperless records. Capturing and recording information for women antenatally and postnatally, as well as during the intrapartum period.	Records Management
C	Neonatal records system *(BadgerNet)*	Expanding the maternity records functionality to Neonatal services.	Records Management
D	Maternity Whiteboard	Introducing screens to share key information with clinicians 'at a glance' to improve patient flow, reduce errors and increase patient facing time.	Decision Support
E	Maternity Dashboard Maturity	Maternity information linked to National Maternity data set	Business and Clinical Intelligence
F	Patient Information Screens	Introducing digital screens to provide up to date information to patients about Maternity Services.	Access and Communications
G	ImproveWell App	Enhancing staff engagement and boosting morale, using the innovative idea hub, push notifications, pulse surveys and sentiment tracker features within the platform.	Not mapped to a MDF theme in the strategy, however, the initiative will support the Maternity Transformation Programme directly
H	Fertility Viewpoint scanners	System and scanners to support fertility management.	Not mapped to a MDF theme in the strategy, however, the initiative will support the Maternity Transformation Programme directly

[1]. What Good Looks Like framework - What Good Looks Like - NHS Transformation Directorate (england.nhs.uk)

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Appendix 4 to LMNS / ICS CNST Update - September 2022

Agenda item	n/a			
Report Title	Transitional Care Quarterly Audit Q1 2022/23			
Executive Lead	Hayley Flavell, Director of Nursing			
Report Author	Sarah Whitehead, Postnatal Ward Manager			
	Link to strategic goal:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people	√	Effective	√
	Our service delivery	√	Caring	√
	Our governance	√	Responsive	√
	Our partners		Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√	BAF 1,2,3,4,7,8	
	For decision / approval	√	**Link to risk register:**	
	For review / discussion		CRR 15	
	For noting			
	For information			
	For consent	√		
Presented to:	*11.08.2022 W&C Divisional Quadrumvirate*			
Executive summary:	This paper is to provide assurance that transitional care activity is audited in line with the standards as directed by BAPM and reflected in the maternity guideline. In line with the CNST maternity incentive scheme safety action 3 this paper supports the process of auditing Transitional Care Services <u>April-June 2022</u> • Reason for admission – 100 % reason recorded • Reason recorded and appropriate as guidance – 100% • Observations and investigations as guidance –100 % • Use of Green discharge proforma – 100 % • Daily Neonatal Team review – 100% • Appropriate NIPE – 100 % • Appropriate coding –100%			
Appendices	Appendix 1: Counts of babies admitted to Transitional Care from birth by reason of admission.			
Executive Lead	Annemarie Lawrence Director of Midwifery The Shrewsbury and Telford Hospital NHS Trust			

1.0 **Introduction.** Transitional care is not a place but a service and can be delivered either in a separate transitional care area, within the neonatal unit and/or in the postnatal ward setting.

1.1 Principles include the need for a multidisciplinary approach between maternity and neonatal teams; an appropriately skilled and trained workforce, data collection with regards to activity, appropriate admissions as per HRGXA04 criteria and a link to community services.

1.2 The philosopy of transitional care is to keep mothers and babies together, mothers become the primary care provider for their babies with care requirements in excess of normal newborn care but do not require admission in a neonatal unit and ensures a smooth transition to discharge home.

1.3 The monthly transitional care audit will be inline with the standards set out in the guideline:

1.3.1 Reason for admission to Transitional care
1.3.2 Reason Recorded and appropriate as guidance
1.3.3 Observations and investigations as guidance and documented appropriately
1.3.4 The use of green discharge proforma
1.3.5 Daily neonatal team review
1.3.6 Appropriate NIPE examination
1.3.7 Coded inline with HRG criteria
1.3.8 Outcomes

2.0 This audit will be done based on the monthly transitional care audit of 8 transitional care babies per month which is approximately 20-25 % of babies who are admitted under the transitional care pathway, recommendations will be shared on a quarterly basis.

	Apr-22	May-22	Jun-22
Preterm	10	1	8
SGA	1	1	1
IV ABX	20	33	30
Total	**31**	**35**	**39**

Table 1: Count of Transitional Care admissions by category

3.0 **Background**. The transitional care guideline has recently been amalgamated with the neonatal guideline and updated, we have introduced NEWTT (Newborn Early Warning Trigger and Track) on 14/09/2020 which gives a clearer definition of babies requiring transitional care as below:

3.1 Criteria for transitional care from birth:

3.1.1 Late Preterm babies from 34 – 35+6 weeks gestation
3.1.2 Babies receiving intravenous antibiotics or other intravenous medications
3.1.3 Babies at risk of neonatal abstinence syndrome (NAS) requiring observations
3.1.4 Congenital anomaly likely to require tube feeding (eg cleft lip/palate)
3.1.5 Low birth weight (< 2nd Centile but more than 1.8 kgs)

3.2 Care for transitional care from NNU:

3.2.1 Baby who is having 'step down care' following admission to NNU who is more than 1.6 kgs and maintaining temperature
3.2.2 Step down care tolerating a minimum of 3 hourly feeds

3.3 Transitional care babies are cared for in a four bedded bay and 2 side rooms on the postnatal ward, with a staffing model of 1 Band 6 midwife and 1 WSA to support.

4.0 **Assessment**. 24 sets of neonatal records were used to complete this audit, Medway System EPR was also used.

4.1 **Analysis**. Overall the audit has highlighted a 100% compliance rate in line with the Transitional Care guideline.

4.1.1 All babies noted in the audit were seen daily by the appropriate neonatal team with clear documentation and plan of care.
4.1.2 All babies received NIPEs within the allocated time frame of 72 hours.
4.1.3 100% of the sample had the appropriate NEWTT observations completed and documented onto Medway Maternity System.
4.1.4 88% of the sample had green proformas noted within the notes with clear descriptions of where the baby had been admitted to and the reasons behind the admission. The remaining 12% who did not have green discharge proforma the Neonatal Discharge letters had already been generated therefore, the green proforma was not required – All information noted on the green proforma is documented in the neonatal discharge letter.

5.0 **Other areas to note**. CNST Safety Action 3 mandates that maternity services must provide the following related information and assurance to QSAC (on behalf of the Board of Directors), the Local Maternity and Neonatal System (LMNS) and ICS, as well as the Maternity and Neonatal

5.1 In accordance with CNST safety action 3, standard b), this paper is designed to provide QSAC, LMNS/ICS and the maternity/neonatal safety champions group, with evidence that a quarterly audit of transitional care is being conducted.
5.2 In addition, maternity services wish to confirm to these groups that in accordance with standard d), a database is maintained which records babies between 34+0 and 36+6 weeks gestation at birth, in order to monitor the number of special care or normal care days where supplemental oxygen was not delivered: this database can be shared on request.
5.3 Maternity services wish to confrim that activity returns per neontal critical care dataset version 2 are retained on file and available for LMNS/ICS scruitany upon request in accordance with safety action 3 standard e).

6.0 **Actions requested of the Women's and Children's Divisional Quadruvirate.** The divisional quadrumvirate are are requested to:

6.1.1 **Approve** this report.

6.1.2 Take **assurance** that this audit highlighted a 100% compliance rate in line with updated Transitional Care guideline.

6.1.3 **Consent** for maternity services to continue with this monthly audit to ensure assess compliance in accordance with the TC guideline (alongside Avoiding Term Admission into the Neonatal Unit).

6.1.4 **Consent** for this report to be shared with the Maternity and Neonatal Safety Champions Group, LMNS Programme Board and ICS Perinatal Quality Surveillance Group, QSAC and the Women and Children's Divisional Committee at their respective August meetings, despite the fact that is has not yet been formally received by the Maternity Clinical Governance Committee.

6.1.5 **Advise** as to whether any further clarification on this report is required.

(Sub) Appendix 1 to Transitional Care Quarterly Audit Q1 2022/23: Counts of babies admitted to Transitional Care from Birth by Reason of Admission (Appendix 4 of LMNS / ICS CNST Update - Sep 2022)

Reason For Admission To TC from birth	Number	Percentage
Preterm	3	12%
Babies receiving IVAB	21	88%
Babies at risk of Neonatal Abstinence Syndrome	0	0
Congenital Anomaly	0	0%
Low birth weight	0	0.00%

Reason For Admission to TC from NNU	Number	Percentage
Step down care' following admission from NNU who is more than 1.6kgs and maintaining temperature	0	0.00%
step down care' tolerating a minimum of three hourly feeds	0	0%

	Reason Recorded	Hospital Notes	Obs in line with GL	Green Proforma	NIPE	Seen Daily
Yes	24	24	24	24%	24	24
No	0	0	0	0	0	0
Total Percentage - Yes	100%	100%	100.00%	100%	100%	100%
Total Percentage - No			0.00%	0%	0%	0%

The Shrewsbury and Telford Hospital NHS Trust

Appendix 5 to LMS / ICS CNST Update - September 2022

Agenda item				
Report Title	ATAIN (Avoiding Term Admissions into Neonatal Units) report Quarter 1 2022-23			
Executive Lead	Carol McInnes, Director of Operations, W&C Division			
Report Author	Rachel North, Women and Children's Quality Governance Officer			
	Link to strategic goal:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people	√	Effective	√
	Our service delivery	√	Caring	√
	Our governance	√	Responsive	√
	Our partners		Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√	BAF 1, BAF 2 BAF 3, BAF 4 BAF 7, BAF 8	
	For decision / approval	√	**Link to risk register:**	
	For review / discussion	√		
	For noting	√		
	For information	√		
	For consent	√		
Presented to:	2022.07.26 Women and Children's Divisional Committee			
Executive summary:	ATAIN (Avoiding Term Admissions into Neonatal Units) report Quarter 1 2022-23 Rates of admissions to the Neonatal Unit of babies >37 weeks is 5.7%. Whilst this is a slight increase on previous quarters, it is still below the National target of 6%. Respiratory conditions remain the largest reason for admission. A weekly MDT meeting continues to review all cases in a timely manner and extract immediate learning or safety concerns. An Audit tool template has been developed using a National standard form to review all cases and an action tracker is used to monitor SMART actions arising from meetings.			
Appendices	Appendix 1: Appendix 1 Action tracker Appendix 2: Appendix 2 Audit form template.			
Executive Lead	C. McInnes	Carol McInnes Director of Operations, W&C Division 22 July 2022		

ATAIN (Avoiding Term Admissions into Neonatal Units) Report for Q1 2022-23

Background

Admission to a neonatal unit can lead to unnecessary separation of mother and baby. There is overwhelming evidence that separating mother and baby at or soon after birth can affect the positive development of the mother-child attachment process and adversely affect maternal perinatal mental health.

Preventing separation except for compelling medical indications is essential in providing safe maternity services.

NHS providers of maternal and neonatal care can use the data collected through ATAIN reviews as a resource to:

- improve the safety of care
- keep mothers and babies together whenever it is safe to do so
- identify local improvement priorities
- develop an action plan to ensure any relevant resources are introduced into clinical practice

Improving the safety of maternity services is a key priority for the NHS and the number of unexpected admissions of full-term babies (i.e., those born at 37 weeks or more), is seen as a proxy indicator that harm may have been caused at some point along the maternity or neonatal pathway.

ATAIN focuses on four key clinical areas that represent a significant amount of potentially avoidable harm to babies:

- respiratory conditions
- hypoglycaemia
- jaundice
- asphyxia (perinatal hypoxia-ischaemia)

Review Systems

Weekly Multi-Disciplinary team (MDT) meetings have now been established to review all cases which may meet the ATAIN criteria. Term admissions to the neonatal unit are currently monitored utilising Neonatal BadgerNet digital system, Datix submissions and a manual check of the Neonatal Unit admission book. A cross reference is made with all three systems as a failsafe to ensure that no case is missed. This information is presented monthly at both Maternity and Neonatal Governance meetings. The MDT team is developing an Action Tracker to ensure any themes are collected and learning can be disseminated, and immediate safety concerns actioned and implemented.

Rates

Term admission numbers for Q1 (April, May June 2022) have increased to 59 per quarter (18,17 and 24, respectively.) This gives an overall admission rate for this quarter of 5.7% of all live births, and accounts for 57% of NNU admissions. This remains below the national target of 6%. Of these admissions, following review by the ATAIN review team, 2 admissions were found to have been potentially avoidable during this quarter.

Quarter 1 data –

Reason for admission	Number of babies >37/40
Respiratory conditions	39
Infection	5
Missing admission data described under the category of monitoring	5
Cardiovascular disorders	3
Hypoglycaemia	2
Failed pulse oximetry	1
Surgery	1
Social issues	1
Known congenital abnormalities	1
Jaundice	1
Hypothermia	Nil
Babies were transferred out for therapeutic hypothermia	Nil

- **Respiratory Conditions**

Respiratory issues continue to make up the majority of admissions, with 39 babies this quarter. There were no babies born at greater than 37 weeks, requiring intubation and ventilation.

- **Hypoglycaemia**

In this quarter there were 2 babies admitted with hypoglycaemia, both were infants of diabetic mothers.

- **Neonatal Jaundice/HIE/NAS**

There was 1 admission for jaundice treatment this quarter.
No babies were transferred to a level 3 NICU with Hypoxic Ischemic Encephalopathy, requiring therapeutic hypothermia.
No babies required Neonatal Abstinence Syndrome treatment.

- **Hypothermia**

No term babies had a temperature of 36.4 degrees centigrade or below on admission during this quarter. This reflects a huge improvement on previous quarter's data of all babies admitted at term.

Plan for Q2 2022/2023

- To maintain regular weekly MDT review meetings and to ensure failsafe processes are in place to confirm all eligible cases are captured for review. (Overseen by Director of Midwifery; to be embedded by September 2022).
- To present the report to Maternity and Neonatal Governance meetings. (Overseen by Divisional Quality Governance Lead, to be embedded by September 2022).
- To review and monitor the action tracker on a weekly basis. (Overseen by Divisional Quality Governance Lead, to be embedded by September 2022).

- To develop a digital system via datix as a place to retain all information for audit purposes, to provide assurance that learning can be drawn from any cases where admissions were deemed to be avoidable. (Overseen by Divisional Quality Governance Lead, to be embedded by September 2022).

Appendix 1 Action tracker

Datix ID Incident	Date of incident	SMART Action	Action holder	Progress / immediate actions implemented.	Anticipated completion date	Date completed
224071	18/04/22	Action 1 DS Ward Manager - to contact MES to clarify process for checking sats probes. Subsequent check to be added to daily checklist.	DS Ward Manager	Information currently being sought	31/08/22	
224071	18/04/22	Action 2 USS to be reviewed to ensure all required USSs were undertaken and subsequent planned mode of delivery was appropriate.	Saving Babies lives Lead Midwife	Review awaited	31/08/22	
224381	23/04/22	Action 1 CTG review required – Fetal Tachycardia noted, to determine if timeliness of delivery was appropriate.	EFM Leads	Awaiting update	31/08/22	

Appendix 2 - Audit form template.

To be completed for all admissions to the Neonatal Unit with birth gestation >37 weeks gestation

ATAIN Audit tool, v2 April 2022

NHS no.				**Gestation**			
DOB				**Birth weight (gms)**			
Transfer / Admission date		**Discharge date**		**Date of Review**			
Transfer / Admission from	Labour Ward / Postnatal Ward / Midwifery Led Unit /Homebirth / Community / Other……			**Category of care on admission**	ITU	HDU	SCBU

TRANSFERS OR ADMISSIONS IN THE FOLLOWING CATEGORIES CAN BE EXCLUDED FROM THE REVIEW PROCESS

☐ *Any admission that is already subject to a formal incident investigation being undertaken elsewhere in the organisation. Learning from reviews undertaken elsewhere in the organisation in relation to a term admission must be incorporated into the actions and improvement work undertaken as part of this process.*

FOR ALL OTHER TRANSFERS / ADMISSIONS – please answer all questions below

Changes in **Antenatal** management may have prevented this transfer / admission? No☐ Yes ☐

Learning points

Changes in **Perinatal** Management may have prevented this transfer / admission? No☐ Yes ☐

Learning points

Changes in **Postnatal** management may have prevented this transfer / admission? No☐ Yes ☐

Learning points

If you have/had Transitional Care Facilities (virtual or real) could this baby have been cared for in a TC setting?

No☐

Comments:

CTG Reviewed? No☐ Yes ☐

To be completed for all admissions to the Neonatal Unit with birth gestation >37 weeks gestation

ACTIONS POINTS	**NB. These action points will be transferred into a local SMART action plan template.**
	Circle the PRIMARY reason for transfer / admission

1	Management of a respiratory problem requiring: ventilation/ CPAP /oxygen/ observation (circle)
2	Hypothermia or need for temperature monitoring requiring: hot cot/ incubator/ normal care (circle) Temp on admission:
3	Hypoglycaemia or need for intervention to maintain blood glucose: IV fluids/ NG feed/ BF only (circle) Blood sugar on admission:
4	Observation following resuscitation : level of care IC/ HD/ SC (circle)
5	Suspected sepsis requiring: IV antibiotics / septic screen / observation only (circle)
6	Administration of antibiotics with no additional requirement for care.
7	Requires short period of observation: up to 4 hrs, 4-8hrs, 8-12 hrs

	(circle)
8	Admission for single procedure: venepuncture, lumbar puncture, cannulation, Sa02 monitor/cardiac assessment (circle)
9	Management of HIE and or seizures: requires cooling Yes/ No
10	Management of jaundice: requires phototherapy / IV fluids/ exchange transfusion (circle)
11	Management of congenital abnormality: known before delivery Yes/ No
12	Diagnosed NAS: requires drug therapy/ urine toxicology only/ observation only (circle)
13	Feed intolerance/ vomiting/ abdominal distension/ GI factors (circle): requires IV fluids Y / **N**
14	Social issues: safeguarding, awaiting adoption/foster care. No clinical factors for admission
15	None of the above, this baby was admitted for: *write reason below*

Names and job titles of the review leads. As a minimum the care should be reviewed by representation from both maternity and neonatal staff groups:

Midwifery: .....

Obstetric: .....

Neonatology/ Paediatric: .....

Neonatal Nursing .....

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Appendix 6 to LMNS / ICS CNST Update September 2022

Agenda item	Appendix 5 to CNST Year 4 Update to QSAC			
Report Title	CNST Safety Action 4 standard a) refresh			
Executive Lead	Carol McInnes, Director of Operations, Women's and Children's Div.			
Report Author	Dr. Mei-See Hon, Clinical Director, Obstetrics.			
	Link to strategic goal:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people	√	Effective	√
	Our service delivery	√	Caring	√
	Our governance	√	Responsive	√
	Our partners		Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√	BAF1, BAF2, BAF4	
	For decision / approval		**Link to risk register:**	
	For review / discussion		n/a	
	For noting			
	For information			
	For consent			
Presented to:	2022.08.23 Women's and Children's Divisional Committee			
Executive summary:	CNST MIS Safety Action 4 ("Can you demonstrate an effective system of clinical workforce planning to the required standard?") comprises four standards, the first of which relates to the obstetric medical workforce. To meet this standard the consultant team must commit to the relevant RCOG workforce guidance and monitor their ongoing compliance. A paper demonstrating compliance with this was provided to, and accepted by, QSAC at their January 2022 meeting. The updated CNST guidance (May 2022) states that Trusts should evidence their position with the Trust Board, Trust Board level safety champions and LMNS meetings at least once from the relaunch of MIS year 4 in May 2022. This paper provides this evidence.			
Appendices	Nil.			
Executive Lead	C. McInnes	Carol McInnes, Director of Operations, Women's and Children's Division		

1.0 **Introduction**. SaTH is partway through the delivery of the ten Safety Actions that comprise the Clinical Negligence Scheme for Trusts' Maternity Incentive Scheme. This paper is intended to provide evidence of completion of the obstetric medical workforce actions (standard 8) of Safety Action 4: "*Can you demonstrate an effective system of clinical workforce planning to the required standard?*". The standard comprises two parts:

1.1 Part 1: "*The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service*"[1]:

1.2 Part 2: "*Units should monitor their compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement should be shared with the Trust board, the board-level safety champions as well as LMNS*."

2.0 **Background**. The author provided evidence of compliance with Part a) in a paper presented to QSAC on 26 January 2022.

2.1 This paper evidenced compliance with Part 1 in the form of:

2.1.1 Documented evidence of discussion of the RCOG document at relevant meetings e.g. consultant meeting and divisional governance meetings.

2.1.2 Circulation of the document to all staff who work in maternity and gynaecology.

2.1.3 Mandatory consultant attendance list has been included in departmental escalation policies

2.2 The paper explained that Part 2 could not be evidenced at the time it was written, because at that time, only pilot audit of 18 case notes had been conducted – a follow-up audit was planned and subsequently carried out.

2.2.1 This audited 45 case-notes of women who gave birth in the month of October 2021 and demonstrated 92% compliance for the consultant, when contacted, attending in a timely manner in compliance with the SOP.

3.0 **Assessment**. Safety Action 4 Standard a) can be considered complete for both parts, for the CNST MIS Year 4 reporting period:

3.1 There is no change to standard a) part 1 and the evidence sited in January 2022 stands, with ongoing communication regarding the RCOG document.

[1] https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/

3.2 Standard a) part 2 was evidenced as compliant (>90%) in the October 2021 case notes audit.

3.2.1 This audit will be repeated in the near future and will be an ongoing part of the Forward Audit and Assurance Plan.

3.2.2 In the meantime, the Consultant Lead for Investigating Incidents monitors compliance of this attendance and this is noted at the Neonatal and Obstetric Incident Review Meetings. There have been no breaches or near misses to date.

4.0 **Requests**. QSAC is asked to:

4.1 **Receive** this report.

4.2 **Take assurance** from the evidence provided within this report, alongside that already provided in the January 2022 paper, that CNST Standard a) has now been delivered.

4.3 **Advise** the Women's and Children's division of any further assurance that may be required.

Appendix 7 to LMNS / ICS Sep 2022 Update

The Shrewsbury and Telford Hospital NHS Trust

Agenda item	137/22 (a)			
Report	Maternity Safe Staffing for Quarter 4 of 2021/22			
Executive Lead	Hayley Flavell, Director of Nursing			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people	√	Effective	√
	Our service delivery	√	Caring	√
	Our partners		Responsive	√
	Our governance	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√	BAF204	
	For decision / approval		**Link to risk register:**	
	For review / discussion			
	For noting			
	For information			
	For consent			
Presented to:	Women's & Children's Divisional Committee			
Dependent upon (if applicable)**:**				
Executive summary:	This is the first quarterly report of the new Director of Midwifery which reviews safe staffing levels for Maternity Services. The aim of this report is to provide assurance of an effective system of workforce planning. The report provides assurance of the following: a) A systematic, evidence-based process to calculate midwifery staffing establishments is complete b) The midwifery coordinator in charge of delivery suite has supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of support for all midwives within the service c) All women in active labour receive one to one midwifery care d) A quarterly midwifery staffing oversight report that covers the staffing/safety issues is submitted to the Board The evidence described in this paper provides assurance that SaTH has an effective system of midwifery workforce planning and monitoring of safe staffing levels with the appropriate escalation plans in place.			
Appendices	Appendix 1- Maternity red flag events, NICE (2015)* Appendix 2 – Quality Impact Assessment & Overlying SBAR* Appendix 3 – Ockenden Final Report Letter* **In Supplementary Information Pack*			
Lead Executive:	H Flavell			

Midwifery Staffing Report

1.0 Purpose

The aim of this report is to provide assurance to the Trust Board that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels during January to March 2022. This is a requirement of the NHSLA Maternity Incentive Scheme for safety action 5 (NHSLA, 2021).

The report also provides an accurate account of the current workforce status and includes an update from recommendations within the paper presented in February 2022. In addition, gaps within the clinical midwifery workforce are highlighted with mitigation in place to manage this. A clear breakdown of BirthRate Plus or equivalent calculations to demonstrate how the required establishment has been calculated is also included.

2.0 Background

The NHSLA Maternity Incentive Scheme requires that the SaTH demonstrates an effective system of midwifery workforce planning to the required standard using the following standards prescribed within safety action 5 of the MIS:

a	A systematic, evidence-based process to calculate midwifery staffing establishments is complete
b	The midwifery coordinator in charge of delivery suite has supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of support for all midwives within the service.
c	All women in active labour receive one to one midwifery care
d	A quarterly midwifery staffing oversight report that covers the staffing/safety issues is submitted to the Board

The activity within maternity services is dynamic and can change rapidly. It is therefore essential that there is adequate staffing in all areas to provide safe, high-quality care by staff who have the requisite skills and knowledge. Regular and ongoing monitoring of the activity and staffing is vital to identify trends and causes for concern, which must be supported by a robust policy for escalation in times of high demand or low staffing numbers.

BirthRate Plus provides an evidence-based methodology for calculating midwifery staffing requirements based on the case mix for women and babies accessing the service. This staffing report will focus on the recommendations of the BirthRate Plus Report (2021) and how safer staffing is facilitated by adoption of the recommendations, as outlined in the previous staffing paper presented in February 2022.

NICE (2015) published guidance on safer midwifery staffing and identifies red flags where further action is required to ensure safety of women and babies. This maternity staffing report will highlight frequency of maternity safer staffing red flags and the reasons for the red flags.

3.0 Current position

Following the systematic, evidenced based process of the BirthRate Plus tool which was undertaken in 2020 and published in 2021, the required clinical workforce was recommended as 200.55wte which, upon the introduction of the Band 3 Maternity Support Worker (MSW) role using a 90/10 split, would be made up of 180.55 clinical midwives, and 20.05 MSW's.

Table 1 presents the current workforce position of both clinical and non-clinical midwives, MSW's, and includes the required number of additional midwives needed to reopen Wrekin MLU on a full-time basis.

Table 1

	Establishment*	In post	Vacancy
Midwives Bands 5-7	180.55	176.01	4.54
MSW's Band 3	20.05	11.6	8.45
Specialist Midwives Bands 6-8	22.06	30.22	+8.16**
To reopen Wrekin MLU	4.84	0	4.84
Total	227.5	216.83	17.83***

** Based upon an establishment which is exclusive of MCoC*
*** Includes fixed term secondments to support the Maternity Transformation Programme*
**** Excluding specialist midwife posts*

Table 2 presents the same data within columns 2&3 of table 1, however also includes an update on positions that have been recruited to but are not yet in post. The vacancy position within column 5 of table 2 is an over recruitment to compensate for attrition rates and unavailability.

Table 2

	Establishment*	In post	Recruited to but not in post	Vacancy
Midwives Bands 5-7	180.55	176.01	B6 = 2.0 B5 = 25.8 RTP B5 = 0.8 2 trainee MW sonographer 1.6***	+24.06**
MSW's Band 3	20.05	11.6	1.6	-6.8
Specialist Midwives Bands 6-8****	22.06	30.22	2.0	0
To reopen Wrekin MLU	4.84	0	0	-4.84
Total	227.5	216.83	32.2	+21.53

** Based upon an establishment which is exclusive of MCoC*
***Over recruitment to compensate for attrition rates and cover unavailability; majority of the workforce available from Autumn 2022*
****Not included in vacancy position as establishment excludes midwife sonographers*
*****All specialist midwives (including managers) in Bands 6-8 have an element of clinical to their role, using either a 50:50, 60:40 or 80:20 split*

3.1. Unavailability

In addition to the current vacancy position, the speciality is also dealing with a significant unavailability rate which is made up of the following:

Table 3

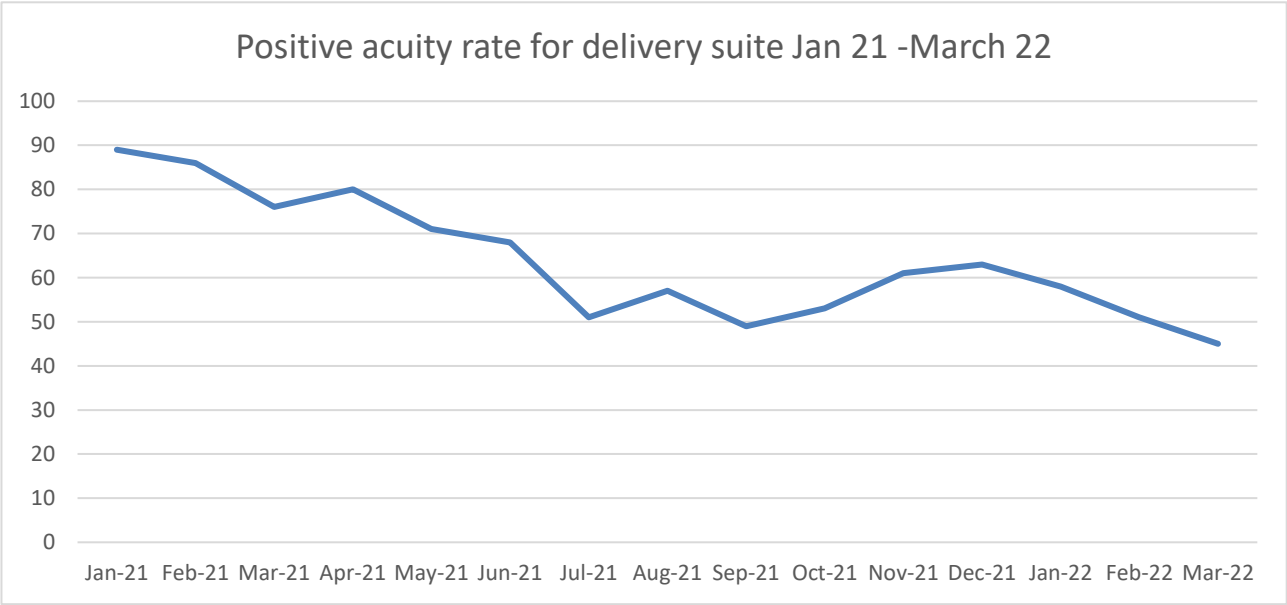
Maternity leave	14.92wte
Long term sickness absence*	14.5wte
Total	29.42wte

*including covid absence

As a service, Maternity has a higher-than-average number of staff on maternity leave, year on year. These posts are usually advertised as temporary positions to enable backfill, however they have historically been difficult to recruit into due to them not being substantial. Given that the service can evidence such a high attrition rate for maternity leave, the decision has been made as part of our workforce plan to convert a portion of the temporary vacancies into permanent positions, resulting in an additional 10wte substantial posts.

3.2. Acuity Data

Graph 1



As can be seen in the graph above, there has been a decline in safe staffing for delivery suite over the last 14 months which is largely due to the transitional phase of introducing the 90/10 skill mix into the clinical workforce and our current vacancy position. This is in addition to unavailability of clinical midwives due to long term sickness and planned maternity leave (table 3). These clinical pressures are being felt operationally daily and are causing challenges in opening the alongside MLU at Wrekin. This is being managed by the escalation policy and twice daily management huddles to ensure services are safely maintained and the MLU is opened when acuity and staffing allows.

Table 4

Month	Number of red flags	1 to 1 care not met	Coordinator not supernumerary	Positive (green) acuity %	acuity red %	Acuity amber%	Acuity compliance rate
January 2022	51	0	5	58%	10%	32%	88.71%
February 2022	109	4	11	51%	14.37%	34.63%	91.07%
March 2022	108	0	10	45%	15.%	40.%	89.25%

The above table evidences the red flag data, in addition to a breakdown of the acuity data for Q4 2021/22. Assurance can be gained from the compliance rate as it is above 85% as agreed by the regions Directors of Midwifery.

4.0 Mitigation

In order to support the workforce during this time of high unavailability and vacancy rates, the following measures have been introduced:

- All specialist midwives have been job planned to work clinically using either a 50:50, 60:40 or 80:20 split which has enabled an additional 4.6wte clinical availability on a weekly basis. This was supernumerary initially however moving forward will be factored into the health roster system and staff counted in the numbers to support safe staffing figures
- Introduction of a 7-day manager of the day rota for maternity services to ensure management support is available to the teams at weekends. This is in addition to the current on-call system as this system is staffed using specialities outside of maternity, i.e., gynaecology, paediatrics, and neonates
- Bank shifts incentivised to 150% for midwives to encourage pick up
- Quality Impact Assessment undertaken to review and suspend Midwifery Continuity of Carer as prescribed within the final Ockenden report (2022) – see appendix 2
- Mobilisation of 4.4wte MCoC midwives into the inpatient workforce to support (with the remaining members of the team
- Representatives of SaTH have joined both Regional and National workforce webinars to ensure the most up to date measures are being undertaken to support staff back to work
- Extension of the HEE funded B7 retention midwife as a commitment to supporting midwives in practice
- Commitment to the Regional campaign of International Midwife recruitment with SaTH committing to supporting 10wte – this commitment also enables the speciality to add diversity to our current workforce

5.0 Midwifery Continuity of Carer

Table 5

	Required establishment for 51% MCoC	In Post Currently
Clinical Midwives	184.97	176.01
MSW's	20.55	11.6
Specialists	22.61	30.22
Wrekin MLU	7.09	0
Totals	= 235.22wte	= 217.83

It is recognised that the midwifery establishment increases when moving towards the implementation of MCoC as additional staff are required to deliver this model of care. For the purposes of this paper, the establishment has been presented exclusive of MCoC in view of the current pause in rollout following the final Ockenden report (2022) (Appendix 3). However, it is worth noting that the requirement for rollout is still present and will need to be factored into to the funded establishment and workforce recruitment campaign therefore the above table (table 5) presents the establishment required to move towards a trajectory of 51% MCoC.

That current BirthRate Plus report should be read with caution as it is only inclusive of the staffing trajectory to achieve a target of 51% and therefore may increase when building in 100% MCoC. Additionally, the report is using data from 2019 despite being published in 2021 therefore it could be argued that it is already out of date. In view of this, there are plans to repeat BirthRate Plus at the earliest opportunity, with a likely start date of June 2022.

6.0 Conclusion

Midwifery staffing is complex; acuity can often change rapidly based on individual care needs and complexities of cases and maintaining safe staffing levels has become more complex recently due to national pandemic challenges and staff isolation, and increased pressures on the workforce as a result of the Ockenden Report and other National Maternity reviews.

A full BR+ report (2021) was commissioned and findings shared with Trust Board via an earlier staffing paper in September 2021. A further BR+ report is scheduled to begin in June 2022 which will look at acuity data from April - June 2022 – these months were specifically selected as the service was solely using Badgernet for its maternity health records system and therefore data reliability increases.

It is anticipated that there will be improved acuity levels in all areas across the service due to the control measures introduced and in turn numbers of red flags generated will be reduced (the data for April and May 2022 shows a positive increase which is in-keeping with the control measures introduced during that month).

Finally, this paper highlights additional scrutiny and monitoring that has been applied to ensure all aspects of safe staffing have been triangulated to provide further assurance. With a clear and robust escalation policy in place and twice daily oversight of the maternity unit's acuity verses staffing being monitored, early interventions can be taken to maintain safety and activate deployment of staff to ensure care needs are maintained and safety remains the priority for the service.

The report highlights that despite a challenging year, the service now has improved oversight of staffing vacancies and oversight of safety metrics with a clear plan in place to address these. It also has a clear workforce plan that utilises a more diverse skill mix, which will enhance care provision and strengthen the clinical workforce.

7.0 Actions Required of the Board of Directors

The Board of Directors is requested to

- Receive this report
- Decide if any if any further actions and/or information are required

Appendix 8

Maternity and Neonatal Safety Champions Group
Locally Agreed Safety Intelligence Dashboard

NHS
The Shrewsbury and Telford Hospital
NHS Trust

Reporting period:	Qtr 1 2022-23	Apr-22	May-22	Jun-22
PMRT	**Findings of review of all perinatal deaths using the real time data monitoring tool**	Stillbirths: 1 Late Fetal Losses >22 Weeks: 1 Neonatal Deaths: 0	Stillbirths: 1 Late Fetal Losses >22 Weeks: 0 Neonatal Deaths: 2 Year 4 Relaunch of CNST Incentive Scheme document was produced. A change has been noted that from 6th May 2022 onwards all perinatal deaths eligible to be notified to MBRRACE-UK should be notified within seven working days.	Stillbirths: 1 Late Fetal Losses >22 Weeks: 0 Neonatal Deaths: 0 All cases with this quarter were reported to MBRRACE within the required timeframe.
HSIB	**Findings of review all cases eligible for referral to HSIB**	May Quality Governance report with April data shows 1 x new SI reported for Maternity in April (stillbirth at 40 wks). Investigation will be led by HSIB. The incident has been uploaded to STEIS. Quality Governance confirm that to assure a more robust monitoring process, any HSIB action plans following the outcome of their investigations, are uploaded to Datix against the relevent incident.	June Quality Governance report with May data shows 3 open Serious Incident investigations ongoing for maternity, 2 of which are being investigated by HSIB. 1 x Closed Serious Incident - there were no safety recommendations from this investigation from HSIB. Learning regarding immediate pain relief needs and alternative analgesia methods, will be disseminated throughout the Division.	2 Serious Incident investigations remain open and ongoing for Maternity with HSIB. The final report from HSIB for the 1 x SI reported last month was approved by RALIG for submission to the commissioners for consideratin of final closure on 30/6/22. Learning of immediate pain relief was communicated to staff via a 3 Minute Brief document on 28/6/22 - an anaesthetist was present during MDT clinical incident review to discuss pain management in theatre.
INCIDENTS	**Report on the number of incidents logged and graded as Moderate or above and what actions are being taken**	11 x incidents were reported as Moderate Harm for April and remain at this level. 1 x incident has been fully reviewed and finally approved. No Moderate harm incidents are currently overdue for review. No severe harm incidents were reported. Where Moderate harm remains following the review, evidence of Duty of Candour is attached to each incident on the Datix system.	2 x incidents were reported as Moderate harm for May and remain at this level. 1 x reported and remains 'death not as a result of the incident' - 26/40 intrauterine death of a twin being reviewed via PMRT process. 1 x baby fall being reviewed as Divisional Investigation.	3 x incidents were reported as moderate harm for June and remain at this level. 1 x escalated appropriately (bladder injury) and management and care in line with guidance. 1 x baby readmitted with jaundice - delay in blood testing, escalated to a Divisional Investigation. 1 x reviewed as an Internal Investigation - patient had a history of recurrent headaches during pregnancy and after birth - CT scan diagnosed a sub-dural haematoma.
TRAINING	**Report on Training compliance for all staff groups in maternity relating to the core competency framework and wider job essential training.**	Maternity specific training continues to be transferred across to LMS, however, some issues are still being resolved and risks around compliance reporting continue to exist. Figures for face-to-face maternity specific training will be held locally on the Maternity Training monitors on the shared drive and will be used for CNST reporting until accurate compliance figures can be obtained from LMS. A number of courses have been booked for May/June/July with support from Ward Manager to remind staff of additional training available.	Relaunch of MIS Y4 from 6 May announced submission deadline extended from June 2022 to 5 January 2023. 90% compliance duing 18 mth period required, acknowledging Cov-19 pressures. The Trust Learning Management System (LMS) piloted since Nov-21 has some issues with registration, transfer of e-Learning data and training compliance figures - these have been highlighted with Corporate Education. A bespoke training package and funding for both equipment and external training courses has been developed to enhance local training. Training risks have been identified and mitigation in place where appropriate. Actions for areas with compliance below 90% have also been identified.	Current SSU compliance report is held by Corporate Education for reporting on Maternity Specific training directly from LMS. First report with accurate data in progress following manual data cleansing process. Available end of July. Maternity Specific Training Compliance figures as at 30 June reports training is largely on track. Action plan is in place to achieve required compliance with MIS Safety Action 8 for NLS training for all staff. Non compliant staff are known to Ward Managers and followed-up by the CPE team to ensure they are booked on to training to include Ad hoc sessions in clinical areas, within the required 12mth period. All staff are to be rostered to attend maternity face-to-face training. Sanctions for non-compliance under review by senior management team.
STAFFING	**Report on minimum safe staffing in Maternity Services:** **- Obstetric cover on the Delivery Suite** **- Midwifery - gaps in rotas - minimum safe staffing planned cover, versus actual**	Obstetric Data: Minimum safe staffing level on the obs unit for doctors is: Tier 1: One from FY2, GPVTS 1-2, ST1-2, equivalent/higher grade Tier 2: One from ST3-7, equivalent/higher grade Tier 3: Consultant covering obstetrics only (gynaecology has its own consultant cover at all times) During the day from 08.30 - 21.00 hrs all three tiers are resident in the building, from 17.00 hrs the Tier 1 and 2 take over cover for gynaecology as well as obstetrics until 08.00 the following day. During nights from 21.00 - 08.30 hrs all three tiers are resident in the building on almost all nights but occasional nights due to sickness may have the tier 3 as non-resident if the resident is the one off sick. On most week days, a second tier 2 doctor will cover obstetric triage from 08.00-19.00hrs. The plan is to extend this provision to the weekend also.	Obstetric Data: Minimum safe staffing level on the obs unit for doctors is: Tier 1: One from FY2, GPVTS 1-2, ST1-2, equivalent/higher grade Tier 2: One from ST3-7, equivalent/higher grade Tier 3: Consultant covering obstetrics only (gynaecology has its own consultant cover at all times) During the day from 08.30 - 21.00 hrs all three tiers are resident in the building, from 17.00 hrs the Tier 1 and 2 take over cover for gynaecology as well as obstetrics until 08.00 the following day. During nights from 21.00 - 08.30 hrs all three tiers are resident in the building on almost all nights but occasional nights due to sickness may have the tier 3 as non-resident if the resident is the one off sick. On most week days, a second tier 2 doctor will cover obstetric triage from 08.00-19.00hrs. The plan is to extend this provision to the weekend also. Midwifery Data: - CE in progress	Obstetric Data: Minimum safe staffing level on the obs unit for doctors is: Tier 1: One from FY2, GPVTS 1-2, ST1-2, equivalent/higher grade Tier 2: One from ST3-7, equivalent/higher grade Tier 3: Consultant covering obstetrics only (gynaecology has its own consultant cover at all times) During the day from 08.30 - 21.00 hrs all three tiers are resident in the building, from 17.00 hrs the Tier 1 and 2 take over cover for gynaecology as well as obstetrics until 08.00 the following day. During nights from 21.00 - 08.30 hrs all three tiers are resident in the building on almost all nights but occasional nights due to sickness may have the tier 3 as non-resident if the resident is the one off sick. On most week days, a second tier 2 doctor will cover obstetric triage from 08.00-19.00hrs. The plan is to extend this provision to the weekend also.

Maternity and Neonatal Safety Champions Group
Locally Agreed Safety Intelligence Dashboard

The Shrewsbury and Telford Hospital NHS Trust

Reporting period:	Qtr 1 2022-23	Apr-22	May-22	Jun-22
SERVICE USER FEEDBACK	**Service User Voice feedback**	Maternity Transformation Programme Team reported the following progress for April: •Devised a format for a larger scale birth preferences card to be displayed on the walls of birth rooms. •Communicated to health professionals to ensure that conversations between colleagues should include the woman involved.	Maternity Transformation Programme Team reported the following progress for May: •Devised plan to manage how information is fed to users of BadgerNotes to help them not feel overwhelmed •Created a 'Who's Who' of consultants for the website	Maternity Transformation Programme Team reported the following progress for June: •Included a checkbox on Badger for continuity discussions. •Commenced the creation of infographic for social media to display maternity related data to service users.
STAFF FEEDBACK	**Staff feedback from frontline champions and walk-abouts**	Walkarounds took place in the Antenatal Ward, Day Assessment Unit and Triage areas during April. Action re. limited number of triage beds in Antenatal ward is ongoing and tracked on Safety champions action log. Plan to present paper next Risk Register meeting and all options for alternative triage locations are being explored with LMNS oversight. Problems regarding privacy are also being addressed.	No walkabout scheduled for May, as three areas were visited in April. Additionally, it has been noted that areas are suffering from 'walkabout fatigue' following the publication of the second Ockenden report.	June meeting stood down due to quoracy not met and unable to reschedule due to unavailability of Chair and DoM. Theatres area to be visited in July and Postnatal ward the following month. Due to the three areas visited in April, it was thought the bi-monthly requirement for CNST is not compromised. A plan for all further visits is in progress.
EXTERNAL AGENCY REQUESTS / CONCERNS	**HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust**	No requests for action have been made directly with the Trust fro HSIB or NHSR.	No requests for action have been made directly with the Trust fro HSIB or NHSR.	There has been 1 x CQC request June. No requests for action have been made directly with the Trust fro HSIB or NHSR.
CORONER REGULATION 28	**Coroner Reg 28 made directly to Trust**	No Coroner Reg 28 made directly to the Trust	No Coroner Reg 28 made directly to the Trust	No Coroner Reg 28 made directly to the Trust
CNST SAFETY ACTION 10	**Progress in achievement of CNST Safety Action 10**	1 x case repoted to HSIB. All qualifying cases reorted to MBRRACE and PMRT commenced in with CNST and compliant with timeframe.	All qualifying cases reorted to MBRRACE and PMRT commenced in with CNST and compliant with timeframe.	Quality Governance report that families have received information on the role of HSIB and the EN Scheme where applicable. Duty of Candour is up to date with all cases.

CQC Maternity Ratings								
	Overall	Requires Improvement	**Caring**	Good	**Safe**	Requires Improvement	Trend: improvement year on year
	Well-Led	Requires Improvement	**Effective**	Good	**Responsive**	Good	

Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)	TBC - data not yet available
Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they would rate the quality of clinical supervision out of hours (Reported annually)	89.06% (source: GMC National Trainees Survey 2021, Appx 13)

West Midlands ICB CEO Collaboration

Agenda item 28-09.022

Appendix A

West Midlands ICBs Joint Committee
Terms of Reference

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1. **Joint Signatories:**

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

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

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

2. **Delegated functions and activities:**

The joint committee has delegated authority from the ICB for the following:

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

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

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

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

1.5 Provision of a forum for collective discussion, agreement and decisions by the constituent members of the committee that is consistent with the delegated limits of each ICB's standing financial orders. So enabling the ICBs to collaborate on areas of work and opportunities that arise.

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

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

3. Accountability

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

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

4. Membership and quoracy

4.1 The joint committee will include the following members:

- The six ICB CEOs
- Consideration may be given to other members being in attendance at the committee. For example:
  - The Senior Manager for the West Midlands ICB CEOs office
  - NHSEI commissioning representative;
  - East Midlands provider collaborative representative;
  - East Midlands public health representative
  - Finance and Clinical representatives from the ICBs

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

4.2 For decisions that are made in relation to section1.5 then quoracy is not required as members are contributing based on their own limits of delegation.

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

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

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

5. Frequency of meetings

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

Appendix B

Joint Commissioning Framework

1. Joint Principles

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

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

1.2.1 improving health outcomes;
1.2.2 improving health inequalities;
1.2.3 improving clinical effectiveness and/or value for money;
1.2.4 supporting the wider economic impact of the ICBs.

1.2 Any joint functions overseen by the joint committee will be organised in such a way that it both:

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

2. Commissioning arrangements

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

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

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

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

3. Joint Commissioning Governance options:

3.1 Lead Commissioner Model

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

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

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

3.1.4 Note: it would be possible for different services to be led by different ICBs (eg: primary care arrangements by one ICB; specialised services by another; 111/999 by another) or for all to be led by one.

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

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

3.2 Shared Commissioning Model

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

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

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

3.2.4 Such an arrangement would normally work well for activities that do not require substantial/complex oversight and/or are delivering shared

functions as opposed to delivering front-line services (such as oversight of shared clinical networks).

3.3 Network Commissioning Model

3.3.1 In this arrangement the six ICBs take a distributed leadership and governance approach to the commissioning of a service. So ICBs will make collective decisions on how a service is to be commissioned but then each ICB oversees the arrangements in their own system.

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

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

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

4. Joint operational delivery arrangements:

4.1 Hosted Model

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

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

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

4.2 Hosted (subcontracted) model

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

4.3 Shared model

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

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

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

4.4 Shared (subcontracted) model

4.4.1 It would similarly be possible for the shared model to be subcontracted from a 3rd party. In this instance the 6 ICBs would all agree the terms of the 3rd party contract (through the joint committee) and each ICB would be a joint contract-holder with the 3rd party.

4.5 Distributed model

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

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

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

ICS Performance Update including People and Finance

Agenda item 28-09.024

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Integrated Performance Report

Appendix A - Data Pack

28th September 2022

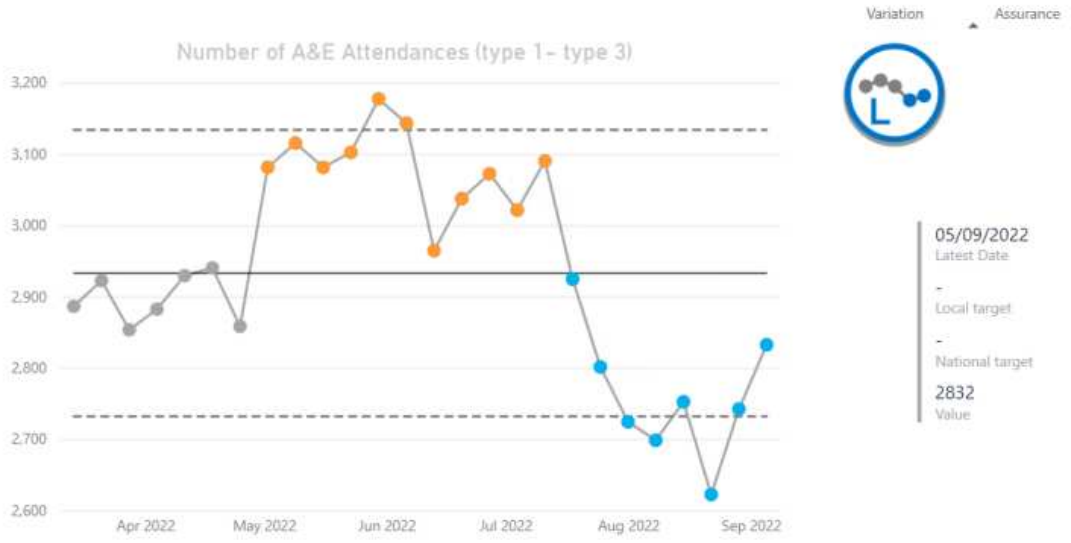
Content

- Urgent & Emergency Care - slides 3-13
- Elective Recovery - 14-15
- Cancer Recovery - 16-17
- Diagnostics Recovery - 18
- Finance - 19-23
- People - 24-26

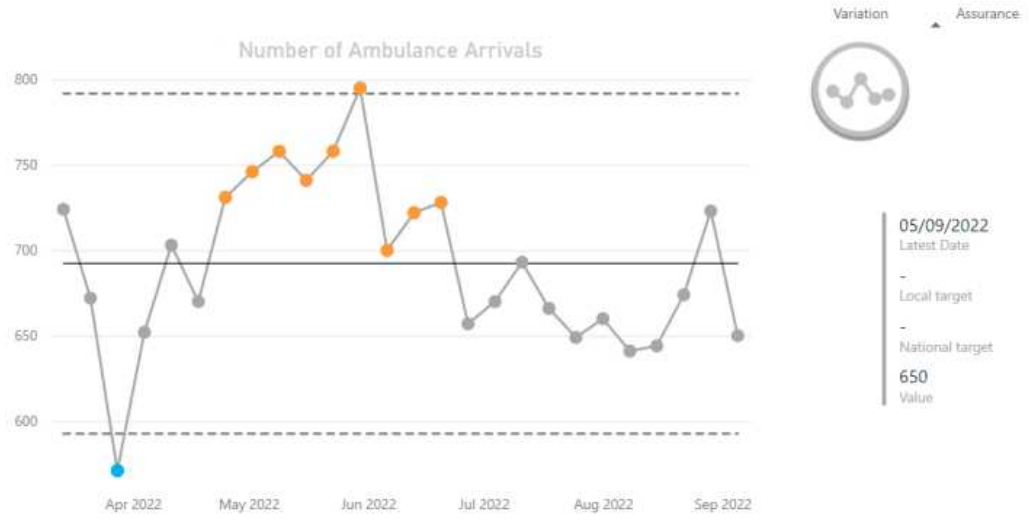
Urgent and Emergency Care

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

Setting the scene: Demand data during the summer holiday period



Attendances at SATH ED/UTC departments have dropped during the School holiday period. This is seasonal trend however, August 22 reported –11.7% (1478 attendances) compared to August 21.



A similar trend is noted for Ambulance arrivals, however a spike in activity was reported during the bank holiday weekend in August.
August 22 reported -19.7% (-684 ambulance arrivals) compared to August 21

UEC Core Metrics

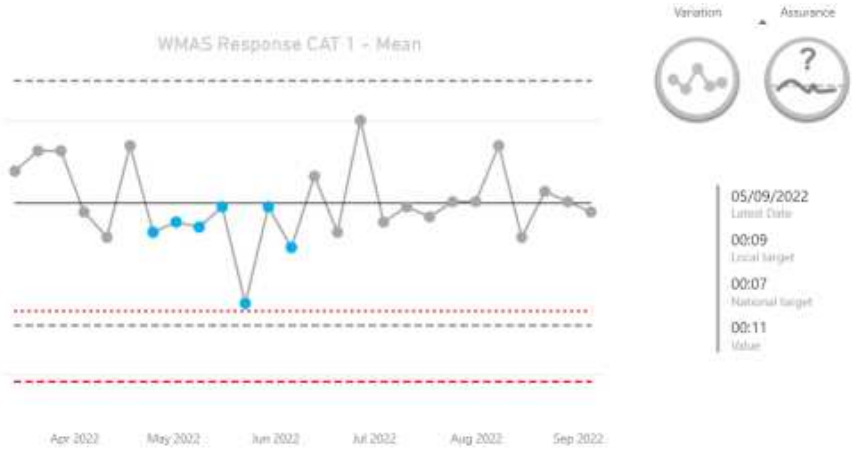
Service	Measure
Pre-Hospital	Response times for ambulances
	Reducing avoidable trips (conveyance rates) to Emergency Departments by 999 ambulances
	Proportion of contacts via NHS 111 that receive clinical input
A&E	Percentage of Ambulance Handovers within 15 minutes
	Time to Initial Assessment - percentage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

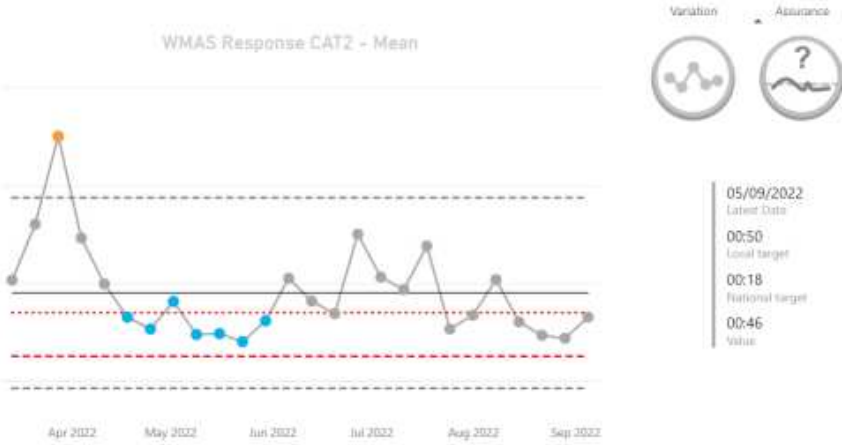
8 of these measures and other supporting metrics to assist achievement of the Core metrics bundle are captured within the UEC dashboard reported via the UEC Operational Group by exception to the system UEC board.

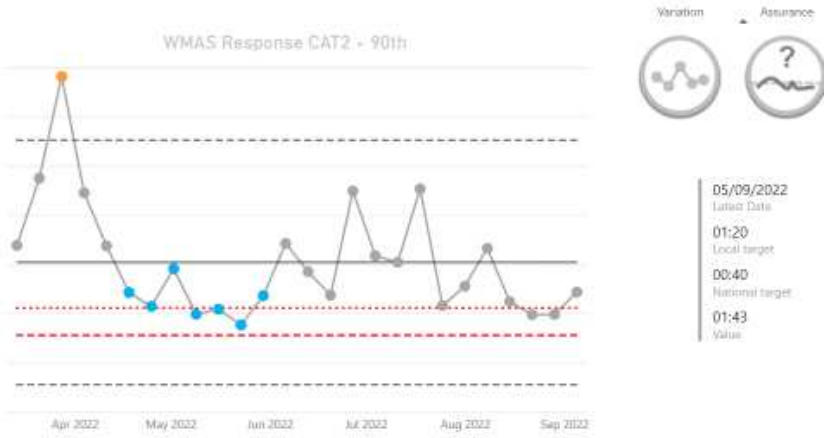
The 2 RED highlighted metrics are not currently captured. Clinically Ready to Proceed will be captured once the new Patient Administration System (PAS) is implemented at SaTH (plan July 23)

Critical Time Standards criteria has not yet been set nationally

UEC Dashboard Latest – Core Metrics cont. Ambulance response times







Cat 1 response time shows little improvement however is consistent within the control limits.
Variation is similar to figures reported across the region

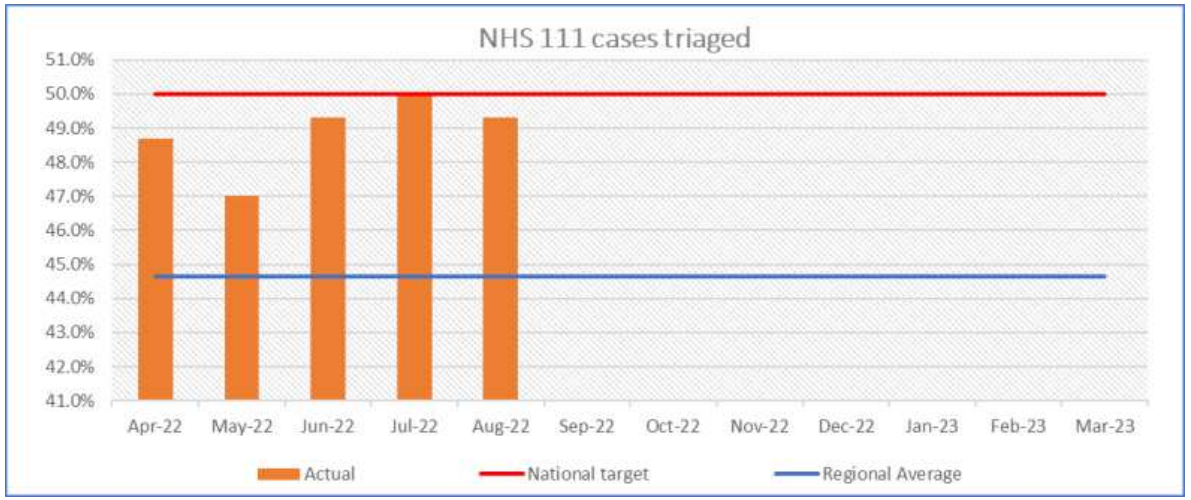
We must be aware that the geographic make up of Shropshire will lead to slightly increase average response times where incidents are in a rural location

Cat 2 has reported improved response time during the summer period and aligned to the reduced activity volumes
Again similar trend to region, but slightly higher due to rural impact

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

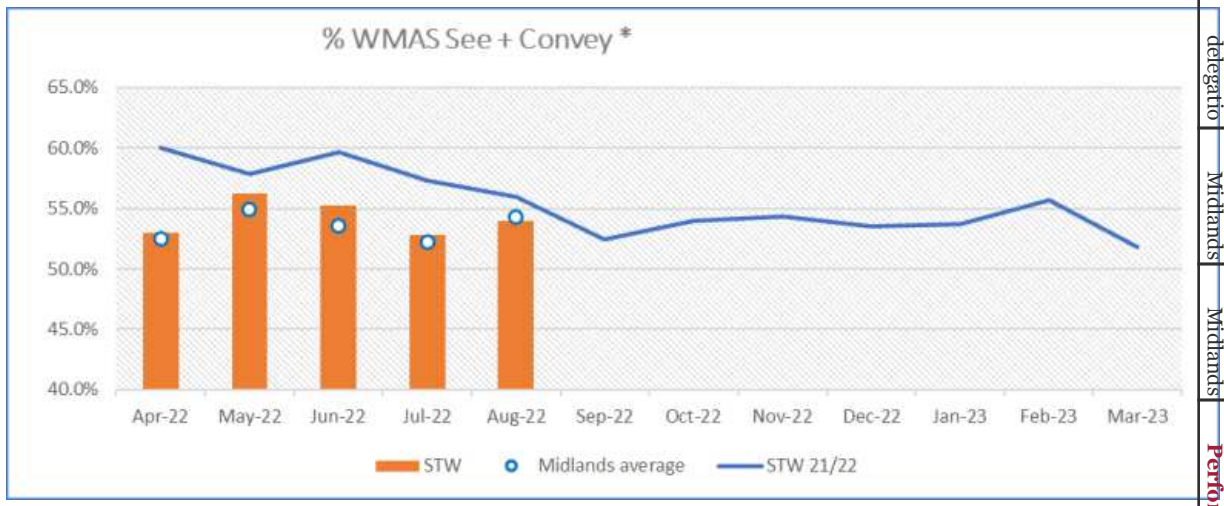
UEC Dashboard Latest – NHS111 and WMAS

NHS111 % of cases triaged



The measure is based on clinical input at any stage during the triage of a NHS111 case in NHS pathways
Similar trends and performance figures are reported by other regions and providers across the country

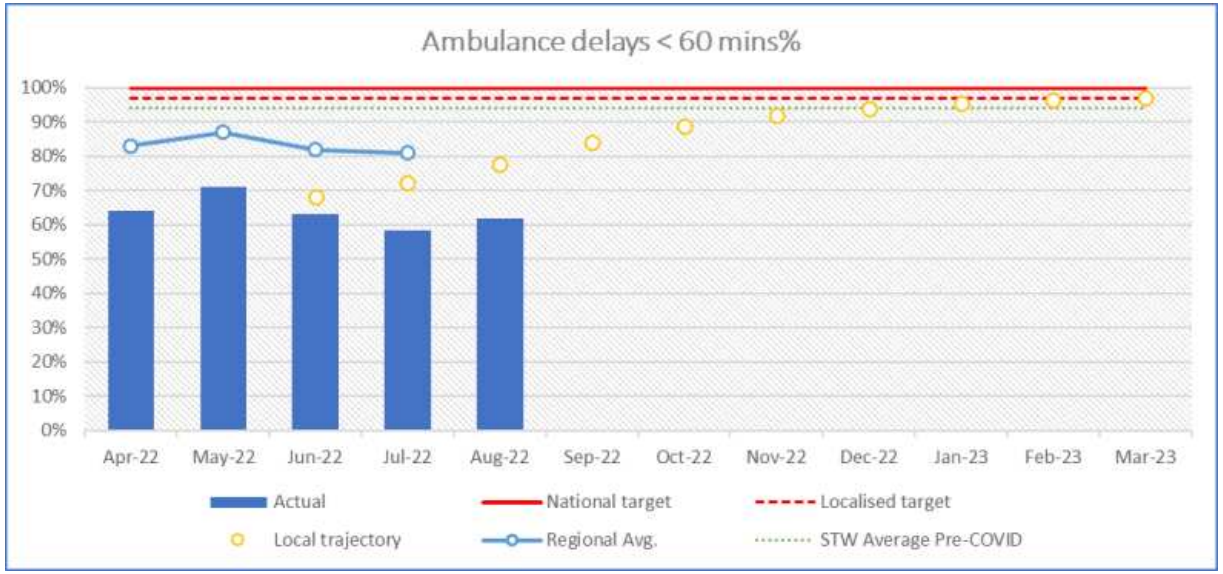
% of Incidents conveyed

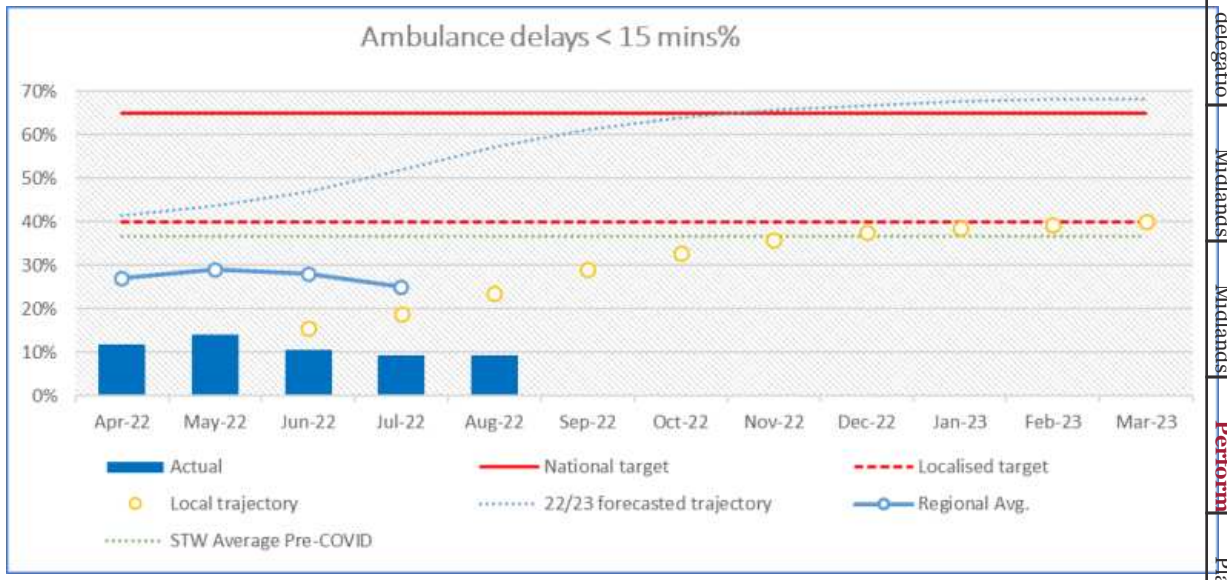


No national target is set for conveyances as each case is based on clinical need.
Figures reported for STW are in line with region
The drop reported for STW aligns to local and regional improvements in access to alternative services including the STW single point of access

UEC Dashboard Latest – Core Metrics

Ambulance Handover delays





Ambulance Delays < 60 minutes %

Currently handovers at SATH are being reported at 62% within 60 minutes. A small improvement from July 22, however total ambulances were lower.

Current performance ~ -20% variance to the improvement trajectory.

Pre -Covid STW reported an average of 94% ambulance handovers <60mins

Ambulance Delays < 15 minutes %

Currently <15 minute handovers at PRH and RSH remain very low at 9.4% of arrivals.

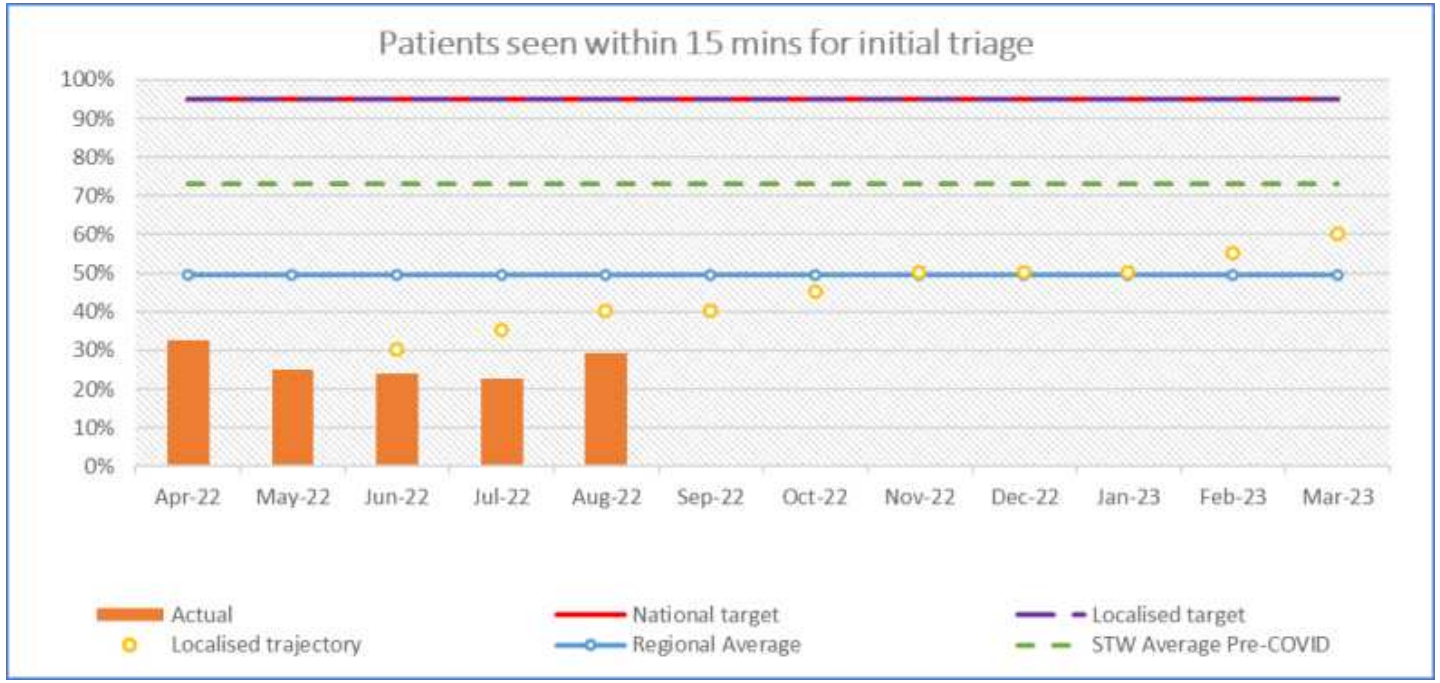
15 minute achievement has been very poor and dropping in last 3 month so currently -76% variance to the local target and -60% to trajectory

The latest (Jul22) figure for the region is 25% with similar worsening trend to STW. (August regional data not available at this time)

However, STW therefore reporting a variance of -62% to the regional average

Pre-Covid STW reported an average of 37%

UEC Dashboard Latest – 15 min initial assesment

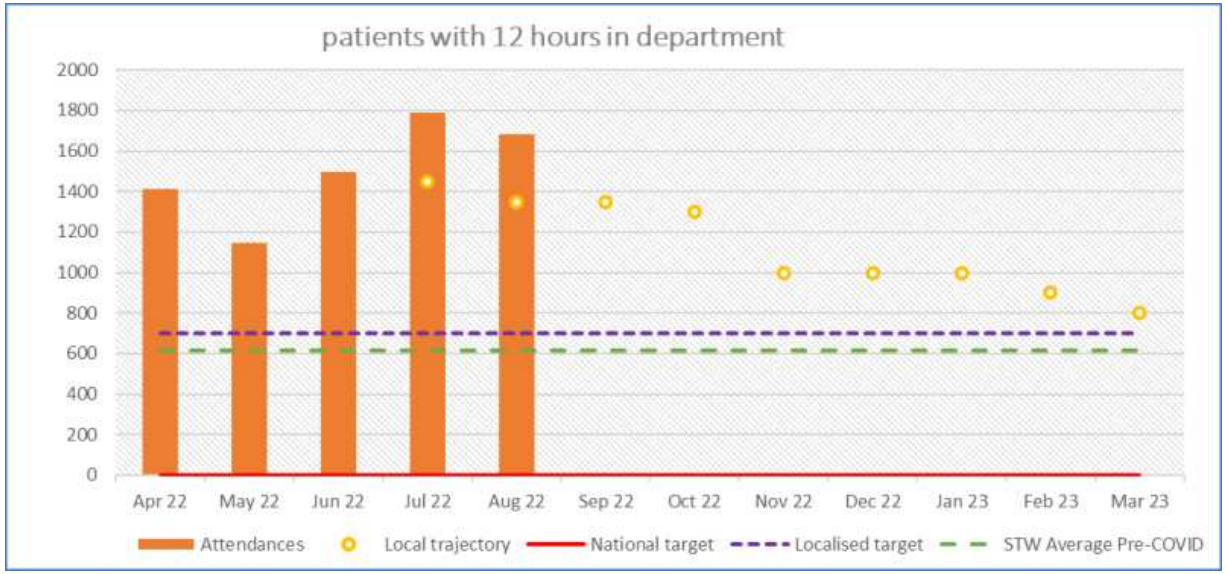


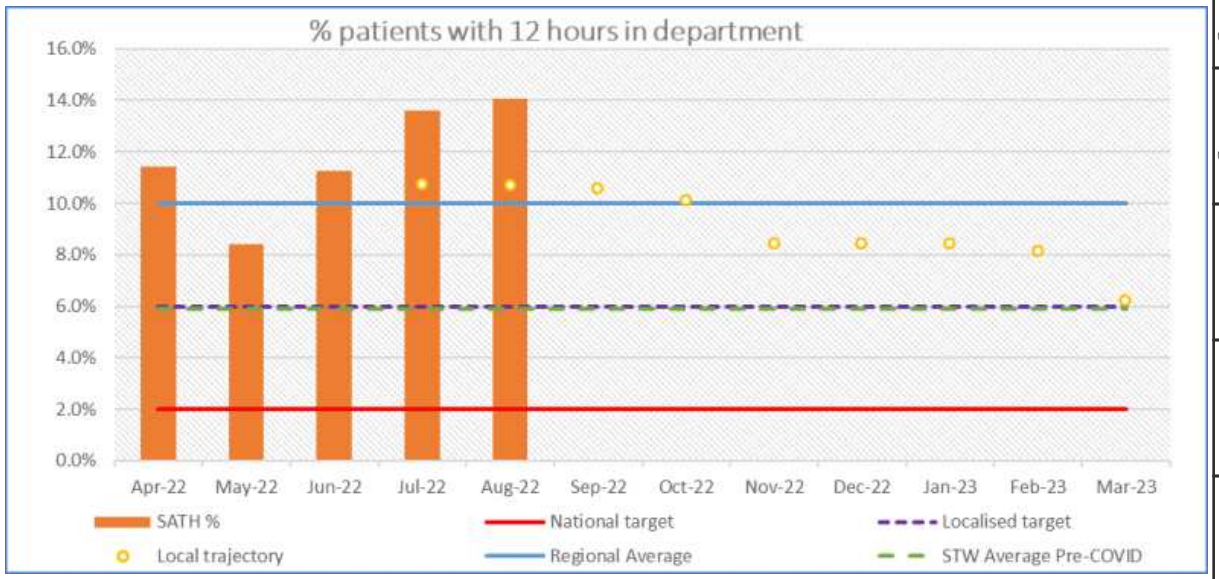
SaTH are aiming to achieve the 95 % target however the UEC interventions identified to help deliver the performance will not be implemented until Sept -Nov.

29% has been reported during August 22.
This is 6% higher than July (23%)
Regional average is reported at 50%
STW is 41% away from the regional average

SaTH Reported an average of 73% Pre-COVID
The lower activity volumes are likely to have supported the improvement during August
Trajectory is set for achieving regional average post implementation of acute floor changes at SaTH

UEC Dashboard Latest – 12 hour patient





The average number of patients per month waiting >12hrs in ED is 1500 - the number of patients waiting >12hrs has increased beyond that during July and August despite the overall drop in total attendances

The Average % of STW attendances waiting >12hrs during 22/23 is 11.8%. The value has increased during July and August to its current peak of 14%.

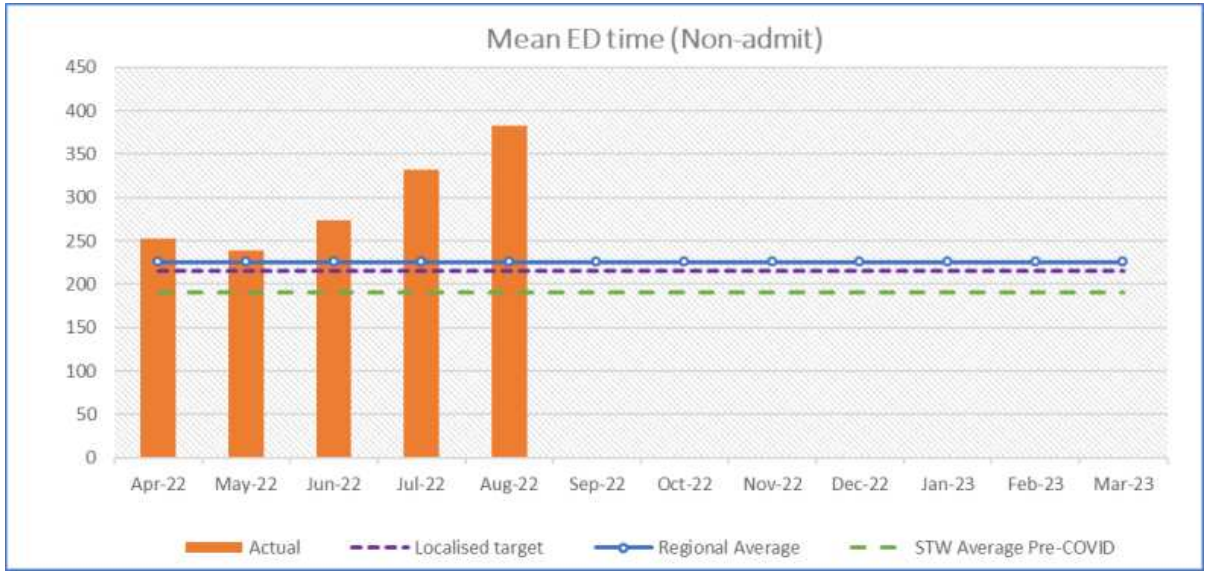
August reported +3.3% higher than planned trajectory (trajectory was 10.7%)

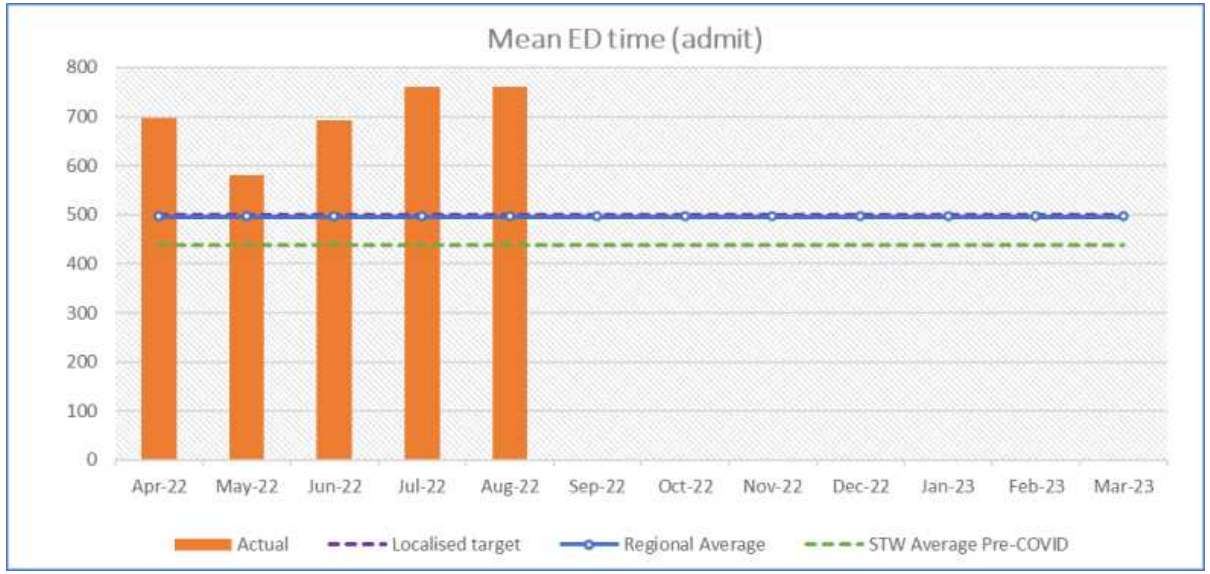
The neighbouring regional systems report an average of 10%. STW has a relative variance 40% higher than regional average

With the department developments of the Acute floor and redesign due to progress from September to November, the trajectory is to achieve pre -Covid performance of 8.5% as a result of the changes

Moving towards the Pre-COVID performance of 5.9% after winter

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





Despite the drop in attendances at SaTH departments during July and August ,STW is reporting increasing mean waiting times for both Non-admitted and Admitted

Non-Admitted

The Average time has increased significantly over last 2 months (Aug22 vs Jun22 = +39%)

The STW average pre COVID reports 190 mins with the regional average of 225 mins

During August 22 STW reported a 69% variance to regional average

Admitted

The average has been higher during July and August (Aug22 vs Jun22 = +10%)

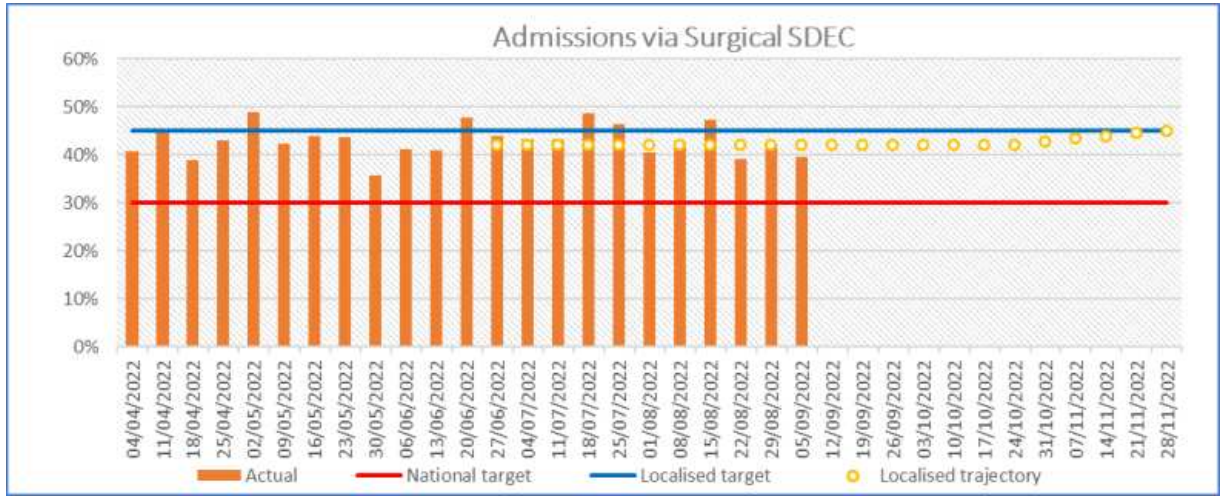
During 22/23 STW has reported an average of 698 mins

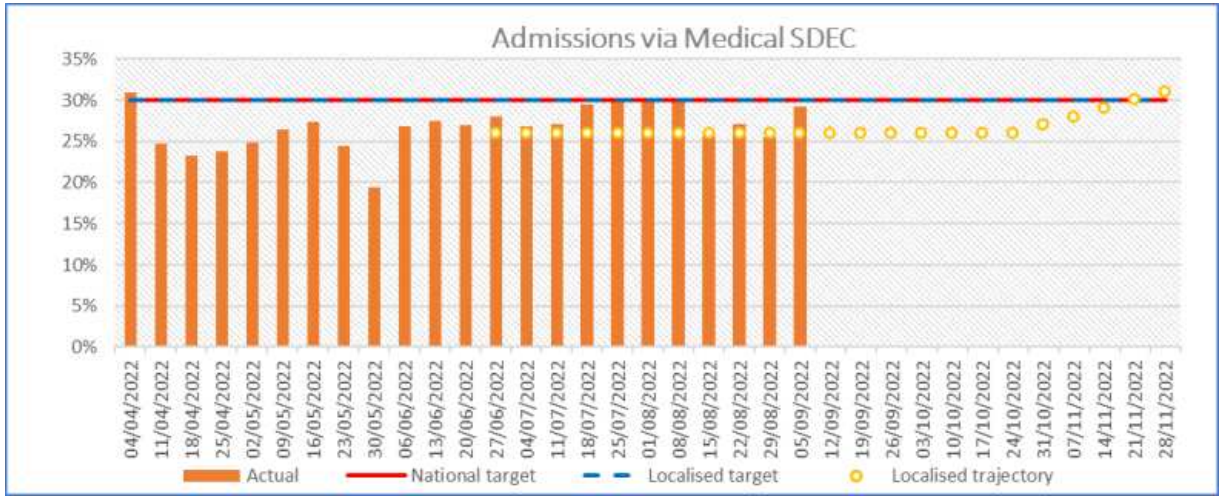
The localised target is set at 500 mins, with regional average reporting 495

STW during August was 52% higher than localised target and 73% higher than Pre COVID average

UEC Dashboard – additional supporting metrics

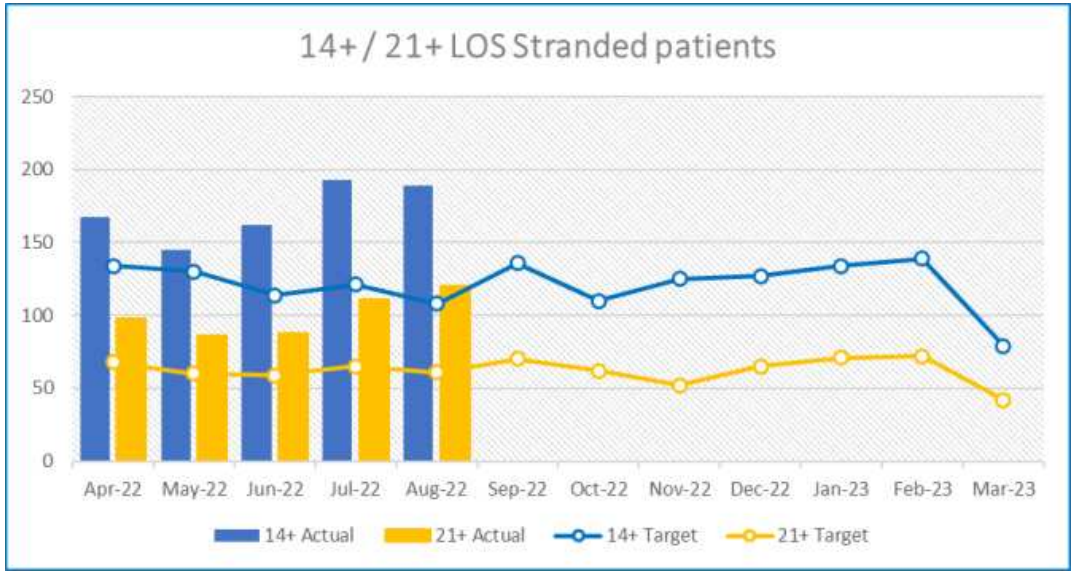
In addition the system has other Key Metrics that are not part of the national Core bundle, these have been selected as essential to monitoring the overall UEC improvement

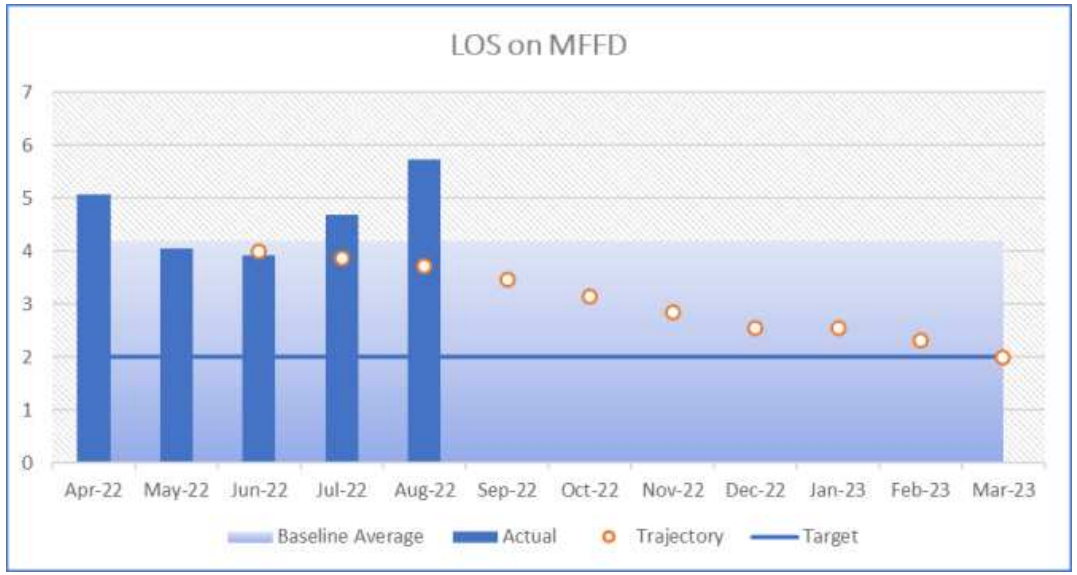




Both surgical and medical SDEC are achieving trajectory with the Medical recently achieving the local target.
The surgical SDEC is consistently above the national target of 30%. A local stretch target of 45% is in place.
The medical SDEC reported a small drop in performance over the Summer period however has remained inline with trajectory and has now moved back towards national target.

UEC Dashboard – Length of stay





The chart above shows the number of patients at month end fitting into 14+ and 21+ LOS. The lines represent the target figures reported for the same month last year 19/20 (Pre-COVID). An increase in longer length of stay is noted during July and August.

In August 22, 21+ LOS were 75% higher than August 19 and 14+ LOS were 96% higher

The chart above shows the average LOS in hospital after captured as medically fit for discharge (MFFD). In line with the increases in 14 and 21 LOS the average LOS for MFFD has also increased during July and August.

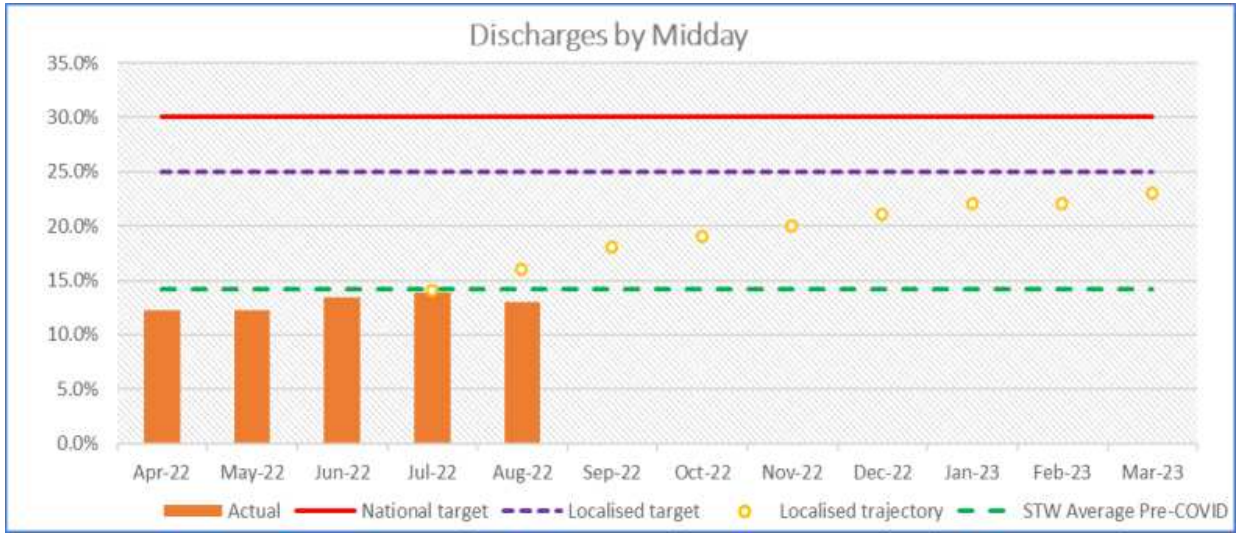
The national average is 2 days and the improvement trajectory for August was set at 3.7 days.

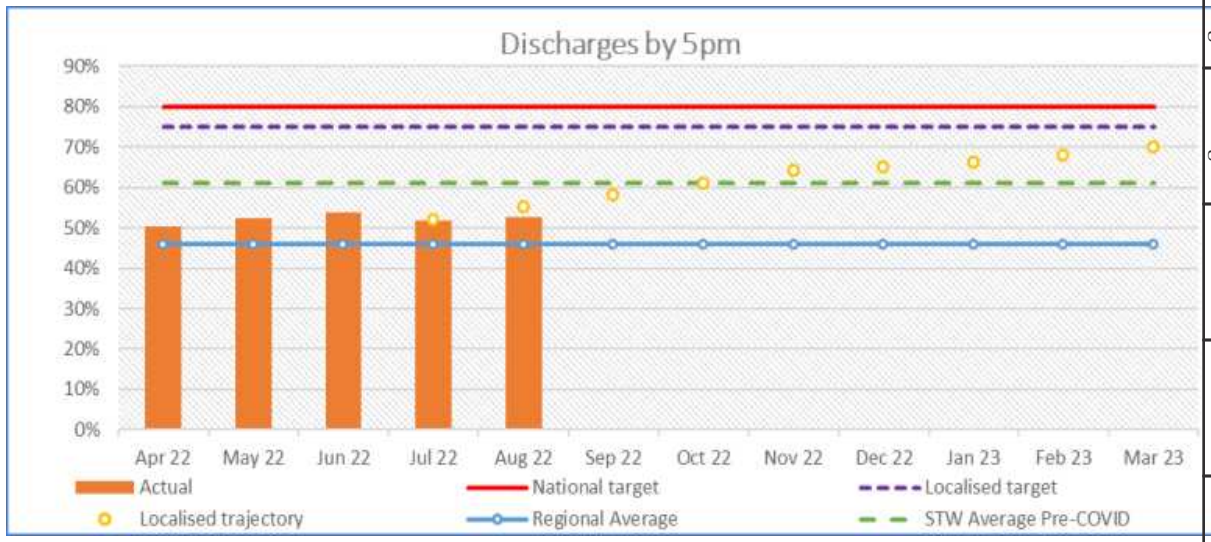
Therefore STW is 186% of target and 54% higher than local plan

The baseline average of 4 is based on 21/22 LOS

The average during 19/20 (pre-covid) was 3.1 days

UEC Dashboard – Discharges



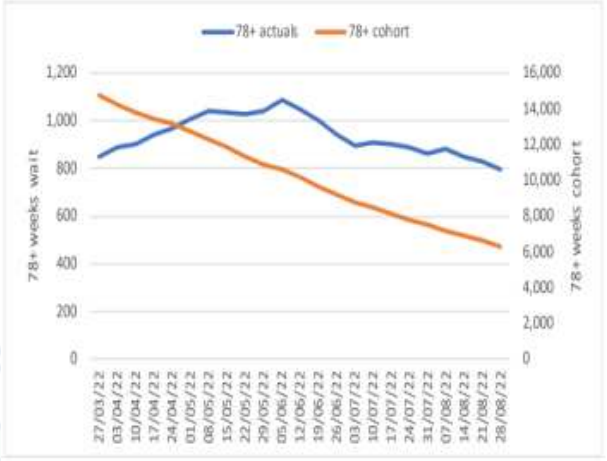


Review of Discharge data has been captured for Midday and 5pm achievement.
Please note that comparative regional performance is only available for 5pm discharges

Midday achievement is similar to pre-COVID performance; however August 22 has not met the trajectory of 16%, only reporting 13%.
5pm discharges have not reported any improvement as of yet however are reporting a consistent rate of 52% during 22/23. The regional average reporting 46%
STW pre-covid achievement was 61%

Elective Recovery

Key Data



Summary

- End of August trajectory for 104-week waits was not achieved, 67 vs plan of 53 across the system. The majority of the challenges remain with the cohort of complex spinal patients and a small number of waits as a result of patient choice.
- Revised system operational plan for delivery of 0 x 104k waits by end of March. System aiming to over-achieve against this plan. Close operational focus in place on a patient by patient basis managing forward delivery. Weekly NHSE review in place with specific support being developed to support spinal disorders.
- The impact of UEC pressures and patient choice a risk to delivery. PRH elective hub long-term solution
- 87% YTD system position against delivery of the 104%; and 92% YTD against delivery of the 110% ambition of value weighted ambition. There are data related issue here due to Welsh activity at our local providers which is still to be resolved with NHSE.
- There were 798 patients waiting 78 weeks and above at the end of August, these were 52 above the plan of 741 for the system. However, gap between actuals and planned narrowed in August and is a significant improvement from the 119 above plan in June and 142 above plan in July.
- Both Trusts focussed on booking all non admitted pathways within 78 ww+ March Cohort (OPD)before end of Oct to allow planning for Nov-March to meet the 78ww trajectory.
- Challenges remain with elective activity at SaTH with limited theatre staffing capacity impacting the ability to open up additional lists and limited elective bed base (impact of emergency care pressures) and DSU capacity on both sites impacting throughput.

What have we done/ next steps

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

Elective Recovery

Key Data

104 week waits

104 ww STW SYSTEM	April 2022	May 2022	June 2022	Jul-22	Aug-22	September 2022	October 2022	November 2022	December 2022	January 2023	February 2023	March 2023
System 104ww Waitlist (PLAN) (EXCLUDES CHOICE) (Based on the Overall system activity to deliver 102.8%)	176	154	99	61	53	45	39	33	27	20	9	0
ACTUAL (Patient Choice)	174	153	11	13	4							
ACTUAL (Complex)			88	64	64							
TOTAL ACTUAL (Inc Choice + Complex)	174	153	99	77	68							
Variance to plan (TOTAL ACTUAL (inc Choice) - PLAN)	-2	-1	0	16	15	16	4					
Forecast(Patient Choice)						1	1					
Forecast (Complex)						60	42					
TOTAL Forecast(Inc Choice + Complex)						61	43					

Forecast based on w.e 11.09.22 ptl

78 week waits

	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022	December 2022	January 2023	February 2023	March 2023
System 78ww Waitlist (PLAN) (EXCLUDES CHOICE) (Based on the Overall system activity to deliver 102.8%)	850	857	776	714	741	713	589	563	621	552	491	458
Variance to plan	145	180	119	142	57							
ACTUAL	995	1037	895	856	798							

Summary

Key Issues impacting 104 ww & 78 ww

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

Key Actions for recovery 104 ww & 78 ww

- Ongoing work with Royal Orthopaedic Hospital
- Focus on Independent Sector Utilisation
- Both Trusts focussed on booking non admitted 78 ww+ March Cohort (OPD)before end of Oct to allow planning for Nov-March to meet the 78ww trajectory.
- In conjunction with above, Diagnostic patients being sent to radiology to plot capacity in advance
- Technical, clinical and administrative validation processes in place.

Cancer Recovery

NHS

Key Data

Current position (as at 28.08.22):
447 patients waiting 63-104 days
188 patients waiting over 104 days.
635 total patients waiting
Plan at end of August – 520

Cancer Waiting Times Q1 2022-23

62 day RTT	28 day FDS
Target 85%	Target 75%
Actual 51.3%	Actual 62.9%
476 patients	7,279 patients
232 breaches	2,697 breaches

Summary

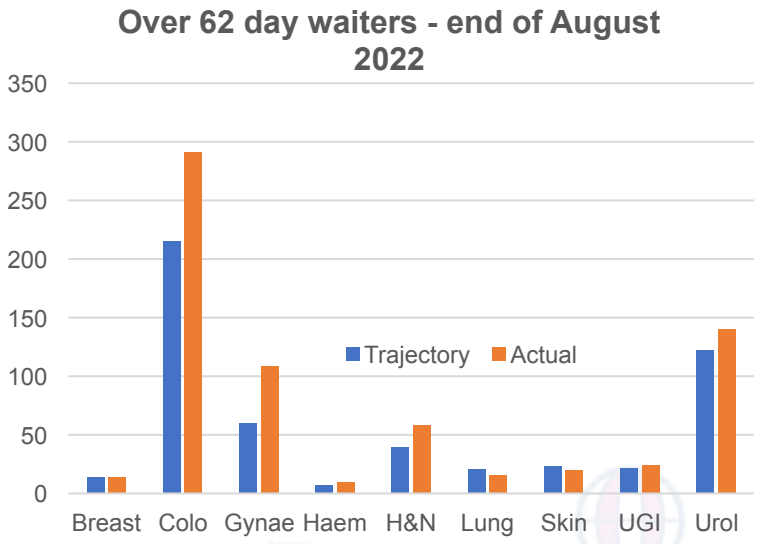
- 62 day improvement performance plans in place for all challenged tumour pathways in SaTH. Delivery monitored at weekly assurance meetings.
- Plan to achieve reduction in 62 day backlog to required levels by March 23.
- Plan to achieve 65% for 28 day FDS by March 23, national target 75% by March 24 further progress currently constrained due to MRI workforce capacity issues.
- Capacity risks associated with workforce in radiology continues to impact on performance.
- Some pathways have had a marked increase in 2ww referrals in month 3 22/23 (urology 24.3% up, skin 13% up, colorectal 11.9% up, breast 10.4% up compared to same month last year).

What have we done and next steps

- Completed a full analysis of the cancer backlog by patient to understand where each patient is in their journey, action plans developed and monitored regularly.
- Reviewing and improving pathways, including utilising a 'Best Practice Pathways Project Manager' for challenged pathways.
- Plan in place with radiology team to get extra capacity from outsourcing.
- Fully utilise breast community pain clinics to reduce pressure on 2ww appointments.
- Fully utilise current FIT process whilst planning to tender new service for April 23.
- Working with NHSE to introduce tele dermatology as a way to reduce pressure on the skin pathway.

Cancer – challenged pathways

Key Data



Summary

- The overall trajectory for over 62 day waiters is skewed by the backlog numbers on the colorectal pathway. The current position (as at end of August) and forecast trajectories at the end of the year for the three most challenged pathways are;
- Urology – above planned trajectory, 140 against plan of 122, with a forecast to meet the plan by the end of the year.
- Gynaecology – above the planned trajectory by 49 patients, trajectory for the rest of the year awaiting D&C modelling.
- Colorectal - significantly over trajectory, 291 patients against planned trajectory of 215, and forecast to be 40 patients over at the end of the year

What have we done and next steps

Urology

- Main breach reason is delay for first appointment. Two key actions to recover planned position:
  - Additional CNS clinic capacity has been put in place
  - Additional Locum Oncologist has commenced

Gynaecology

- Predicted drop off in referrals for PMB USS has not materialised, thought due to changed prescribing habits in primary care
- D&C modelling shows 40 extra USS slots a month needed, currently covered by WLI solution

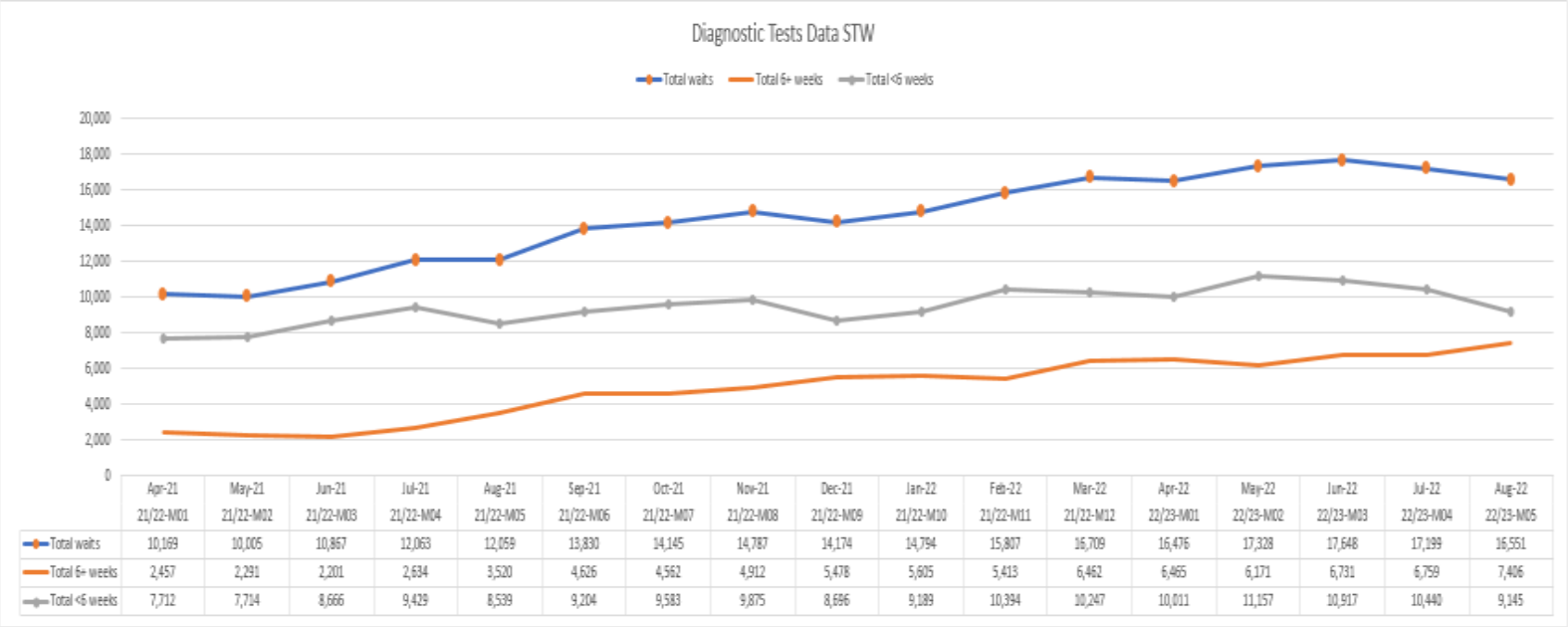
Colorectal

- Surge in demand following recent high profile case
- Urgent work on improving FIT pathway taking place to improve pathway and reduce colonoscopies

Diagnostics Recovery

NHS

Key Data



	Apr-21 21/22-M01	May-21 21/22-M02	Jun-21 21/22-M03	Jul-21 21/22-M04	Aug-21 21/22-M05	Sep-21 21/22-M06	Oct-21 21/22-M07	Nov-21 21/22-M08	Dec-21 21/22-M09	Jan-22 21/22-M10	Feb-22 21/22-M11	Mar-22 21/22-M12	Apr-22 22/23-M01	May-22 22/23-M02	Jun-22 22/23-M03	Jul-22 22/23-M04	Aug-22 22/23-M05
Total waits	10,169	10,005	10,867	12,063	12,059	13,830	14,145	14,787	14,174	14,794	15,807	16,709	16,476	17,328	17,648	17,199	16,551
Total 6+ weeks	2,457	2,291	2,201	2,634	3,520	4,626	4,562	4,912	5,478	5,605	5,413	6,462	6,465	6,171	6,731	6,759	7,406
Total <6 weeks	7,712	7,714	8,666	9,429	8,539	9,204	9,583	9,875	8,696	9,189	10,394	10,247	10,011	11,157	10,917	10,440	9,145

	Apr-22		May-22		Jun-22		Jul-22		Aug-22	
Diagnostic	22/23 Actual as % of 19/20 Baseline	22/23 Actual vs 22/23 Operational Plan %	22/23 Actual as % of 19/20 Baseline	22/23 Actual vs 22/23 Operational Plan %	22/23 Actual as % of 19/20 Baseline	22/23 Actual vs 22/23 Operational Plan %	22/23 Actual as % of 19/20 Baseline	22/23 Actual % of 22/23 Operational Plan	22/23 Actual as % of 19/20 Baseline	22/23 Actual % of 22/23 Operational Plan
Diagnostic Tests - Cardiology - Echocardiography	134%	96%	130%	111%	132%	109%	125%	106%	101%	95%
Diagnostic Tests - Colonoscopy	90%	80%	133%	93%	112%	94%	156%	117%	100%	86%
Diagnostic Tests - Computed Tomography	120%	108%	119%	114%	117%	116%	144%	126%	112%	105%
Diagnostic Tests - Flexi Sigmoidoscopy	36%	80%	47%	99%	41%	92%	37%	81%	42%	101%
Diagnostic Tests - Gastroscopy	88%	90%	93%	78%	84%	89%	91%	99%	101%	96%
Diagnostic Tests - Magnetic Resonance Imaging	94%	106%	92%	114%	96%	114%	118%	118%	104%	108%
Diagnostic Tests - Non-Obstetric Ultrasound	94%	107%	94%	107%	96%	110%	105%	110%	91%	105%

Summary

- Overall Diagnostic waits have increased over the last 1.5 years and recovery has been challenged due to staffing pressures, IPC restrictions due to Covid and lack of capacity.
- For 22/23 although the plan and recovery baseline (target 120% of 19/20 baseline by march 23) is being met in most modalities the demand levels have significantly increased meaning there is no impact on the backlog despite performance being above plan in large volume areas such as CT and MRI
- August performance impacted across all modalities with recovery expected in September.
- Non-Obstetric Ultrasound activity has not meet the baseline for 4 out of the last 5 months despite doing better than 22/23 plan. There is a planned increase in capacity which is expected during March as a result of recruitment and improved IS provider working relationships.
- Gastroscopy activity is below baseline and work is ongoing with waiting list initiatives in place to provide weekend and out of hours sessions along with an additional 3 rooms have been allocated and the business case in progress for additional staffing
- Flexible Sigmoidoscopy requires a new baseline due to pathway changes since 19/20.

What have we done and next steps

- RJAH - Recently completed international recruitment and staff are to commence in post imminently to run additional evening and weekend clinics but this additional capacity will not reduce the waiting list and a proposal has been taken through the organisation and system requesting a staffed mobile MRI scanner which will support in the reduction of their waiting list.
- SaTH – Radiology -International recruitment also ongoing. Some limited success with radiographers but still unable to fully staff the CT/MRI Pod. There is also planned improvement in activity expected Nov/Dec 22 when the first CDC becomes available
- SaTH –A business case for additional CT and MRI capacity has been submitted to NHSE to support with the delivery from October onwards to help support in the reduction of the backlog

Finance- M5 Revenue position

Key Data

- £8.1m adverse to plan YTD at M5
- £4.1m adverse to plan FOT at M5
- £3.1m COVID expenditure above plan at M5, The rest of the overspend is mainly linked to increased staffing costs due to open escalation areas at SATH, overspends in the ICB on Independent sector ophthalmology activity and community discharge beds which are partially offset with prior year accrual reversal benefits.
- Plans currently forecast to deliver with exception of COVID overspends already incurred.

	M5 YTD			FULL YEAR		
Organisation	Plan Surplus/ (Deficit) £000	Actual Surplus/ (Deficit) £000	Variance to Plan £000	Plan Surplus/ (Deficit) £000	Forecast Surplus/ (Deficit) £000	Variance to Plan £000
Commissioners						
NHS Shropshire, Telford and Wrekin	(4,902)	(6,445)	(1,543)	(11,743)	(12,741)	(998)
System Affordability Gap	0	0	0	13,936	13,936	0
Total Commissioners	**(4,902)**	**(6,445)**	**(1,543)**	**2,193**	**1,195**	**(998)**
Providers						
The Shrewsbury and Telford Hospital NHS Trust (SaTH)	(8,989)	(15,968)	(6,979)	(19,135)	(22,357)	(3,222)
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT (RJAH)	(2,276)	(2,370)	(94)	(772)	(772)	0
Shropshire Community Healthcare NHS Trust (SCHT)	221	765	544	(1,330)	(1,208)	122
Total Providers	**(11,044)**	**(17,573)**	**(6,529)**	**(21,237)**	**(24,337)**	**(3,100)**
TOTAL SYSTEM Performance Financial Position Surplus/(Deficit)	**(15,946)**	**(24,018)**	**(8,072)**	**(19,044)**	**(23,142)**	**(4,098)**

Finance- M5 Revenue position

Summary

- A number of operational pressures are impacting on our system and the financial impact of these is manifesting in our expenditure run rate. We are working through a thorough review of anticipated spend and actions to mitigate costs for the rest of the year. This has not been possible to complete in time for submission of the month 5 position and therefore, subject to the outcome of a joint review process agreed with NHSE and internal sign off for each system partner, will be included in the month 6 return.
- The pressures which place further stress on the STW deficit plan are well recognised both within the system and by the Regional NHSE team. The forecast scale of the impact of these is a matter of serious concern for which STW ICS commit to giving close scrutiny and challenge.
- The current forecast outturn (FOT) position shows a £4.1m adverse variance to plan in line with the forecast reported at M4. The majority of this variance relates to the unrecoverable year to date COVID overspend and escalation areas remaining open and includes assumptions about mitigations to current overspends which will be tested as part of the exercise to review the FOT. These mitigations are currently flagged as high risk.
- There remains significant risk around delivery of the financial plan with key risks centred around:

  - Continued COVID impact above BAU levels
  - Delivery of backloaded efficiency programme
  - Community based discharge pressures when aiming to support escalated activity in UEC
  - Management of Independent Sector activity increases post COVID
- Whilst excess inflation was funded in the planning round, there is a risk that increasing inflation pressures later in the year may also impact on the position though an estimate for this has not been calculated at this point.
- £10m of expenditure requirement noted as a priority for the system is currently sat outside of the financial plan. Whilst not a financial risk whilst expenditure is not incurred, this does pose a quality risk for our system if left unaddressed in the long term.

What have we done and next steps

- STW recognizes its material underlying deficit and local challenges, including those associated with geography, configuration of estate and availability of substantive workforce. We remain committed to delivering our plans at a time when we are also battling heavy demand in urgent care and COVID-19 pressures.
- Review of forecast position underway – meeting with regional FD on 4th October.
- Medium to long term financial plan development underway for refresh in Q3, includes detailed mapping of underlying position as part of above exercise
- Updates to 'triple lock' process actioned
- Work to better understand drivers of community/discharge costs
- Efficiency plan development (see efficiency slide)
- Financial sustainability self assessment audit underway with Internal Auditors- Aug /Sept
- Detailed analysis re run rate and regular monthly enhanced reporting actioned around COVID, Agency, ERF and efficiency trajectories- Aug/Sept Medium to long term financial plan development underway

Financial Performance by Organisation- Revenue

NHS Shropshire, Telford and Wrekin

At month 5 the ICB has an adverse position against plan of £1.5m YTD. The overspend is mainly due to independent sector NCA ophthalmology activity, a small COVID overspend and continued community discharge expenditure offset with primary care prior year benefits. FOT remains in line with M4 and assumes mitigations to overspending areas.

Shrewsbury and Telford Hospitals NHS Trust

At Month 5 SaTH has an adverse position against plan of £7.0m YTD. This variance is mainly due to escalation areas remaining open due to COVID and staffing cost increases due to higher tier agency staff, offset by reduced elective activity due to COVID levels. Significant risk remains with regards to bringing the COVID spend back in line with plan. The forecast position is based on the unrecoverable YTD COVID position and escalation areas remaining open.

Robert Jones and Agnes Hunt

At Month 5 RJAH has an adverse position against plan of £0.1k YTD. Clinical income is adverse to plan, driven by activity underperformance against planned levels, offset by reductions in marginal costs, partial recovery of private patient income and benefit from ERF reserves assuming no clawback YTD.

Shropshire Community Health Trust

At Month 5 SCHT has a favourable position against plan of £0.5m YTD. Covid vaccination activity is below plan, resulting in lower income and cost. Overperformance YTD is due mainly to high levels of vacancies with net leavers over 5% of staff in post at 31 March 2022, plan is to grow workforce. FOT improvement due to transfer of Shropdoc Service (net of Healthcare Matters from the ICB) to the ICB from M04.

Risk

Risk Summary	SATH	RJAH	SCHT	ICB	System	Total System Gross risk	Potential Mitigation	Total System Net risk
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Elective Recovery - risk 75% income not realised but costs in place	(4,458)	(1,380)		(471)		(6,309)	6,309	0
Other income risks (eg spec comm contract)	(4,548)	(465)				(5,013)	100	(4,913)
Growth risk on non system contracts	(2,920)					(2,920)		(2,920)
Inflation/Energy		(733)	(300)			(1,033)	200	(833)
High cost drugs	(603)			(1,000)		(1,603)		(1,603)
Capitalised Salaries	(919)					(919)	919	0
IS activity increases post covid				(6,000)		(6,000)		(6,000)
Impact of continued COVID expenditure	(10,120)	(1,390)	(600)	0		(12,110)	1,590	(10,520)
Escalation areas remain open	(2,116)					(2,116)		(2,116)
Efficiency Programme		(377)	(600)	(788)		(1,765)	1,465	(300)
System efficiency stretch risk					(13,936)	(13,936)	5,649	(8,287)
Activity Delivery/Casemix/Delayed recovery		(2,118)	(300)			(2,418)	2,001	(417)
Workforce Recruitment		(733)	(420)			(1,153)	1,153	0
Vaccination team costs, mitigation assumed 100% funding or exit strategy			(700)			(700)	700	0
Agency Expenditure above Ceiling			(1,000)			(1,000)	1,000	
Individual Commissioning risk and additional efficiency mitigation				(7,656)		(7,656)		(7,656)
Non NHS contract negotiations				(250)		(250)		(250)
Community bed/discharge scheme				(8,000)		(8,000)		(8,000)
	(25,684)	(7,196)	(3,920)	(24,165)	(13,936)	(74,901)	21,086	(53,815)

The level of risk in the system remains high at £74.9m, and £53.8m after potential mitigations.
Key issues remain around:

- Levels of COVID expenditure – all mitigations removed as no additional National funding for 22/23
- Delivery of efficiency programmes
- IS activity increases
- Unfunded discharge beds/schemes
- Overall inflation levels

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

Finance- M5 Capital Position

Key Data

- Capital programme underspending by £6.9m YTD at M5
- Forecast remains at plan

Summary

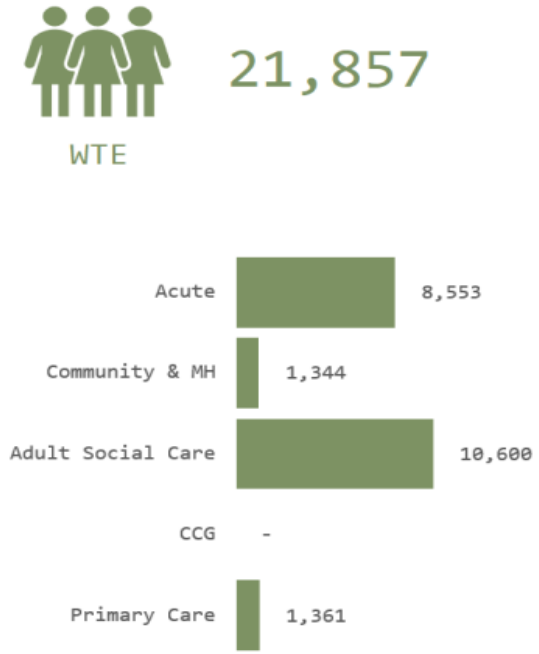
- SATH YTD slippage relates to the estates programme and the off site renal unit at Hollinswood House although it is expected that the work will be completed by the end of March 2023.
- RJAH YTD slippage relates to EPR and diagnostic equipment expenditure. The diagnostic equipment expenditure is a delay as a result of the discovery of asbestos in the walls which has delayed the programme by 6 weeks
- There are a number of business cases and bids that have been submitted to the regional and national teams for additional capital funding including for the development and expansion of an Elective Hub at PRH, the Community Diagnostic Centre at Telford and a number of system wide digital programmes.

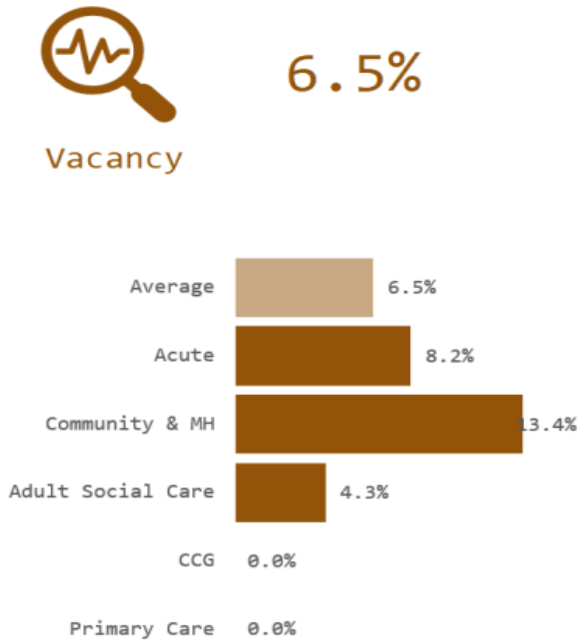
CAPITAL PROGRAMME	M5 YTD			FULL YEAR		
Organisation	Plan £000	Actual £000	Variance to Plan £000	Plan £000	Forecast £000	Variance to Plan £000
NHS Shropshire, Telford and Wrekin	0	0	0	0	0	0
The Shrewsbury and Telford Hospital NHS Trust (SaTH)	(7,849)	(1,610)	6,239	(19,822)	(19,822)	0
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT (RJAH)	(2,293)	(1,814)	479	(11,659)	(11,659)	0
Shropshire Community Healthcare NHS Trust (SCHT)	(873)	(673)	200	(2,500)	(2,500)	0
TOTAL SYSTEM	**(11,015)**	**(4,097)**	**6,918**	**(33,981)**	**(33,981)**	**0**

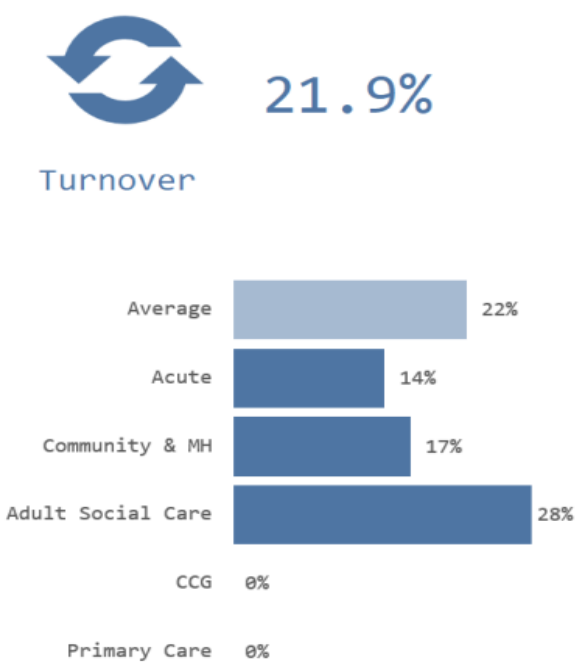
What have we done and next steps

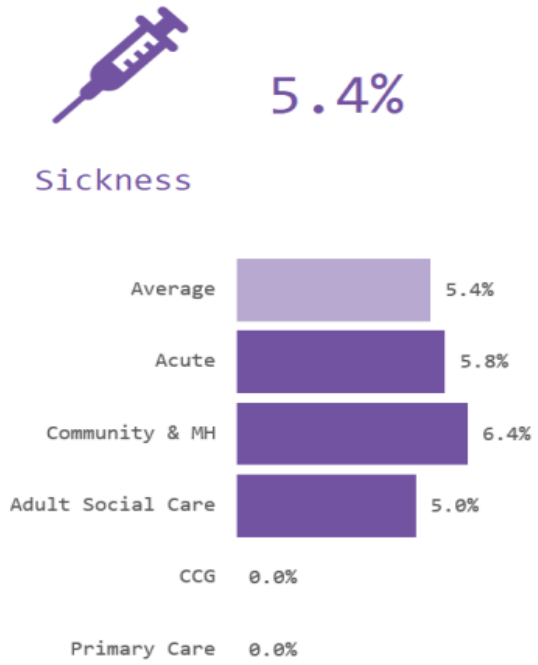
- Capital Prioritisation and Oversight Group (CPOG) have met for its inaugural meeting. Terms of Reference and Workplan to be brought to October Finance Committee.
- Work has commenced on having a detailed 2022/3 forecast outturn for the capital programme across all providers
- Over the coming months, a detailed 24 month, 5 year and 10 year capital plan will be developed across the system.
- Ambition to merge CPOG with Investment panel as approach to prioritisation matures
- CPOG to oversee longer term capital plan to run alongside revenue plan

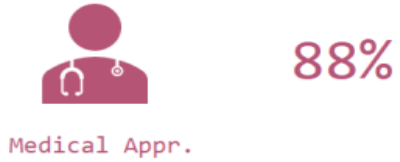
ICS Workforce Dashboard – M05











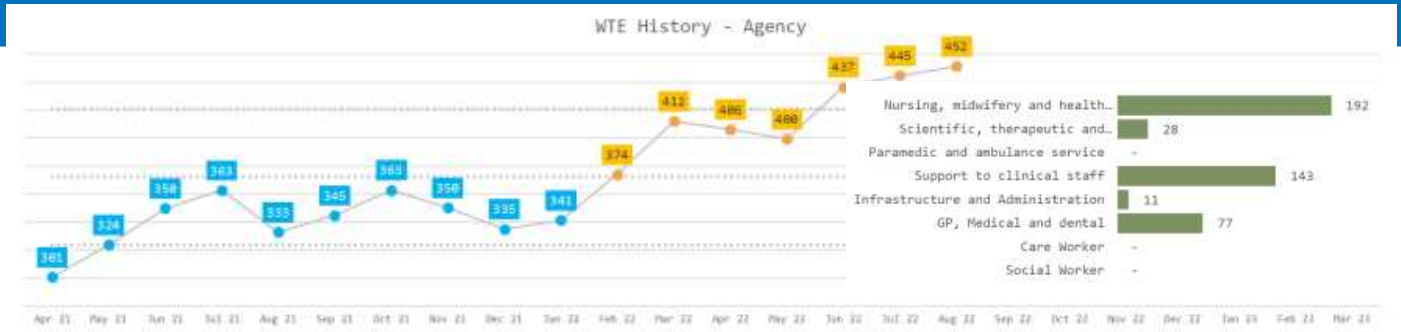
Month/Year	WTE	Vacancy	Turnover	Sickness
Aug 22	21,857	6.5%	21.9%	5.4%
Jul 22	21,865	5.8%	21.9%	5.8%
Jun 22	21,879	5.8%	21.8%	5.3%
May 22	21,738	5.7%	21.6%	5.0%
Apr 22	21,683	5.9%	21.7%	5.2%
Mar 22	21,835	5.5%	21.6%	4.9%
Feb 22	21,732	5.5%	21.4%	4.8%
Jan 22	21,645	5.6%	21.3%	5.1%
Dec 21	21,484	5.6%	21.3%	5.1%
Nov 21	21,545	5.5%	21.0%	5.1%
Oct 21	21,462	5.8%	21.0%	5.2%
Sep 21	21,478	6.0%	20.8%	5.1%

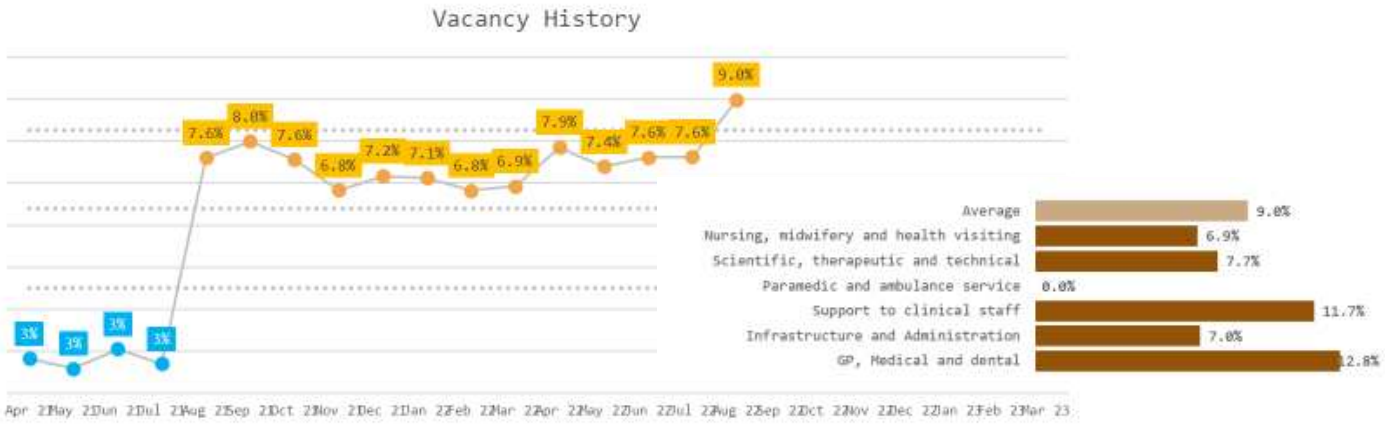
Data Sources:
NHS Trust Monthly Provider Workforce Returns
Skills for Care Sept 2019 and March 2020
Primary Care NHS Digital June 2022

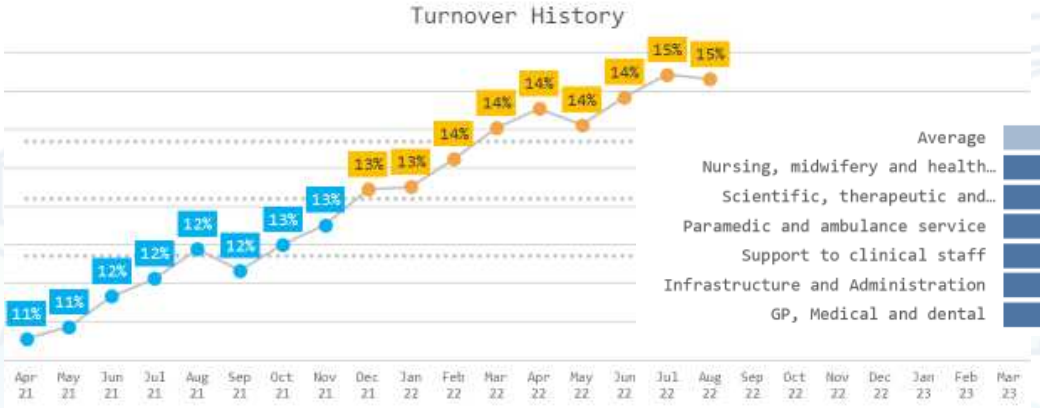
ICS Workforce Dashboard - M05 August 2022 (NHS Only)

Measure	Dimension	Data Source	Data Period	System	SaTH	RJAH	SCHT
Sickness Absence	Monthly Sickness Absence Rate	PWR	Aug 22	5.9%	6.0%	4.8%	6.4%
Staff in Post (WTE)	Total	PWR	Aug 22	8,804	6,157	1,405	1,242
	Registered Nursing & Midwifery	PWR	Aug 22	2,530	1,805	285	440
	HCSW	PWR	Aug 22	1,249	939	174	136
	Infrastructure	PWR	Aug 22	1,868	1,051	520	298
	GP, Medical and Dental	PWR	Aug 22	843	682	141	20
Vacancies (WTE)	Total	PWR	Aug 22	869	549	128	192
	Registered Nursing & Midwifery	PWR	Aug 22	186	85	31	70
	HCSW	PWR	Aug 22	116	83	29	4
	Infrastructure	PWR	Aug 22	140	44	26	70
	GP, Medical and Dental	PWR	Aug 22	124	100	20	4
Vacancy Rate %	Total	PWR	Aug 22	9.0%	8.2%	8.4%	13.4%
	Registered Nursing & Midwifery	PWR	Aug 22	6.9%	4.5%	9.9%	13.7%
	HCSW	PWR	Aug 22	8.5%	8.1%	14.4%	2.6%
	Infrastructure	PWR	Aug 22	7.0%	4.0%	4.8%	18.9%
	GP, Medical and Dental	PWR	Aug 22	12.8%	12.8%	12.2%	18.3%
Temporary Staffing	Bank WTE	PWR	Aug 22	641	535	54	53
	Agency WTE	PWR	Aug 22	452	377	26	49
Turnover	In-month leavers rate	PWR	Aug 22	14.7%	14.8%	12.0%	16.7%
	Leavers - All	PWR	Aug 22	1,290	914	169	207

ICS Workforce (NHS) Dashboard – M05 August 2022





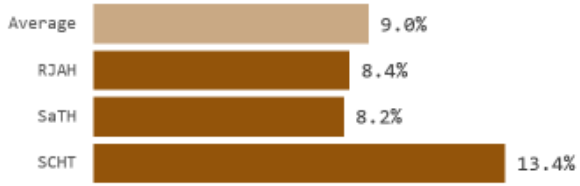


Agency WTE and Staff Group

- Large increase since May of 52 WTE
- 42% of agency is for nursing & midwifery (decreased)
- 32% of agency is for support to clinical (increased)
- 17% of agency is for GP, medical & dental (decreased)

Vacancies

- SCHT have the highest vacancy rate of 13.4% compared to SATH 8.2% and RJAH 8.4%
- Medical & dental 12.8% (increasing)
- Support to clinical staff 11.7% (increasing significantly)
- Nursing & midwifery 6.5% (decreasing)



Turnover

- Turnover is steadily increasing each month
- Nursing turnover is at 15%
- Remaining staff groups are all generally around 14% to 15%

Winter Plan

Agenda item 28-09.025

Shropshire, Telford & Wrekin
Integrated Care System

SHROPSHIRE, Telford and Wrekin Winter Plan 2022/23

DRAFT

Shropshire, Telford & Wrekin
Integrated Care System

Version History

Author:	Angela Parkes Deputy Director of Planning
Date:	16 September 2022
Version:	2

DRAFT

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1 Executive Summary

The winter plan communicates the Shropshire Telford and Wrekin system approach for winter. The plan has been developed using four key methods for sourcing information and collecting feedback:

- Utilising existing system groups
- Targeted work within the System Demand and Capacity Group to develop bed modelling and other impact information
- Individual discussions with identified people across the system to get specific information for the plan
- Utilising existing business cases and documents for information on interventions

The bed modelling has been undertaken to identify an initial most likely case scenario and a worst-case scenario shown in figure one.

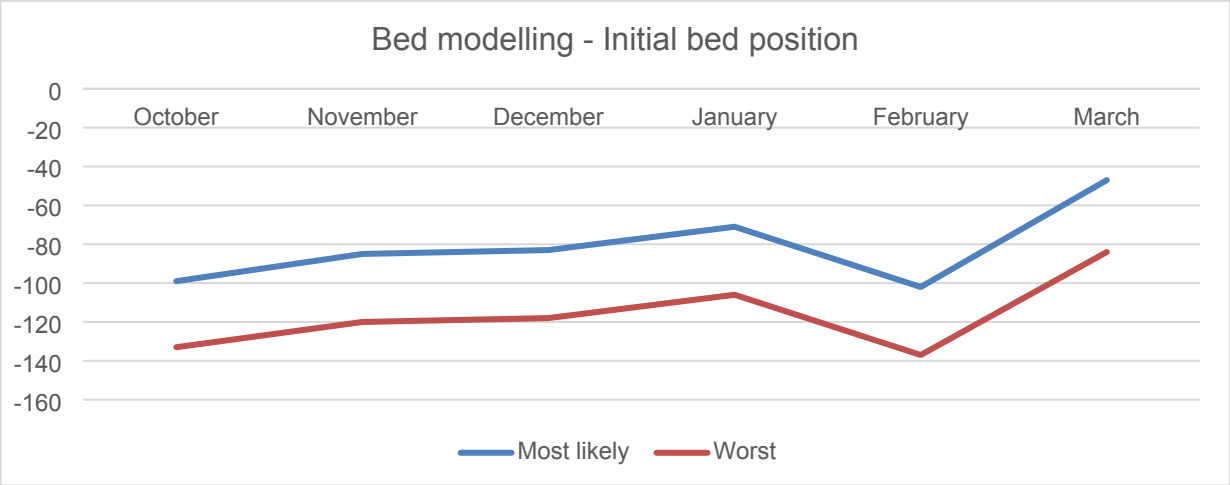

Figure 1: Bed modelling for initial position for most likely and worst-case scenario

The modelling shows an average bed gap of 81 in the most likely case scenario and 113 in the worst-case scenario.

The interventions and expected impact are outlined in table one.

Table 1: Identified interventions and the expected impact by area

Area	Intervention	Expected Impact
Primary care	Extended access appointments	500 hours of extended access appointments per week
	Winter funding UEC appointments	12,927 additional appointments
Community	Rapid response expansion	Reduce ED attendances by 6,600 per year Reduce ambulance conveyances by 1,900 per year Reduce non-elective admissions by 2,200 per year
	Virtual ward beds	Improve acute bed gap by 38 in October rising to 56 by March
	Enhanced therapy support	Reduced length of stay could enable a 20% increase in the number of episodes through reablement beds
	Positive Lives Service	Reduce ED activity by 195

Area	Intervention	Expected Impact
		Reduce non-elective activity by 42 Reduce ambulance incidents by 121
Acute	Cohorting capacity	6 additional spaces in ED
	Acute floor	17 beds in bed model to achieve the initial bed position
Social care	Additional reablement beds	Improve acute bed position by 13.5

Where the interventions have an impact on the bed model, they have been factored in to get to a final predicted bed position for the most likely case scenario and the worst case scenario shown in figure two.

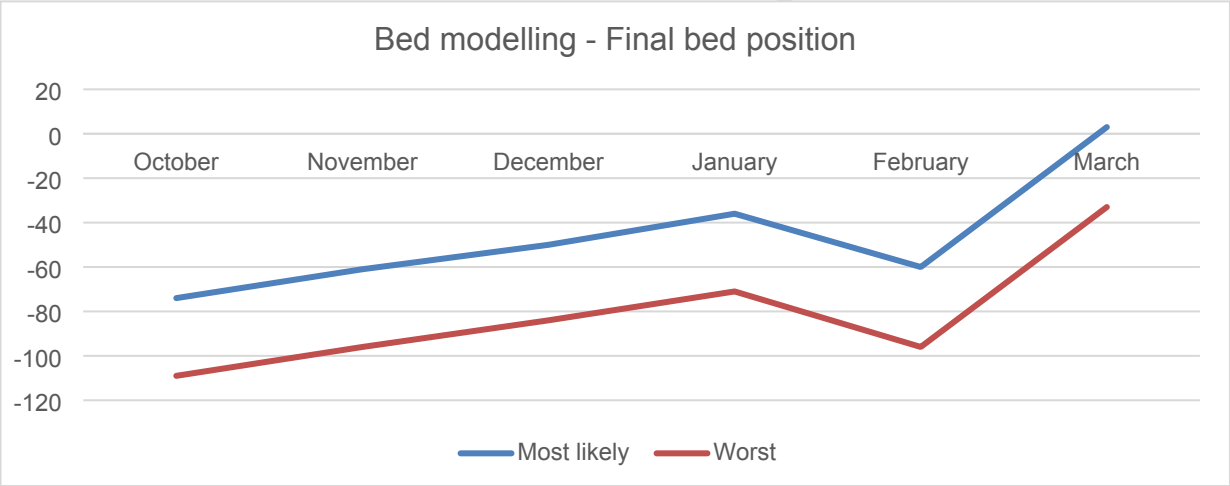

Figure 2: Bed modelling for final position for most likely and worst-case scenario

The modelling shows that after the interventions are factored in there is an average bed gap of 46 in the most likely case scenario and 82 in the worst-case scenario.

Within the model the bed occupancy rate within the acute trust is set to 92%. One option the system could consider to further bridge the gap is to increase this rate. The impact of this is that flow would be significantly affected and waits within ED would be likely to increase. Some trusts operate well with high bed rates by compensating with more senior workforce, narrowing the gap between beds becoming available and being filled, having timely hospital discharge, more flexible community options, reducing length of stay and delayed transfers of care, and increased use of same day emergency care.

The plan includes summaries of enabling work across the system including:

- Vaccination plans
- Critical care capacity
- Comms and engagement
- Winter surge plans

2 Context

The purpose of the winter plan is to communicate the Shropshire Telford and Wrekin system approach for winter, the specific pressures that winter presents for our system and how we intend to mitigate them.

Urgent and Emergency Care (UEC) is under significant pressure across the country. Staff have faced one of the busiest summers ever with record numbers of ED attendances, ambulance call outs and another wave of Covid. Despite our best effort staff have not always been able to provide timely access for our patient in the way they would have wanted. The NHS core objectives and actions have been introduced to begin to address these issues:

Core objective/action	Section of plan
Prepare for variants of Covid-19 and respiratory challenges including an integrated Covid and flu vaccination programme.	**5**: Vaccination/ immunisation
Increase capacity outside of acute trusts, including the scaling up of additional roles in primary care and releasing annual funding to support mental health through the winter	**4.1**: Interventions Primary care **4.2**: Interventions Community
Increase resilience in NHS 111 and 999 services, through increasing the number of call handlers to 4.8k in 111 and 2.5k in 999	
Target Category 2 response times and ambulance handover delays, including improved utilisation of urgent community response and rapid response services, the new digital intelligent routing platform, and direct support to the most challenged trusts	**4.2**: Interventions Community **4.3**: Interventions Acute
Reduce crowding in A&E departments and target the longest waits in ED, through improving use of the NHS directory of services, and increasing provision of same day emergency care and acute frailty services.	**4.3**: Interventions Acute
Reduce hospital occupancy, through increasing capacity by the equivalent of at least 7,000 general and acute beds, through a mix of new physical beds, virtual wards, and improvements elsewhere in the pathway	**4.2**: Interventions Community **4.3**: Interventions Acute
Ensure timely discharge, across acute, mental health, and community settings, by working with social care partners and implementing the 10 best practice interventions through the '100 day challenge'.	**4.3**: Interventions Acute
Provide better support for people at home, including the scaling up of virtual wards and additional support for High Intensity Users with complex needs.	**4.2**: Interventions Community

The introduction of the new Board Assurance Framework (BAF) gives the system a useful tool to monitor progress against System Capacity Plans, Actions and Good Practice basics and improvement priorities. Alongside the BAF six specific metrics, key to the provision of safe and effective UEC, have been identified.

Core objective/action	Section of plan
111 call abandonment	
Mean 999 call answering times	
Category 2 ambulance response times	**4.2**: Interventions Community **4.3**: Interventions Acute
Average hours lost to ambulance handover delays per day	**4.3**: Interventions Acute
Adult general and acute type 1 bed occupancy (adjusted for void beds)	**4.3**: Interventions Acute
Percentage of beds occupied by patients who no longer meet the criteria to reside	**4.3**: Interventions Acute

One of the key areas of concern across the system relates to ambulance handover times. The delays in ambulance handovers result from a range of issues across the patient pathway from pre-hospital to discharge back to the correct setting. Evidence shows that full transparency on operational position has a material impact on flow and reducing ambulance handovers and the

development of a new system wide approach to operational management will increase grip within the system. The system Urgent and Emergency Care (UEC) Improvement Programme is our most significant tool in improving ambulance performance, specifically ambulance handover delays. The UEC plan focuses on the set of key actions we believe will have the biggest impact across the UEC pathway and ultimately in improving ambulance performance. In addition, a two-phase Ambulance Handover MP summit was held over the summer to focus on briefing MPs on background and specific actions that are being taken under the UEC Programme. The summit noted a number of areas where developments were already having a positive impact on performance including the Single Point of Access, developments in relation to primary care access, increased care home provision and the rollout of the Rapid Response service. The system will continue to focus on delivering the UEC plan. For further details around the UEC Improvement Plan please refer to section 4.3.

For winter 2022/23 there will still be an impact of Covid-19 including the national requirements to continue to rollout the vaccination programme. In addition, other infections and viruses that were not prevalent during the last few years are expected to experience a resurgence, e.g. influenza, norovirus and pneumonia. As part of the plans to increase protection against respiratory virus's ahead of winter, everyone aged 50 and over as well as those who are clinically at risk will be offered a Covid-19 booster and a flu vaccination this autumn. For further details of the vaccination plans please refer to section 5. Communications plans specifically aimed at reducing the spread of infectious respiratory disease are being implemented across the system. For further details of the communications plans please refer to section 9.

A challenging winter and spring in 21/22 with increased urgent care demand and Infection Control Procedures requiring segregation of Covid positive patients has meant that elective activity has not increased to the levels required to treat backlogs and manage demand. Routine elective care has been vulnerable to cancellation when there has been increased emergency pressures. The system needs to balance the requirements of elective recovery with the pressures winter brings to urgent and emergency care. For further details of the elective recovery please refer to section 8.

3 Bed Modelling

3.1 Most likely case scenario

The bed modelling for the acute trust in figure three has highlighted that the average expected bed gap over the winter period would average 81 beds. The average is taken from October to March in the row shaded yellow.

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	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Beds available							
Core Bed Base (Adult)	699	669	696	696	696	696	696
Paediatrics	36	36	36	36	36	36	36
Day ward	25	25	25	25	25	25	25
Unused escalation beds	6						
SITREP position	766	730	757	757	757	757	757
Acute floor	- 24	- 24	17	17	17	17	17
Ward 18	17	17	17				
Critical care (elective)		14	14	14	14	14	14
Winter Beds (ICB funded)			7	7	9	9	9
Efficiency savings and discharge actions	15	15	15	15	15	15	15
Occupancy Target @ 92%	- 57	- 55	- 61	- 60	- 60	- 60	- 60
Beds Available to meet patient demand (exc Covid)	**650**	**636**	**705**	**689**	**691**	**691**	**691**
Beds required							
Non Elective - Total forecast beds occupied	**701**	**675**	**722**	**714**	**713**	**740**	**681**
Additional covid/flu activity	0	20	26	16	18	8	9
Non Electives (inc additional covid)	**701**	**695**	**748**	**730**	**731**	**748**	**689**
Elective Activity Plan*	42	39	42	42	31	45	49
Average Beds required to deliver forecast activity	**743**	**734**	**789**	**772**	**762**	**793**	**738**
Average Shortfall in Beds per Month	**- 92**	**- 99**	**- 85**	**- 83**	**- 71**	**- 102**	**- 47**
Elective recovery							
Elective Q1-2 recovery beds needed	8	8	8	8	6	9	10
Average beds after elective recovery beds added	**- 101**	**- 106**	**- 93**	**- 91**	**- 77**	**- 111**	**- 57**
Demand interventions							
Reverse Queueing	-	-	-	-	-	-	-
Virtual ward	19	28	28	38	38	47	56
Average beds after impact of demand interventions	**- 82**	**- 78**	**- 65**	**- 54**	**- 40**	**- 64**	**- 1**
Discharge interventions							
Additional Reablement beds (NHSE/I funded £1.212m)		4	4	4	4	4	4
Additional Reablement beds (NHSE/I additional funding TBC)							
Average bed impact after discharge interventions	**- 82**	**- 74**	**- 61**	**- 50**	**- 36**	**- 60**	**3**

Figure 3: Bed modelling for acute trust (Most likely case)[1]

The initial part of the modelling includes the impact of the following interventions:

- Acute floor. For further details please refer to section 4.3
- Ward 18
- 14 additional beds created in the space previously used as Critical care at RSH (elective)
- Winter beds ICB funded. For further details please refer to section 4.4
- Efficiency savings and discharge actions. For further details please refer to section 4.3

The second section of the modelling shows the beds that would be required for elective recovery to deliver the operational plan. This is what is required over and above the original plan for the period from Oct-March to recover the planned activity lost in the first half of the year due to a mixture of workforce shortages and emergency pressures. This would deteriorate the bed position by a further 8 to 10 beds over the winter period.

The third section outlines the demand interventions. The reverse queuing intervention that has been funded through the ambulance handover plan improves flow within the emergency department but is not predicted to impact on the bed position. The bed modelling includes a line

[1] Assumptions for bed modelling can be found in appendix two

for this intervention for completeness. The virtual ward intervention will help to bridge the bed gap to the value of 28 beds in October through to 56 beds in March. If the virtual ward intervention meets its higher targets over the winter this will further improve the acute bed position. For further details please refer to section 4.2.

The final section of the model outlines the discharge interventions. An additional 16 reablement beds have been funded through the ambulance handover plan. These additional beds help to bridge the bed gap to the value of 4 beds between October and March. For further details please refer to section 4.4.

Further funding opportunities are currently being explored for additional reablement beds. A line has been included within the bed model so that should these funding opportunities come to fruition the model can be easily updated to accommodate.

Likely case final bed position: Average bed gap of 46

3.2 Worst case scenario

	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Beds available							
Core Bed Base (Adult)	699	669	696	696	696	696	696
Paediatrics	36	36	36	36	36	36	36
Day ward	25	25	25	25	25	25	25
Unused escalation beds	6						
SITREP position	766	730	757	757	757	757	757
Acute floor	- 24	- 24	17	17	17	17	17
Ward 18	17	17	17				
Critical care (elective)		14	14	14	14	14	14
Winter Beds (ICB funded)			7	7	9	9	9
Efficiency savings and discharge actions	15	15	15	15	15	15	15
Occupancy Target @ 92%	- 57	- 55	- 61	- 60	- 60	- 60	- 60
Beds Available to meet patient demand (exc Covid)	**650**	**636**	**705**	**689**	**691**	**691**	**691**
Beds required							
Non Elective - Total forecast beds occupied	**701**	**675**	**722**	**714**	**713**	**740**	**681**
Additional covid/flu activity	**0**	**25**	**31**	**21**	**23**	**13**	**14**
Impact of disease outbreaks and temporary care home closures		**30**	**31**	**30**	**30**	**31**	**31**
Non Electives (inc additional covid)	**701**	**730**	**783**	**764**	**766**	**783**	**726**
Elective Activity Plan*	42	39	42	42	31	45	49
Average Beds required to deliver forecast activity	**743**	**769**	**825**	**807**	**797**	**828**	**775**
Average Shortfall in Beds per Month	**- 92**	**- 133**	**- 120**	**- 118**	**- 106**	**- 137**	**- 84**
Elective recovery							
Elective Q1-2 recovery beds needed	8	8	8	8	6	9	10
Average beds after elective recovery beds added	**- 101**	**- 141**	**- 129**	**- 126**	**- 112**	**- 146**	**- 93**
Demand interventions							
Reverse Queueing	-	-	-	-	-	-	-
Virtual ward	19	28	28	38	38	47	56
Average beds after impact of demand interventions	**- 82**	**- 113**	**- 100**	**- 88**	**- 75**	**- 100**	**- 37**
Discharge interventions							
Additional Reablement beds (NHSE/I funded £1.212m)		4	4	4	4	4	4
Additional Reablement beds (NHSE/I additional funding TBC)							
Average bed impact after discharge interventions	**- 82**	**- 109**	**- 96**	**- 84**	**- 71**	**- 96**	**- 33**

Figure 4: Bed modelling for acute trust (Worst case)

The worst-case scenario in figure four shows increased demand for Covid, Flu and other respiratory conditions and a deteriorating position in relation to medically fit for discharge patients should the care market also be affected by infection outbreak related closures and/or staffing shortages. The increases can be seen in the two lines in purple text in figure four.

The impact of this increased demand can be seen in the line shaded yellow where the bed gap from October to March would average 113 compared to 81 in the most likely case.

The impact of the interventions is unchanged from the most likely case.

Worst case final bed position: Average bed gap of 82

4 Interventions/Actions

4.1 Primary Care

Demand in primary care is unprecedented, even though General Practice are providing more appointments than before the pandemic. Over 90% of patient contacts in the NHS are delivered through primary care and therefore primary care expect to see the demands on them increase significantly this winter.

Pressure point for primary care	How primary care will address
Increased winter demand whilst managing the impact of the backlog in elective care	Practices will provide additional appointments through locum, agency and extension of existing staff hours as part of the winter scheme[2].
Business continuity – the relatively small nature of practices means that anything that adversely impacts on staff numbers covid and other illnesses and recruitment and retention can severely impact their ability to deliver core services	Access to work from home for most staff. Clinical remote appointments are now normal practice. Growing number of ARRS roles and strengthening of clinical team Growing number of locums and other clinical staff on the Lantum online booking platform. Number of initiatives underway to improve GP recruitment and retention Business continuity plans in place and tested throughout 2019-2021 Stronger relationships within PCNs to be able to offer support.
Rurality: patients being able to access services	Remote triage and appointments via phone and video. Use of remote monitoring digital solutions such as Docabo in Care Homes LA support with cost-of-living grants
Delivery of Flu and Covid vaccinations	Early planning and ordering. Models tested in 2021.

Primary care has acknowledged that changes are required to ensure access to practices by phone is improved. Redcentric, the telephone system supplier, has been commissioned to undertake a piece of work with the practices to provide enhanced bespoke support to understand the call flows. The output from this work will be recommendations for changes to optimise the

[2] Subject to approval

functionality of the system to improve patient call experience. Practices that are not currently using the Redcentric system have been offered support to commission an enhanced support package from their own service provider. The feedback on the outcomes of this work is expected in September 2022. The impact of this work is that patients will find it easier to get through to practices on the condition that practices are able to maintain sufficient call handling staff. Recruitment and retention of this staff group remains an ongoing challenge for some practices.

The new enhanced access PCN delivered service is the amalgamation of two current services, PCN extended hours and GPFV extended access into a consolidated single consistent offer. PCNs will provide enhanced service access from 6:30pm to 8pm on weekdays and 9am to 5pm on Saturdays. PCNs will provide 60 minutes of appointments per 1,000 PCN population delivered within the hours stipulated. Appointments will be pre-bookable and same day and will offer a range of appointment types from routine, screening, sexual health, LTC management. There will be a range of options from face to face, telephone and online and telephone booking.

As part of the ICB Winter Plan funding a proposal for additional primary care appointments has been approved. This scheme enables primary care networks (PCNs) to increase planned staffing and activity between October and March depending on the individual PCN demand predictions. This increase in primary care capacity will help to prevent attendance at urgent and emergency care portals over the winter period. The scheme will target the appointments to the areas of greatest need.

Impact: 500 hours of extended access appointments per week and 12,927 winter funding UEC appointments

4.2 Community

The Local Care Programme aims to build on existing good practice and develop more systematic, preventative, integrated interventions that will support the independence and wellbeing of residents in our local communities. The following interventions as part of this programme are expected to have a positive impact on admissions avoidance over winter 2022/23:

- Expansion of rapid response service
- Rollout of virtual ward beds to support admissions avoidance.

Rapid Response Expansion

The Rapid Response Service is a multi-disciplinary team that responds within 2 hours to support people with an urgent need to remain well and recover in their usual place of residence. The model promotes a Home First approach and focuses on early intervention and timely discharge.

Impact of rapid response expansion: Reduce ED attendances by 6,600 per year; Reduce ambulance conveyances by 1,900 per year; Reduce non-elective admissions by 2,200 per year

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Virtual Ward Beds

Virtual ward beds are being implemented to support admissions avoidance. The aim of the programme is to have 60 beds by the end of September, 120 beds by the end of December and 180 beds by the end of March. A conservative position has been modelled of 50% of the expected beds to be in place each month. This conservative modelling has been made to account for concerns in relation to the ability to recruit and the clinical engagement. The impact of these beds based on expected length of stay follows a ratio of 1.6 virtual ward beds being equivalent to 1 acute bed.

Impact of virtual wards: Improve acute bed gap by 38 in October rising to 56 by March

As part of the ICB winter funding a scheme was supported for enhanced therapy support for pathway two beds between November and March. The scheme aims to further reduce the length of stay within pathway two beds to 20 days and increase the potential capacity.

Impact of enhanced therapy support: Reduced length of stay could enable a 20% increase in number of episodes through reablement beds

The system has commissioned a Positive Lives service from British Red Cross that goes live 1 October 2022. The service will work proactively with individuals who are over-reliant on emergency services and will take is caseload from data including frequent callers to 111, frequent GP practice visitors, frequent 999 ambulance callers and frequent ED attenders. Through new ways of working the service will provide proactive prevention, coaching, support, counselling, and signposting to other services. This will help reduce some of the demand on emergency services.

Impact of Positive Lives Service: Reduce ED activity by 195; reduce non-elective activity by 42; reduce ambulance incidents by 121

4.3 Acute

The current model of delivery for urgent and emergency care (UEC) is under pressure and is not sustainable. High demand is impacting on responsiveness, risk to patient safety and patient outcomes.

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Figure 5: Challenges for UEC in STW

The vision for urgent and emergency care in STW remains that it is focused on continuing to transform our services into an improved, simplified and financially sustainable 24 hour/7-day model; delivering the right care, in the right place, at the right time for all our population. The STW UEC Improvement Plan focuses on three specific workstream areas:

- Pre-hospital
- Hospital Improvement and Flow
- Discharge

The plan has been developed following a review of 21/22 UEC Improvement Plan and incorporating learning from winter 21/22 and the Covid-19 pandemic response. It outlines how the system will work together and across the region to ensure the services meet the needs of the local population.

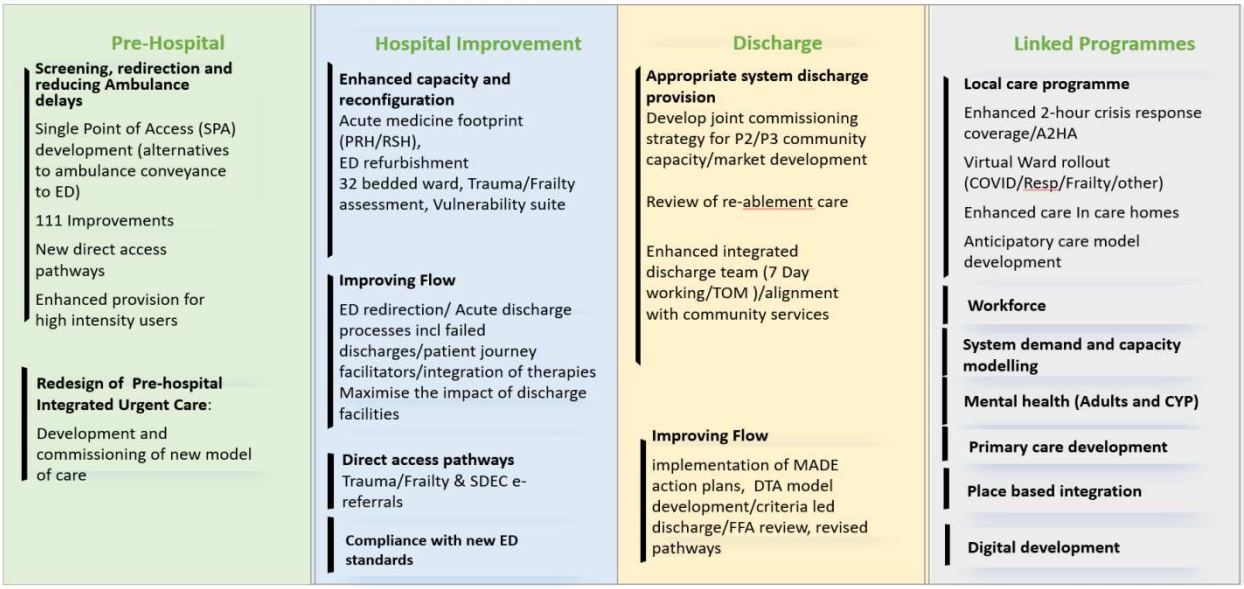


Figure 6: STW UEC Priority Transformation Programmes

UEC Workstream	Benefits
Pre-hospital	Increase direct access pathways by 5 by December
	Increase cases from WMAS to Single Point of Access (SPA) to 20 per week by September and 30 per week by March
	Maintain 95% of cases from WMAS to SPA diverted away from ED
Hospital Improvement	Improve ambulance waits of less than 60 minutes to 89% by November and 97% by March
	Improve ambulance waits of less than 15 minutes to 33% by October and 40% by March
	Improve the number of patients within 12 hours in ED department from 212 per week to 165 per week by November and 66 per week by March
	Improve the percentage of patients seen within 15 minutes for initial triage in ED to 50% by November and 95% by April
	Improve the mean time in ED for non-admitted patients
	Improve the mean time in ED for admitted patients
	Consistently achieve 45% admissions via surgical SDEC
	Exceed the national target of 30% admissions via medical SDEC
	Reduce GP admissions through ED to 50
Discharge	Improve percentage of discharges before midday to 17% by November and 25% by March
	Improve percentage of discharges before 5pm to 65% by November and 75% by March
	Increase use of discharge lounge to 50%
	Reduce total stranded bed day delays
	Reduce delays for optimised medically fit for discharge patients
	Reduce cancelled discharge to 1% of daily discharges
	Reduce average length of stay on medically fit for discharge list to 2 days
	Reduce number of patients stranded for 14 or more days to 2019 level
	Reduce number of patients stranded for 21 or more days to 2019 level
Linked workstream – primary care	Deliver 60 minutes of extended access per 1,000 population
	Reduce emergency admissions for specified ambulatory care sensitive conditions per 1,000 population
	Deliver 5 online consultations per 1,000 population
	Reduce emergency admissions per 100 care home residents by 10%
	Deliver 0.65 community pharmacy consultations per 1,000 population

Prior to hospital admission

Many of the actions within the UEC plan will be implemented prior to and during the winter period and will support the system to manage demand. To meet local and national priorities the system will:

- Provide better signposting to all urgent care services available, such as walk-in services, pharmacy care and ED
- Work as a network so that care is given at the right time, by the right staff, in the right place with the right equipment
- Ensure the appropriate links between urgent and emergency care transformation and community service transformation, working closely with primary care colleagues and community teams to meet the needs of patients close to their home/where they live to make sure that only people most in need will go to hospital
- Work with the Ambulance Service to manage ambulance demand, handovers and alternative pathways
- Make sure that the system is using technology to help offer the most up to date services and treatments
- Reshape services where necessary to provide the best patient care and experience

Alternatives to hospital admissions interventions that support acute care by offering other options rather than attending ED will be implemented within the system. For further details please refer to section 4.3.

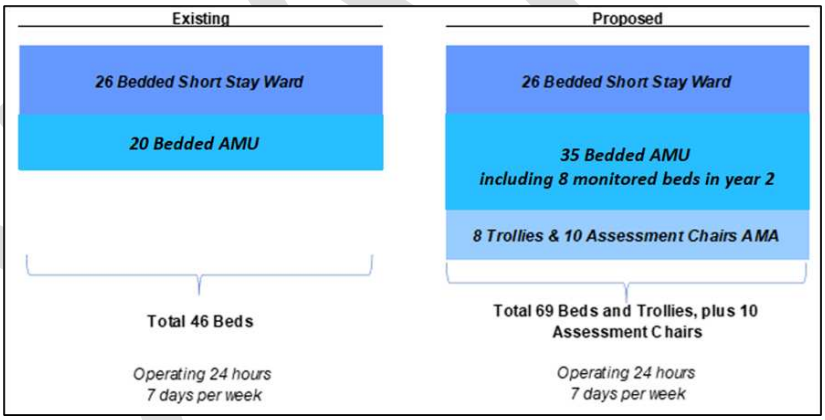
The Ambulance Handover Plan includes the provision of cohorting staff to create additional reverse queuing capacity in SaTH which will help to reduce demand at the front door. The additional SaTH staff for the cohort areas will release ambulance staff from current cohorting arrangements which will reduce/eradicate patients reported as being delayed while they are actual being cared for with the ED environment. The outcome of this investment will be an additional six spaces in ED. The impact of this change will be to improve ambulance handover times.

Impact of additional cohorting capacity: 6 additional spaces in ED

Acute Floor

The system is developing an Acute Floor that creates new pathways and capacity at the front door to support early specialty assessment and direct admission pathways for medicine, orthopaedics and oncology. The proposal creates the following:

- A co-located Acute Medical Assessment area (AMA), a larger Acute Medical Unit (AMU) and a short stay unit
- A co-located trauma and assessment unit and orthopaedic ward
- A co-located oncology assessment area within the oncology ward



Part of the programme will be implemented by the end of December which will have a positive impact on the position over the winter period. These changes will reduce footfall and demand on ED improving performance against UEC measure, reducing ambulance handover delays and improving patient care and experience. This will also improve the working environment for our staff having a positive impact on recruitment and retention.

Impact of acute floor: 17 beds applied within bed model to achieve -81 bed position (most likely case) or -113 (worst case)

Improving flow (including discharge)

As part of the UEC Transformation Programme work has been undertaken to improve patient flow. This work aims to ensure patients are able to move through the hospital in the most efficient way, that supports their care needs and results in care being delivered in the right place, at the

right time, with the most appropriate team. The work has ensured processes are in place for updating systems efficiently and accurately, developed a Standard Operating Procedure for the discharge lounge and improve communications to improve the use of the lounge for all discharges. These changes will all improve the flow within the hospital.

Earlier in the year the ED was reconfigured to ensure the capacity and estates are used to maximum effect and to ensure the most efficient service with the best outcomes for our patients. These changes will help to improve the flow within the hospital over winter when compared to last year.

An ED redirection tool is being introduced to support the audit of attendances that should have been signposted away from ED. This tool is due to go live at the beginning of October as a pilot. The valuable information that will be collected as part of this audit will help the system continuously improve flow throughout the winter period.

The system has developed a Discharge Alliance Plan targeted at improving discharges from acute care. The plan includes the implementation of a number of 100-day challenges for completion by the end of September:

100 day challenges	Actions
• Identify patients needing complex discharge support early • Ensure multi-disciplinary engagement in early discharge planning • Set expected date of discharge within 48 hours • Ensuring consistency of process and documentation in ward rounds • Streamline operational transfer of care hubs • Revise intermediate care strategies to optimise recovery and rehabilitation	• Developing Trusted Assessors • Reigniting End PJ Paralysis work • Completion of Therapy Review • Encourage patients to take responsibility for their mobilisation • Develop criteria led discharge • Develop evidence based expected date of discharge • Complete IDT review to embed key Discharge to Assess including Home First as a principle • Consider case management approach across IDT

North Bristol Pathway
<Awaiting information about critical care from SaTH (Karen Evans)>

4.4 Social Care

The ICS recognises the need to support the care market and knows the impact upon health if it does not work as a system collectively to support and manage the care market to ensure continued sustainability and high-quality provision.

The system needs to have the right resources and work collectively to ensure continued throughput and flow out of the acute and community hospitals and even more importantly preventing the need for admission.

The system will continue to work together to address the workforce issues across the system and with LA's targeting areas of high risk such as the domiciliary care and care home sector.

The ICS will work with Care Providers and in particular care homes to manage safe discharges and support them to manage outbreaks and reduce the risk for hospital admissions.

This winter it will be more important than ever to work as one system, we will not only have the pressure from both covid and flu; we will also have the additional pressures as a result of the cost-of-living crisis play out which could enhance the pressure on health and other services taking it to another scale. In order to address this the LA's are working across a number of organisation to support its communities. Across Shropshire a Task Force focusing on the rising cost of living and its social impact locally. The forum provides an opportunity to bring a range of stakeholders together to share their knowledge of the impact and support available for our population and communities. Members include CAB, Age UK, Councillors, SPIC, Shropshire Food Poverty Alliance, Marches Energy Agency, Energize, Qube, Police, Landau, Headteachers, DWP, LEP, ICS, SATH and Shropshire Council (housing, welfare, food insecurity, communications, public health, libraries, economic development, affordable warmth). The Task Force continues to meet monthly to look at gaps and further actions stakeholders can take jointly within Shropshire to support our residents struggling with the cost-of-living increases, with a focus on ensuring that the most vulnerable in our community are supported.

1) Review capacity across the system to support people in Shropshire with the cost-of-living crisis. Consider which resources and skills are available. Triage and offer specialist support for those in need.
2) Improved information sharing between partners in relation to the cost-of-living crisis to ensure that partner organisations are kept informed of up-to-date information on assistance available so they can cascade to the people they support (e.g., Household support fund, HAF scheme).
3) Joint working to create protocols around more common debts.
4) Workforce training/Improved signposting information for frontline staff and volunteers to boost their knowledge of support available and increase confidence to hold difficult conversations around the increases in the cost of living.
5) Data & Insight. Continue to review what insight is held on groups most likely to be impacted by the cost-of-living crisis. Plan an event to learn what data is available.
6) Work with Stakeholders to review the Household Support Fund allocation to date.
7) Joint communications on the cost-of-living crisis highlighting help available, including panels on Shropshire Radio. Key messages include: Encouraging householders to contact Marches Energy Agency (MEA) now for help with energy efficiency measures over the summer to help householders get ready for Autumn/Winter & Energy advice. Communications around how to make best use of the £650 government support payment. Promotion of Breathing Space to prevent government support payments being allocated to overdraft/debt repayments/rent arrears.
8) Assessment of the impact of the cost-of-living crisis on the workforce, including how it will impact their ability to effectively do their jobs. A key focus on workers on lower incomes, particularly the impact on carers.

Local authorities continue to support the system through prevention for example scoping further use of technology solutions to support discharge and prevent admissions. Social prescribers continue to work with those who need help and support, information, and guidance to direct people away from primary care and acute services where appropriate and engage people within their communities to remain healthy and independent.

As part of the ICB winter funding two schemes were supported to provide additional reablement beds across the county to support timely discharge from acute care. The proposal delivers the following additional capacity:

- 28 beds from November to March
- An additional 10 beds from January to March when demand is higher.

The impact of the additional reablement beds has been built into the system demand model in section 3.

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The Ambulance Handover Plan includes some additional bed-based interventions commissioned through the local authorities with 16 further reablement beds, capacity

Impact of reablement bed: Improve acute bed position by 13.5

4.5 Mental Health

Midlands Partnership Foundation Trust (MPFT) has been working closely with the third sector to develop non-clinical alternatives to broaden the Crisis Intervention support, which should lead to reduced need for admission and reduce the need for inappropriate out of area placements. As part of improving access to 24/7 support to patients an all-age mental health crisis helpline has been extended since last winter to include professionals supporting children and young people within the access team.

As part of the Dementia Transformation Programme the development of a Dementia Crisis Service is being planned. This will establish and build on the current Hospital Avoidance offer piloted by Midlands Partnership Foundation Trust and provides assessment and treatment of older people with mental health problems. The interventions are focused on maintaining people in their own home/care environments and facilitating early discharge from hospital. The key aim of the service is to reduce ED attendances and support early discharge from acute care.

Since last winter MPFT has appointed Mental Health Practitioners within the Primary Care Networks. These roles are integral to the multi-disciplinary team who will support people presenting with mental health problems to achieve overall wellbeing.

In addition, STW ICS has been allocated a small amount of funding to support children and adults' mental health over winter and discussions are currently underway across system partners to agree and develop a range of suitable schemes.

4.6 RJAH

Mutual aid for elective orthopaedic work will be delivered over the winter period through a combination of:

- Work undertaken at RJAH by RJAH workforce
- Work undertaken at RJAH by SaTH workforce
- Additional work commissioned by the independent sector

Sheldon

The Trust's activity plan is based on the 5 beds on Sheldon ward being utilised for elective activity within the Trust as the commissioned capacity for care of the elderly provision is 15 beds. If these beds were repurposed for winter care of the elderly capacity this would create an impact on elective delivery for the Trust and the system which in turn would impact on the elective recovery fund (ERF) delivery.

MCSI

Current pressures with West Midlands for acute Spinal Cord Injury (SCI) beds remain at unprecedented high levels requiring us to work closely with NHSE to ensure patients are being managed safely until they can be admitted to The Midland Centre of Spinal Injuries (MCSI). This bed demand and capacity mismatch results in patients having to wait much longer in MTC's, DGH's (including RSH and PRH) and local hospitals prior to admission to the specialist SCI

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centre. MCSI also has bed pressures attributed to re-admissions; primarily urology, pressure ulcer and rehab wait lists.

We propose to ringfence 3 beds Sheldon beds for appropriate MCSI patients and 2 beds for rheumatology elective recovery. The case mix of patients planned these beds impacts on the staffing requirement for the ward. The expenditure budget only allows for staffing for rheumatology / metabolic patients on the ward. If some of the beds were re-purposed for Spinal Cord Injury, funding would be received from NHS England to flex the required staffing levels to support the different case mix on the wards. As the beds are planned to be used for elective Spinal Cord Injury rehab activity re-purposing to MCSI will not impact on the elective delivery plan.

The Networked model of care bid that was successful earlier in 2022, is now being operationalised and will provide and enhanced outreach support across the West Midlands. As the Network Model of Care is intertwined with the current MCSI Surveillance Team, this will positively impact both MTC's and DGH's within the West Midlands

4.7 Remaining Bed Gap

Following the identified interventions there remains a predicted bed gap in our Acute Hospital. In the most likely case scenario, the bed position averages -46 beds and in the worst case scenario this averages 82.

To address this the system may need to consider some unpalatable options. Within the bed modelling in section 3 there is an assumption of a bed occupancy rate of 92%. The system may need to consider increasing the bed occupancy up to 100%. The impact of increasing bed occupancy rates is that flow would be significantly affected and waits within ED would be likely to increase. Some trusts do operate well with high bed rates by compensating with more senior workforce, narrowing the gap between beds becoming available and being filled, having timely hospital discharge, more flexible community options, reducing length of stay and delayed transfers of care, and increased use of same day emergency care.

5 Vaccination/Immunisations

Covid-19 Context

As the we transition from a period of pandemic emergency response to pandemic recovery, the focus is increasingly on protecting those in society who continue to be more at risk of severe COVID-19 infection. To achieve this, a planned and targeted vaccination programme is considered more appropriate than a reactive vaccination strategy.

The Shropshire Telford & Wrekin (STW) COVID-19 vaccination programme has been very successful in ensuring good uptake across the system and has regularly been one of the best performing systems both regionally and nationally. Our work amongst our underserved communities and those with health inequalities has been used as an exemplar in regional briefings. The programme has successfully worked with all system partners to achieve this success.

Delivering a sustainable COVID-19 vaccination programme, is an essential mainstay of health prevention. We will make vaccination services accessible to all eligible groups, including those affected by health inequalities by:

- Ensuring there is sufficient capacity across the system to safely deliver a sustainable COVID-19 vaccination programme to the eligible population.

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- Ensuring we have a skilled and competent workforce to deliver the programmes safely
- Develop a vaccination offer that provides convenience and ease of access across the system. This will include outreach sessions and focused work that addresses inequalities and harder to reach communities.
- Ensuring that the vaccination offer is consistent utilising a combination of fixed centres and roving/pop-up sites
- Develop contingency plans for periods of surged activity (for example new COVID-19 variant response)
- Develop a coordinated vaccination programme that incorporates co-delivery of other vaccinations when possible and that Makes Every Contact Count (MECC) by incorporating appropriate health advice/screening in line with the NHS Core20PLUS5 approach.

Covid-19 Vaccination Programme

The following groups of people will be eligible for an Autumn Booster according to the current JCVI Guidance (as of September 2022):

a. residents in a care home for older adults and staff working in care homes for older adults
b. frontline health and social care workers
c. all adults aged 50 years and over
d. persons aged 5 to 49 years in a clinical risk group, as set out in Tables 3 and 4 of the Green Book Chapter 14a
e. persons aged 5 to 49 years who are household contacts of people with immunosuppression (as defined in Tables 3 and 4 of the Green Book)
f. persons aged 16 to 49 years who are carers (as defined in Table 3 of the Green Book)

The system continues to offer 1st and 2nd doses to those that have not yet received those doses as part of our 'Evergreen' service.

During the Autumn campaign we will use a blend of providers; PCNs, Community Pharmacies, Hospital Hubs and a Vaccination Centre located across the county. Pop-up clinics and roving teams will also be utilised by the programme to ensure we maximise potential to reach our eligible cohorts. Our COVID-19 Vaccination sites will offer both booked and walk-in appointments. We will have a total of 28 static sites delivering COVID-19 Vaccinations to all eligible groups through the Autumn 2022 campaign.

Shropshire Community Trust will deliver the COVID-19 vaccination control clinic for people who have severe allergies and anaphylaxis once a month from the Royal Shrewsbury Hospital (RSH) site. The service will see approximately 10-15 patients per clinic. The team will be looking to move the referral route into this service to the e-referral system to make it more effective.

Seven of our PCN's have signed up to deliver the COVID-19 Vaccination service to their mandated cohorts within the Enhance Service Specification commissioned by NHS England. The mandated cohorts are:

- Care home residents and staff (to be completed within 10 weeks)
- Housebound patients
- Immunosuppressed patients

Our eighth PCN, Shrewsbury, only the 5 rural GP Practices within this PCN will be delivering the COVID-19 Vaccination service to the mandated cohorts. SCHT will be delivering the COVID-19 Vaccination service to the remaining patients who fall within the mandated cohorts. SCHT will

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work closely with those Shrewsbury PCN practices to ensure patient lists are shared in line with data protection guidance.

Three PCNs will also be delivering to all eligible groups (Teldoc PCN, Southeast Shropshire PCN and South West Shropshire PCN). Teldoc PCN are currently available on the National Booking System (NBS), and the other two PCNs are being encouraged to use the NBS for Autumn campaign. This will enable us to articulate simple and consistent public facing communications around how to access autumn boosters.

The Autumn campaign will see the introduction of more Community Pharmacies offering a COVID-19 Vaccination, particularly in those hard-to-reach areas of the county. Following a Community Pharmacy expression of interest exercise managed by NHS England, we were able to pick which new Community Pharmacies we wanted to deliver COVID-19 Vaccinations in our system to add to our capacity. We have asked for an additional 11 Community Pharmacy sites to be commissioned by NHS England to deliver the service to ensure we have enough capacity within our system to deliver the Autumn campaign within timeframes. These sites are currently going through an assurance process with NHS England.

SCHT will deliver the COVID-19 Vaccination service from 3 Hospital Hub sites and 1 Vaccination Centre:

- Royal Shrewsbury Hospital
- Princess Royal Hospital
- Coral House, Shrewsbury
- Robert Jones and Agnes Hunt (RJAH) Vaccination Centre

The priority cohort for the Hospital Hub sites will be Frontline Health and Social Care Staff working in STW.

The weekly available maximum capacity to deliver vaccinations will be 31,152 across the system, with the ability to increase capacity to 40,000 vaccinations per week in a surge situation. The system must prioritise this capacity to ensure that 100% of our care home residents and staff are offered a vaccination within the first 10 weeks of the campaign.

The Autumn campaign is forecast to deliver 210,786 vaccinations by 15th January 2022. This equates to 50% of the STW adult population. Of the forecast activity, 70% is forecast to be delivered by our Community Pharmacies, 16% by our PCNs, and 14% by SCHT. Based on historic data, the programme team are forecasting week commencing the 26th September to be the peak week of activity with an estimated 28,287 vaccinations being administered.

<u>Covid Surge Planning</u>

The Covid-19 Vaccination programme has developed a surge plan to be implemented in the event demand exceeds available capacity. The plan is outlined below:

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NHS
Shropshire Community Health
NHS Trust

1e. COVID-19 Vaccination Campaign Autumn 2022 Surge Plan

Shropshire, Telford & Wrekin (STW) COVID-19 Vaccinations programme has a weekly available maximum capacity to deliver vaccinations will be 31,152 across the system, with the ability to increase capacity to 40,000 vaccinations per week in a surge situation. In discussion with our PCN and CP partners, it is expected that they would need up to a week to ramp capacity up to surge levels.

Local Authority Engagement	Demand Planning	Capacity Planning	Workforce Plan
• Contact made with the director public health team to agree joint planning arrangements • Discussion taken place about local authority support which can be provided – estates, call centre capacity	• Unvaccinated population data reviewed • Vaccine equalities tool utilised to understand underserved locations and populations • Geographical areas mapped and scoped for increased existing site activity • New and additional pop-up locations identified in partnership with local communities • Communications plan in place – local media, social media, online content and leaflet drops • Community, faith groups and third sector contacted to agree supportive marketing plan to increase vaccination in underrepresented groups • Requesting councillors and community leaders to increase their visible support of vaccinations and share 'pop-up' plans to raise awareness and stimulate demand	• Maximisation of current network capacity (e.g. extending opening hours) • Maximise utilisation – 'sweating' existing assets to ensure maximum capacity from existing sites (e.g. additional clinics/estate capacity at existing sites) • Identifying additional sites either by delivery model type or outreach model e.g. pop-up, buses etc. • Appropriate technology secured to support onsite clinical administration • Local booking service (simply book) in place to handle expected demand • Walk in sites identified • Clinical protocols reviewed for existing and new site operations • Consumables ordered and secured for new sites/pop-ups • Fridges ordered • Cold chain logistics scoped and mapped	• A site by site roster / workforce plan detailing shift dates, times and role requirements has been developed – clinical, support and volunteers • The national protocol has been implemented for new and pop-up activity sites to maximise resource allocations • Lead employer contacted to secure locally recruited resources and draw down from national suppliers • Rapid contingency staffing solutions from NHS Professionals and St John Ambulance engaged • Local system mutual aid requested • Site level induction and daily stand ups scoped into daily roster to ensure safety and clinical skill briefings

The COVID-19 Vaccination Programme team will work closely with system partners to ensure that during periods of surge the system is supported both in the response to COVID-19 Infection and increasing demand for COVID-19 Vaccinations. As a system our aim is to manage our response appropriately while minimising impact on our elective care activity. The system will stand-up the Gold, Silver and Bronze escalation governance structure and procedure. Members of the COVID-19 Vaccination Programme Team will attend system Gold, Silver and Bronze calls.

Improving Lives In Our Communities

Flu Vaccination Programme (included last years section until further information available)
The flu vaccination programme will be starting in September for adults aged over 65 and those identified as at risk. All 51 practices will be offering flu vaccines with 31 practices offering them alongside Covid vaccines. The majority of practices will be offering the flu vaccine at practice level with a small number offering them across the PCN footprint. The latest start date for practices will be week commencing 10 October. There is an aspirational target for over 65s of 75% and for those under 65 who are risk of 65%. The delivery of vaccines will be monitored at a practice level on a weekly basis and will be shared across the PCNs.

6 Critical Care

<Awaiting information about critical care from SaTH and critical care collaborative (Andrena Weston). Expected date: 15 September>

7 Infection Prevention and Control

Winter 22/23 is expected to see higher than average influenza rates, the return of norovirus outbreaks and a further wave of COVID19 with the potential for new variants as the population regains normal social activity. Shropshire Telford and Wrekin have the following measures in place to address this.

- Arrangement with primary care out-of-hours provider to prescribe flu prophylaxis to those meeting the clinical requirements.
- COVID19 Medicines Delivery Unit (CMDU) 7 days a week.
- Care home IPC support including local outbreak management, support and a prompt re-opening review process supported by a SOP.
- ICS wide IPC group to share best practice, standardise approaches to guidance implementation, learn from outbreaks and monitor infection rates.
- Pre-winter review of ventilation in inpatient/residential health and care settings.
- Pre-winter review of learning from outbreaks in NHS providers to inform outbreak management practice.

- ICB engagement in all outbreak meetings across the system.
- Provider local policies and processes to maintain safe respiratory pathways and prevent the spread of infection.

8 Workforce

Workforce plans outlined within the operational plan are expected to improve the workforce position when compared to last winter. Some of the key actions are outlined in table two.

Table 2: Workforce plan actions and the expected impact

Actions	Impact
Ongoing proactive recruitment including international recruitment	To reduce vacancies
Use of rotational or shared posts	More attractive offer for potential employees
Increased support to international nurses	Improve retention
Improved health and wellbeing support to staff	Reduce sickness absence Improve retention
Trauma and resilience management (TRiM) pathway. Support to people who have experienced a potentially traumatic event.	Reduce sickness absence Improve retention Improve staff wellbeing
Staff psychological wellbeing hub. Support, advice and triage for anyone worried about their mental health	Reduce sickness absence Improve retention Improve staff wellbeing
Tools for understanding burnout/stress and building resilience	Reduce sickness absence Improve retention Improve staff wellbeing
Tools to support carers and families	Reduce absence Improve staff wellbeing
Transition from vaccination workforce to surge/winter workforce	To have access to a workforce that can be deployed across the system during times of surge
Embed a sustainable reservist model across the system	To have access to a workforce that can be deployed across the system during times of surge
Increased use of apprenticeships	From September increased use of apprenticeships within radiology, orthopaedics and nursing associates

9 Elective Care and Cancer

Elective Recovery

Waiting lists nationally have grown following the Covid-19 pandemic. A challenging winter and spring in 21/22 with increased urgent care demand and Infection Control Procedures requiring segregation of Covid positive patients has meant that elective activity has not yet increased to the levels required to treat current backlogs and manage current demand. Routine elective care has been vulnerable to cancellation when there has been increased emergency pressures with lack of interim bed capacity to support discharge and staff absence to a level that is outside of seasonal norms.

During the winter period our three main hospitals within the system, two acute sites and the specialist orthopaedic hospital, will aim to continue to provide elective surgery to minimise any potential impact on waiting lists. There is recognition that this will be a challenge due to the large bed gap (set out above) that has been identified through the demand and capacity modelling.

The system will continue to use the independent sector capacity both in and out or area (due to the limited capacity within the local system) as well as mutual aid provision through agreement with other NHS providers.

All three providers will also continue to focus on Outpatient transformation with increased focus on virtual appointments and Advice & Guidance to maintain activity levels when capacity is constrained.

Given the likely pressures in the system there will be increased promotion of the "My planned care" app to ensure patients are kept informed of the status of their pathway

The system has identified a number of actions through the operational planning which will contribute to elective care recovery over winter including:

- Fully scoped the use of alternative outpatient and diagnostic capacity including mutual aid and independent sector both in and out or area (due to the limited capacity within the local system).
- Optimising the use of patient-initiated follow-up for patients to release capacity
- Increase in stratified follow ups for cancer patients
- Improving theatre utilisation
- Improving theatre scheduling to align to specialties at risk of cancelling routine patients and to maximise operational hours
- Implement process to backfill patients in terms of short notice cancellations
- Review of operating models and community pathways to implement improvements
- Implementation of teledermatology
- Increased use of virtual consultations
- Optimising the use of advice and guidance by launching new process in advance of winter

The system will continue to implement the System Escalation Policy which on OPEL level 3 and 4 requires a review of elective care activity to ensure there is sufficient capacity to meet the non-elective demand. As part of this review, electives relating to cancer treatment or that are clinically urgent will be prioritised and providers will aim to maximise this activity though existing capacity.

Elective Transformation

The system is undertaking a major transformation programme relating to developing new ways to provide outpatient services. The work is well underway and includes optimised use of advice & guidance, patient initiated follow up discharges, virtual consultations, remote monitoring, nurse-led telephone follow ups and 1 stop clinics all of which, combined, is reducing the number of people requiring face to face appointments in the acute: thereby reducing physical demand in SaTH and RJAH.

An added benefit of this more efficient way of working and providing outpatient service is releasing capacity in the acute hospital. This includes the ability to reutilise clinical space, clinical or admin time that would otherwise be used for face-to-face appointments.

The system is undertaking a piece of work to review and validate waiting lists with the ambition of reducing follow up waiting lists by 25% by March 2023 which will reduce elective care pressures within the system.

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There is a risk to elective care over the winter in that urgent care pressure take priority which results in elective activity getting suspended and clinical and operational colleagues being diverted to support with dealing with these pressures. This may compromise progress of some of the elective care work.

10 Communications and Engagement

The aim of the STW winter comms campaign will be:

- To empower the citizens of Shropshire, Telford and Wrekin to keep well this winter
- Ensure our health and social care system runs as smoothly as possible
- Reducing ambulance handover delays

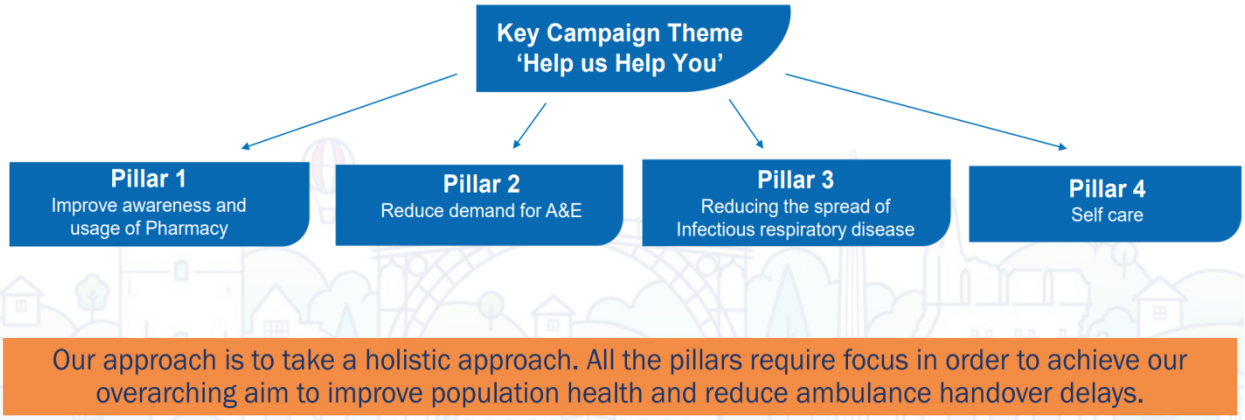

Figure 7: Overarching winter comms campaign and pillars

Pillar 1: Improve awareness and usage of Pharmacists

The system conducted interviews with residents, pharmacists and GPs with the STW system to gain insight on the role and barriers to using pharmacy. The key finding of this were:

- A significant proportion were not aware that the pharmacy offered advice and treatment of minor ailments
- The highest rated benefit of a pharmacist was the fact that no appointment was needed followed by receiving faster answers
- The lowest satisfaction was the ability to talk in private

Drive awareness of the wide range of advice and treatment offered by Pharmacists, whist, highlighting the speed in which you can be seen.

Pillar 2: Reduce demand for A&E

The attendances at A&E between April and June were analysed to gain insight into behaviours. The key findings were:

- Over half of attendees fell into categories indicating minimal or no investigation or treatment was necessary, with 75-80% of these relating to soft tissue injuries
- These attendances are most likely to happen in the evenings

- These attendances are slightly more prevalent amongst our younger and less affluent populations

Drive awareness of when to use A&E, alternatives to A&E (NHS 111 & MIU) and highlight everyone's part in making our system run well this winter

Pillar 3: Reducing the spread of infectious respiratory disease
As we move into colder months viruses such as flu and Covid are more likely to spread quickly when people are crowded together. Cold weather can also make some health problems worse and even lead to serious complications, especially for those aged 65 and over. This can put additional pressure on our hospitals. We can reduce the spread of respiratory disease by:

- Keeping vaccinations and boosters up to date (Flu and Covid)
- Hygiene: Hand washing
- Staying home when ill
- Masks (in some settings)

Drive awareness and need of minimising the spread of respiratory disease this winter and actions they can take to minimise the risk

Pillar 4: Self-care and maximising your wellbeing
We can raise awareness of important self-care techniques that will help people and their families to stay well and help ease pressures on local health services:

- Simple steps include eating well, taking daily vitamins and staying active
- Wrapping up warm whilst you're out and about this winter
- Stocking up on self-care essentials (OTC medicines, at pharmacies and supermarkets, help relieve many common symptoms of illness)
- Look after yourself, your loved ones, and your neighbours, and get the right care in the right place

Drive awareness of how to keep yourself, your family, and neighbours healthy this winter by doing all you can to stay healthier

Comms Strategy

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Paid social media

- Hyper target and localise to creatively reach audiences who fit our key segments
- Unlimited adverts running at once

Youtube

- Key channel to drive awareness
- Build short form video content

Programmatic Display

- Ads on news and entertainment sites showing only to people likely to be ready to change behaviours

Radio

- Split into traditional and Instream to ensure multiple demographics targetted

PR

- Use close links with local media to amplify the campaign and focus on good news stories

Digital toolkit

- Pull together a digital toolkit containing campaign assets for partners to share

Maildrop

- Targetted maildrops around the local hospitals and areas of low cost hosptial attendance
- Posters and leaflets distributed by partners to target hard to reach groups

Loading page content

- Launch a campaign page on the NHS Shropshire, Telford and Wrekin website

11 Risk Analysis

The system has identified a number of risks to the delivery of the winter plan and these are outlined in table three.

Table 3: Risk summary

Risk Description	Mitigating actions
The winter schemes implemented could address unmet need which would meant that the expected impact was not achieved	Work with project leads to identify key measures and milestones for monitoring. Closely monitor winter schemes to identify if they are addressing the expected cohorts.
The system may not be able to change the established behaviours of its workforce	Use the clinical leadership within the system to drive change Comms and engagement with key stakeholders to ensure workforce is informed and involved
The system may not be able to change the established behaviours of patients and the general population	Comms and engagement with our population. For further details please refer to section 9.
The system may not be able to recruit to the required posts which could affect the ability to deliver the expected changes	Implement workforce plan in relation to recruitment. For further details please refer to section 7.

Risk Description	Mitigating actions
The system may have to rely on agency staffing which will be more costly than planned	Implement workforce plan. Ongoing monitoring of use of agency staffing. For further details please refer to section 7.
The system may destabilise another area with its recruitment to additional posts by creating an internal market	Implement workforce plan in relation to recruitment. For further details please refer to section 7.
The system may not be able to manage competing priorities e.g., additional Covid-19 waves	Regular monitoring of demand and review of plans
The inconsistency in relation to 7 day working across the system may affect the ability to manage out of hours discharge	Regular monitoring of impact at weekends. Planning discharges early to mitigate impact of weekend discharges
The large, expected bed gap may not be able to be bridged	Interventions detailed throughout the winter plan. For further details please refer to section 4.
The system may not be able to effectively manage walk in demand for urgent and emergency care	Managing demand through interventions identified. Ongoing monitoring of walk-in demand for urgent and emergency care. For further details please refer to section 4.
The system may not be able to effectively manage admitted demand for urgent and emergency care	Managing demand through interventions identified. Ongoing monitoring of ambulance and prebooked demand. For further details please refer to section 4.
The impact of infections, e.g. Covid-19 or influenza, may be underestimated which could destabilise the system	Modelling of impact and projections to be monitored for early warning.
The impact of unexpected severe seasonal weather on the system ability to deliver services	Business continuity plans
The system may not be able to effectively deal with the conflict between dealing with system recovery and the winter demand	Ongoing monitoring of elective recovery and winter demand. For further details of interventions relating to elective recovery please refer to section 8.
The system may not be able to identify the capacity for EMI to meet the demand	Quantified as part of demand and capacity modelling
The system may not be able to manage the specific workforce constraints within theatres and radiology	Plans in place to manage specific workforce constraints within theatres and radiology
The impact of the market issues relating to domiciliary care may restrict flow out of hospital or reduce the number of patients able to be discharged home	Ongoing monitoring of market for early identification. For further details please refer to section 4.4
The impact of market issues relating to community bed based care may restrict flow out of hospital	Ongoing monitoring of market for early identification. For further details please refer to section 4.4
Capacity in people team to develop plans	Work with System Planning and Performance Group to identify resource requirements in relation to planning
Independent sector capacity is not at sufficient scale to mitigate gap in NHS capacity	Ongoing monitoring of independent sector capacity. Maximise use of available independent sector capacity. Explore mutual aid arrangements.

A full risk register with mitigating actions will be developed to coincide with the move into the implementation stage which will be owned by the System Planning and Performance Group.

12 Surge Plan

<Awaiting update following surge planning meeting held 9 Sept>

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Appendix one: Engagement activities

Engagement	Impact
Winter planning workshop held in June with representation from health and social care	Launched process for winter proposals. Identified areas of focus for winter planning Information from breakout sessions fed into demand and capacity work and winter plan.
Non-elective demand and capacity group with representation from health and social care	Demand and capacity information used to frame winter plan. Identification of assumptions and known interventions
Head of Planning and Systems Operation (SCHT)	Covid vaccination information for winter plan
Director of Communications and Engagement (ICB)	Communications winter planning summary for the winter plan
Head of Elective Care and Transformation (ICB)	Elective care section of the winter plan
Associate Director of Primary Care (ICB)	Primary care section of the winter plan
Director for Local Care Programme (SCHT)	Local Care Programme impact for winter plan
Assistant Director of Joint Commissioning (Shropshire Council) and Place Based Strategic Commissioning Procurement Lead (Telford and Wrekin Council)	Social care section for winter plan
Service Delivery Manager: Hospital and Engagement (Telford and Wrekin Council)	Discharge Alliance Plan for inclusion in the acute interventions section of the winter plan
Centre Manager, Patient Access, Theatres, Anaesthetics and Critical Care (SaTH)	Critical care section of the winter plan
Head of Mental Health and Transformation (ICB) Head of Operations (MPFT)	Mental health section of the winter plan
Surge Planning Meeting with RJAH, SaTH, SCHT and ShropDoc	Surge plan section of the winter plan
Interim Deputy Chief Operating Officer (SaTH)	Finalising acute bed modelling used to frame winter plan
Operational leads	Feedback requested – none received

Updates provided to the following groups at various points between June and September:

- Chief Executive Group
- Urgent and Emergency Care Board/Group
- Systems Planning Group

Where documents have been submitted to UEC group and other relevant forums these have been used to develop the plan e.g. acute floor business case.

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Appendix two: Assumptions for bed modelling

The assumptions that apply to both scenarios for the bed modelling are outlined below:

- Demand is forecast based on the historic trend of non-elective discharges and bed days from January 2019, excluding the period March 2020 to April 2021. This uses a linear regression model where the algorithm takes the impact of underlying changes in LOS, MFFD patients and admissions and accounts for seasonality. The training data for the model extends to July 2022 to take into account the significant changes that have occurred in bed days utilisation over the last few months and ensure these are captured in the forecast. Total bed day usage and discharges are forecast separately, and these can be used to calculate the change in length of stay, however this is not a specific input into the model itself.
- Covid – These are included in the baseline forecast as drivers of historic activity over winter and throughout the year. Additional demand is included from October to January, to allow for a disproportionately high winter season
- Flu - These are included in the baseline forecast as drivers of historic activity over winter and throughout the year. Additional demand is included from October to January, to allow for a disproportionately high winter season
- Norovirus - These are included in the baseline forecast as drivers of historic activity over winter and throughout the year. Additional demand is included from October to January, to allow for a disproportionately high winter season
- Length of stay (LOS) – The change in LOS is calculated from the forecasted change in bed days and discharges. This 22% higher than the 19/20 position on average, with higher LOS in the winter months. As this calculated from other fields, it is not possible to revise the model by changing the increase in LOS alone.
- MFFD – MFFD patients are included in the training data, starting from the current high baseline of around 145. These will increase over winter with the seasonal increase in bed days seen in previous years but are not a separate part of the model that can be altered. Therefore, the additional impact of the 38 extra winter pressure funded reablement beds (calculated form the acute discharge demand & capacity model) is already accounted for within this model.
- Elective demand – this is taken from the operation plan for 2022/23
- Capacity – Bed base changes year on year based on improvement and developments. The acute floor development through the autumn means that there are significant ward changes through this period.
- Virtual ward – A conservative position has been modelled of 50% of the expected beds to be in place each month. This conservative modelling has been made to account for concerns in relation to the ability to recruit and the clinical engagement. The impact of these beds based on expected length of stay follows a ratio of 1.6 virtual ward beds being equivalent to 1acute bed.
- Winter beds ICB funded and reablement beds – The impact of these beds follows a ratio of 4 reablement beds to 1 acute bed due to differences in expected length of stay.

The additional assumptions that apply to worst case scenario for the bed modelling are outlined below:

- Covid - Additional impact is also factored in around the closure of care homes on LOS, see "impact of disease outbreak" line
- Flu - Additional impact is also factored in around the closure of care homes on LOS, see "impact of disease outbreak" line

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- Norovirus - Additional impact is also factored in around the closure of care homes on LOS, see "impact of disease outbreak" line
- Impact of disease outbreaks and temporary care home closures - Worst case assumption that disease outbreaks will affect discharge pathways and increase LOS of P1 and P3 patients by 50% from their 22-23 position. Use this to calculate an additional bed day utilisation for these patients and therefore beds needed

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Audit Committee Chair's report for the meeting held on 21st September 2022

Agenda item 28-09.026

MINUTES OF THE AUDIT COMMITTEE
HELD VIA MICROSOFT TEAMS ON
WEDNESDAY 18th MAY 2022 AT 9.30AM

Present

Mr Geoff Braden (Chair)	Chair and Lay Member for Governance
Mrs Donna MacArthur	Lay Member for Primary Care

In Attendance

Miss Alison Smith	Director of Corporate Affairs, CCG
Mrs Laura Clare	Deputy Director of Finance, CCG
Mrs Vanessa Whatley	Deputy Director of Nursing and Quality, CCG
Mr Paul Capener	Interim Consortium Director
Ms Sarah Swan	Assistant Director, CW Audit Services – Internal Audit
Ms Lisa O'Brien	Audit Manager, CW Audit Services – Internal Audit
Mr Paul Westwood	CW Audit Services – Head of Counter Fraud Services
Mr Andrew Smith	Partner, Grant Thornton – External Audit
Mrs Tracy Eggby-Jones	Corporate Affairs Manager, CCG – for agenda item AC-22-05.052 – Policy Alignment Update (attended 10.05am to 10.25am)
Mrs Lisa Kelly	HR Business Partner, MLCSU – for agenda item AC-22-05.048 – Due Diligence Progress Report (attended 9.30am to 9.55am)
Ms Nuala O'Kane	ICS Audit and Risk Committee (attended 9.30am – 10.03am)
Mr Harmesh Darbhanga	ICS Audit and Risk Committee (attended 9.30am to 10.06am)
Mr David Matthews	ICS Audit and Risk Committee
Cllr Roy Aldcroft	Attended on behalf of Cllr Brian Williams, ICS Audit and Risk Committee (attended 9.30am to 10.11am)
Mrs Karen Ball	Corporate PA (Minute taker)

AC-22-05.046 – Apologies

1.1 Apologies were received from Mrs Claire Skidmore, Mr Meredith Vivian, Mr Ash Ahmed and Miss Maria Tongue.

AC-22-05.047 – Declarations of Interest

2.1 There were no declarations of interest to note.

AC-22-05.048 – CCG Transition to Integrated Care System – Due Diligence Progress Report

3.1 Miss Smith thanked colleagues from the ICS Audit and Risk Committee for attending the meeting.

3.2 For the benefit of the ICS Audit and Risk Committee, Miss Smith highlighted that the due diligence exercise was taking place to ensure that the functions of the CCG are in a fit state to be passed to the ICB when it comes into existence on 1st July 2022.

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3.3 Miss Smith noted that the due diligence checklist (appendix 1) had been provided by NHSEI. It is not mandated that the CCG should use it, however it is suggested that it is a good consistent way of working through all the different elements of the functions of the CCG to ensure that everything is captured and covered.

3.4 Appendix 2 is a short report that was produced following assurance panel meetings, which had taken place in December 2021, to enable a deep dive of areas that hold more risks than others. The report included recommendations made by the panel and responses made around the actions that would be taken by management.

3.5 A formal handover has begun between the CCG directors and the new ICB directors, some of whom have started their new roles. Meetings are being planned as part of the handover process and will commence week commencing 23rd May.

3.6 Miss Smith highlighted the timetable within the covering report and the next steps after this meeting. Any concerns or comments raised at the meeting, will be considered, and addressed.

3.7 Some of the elements of the due diligence process will be continually reviewed right up to the 30th June which are coloured amber on the checklist to ensure that there are no particular risks occurring between now and 30th June that would need to highlighted or mitigated.

3.8 Miss Smith asked for any questions or concerns particularly in relation to the checklist. Miss Smith noted that she had invited Mrs Lisa Kelly to the meeting, who is the CCGs Business Partner from the CSU for HR and commented as the CCG nears the end of June the action with the higher risk level that will take place is the transfer of staff from the CCG to the ICB. They will need to ensure that all the people who are moving across are captured accurately and in their entirety.

3.9 To provide further assurance Miss Smith said that one of the elements of the checklist is around the ICB Constitution, which is currently amber, this is mainly around the continuing changes NHSEI have been making to the model constitution. They are currently on version five. Miss Smith noted that on Friday, 20th May, the final version of the constitution will be submitted to NHSEI for consideration. There is one outstanding element of the constitution, that hopefully will be resolved before Friday. NHSEI had provided feedback each time the draft constitution had been submitted to them. NHSEI are largely content with the document apart from the one element that is currently being looked at. Miss Smith suggested that the amber risk is now green.

3.10 Mr Braden opened the meeting for any questions or comments from both the Audit Committee and ICS Audit and Risk Committee members.

3.11 Mr Darbhanga asked how confident the CCG was of meeting the deadline of 30th June and asked if there were any risks, which may arise between now and then. Miss Smith responded that the only one she was aware of was the line around risk management for the ICB and she believed that the timeline on this had been moved back due to capacity issues and had therefore been highlighted as amber. Discussions had taken place with the Good Governance Institute around helping facilitate some discussions, via workshops around the risk appetite for the ICB. As yet these workshops had not been implemented, however it is likely that they would take place in June. It is therefore, unlikely that the work required to develop a draft Risk Management Policy for the ICB, would not start until July.

3.12 Mr Darbhanga asked what the key risks would be in relation to HR and electronic staff records. Miss Smith's understanding was that although the CCG via the CSU hold staff information on Electronic Staff Records (ESR) there are elements of personnel files and records that are held as hard copies within the CCG. An exercise is currently taking place to check the content of hard copy and electronic copy personnel files to ensure they have the fundamental documents required to be kept by the new employer.

3.13 Mr Darbhanga asked in relation to the ESR records, which will be transferred to the new organisation, would the retention period for the records start when they are transferred or would it continue from the time the records were produced. Mrs Kelly started by responding to Mr Darbhanga earlier question in relation to the transfer of ESR and said that the transfer was very straightforward and is just a case of picking up all the CCG staff records and transferring them to the ICB. Checks and balances are in place to ensure that no one is missed. As all CCG staff are paid via ESR the risk of anyone being missed off was very low.

3.14 In relation to the HR records there are some timescales in relation to how long, leavers records are kept. Mr Darbhanga also highlighted other records such as any disciplinary investigations and appraisal and review records. Mrs Kelly responded that disciplinary records have a timescale as to how long they are kept on file, which starts from the time of the event and there are checks and balances in place to ensure that when the time expires, they are removed by the line manager.

3.15 Mrs MacArthur asked, with regards to mandatory training, would it still be acknowledged and relevant when staff move to the ICB. Mrs MacArthur also noted that some people may choose to leave the CCG and not move into the ICB and would checks be made to ensure they are removed from ESR before the transfer. Mrs Kelly responded that mandatory training is linked to ESR and would therefore move over when the transfer is made. However, if there were to be any issues staff would be supported to resolve these. In relation to staff who do not transfer into the ICB, this is being checked on a weekly basis and will continue to be done up until 30th June to ensure new starters are included and those who leave prior to and on 30th June are removed.

3.16 Mr Braden asked Mrs Whatley, what the position was in relation to quality and staff turnover. Mrs Whatley responded that there had been some positive recruitment within the quality team and there had also been a move around in relation to portfolios to ensure the key areas are being covered including quality visits. There are some pressures, particularly around the growing LeDer workload, which is being directed nationally. Mrs Whatley was therefore confident that this was not a risk. Mrs Whatley acknowledged that the team were pressured but are working really hard and noted that it is a reducing risk from the position that was in, in December 2021.

3.17 Miss Smith said that she would be writing a final due diligence report, which would be presented to Mr Mark Brandreth and Mr Simon Whitehouse, which will be used for assurance / reliance in the writing of the Accountable Officer's assurance letter to NHSEI. This will be presented at the CCG Governance Body meeting, which is taking place on 8th June. It will also form part of a suite of papers being presented at the ICB meeting, taking place on 1st July.

3.18 Mr Braden thanked the members of the ICS Audit and Risk Committee and Mrs Kelly for attending the meeting.

NHS Shropshire, Telford and Wrekin CCG Audit Committee and ICS Audit and Risk Committee:

- noted the content of the report and the assurance due diligence checklist attached as **appendix 1**;
- noted the final version 2 of the management assurance responses to the Assurance Panels recommendations attached as **appendix 2**.
- considered but did not highlight any areas as requiring additional actions to enhance the level of assurance needed to assure the CCG Interim Accountable Officer and ICB Interim Designate Chief Executive prior to their assurance being submitted to NHSEI on 1st June 2022, that the due diligence process had been completed.

AC-22-05.049 – Adult and Children's Safeguarding Final Reports – Action Plans Update

4.1 Mrs Whatley said that the key actions in relation to adults safeguarding are around reviewing the safeguarding dashboard, job descriptions and training content and delivery, as well as there being a robust programme of safeguarding visits in place. Mrs Whatley said that she was happy that all of these actions were in train or completed and would recommend that the action plan be signed off today as complete.

4.2 Policies, supervision and training have been updated. In relation to safeguarding training there is good training compliance, with adult safeguarding being around the 90% mark. There is a need to ensure that this is robust going forward and Mrs Whatley had requested weekly monitoring until it is at a sustainable level, when it will go to monthly monitoring.

4.3 In relation to children's safeguarding there were a few outstanding actions including the recruitment of a designated doctor; this post is currently being advertised on NHS Jobs with a closing date of 31st May and interviews will be held on 13th June. As an interim when advice is required this is being supplied by the designated doctor for Staffordshire.

4.4 The contract amendments for children's safeguarding are completed for two organisations and they should be finished by the end of the week. The supervision policy has been updated as has the children's safeguarding policy, to reflect the supervision requirements and monitoring.

4.5 The programme of quality visits had commenced. A deputy designated nurse had commenced work last week. Job descriptions have been reviewed in line with intercollegiate guidance.

4.6 Mr Braden said he wished to explore further the adult's and children's quality visits and assurance regarding monitoring. Mr Braden acknowledged that they had started again in April and asked how many had taken place since then. Mr Braden also asked when the monitoring actions would be concluded. Mrs Whatley responded that there had been one visit in April, which was to the Redwoods and children's services. An action plan is being agreed with the Trust. The reason that only one visit had taken place so far was due to the fact that they were waiting for the deputy designated nurse to be in post. The second visit has been arranged.

4.7 Mr Braden went on to ask how many visits were planned and commented that during the past two years very few had taken place. Mrs Whatley responded that she was not able to give the precise number but would feed it into the actions. Mr Braden said it would be helpful to bring this back to the June 2022 extraordinary meeting around the quality visits and the monitoring, which would be useful to gain some assurance that it is an appropriate number of visits and themes are being picked up and concluded. Mrs Whatley agreed that she would do this.

4.8 Mrs MacArthur said that in relation to adult safeguarding and responses she was more confident in the way that the actions had been picked up than she did with the children's safeguarding. Mrs MacArthur highlighted an example in the way section 5.2 had been worded where it said request made, awaiting response, however there was no indication as to when the request was made and whether it should be followed up. Mrs MacArthur said that she felt less confident in terms of the response. Mrs MacArthur went on to ask about the interim arrangements for the designated children's safeguarding doctor and whether this arrangement would have to be extended.

4.9 Mrs Whatley responded that in relation to 5.2 two of the four contracts had been signed and supervision would be reported to the CCG. The other two contracts are being worked through currently and Mrs Whatley did not envisage any risks and that they would be signed off without a problem. In terms of the interim arrangement Mrs Whatley felt that this needed to be looked at in terms of how long as even if a doctor where to be recruited on 13th June it may take some months before they are in post. Mrs Whatley commented that it was a more attractive offer with 5 sessions, which is an increase from 2 sessions. The advert would also be shared by the medical directors and regionally. Mrs Whatley noted that they are not easy posts to fill.

4.10 Mr Darbhanga asked with regards to recruitment what discussions had taken place with local authority partners around shared posts. Mrs Whatley said that in terms of children's safeguarding it was already a multi-agency approach.

4.11 Mr Braden suggested that it would be useful to carry this agenda item over to the June meeting as it is such a critical area. Mr Braden said that he really needed to be assured and pass on that assurance relating to safeguarding to the ICB.

4.12 Mr Braden said he wished to recognise the work and progress that had been made.

4.13 Updated reports will be brought to the June extraordinary meeting, when practical steps to close them can be seen.

Actions:

- Mrs Whatley to update the June extraordinary meeting on how many quality visits will take place along with monitoring, in order for the Audit Committee to gain some assurance that it is an appropriate number of visits and themes are being picked up and concluded.
- Updated reports will be brought to the June extraordinary meeting, when practical steps to close them can be seen.

NHS Shropshire, Telford and Wrekin CCG Audit Committee:

- Requested that both a children's and adult's safeguarding report be brought to the June extraordinary meeting for final review.
- Acknowledged progress with the children's report and seek assurance on action.

AC-22-05.050 – Final – Provider Serious Incidents

5.1 Miss O'Brien informed members that following presentation of the report at the March audit committee meeting, work had been undertaken to review and to respond to the recommendations within the report. Some of the recommendations had been addressed and some are in progress.

5.2 The key finders were around the need to evidence action taken by the CCG when challenging or holding providers to account and also when duty of candor documentation is not in line with requirements. It was also noted that reporting to the Quality and Performance Committee needed to be improved particularly with regards to performance of RCA and investigation turnaround by providers and the duration of open cases.

5.3 Mr Braden's only observation was the moderate assurance had been given and he thought it would have been limited assurance, due to the number of serious incidents (SI's) and also the requirement to close them down within 60 days. Nearly half of the SI's had not been concluded within the 60 day period. This could result in the same SI happening again due to the fact lessons had not been learnt. Miss O'Brien responded that they had taken into account, when arriving at the assurance level, the revised regime which was applied under Covid, when there was some relaxation or suspensions in terms of reporting timelines for RCA investigations. Miss O'Brien noted that it was a poor moderate assurance and they would be content to move it to limited assurance if the audit committee wished. However, Miss O'Brien wished to emphasise that the focus needed to be on what is being done to complete the actions.

5.4 Mrs MacArthur said she echoed what Mr Braden had said. Mrs MacArthur went on to ask if the report had been shared formally with CSU given that they undertake work on behalf of the CCG. With regards to where it says that information on serious incidents is shared out of area where relevant and who determines this. In terms of learning should it not be going as wide as possible and asked how this could be achieved.

5.5 Miss O'Brien said that the internal auditors report goes directly to the CCG and it would then be for the CCG to share it with those they feel are relevant.

5.6 Mrs Whatley said that aspects of the findings had been shared with the CSU and there had been a formal sharing of the completed report. Working with the CSU, on an operational level, to strengthen the process and to ensure that the CCG is receiving the matrix. With regards to out of area learning; there is a review process around reporting regionally and the regional team are currently working through a standard operating procedure (SOP) for reporting certain SI's into the regional team and for onwards communication. Every month key issues and risks are reported into the monthly regional system quality meeting. There is also very good communication with NHSEI.

5.7 Mrs MacArthur asked if SI's from other areas are shared with SaTH as part of a learning process. Mrs Whatley responded that there is learning, which goes through each Trusts patient safety specialists and they have regional, system and national meetings to discuss any themes, which will also be escalated. Regular one to one meetings also take place with the chief nurses within the system, where such things are discussed. Weekly one to one meetings also take place with the regional chief nurse.

5.8 Mr Braden asked Mrs Whatley if she would bring an update on RCA status to the June extraordinary meeting. Mrs Whatley responded that she would be happy to do this.

5.9 Mrs Whatley noted that a revised SOP for SI reporting, a letter to providers and the stop the clock SOP had all been updated in the past few weeks so with results of these will be seen in the next month or two.

Action:
- Mrs Whatley to bring an update on RCA status to the June extraordinary meeting.

NHS Shropshire, Telford and Wrekin CCG Audit Committee ***NOTED*** the content of the report.

AC-22-05.051 – Minutes and Actions from the Audit Committee Meetings held on:

6.1 **16th March 2022**

The minutes from the Audit Committee held on 16th March 2022 were agreed as being a true and accurate record of the meeting.

6.2 **Extraordinary Meeting – 20th April 2022**
The minutes from the Audit Committee held on 20th April 2022 were agreed as being a true and accurate record of the meeting.

Matters Arising from the minutes

7.1 AC-21-01.004 – BAF and DRR – It was agreed that this action should be closed. Mr Brandreth will be attending the June meeting.

7.2 AC-22-03.026 – IG Update – This action has been deferred and the report will be brought to the June meeting.

7.3 EAC-22-04.045 – Draft Annual Report 2021/22 – All actions have been completed and can be closed.

7.4 The remaining actions are complete and will be removed from the action list.

GOVERNANCE

AC-22-05.052 – Policy Alignment Update

8.1 Mrs Eggby-Jones said that the only policy left for sign off was the fertility policy and hopefully it would be signed of this afternoon by the Strategic Commissioning Committee.

8.2 Mrs Liz Walker had been overseeing the review of the medicine management policies and had provided an update, which is appendix 2 of the papers.

8.3 A memorandum of understanding and information sharing agreement relating to the POD is outstanding but these are not technically policy documents that would be captured in the policy alignment exercise. However, it is in the process of being signed off through the IG process.

8.4 Mr Braden thanked Mrs Eggby-Jones for the well written report that summarised exactly where the CCG was in relation to policy alignment. Mr Braden also thanked Mrs Eggby-Jones and those involved in the work undertaken to get the polices to where they should be when going forward into the ICB. Mr Braden said that he did not underestimate how hard it had been to get them to the position they are currently in.

NHS Shropshire, Telford and Wrekin CCG Audit Committee ***noted*** and were ***assured*** **by**:
- **Appendix 1** outlined the last remaining policy yet to be aligned, together with an indication of when the review and approval process will be completed.

- Current position in relation to the review of Medicines Management policies and procedures as outlined in **Appendix 2**.

AC-22-05.053 – Board Assurance Framework (BAF) and Directorate Risk Register (DRR)

9.1 Miss Smith reminded members that at the March meeting discussions had taken place around BAF risks 1; public engagement and risk 9; safeguarding looked after children, which was around insufficient capacity to carry out safeguarding responsibilities, on the BAF. At the time some concerns were raised around the proposal to move both risks to the DDR due to the risk ratings reducing due to the mitigations that had been put in place. Miss Smith raised the concerns with the respective directors and Mrs Edna Boampong was still recommending that the risk 1 on Communications and engagement should be moved to the DRR. The respective risk have been left on the DRR in grey.

9.2 For Mrs Whatley's benefit, Miss Smith said that Mrs Young proposed that due to the recruitment that had taken place risk 9 could be lowered and moved to the DRR. However, in light of the internal auditors reports on safeguarding and Sis it was agreed by the Deputy Director for Nursing and Quality that this risk should remain on the BAF and that she would review its content in light of the issues that had already been raised earlier in the meeting on safeguarding and SI's.

9.3 Mr Braden added that the narrative within the action plan mentioned quality visits, however as highlighted previously only one had taken place. Mr Braden went on to say that audit committee, at this stage, were reassured but did not have assurance.

9.4 Mrs Whatley noted that one key post had been filled with the other out for recruitment. There are also updated matrix and dashboards for the providers. Contract discussions are taking place but the matrixes need to come back for assurance purposes. Following the conversation that had taken place at the meeting Mrs Whatley said that she would be happy to keep risk 9 on the BAF for a little while longer in line with next month's update on the audit.

9.5 Mrs Swan asked if there was a need to reflect on risk 6 on the BAF, quality and safety, and Mr Braden noted that it was still a high risk score and asked Mrs Whatley if she could update it, specifically in relation to the SI's. Mrs Whatley said that she would.

9.6 There is a new risk, 19, on the DRR, following the discussion that had taken place at the March meeting. The risk is around capacity relating to individual commissioning.

9.7 Mr Braden asked if issues relation to the West Midlands Ambulance Service (WMAS) in relation to ambulance handover delays and significant cost pressures should be on the BAF. Miss Smith responded by saying that ambulance handover delays form part of two complex and high risk areas; quality and urgent care pressures, which the system continues to experience. It is whether the risk around ambulance handover delays is sufficient for it to appear on the BAF as it is part of a complex picture that are symptoms of A&E pressures. Ambulance handover delays are one component but not the only component. One of the major issues currently is that there are still covid patients who need to be isolated within the hospitals, which puts extra pressure on the beds that are available. Miss Smith said that her view would be that as a single component it would not feature on the BAF because in its own right it would not be a sufficiently material risk for the CCG.

9.8 Miss Smith suggested that she would speak to Mrs Whatley in relation to looking at whether risk 6 needed to have more detail within it, from a quality point of view. She would also speak to Mrs Tilley in relation to risk 10, which is around sustained UEC pressure, and whether it need more detail around some of the mitigating actions the system is taking. Mr Braden suggest some input should be sought from Mrs Clare around the financial risk as well. It was agreed that the BAF and DRR would be brought to the extraordinary meeting in June.

Actions:

- Mrs Swan asked if there was a need to reflect on risk 6, quality and safety, on the BAF and Mr Braden noted that it was still a high score and asked Mrs Whatley if she could update it, specifically in relation to the SI's. Mrs Whatley said that she would.
- Miss Smith suggested that she would speak with Mrs Whatley in relation to looking at whether risk 6 needed to have more detail within it, from a quality point of view.
- Miss Smith would speak to Mrs Tilley in relation to risk 10, which is around sustained UEC pressures, and whether it needed more detail around some of the mitigating action the system is taking.
- Mr Braden suggested some input should be sought from Mrs Clare around the financial risk.
- It was agreed that the BAF and DRR would be brought to the June extraordinary meeting.

NHS Shropshire, Telford and Wrekin CCG Audit Committee:

- Reviewed the BAF and DRR and considered the additional assurances that were necessary that the risks to the strategic objectives are being properly managed as outlined above.
- Provide assurance to the CCG Governance Board that the principal risks of the CCG not achieving its strategic and operational priorities and have been accurately identified and actions taken to manage them with the exception of the areas requiring further assurance as outlined above.

FINANCE

AC-22-05.054 – Losses, Special Payments and Procurement Waivers – March / April 2022

10.1 Mrs Clare reported that there were nine waivers since the last audit committee meeting. All of which were signed off by Mrs Skidmore.

10.2 Mrs Clare noted that as the CCG approaches the time it becomes an ICB, there will be new budget holders and SFIs, which will be agreed as part of the new constitution. Work would be undertaken with the new budgets holders to clarify the guidance around single tender waivers, when they should and should not be and should only be used in exceptional occasions.

NHS Shropshire, Telford and Wrekin CCG Audit Committee ***NOTED*** the content of the report.

INTERNAL AUDIT

AC-22-05.055 – Annual Internal Audit Report 2021/22 and Head of Internal Audit Opinion

11.1 Mrs Swan informed members that the report had been updated since it was presented as the draft version. The update was to recognise the second Ockenden report and the service audits that had taken place.

11.2 Miss Smith asked Mrs Swan if she could share the Microsoft Word version of the opinion so that it can be inserted into the annual report.

11.3 No questions or comments were raised.

Action:

- Mrs Swan to share the Microsoft word version of the Head of Internal Audit Opinion with Miss Smith.

NHS Shropshire, Telford and Wrekin CCG Audit Committee ***NOTED*** the content of the report.

AC-22-05.056 – Final Report - BAF

12.1 Mrs Swan informed members that the overall format and arrangements had not been under any significant changes this year. In terms of meeting the requirements it had been given level A.

12.2 As always there is a need to focus on the assurances received and keeping the document timely.

12.3 No questions or comments were raised.

NHS Shropshire, Telford and Wrekin CCG Audit Committee ***NOTED*** the content of the report.

AC-22-05.057 – Audit Recommendations Update Report

13.1 There were no overdue recommendations to report; however, there are some deferrals, three of which refer to the child safeguarding recommendation; recruitment and the subsequent development of an SLA for the designated doctor and finalisation of the provider performance dashboards, which will include some assurance reporting around supervision arrangements. These will be monitored closely through to completion. A follow up of children's safeguarding has been included within the 2022/23 audit plan.

13.3 The remaining 2 deferrals were presented at the previous audit committee meeting and have revised completion dates at the end of June 2022, they therefore appear on the report again as work is ongoing. These relate to the development of some additional procedures and SOPS within the individual commission team around CHC processes and development of a primary care estates strategy.

13.4 No comments or questions were raised.

NHS Shropshire, Telford and Wrekin CCG Audit Committee ***NOTED*** the content of the report.

EXTERNAL AUDIT

AC-22-05.058 – External Audit Progress Report

14.1 Mr Smith gave a verbal update at the meeting and the following points were noted.

14.2 Mr Smith said that they were approaching the halfway point of the year end audit and were on track. Getting good responses from the finance team in terms of responding to queries and the information required.

14.3 There are a couple of areas where there had been a delay and these were around samples for payables and continuing healthcare, which for the later had been due to staff absence. With regards to payables this had been due to lot of contra-entries; the only way to deal with this is to pick an artificially high number of samples or for the finance team to go through and cleanse that population, however there are too many lines to do this and the most efficient route is to pick a high sample, therefore there had been some delays around this.

14.4 Overall making good progress. Will be in a position to report at the June extraordinary meeting.

14.5 No significant issues to report at this time. Some challenges had been raised around the draft accounts, queries around comparators.

14.6 Mr Smith went on to say that as the CCG had made a deficit in year they are required to write to the Secretary of State and undertake a Section 30 Report. Mr Smith did not feel that this should be of concern to members. Will be going to panel to get a moderated view around the ongoing sustainability of the CCG / ICB and the wider healthcare system, going forward, due to the challenges being faced. The panel meeting is due to take place week commencing 23rd May so Mr Smith will be able to report back at the June meeting. It is expected that there will be a significant weakness in this area.

14.7 There were no questions or raised.

NHS Shropshire, Telford and Wrekin CCG Audit Committee ***NOTED*** the content of the verbal report.

COUNTER FRAUD

AC-22-05.059 – Counter Fraud Progress Report

15.1 Following on from the March meeting where a potential fraudulent forged document and prescription had been highlighted Mr Westwood said that this had been passed to the West Mercia police, who were aware of the individual due to unrelated issues. The CPS, however said that the person won't be charged as it did not pass the evidential test. This case has therefore been closed.

15.2 A staff survey has recently taken place, with the initial results being analysed and the initial results are positive. A report on this will be brought to the June meeting for information.

15.3 Mr Westwood is currently working on the annual report to the Counter Fraud Authority, which he will share with Mrs Skidmore and Mrs Clare; signoff is required by Mr Braden and Mrs Skidmore. The deadline has been extended to 10th June and Mr Westwood did not envisage any issues with this.

15.4 There were not comments or questions raised.

Action:

- Mr Westwood to provide a report on the counter fraud staff survey for information at the June extraordinary meeting.

NHS Shropshire, Telford and Wrekin CCG Audit Committee ***NOTED*** the content of the report.

AC-22-05.060 – Draft Counter Fraud Workplan 2022/23

16.1 With the CCG moving to the ICB this is a flexible document, which can be changed at a later date if required.

16.2 It is based on the same costings as previous years, although this may need to be increased in line with inflation. It includes extracts of the medium risks. In accordance with the new government functional standards a full risk assessment has to be completed. The Counter Fraud Authority have identified 123 potential fraud risks for NHS organisations. Around 40 of these have been extracted, which are felt to be more relevant for CCGs. There are 5 or 6 medium risks that have been included. These need to be manage in accordance with the CCG's Risk Management Policy and would be shared with Miss Smith outside of the meeting.

16.3 Mrs MacArthur asked if a statement would be made against it that the CCG will be moving to the ICB and whether it will be refreshed at that point. Mr Braden responded that this would be part of the due diligence process and there will be a process for the transition into the new organisation. Mr Westwood agreed with what Mr Braden had said.

Mr Braden thanked Mrs Whatley for attending the meeting at short notice on behalf of Mrs Young. Mr Braden went on to say that he appreciated the progress that had been made and the acceptance that work needed to be concluded and are looking for assurance rather than the actions and it was not meant to be as a negative.

NHS Shropshire, Telford and Wrekin CCG Audit Committee ***NOTED*** the content of the report.

FOR INFORMATION ONLY

AC-22-05.061 – Health and Safety and Security Management Annual Report 2021/22

17.1 This report was presented for information only.

AC-22-05.062 – EPRR Update

18.1 This report was presented for information only.

AC-22-05.063 – Any Other Business

19.1 No items of any other business were discussed.

Date and Time of Next Meeting

Audit Committee – Wednesday 15 June 2022, 2pm via Microsoft Teams

Meeting closed at 11.01am

DRAFT

MINUTES OF THE EXTRAORDINARY AUDIT COMMITTEE HELD VIA MICROSOFT TEAMS ON WEDNESDAY 15th JUNE 2022 AT 2PM

Present

Mr Geoff Braden (Chair)	Chair and Lay Member for Governance
Mr Ash Ahmed	Lay Member for Patient and Public Engagement - EDI
Mr Meredith Vivian	Lay Member for Patient and Public Engagement

In Attendance

Mr Andrew Smith	Partner, Grant Thornton – External Audit
Mr Neil Preece	Manager – Audit, Grant Thornton – External Audit
Ms Maria Tongue	Head of Financial Accounting and Reporting, CCG
Ms Sarah Swan	Assistant Director, CW Audit Services – Internal Audit
Mr Paul Westwood	CW Audit Services – Head of Counter Fraud Services
Miss Alison Smith	Director of Corporate Affairs, CCG
Mrs Claire Skidmore	Executive Director of Finance, CCG
Mrs Laura Clare	Deputy Director of Finance, CCG
Dr John Pepper	Chair, CCG
Mr Mark Brandreth	Interim Accountable Officer, CCG (joined at 2.30pm)
Mr Roger Dunshea	Designate Non Executive Director – NHS Shropshire, Telford and Wrekin
Mrs Zena Young	Executive Director of Nursing and Quality, CCG (joined at 2.33pm left at 2.44pm)
Mrs Vanessa Whatley	Deputy Director of Nursing and Quality, CCG
Mr Brett Toro-Pearce	Associate Director – Individual Commissioning (joined at 2.25pm left at 2.51pm)
Mrs Karen Ball	Corporate PA (Minute taker)

EAC-22-06.064 – Apologies

1.1 Apologies were received from Mrs Donna MacArthur, Mr Paul Capener and Ms Lisa O'Brien.

EAC-22-06.065 – Declarations of Interest

2.1 There were no declarations of interest to note.

EAC-22-06.066 – Minutes / Actions from Audit Committee meeting held on 18th May 2022

3.1 The minutes of the Audit Committee meeting, which took place on 18th May 2022 were agreed as being a true and accurate record of the meeting.

3.2 It was noted that the items on the action list would be picked up as agenda items at the meeting and could be removed from the action list.

EAC-22-06.067 – Annual Report and Accounts: To receive External Auditor's Findings Report

4.1 Mr Smith expressed his thanks to the finance team for the quality of draft accounts and was grateful for the support the finance team had provided throughout the audit process.

4.2 Mr Smith noted that at the time of writing the report there was some outstanding work but was pleased to report that this had now been completed. The process was now moving towards final checks and sign off, which would hopefully take place on Friday, 17th June.

4.3 In terms of the headline opinion it is proposed that a qualified opinion would be issued in the sense that the CCG had exceeded its revenue resource limits, which is referred to. There is a modification around the disclosure notes that highlights the cessation of the CCG on 30th June. There are also modifications to the standard audit opinion. The opinion on the accounts is unqualified to reflect that no material issues had been found.

4.4 One unadjusted misstatement had been identified, which related to prescribing expenditure and it was thought that the value, which may need to be updated and might be lower than the one reported on. Mr Smith noted that the adjustment was well below materiality levels and whilst it does need to be reported to the CCG, it is not a significant issue.

4.5 The annual governance statement and annual report had been reviewed, in terms of compliance with the statutory requirements and to ensure that they were consistent with the figures within the statements.

4.6 Dr Pepper agreed with the recommendation on page 12 within the Auditor's Annual Report to include the financial implications of actions within quality and performance reports particularly the part highlighting the impact of action or inaction on each aspect, especially given the financial constraints that the system is being faced with and would continue to be faced with over the next 12 months, Dr Pepper felt that this was a key area and would commend this and hoped that it would be taken up and followed through.

4.7 Dr Pepper said that in relation to page 16, of the Auditor's Annual Report, where it mentioned the CCG it read as if the CCG was continuing to exist as part of ICS and not that the CCG's functions would continue within the ICS. Dr Pepper noted that later in the report it was clear that the CCG ceases to on 30th June. Mr Smith said he would have a look at the wording on page 16 and noted the comments Dr Pepper had made in relation to page 12.

4.8 Mrs Skidmore extended her thanks to Ms Tongue and the finance team. In relation to the external audit team, due to the normal turnover of auditors this year there had been a new team of external auditors working alongside the CCG finance team, but the transition had been seamless. Mrs Skidmore went on to thank Mr Smith, Mr Preece and their team for their supportiveness through the process. Mrs Skidmore said she was extremely pleased with the report, which was testament to the hard work that had gone into it. Mr Braden echoed Mrs Skidmore comments and thanks the finance team and audit team for a positive process.

4.9 Mr Preece thanked Ms Tongue who had responded to all their questions while demonstrating extraordinary patience.

4.10 Mr Preece drew the committee's attention to the key messages within the Auditor's Annual Report and particularly the Value for Money (VFM), which had been built on this year. A number of clinical governance colleagues within the auditor team, had

considered the quality challenges the CCG had faced during the year and had looked particularly at the CCG's relationship with SaTH and the oversight the CCG has had of SaTH quality processes and concluded that there was nothing more they could recommend in terms of further actions in this regard.

4.11 A risk had been identified around financial sustainability and a key recommendation had been made and the CCG were doing all they can to mitigate the risk.

4.12 In relation to governance there were no major areas of concern, however three areas had been identified where there was room for improvement. These areas were not material issues and if nothing was done it would not create a problem. Dr Pepper had picked up on one of those areas earlier in the meeting.

4.13 In relation to the three EEEs, two risks had been identified initially regarding the move to the ICB/ICS and oversight of SaTH. There are no issues with either of these risks.

4.14 Mr Braden commented that it was good that the external auditors had recognised all the hard work that had been done to improve the CCGs financial position. However, he recognised that there was still more to do to improve the situation. Mr Braden had found the report to be both honest and constructive.

4.15 Mr Smith thanked everyone who had been involved in the VFM work and recognised the demands put on CCG staff. Mr Smith went on to echo what Mr Preece had said in relation to the signification weakness around the medium-term financial plans, however on the whole it was a very positive report.

4.16 Mr Braden recognised how professional and diligent Ms Tongue and the finance team had been throughout the process. Mr Braden also thanked Mrs Skidmore and Mrs Clare.

ACTION:

- Dr Pepper said that in relation to page 16, of the Auditor's Annual Report, where it mentioned the CCG it read as if the CCG was continuing to exist as part of ICS and not that it meant that the CCG functions would continue to exist withing the ICS. Dr Pepper noted that later in the report it was clear that the CCG ceases to exist on 30th June. Mr Smith said he would have a look at the wording on page 16 and noted the comments Dr Pepper had made on page 12.

NHS Shropshire, Telford and Wrekin CCG Audit Committee:

- Noted the content of the report.

EAC-22-06.068 – Approval of Annual Report, Annual Accounts, Annual Governance Statement and Letters of Representation 2021/22

5.1 Mrs Skidmore took the report as read and only wished to add one comment which was to note that the management representation letter for 2021/22 was a standard letter that both Mr Brandreth and Mrs Skidmore would sign off. This gives assurance that they are content that a true and fair view had been given within the accounts.

5.2 Mr Vivian commented that within Mr Brandreth's accountable officer's statement, within the Annual Report, the second sentence, referred to the CCG providing services and thought it should read "make arrangements to provide" or "commission" as the CCG does not provide services. Miss Smith said that Mr Vivian had raised this at the last time Audit Committee meeting and she had asked for it to be

amended to "commissioned" so apologised that this had not been done and would ensure that it was.

5.3 Mr Vivian also said that there were a couple of references to the Department of Health (DoH) guidance or manual and wondered whether it should say Department of Health and Social Care but recognised it might have been issued when the DoH was just that.

5.4 Dr Pepper highlighted that on page 31 the section on Children and Young People's Mental Health long-term plan. Dr Pepper said that the timeline talked about children or young people with ADHD or ASD, the diagnostic pathways and it states that they would have started their assessment by the end of April 2021 and wondered if this was correct. Miss Smith responded that she would have this checked.

ACTION:

- Mr Vivian commented that within Mr Brandreth's accountable officer's statement, within the Annual Report, the second sentence, referred to the CCG providing services and thought it should read "make arrangements to provide" or "commission" as the CCG does not provide services. Miss Smith apologised and said that Mr Vivian had raised this the last time it was brought to Audit Committee and had asked for it to be amended to "commissioned" so apologised that this had not been done and ensure that it was.
- Mr Vivian also said that there were a couple of references to the Department of Health (DoH) guidance or manual and wondered whether it should say Department of Health and Social Care but recognised it might have been issued when the DoH was just that.
- Dr Pepper highlighted that on page 31 the section on Children and Young People's Mental Health long-term plan, Dr Pepper said that the timeline talked about children or young people with ADHD or ASD, the diagnostic pathways and it states that they would have started their assessment by the end of April 2021 and wondered if this was correct. Miss Smith responded that she would have this checked.

NHS Shropshire, Telford and Wrekin CCG Audit Committee:

- Approved on behalf of the CCG Governing Body; the Annual Report 2021/22 which includes the Annual Governance Statement 2021/22, the Annual Accounts 2021/22 and Letter of Representation.

EAC-22-06.069 – Adult and Children's Safeguarding Final Reports – Action Plans Update

6.1 Mrs Young said that she been through the action plans and tidied up the wording to be explicit where she felt further information could be provided and there was evidence to close the actions.

6.2 Mrs Young noted that the cover sheet detailed that additional information was requested by way of a visit schedule and some examples of those visits had been included.

6.3 The report asked the Audit Committee to agree to the closure of the adult safeguarding internal audit report, as all actions had been completed and to acknowledge the progress that had been made with the children's report with the majority of actions having been completed with the exception of the contract amendment action 8.1, which is expected to be completed by the end of June 2022. Action 1.4 is complete as funding arrangements had been confirmed along with the job description and the details of how an SLA might work, however as yet there is no candidate in post. The post is out to advert for a second time and Mrs Young had

asked NHSE for some support in the recruitment process. As highlighted by Mrs Whatley, at the last meeting, there is an interim arrangement in place where they are able to seek support from a Staffordshire Designated Doctor colleague. Both these actions are included within Mrs Young's due diligence handover document.

6.4 In relation to the visit schedules Mrs Young said that when quality visits are undertaken, whether it be the infection control nurse or maternity safety champion they not only look at their area but also look to see if there may be any safeguarding issues.

6.5 There is an operating procedure around visits and it does give room for detailing out the reasons for the visit, whether standard or routine or triggered by intelligence. Mrs Young said that this needed to be added to the quality schedule so that it is a standalone document.

6.6 Mrs Young shared with the committee that this week, she had appointed an interim Assistant Director of Safeguarding, due to the fact that the substantive postholder is currently not at work. Mrs Young has asked them to look at all of the evidence to ensure that she can identify all the information she is stating to the committee today is in place. Mrs Young will receive a full response either by the end of June or the first week in July. Any variant will be part of the due diligence handover to the ICS Chief Nursing Officer.

6.7 Mr Braden said he was particularly concerned him was the lack of visits and visibility and the reintroduction of visits as we were coming out of Covid. Mr Braden went on to ask Mrs Young how confident she was that visits would ramp up and what visibility would the quality group receive if the visits do not happen or are cancelled. Mrs Young responded that some of the barriers to conducting the visits during the last two years had been around the infection prevention and control measures that had been instigated via government directive. These arrangements had significantly changed and we are back to a business as usual approach with appropriate risk assess measures in place. Mrs Young went on to say that they do not stop triangulating other sources of information. Mrs Young said that the schedule would go from strength to strength and increase in number. Mrs Young noted that the CCG had worked with CQC colleagues, in relation to care homes, where quality checks and safeguarding check had taken place.

6.8 Mr Vivian asked how the interim arrangements for the designated doctor would work. Mrs Young responded that the role of a designated doctor is around points of escalation, advice and guidance. There are two named GPs that are a layer below that. The designated doctor would provide clinical supervision to the GPs and this is where the gap is currently. The Staffordshire arrangement allows the GPs and others to make contact for any points around individual cases on a case by case basis. Mrs Young went on to say that this can be around how serious case reviews are being handled so is not as much around advice in the moment but it is about when looking at a case review, professional judgment on what happened, was it okay or should it have happened differently? Sometimes this needed to be debated with the designated doctor, which can be handled within the arrangements in place with Staffordshire.

6.9 Dr Pepper said that on page 3 the visit to MPFT in April, it mentions that the CCG had requested a meeting with the Trust in June for wider exploration of the sexual safety SOP and asked if there was further information as to why the meeting was requested and was it something that had come out of the visit. Mrs Whatley responded that concerns had been raised as part of the visit as MPFT, who had single sex wards, reintroduced mixed sex wards due to an increase in the number of

patients and issues around Covid. The meeting, which is due to take place shortly, is around making sure the SOPs have been updated. There had also been a couple of incidents so it would be an opportunity to take these forward.

6.10 Dr Pepper said that page 6 of the auditors report on child safeguarding mentions vulnerable adults and it should say vulnerable children.

6.11 The maternity safety champion walkaround mentioned on page 51 made reference to 'walkaround fatigue' and Dr Pepper wondered whether it was felt that this had impaired the quality of the visits. Mrs Young responded that this was in the context of maternity being under significant scrutiny locally. The maternity safety champion programme of work is mandated and is led by the non-executive director for maternity safety at SaTH. The CCG are partners and Mrs Young had gained agreement that one of the quality leads would join the maternity safety campion walkarounds instead of the CCG doing their own additional visits. This is a way of avoiding duplication and avoiding creating an additional burden. What is important is that the dialogue is maintained with the staff at SaTH so they understand the value of the visits and it is a really good way of engaging with the staff and managers.

6.12 Mr Braden asked, in relation to the timetable of children's visits, there appeared to be limited assurance whether they should take place annually or more frequently. Mrs Young responded that there are quality visits and audits that are undertaken by partner organisations and the safeguarding team are engaged with these. The CCG had focused on some specifics where the CCG is responsibility for commissioned services and the main NHS providers. Some of the community trust provision is commissioned by the local authority, public health, so they would also have scheduled visits. Mrs Young said that with a new safeguarding team member in place they are better placed to get on with the visits and although they are annual they would be done within a nearer timeframe. Mrs Young suggested that this would happen within the next quarter, quarter two, when they will have committed to undertake the majority of the visits.

6.13 Mr Braden said that he appreciated how hard Mrs Young, Mrs Whatley and the safeguarding team had been working to close down the actions.

6.14 Mr Braden thanked Mrs Young for attending the meeting.

NHS Shropshire, Telford and Wrekin CCG Audit Committee:
- Received the audit schedule as assurance of quality oversight visits in plan;
- Approved the adult report as closed;
- Acknowledged progress with the children's report and seek assurance on action.

EAC-22-06.070 – Final – Provider Serious Incidents Update

7.1 Mrs Whatley noted that the table that had been presented with the papers was one that is sent weekly to the quality team. The table had been reflected on in light of the discussions that had taken place at previous audit committee meetings and it had been tightened up. In addition to this there are weekly touch points with each provider organisation to ensure that serious incidents are being regularly tracked. The position we are in now is much better. There are a couple of things that are anomalies; one is that there are two cases at SaTH where the RCA is over 60 days without a plan in place. However, Mrs Whatley was able to updated that there is now a plan in place. With regards to the other RCA an extension had been granted to early July.

7.2 There are two specialised commissioning cases, which are both mental health cases, which relate to the failure to find bed for a child and they are both within 60 days.

7.3 The longest RCA is from July 2021, which is a maternity case. An extensive investigation had taken place and there is an agreed extension with a date in place.

7.4 Mrs Whatley felt with the table going to the team on a weekly basis was a more robust process. Also she was looking to incorporate the table into the system quality metrics for July.

7.5 Mrs Swan noted that safeguarding and provider serious incident audit follow ups would take place in due course.

7.6 Mr Braden said that he appreciated that was still work in progress but recognised the progress and improvements that had been made.

NHS Shropshire, Telford and Wrekin CCG Audit Committee:
- Considered the report information as full assurance against the Internal Audit recommendations, and closed the Internal Audit report as completed.

EAC-22-06.071 – Individual Commissioning – Funded Nursing Care (FBC) - Update

8.1 Mr Toro-Pearce took the report as read and noted that the recommendations from the audit report had either been implemented or were in the process of being completed.

8.2 It still remained a challenge with regards to capacity and demand and Mr Toro-Pearce noted that Covid had increased the referral rate.

8.3 Mrs Skidmore commented that the business case for additional staff in tis team had been agreed through the system investment panel with the support of colleagues within the CCG and this was very well supported in terms of an invest to save proposition. There is just the final step to take it through sustainability committee, which would then formalise the triple lock process and it should then be given the green light to go ahead with the recruitment, subject to a couple of things the panel had asked for, which were not difficult or unreasonable to do.

8.4 Mr Braden noted that it was an excellent report and thanked Mr Toro-Pearce for attending the meeting.

NHS Shropshire, Telford and Wrekin CCG Audit Committee:
- Noted the current risks and mitigating actions taken;
- Noted the content of the service update and business case;
- Made comment on any additional assurance or increase committee reporting requirements.

GOVERNANCE

EAC-22-06.072 – Board Assurance Framework (BAF) and Directorate Risk Register (DRR)

9.1 Miss Smith said that following the queries raised at the last meeting she had spoken to the respective directors to provide updates. Mrs Whatley and Mrs Young have updated the BAF in light of the queries relating to safeguarding and serious incidents review.

9.2 Risk one has moved to the DRR due to the significant lessening of the risk.

9.3 Miss Smith recommended that the ICS transition risk is removed from both the BAF and DRR as this was in relation to the transition to the ICB which was nearing completion.

9.4 There has been additional narrative added to risk 10 around UEC pressures particularly in relation to ambulance handover performance around quality and costings.

9.5 Miss Smith noted that risk 11, paediatric ophthalmology, has been moved from the BAF to the DRR due to the fact that it is not considered to be a strategic enough risk to be on the BAF.

9.6 Dr Pepper highlighted risk 2 on the DRR, inequalities of the 12 month cancer survival target. It mentioned that the actions are that the SaTH CQRM would be asked to oversee the review and adherence to the NICE guidance in cancer pathways and Dr Pepper asked if CQRMs would continue in the ICB. Miss Smith responded that she did not know. However at the Quality and Performance Committee it had been reported that they would be phased out. Miss Smith would therefore pick this up with Mrs Whatley and Mrs Young for clarity. Miss Smith went on to say that the BAF and the DRR are one of the key documents that would be passed over to the ICB formally through the due diligence process, therefore by adding any information to it, it would be captured by the ICB. Miss Smith would seek clarification and amend the narrative for this risk accordingly.

ACTION:

- Dr Pepper highlighted risk 2 on the DRR, inequalities of the 12 month cancer survival. It mentioned that the actions are that the SaTH CQRM would be asked to oversee the review and adherence to the NICE guidance in cancer pathways and Dr Pepper asked if CQRMs would continue. Miss Smith responded that she did not know, however at the Quality and Performance Committee it had been reported that they would be phased out. Miss Smith would, therefore pick this up with Mrs Whatley and Mrs Young for clarity.

NHS Shropshire, Telford and Wrekin CCG Audit Committee:

- Reviewed the BAF and DRR and considered if the additional assurances provided allowed the Committee to conclude that the risks to the strategic objectives are being managed;
- Provided assurance to the CCG Governance Board that the principle risks of the CCG not achieving its strategic and operational priorities and have been accurately identified and actions taken to manage them.

AC-22-06.073 – IG Update and Annual Report – 2021/22

10.1 Mrs Clare noted that the normal submission date for the IG Toolkit is the end of March, however this year it had been extended to the end of June. A draft submission was submitted in March and Mrs Clare gave a final view of what was submitted for the end of June deadline.

10.2 Mrs Clare noted that members had received, with the papers for the meeting, a copy of the IG annual report, an update on the due diligence checklist list, including all the work that was done on the shared drive data migration. Appendix C gave the details of all the subject access requests received throughout the year.

10.3 the submission of the DSPT was completed on time and all of the standards where met. IG training the CCG was compliant across the organisation with 95% and 100% of board members where trained.

10.4 In terms of due diligence the majority of the work is complete, however there are a few things awaiting final signoff including the registration of the new Caldicott Guardian, the new SIRO and having the ICA.

10.5 It was noted that no questions or comments were raised.

NHS Shropshire, Telford and Wrekin CCG Audit Committee:
Noted:

- The key messages from the IG Annual Service report from MLCSU IG team including the timely submission of the Data Security and Protection Toolkit with all standards met;
- The ongoing work to complete the due diligence checklist for IG, with no material transition risks identified at this stage;
- Subject Access Request log.

COUNTER FRAUD

EAC-22-06.074 – 2021/22 Annual Counter Fraud Report

11.1 Mr Westwood reported that the CCG had to provide the Counter Fraud Authority with an annual assessment against the 12 components of the government functional counter fraud standard. An overall green rating was submitted. However there were a couple of amber ratings and one red rating, which needs to be moved forward. Mrs Skidmore and Mrs Clare are aware of the ratings and Mr Westwood would be doing work to turn the amber and red ratings to green in the coming year.

11.2 Dr Pepper suggested that it would be good if Mr Westwood could join a meeting of the CCG Leaders, which takes place on a Wednesday at 8am, to describe to them the work he does. Mr Westwood would be happy to do this.

NHS Shropshire, Telford and Wrekin CCG Audit Committee ***NOTED*** the content of the report.

FOR INFORMATION ONLY

EAC-22-06.075 – Counter Fraud – Staff Survey

12.1 This report was presented for information only.

EAC-22-06.076 – Any Other Business

13.1 Mrs Skidmore said that she was saddened to announce that Ms Tongue would be leaving the CCG at the end of June. Mrs Skidmore went on to give a huge thank you to Ms Tongue and commented that she had been instrumental and a guiding light in bringing probity and structure into the finance team, Ms Tongue would be sorely missed. Ms Tongue thanked Mrs Skidmore for her kind words and said she had really enjoyed working with everyone across the CCG. Mr Braden echoed what Mrs Skidmore had said.

13.2 Mr Vivian said that having benefited from Mr Braden's chairmanship over the past couple of years he wished to say well done to Mr Braden and it had been pleasure working with him and he had been an excellent chair.

13.3 Mrs Swan thanked Ms Tongue for all her help with the audits. Mrs Swan also thanked Mr Braden for his support in relation to the internal audit and for helping drive through improvements and change.

13.4 Mrs Claire reported that there was a new senior financial accountant, who started at the beginning of June, Mr Anil Duggal, who is currently working with Ms Tongue on a handover process. From a senior finance manager point of view, Mr Angus Hughes would be taking over the area Ms Tongue currently looked after. Mr Hughes would attend one of the first audit committee meetings of the ICB.

13.5 Mr Braden thanked everyone for all the input and support he had, had as Audit Chair for both Telford and Wrekin CCG and Shropshire, Telford and Wrekin CCG. Particularly he thanked Miss Smith and Mrs Ball for their unstinting support with the governance and administration of the meetings.

Meeting closed at 3.04pm

Publication of the Independent Inquiry into Child Sexual Exploitation in Telford

Agenda item 28-09.027

Publication of the Independent Inquiry into Child Sexual Exploitation in Telford

1.0 Introduction

The Independent Inquiry Report into Child Sexual Exploitation (CSE) in Telford was published 12 July 2022 and has attracted considerable national, local and social media interest. This paper provides a synopsis of the above Report, particularly through a health lens and comments on the role of the ICB (previously the CCG) as the statutory health partner on the Telford & Wrekin Family Safeguarding Partnership Board (previously named as the Local Child Safeguarding Board).

The Inquiry Report it identifies where public services have failed and is notably critical of West Mercia Police (WMP) and Telford & Wrekin Council (the Council) Children's Social Care and Education in their actions to recognise and tackle CSE over time. It also reports on insufficiencies in the health response to CSE, particularly relating to primary care and sexual health services whereby opportunity to recognise and refer young people as a safeguarding concern or to clinical services were missed. Lack of records contributed to uncertainty on this. We cannot be complacent as a statutory organisation, but there is also a role for community awareness as well as the professional inquisitiveness. Other national reports (Rotherham, Oldham) highlight that at strategic level Safeguarding Partnership arrangements have not changed sufficiently, and this is an opportunity to review our local arrangements to enable us to be assured we are delivering a real difference to our population.

It is important that we recognise past failings and we apologise unreservedly for those, as well as welcoming recommendations in the Report that will help drive further improvements. The Inquiry Report's author pays tribute to victims and survivors whose experiences informed the work of the Inquiry and to those who felt able to come forward to give evidence. Of particular note is the inclusion of the victim/survivor voice throughout the Report and their accounts remind us all of their devastating experiences and how we could have collectively done more to safeguard them.

Much has already changed, and we have confidence that safeguarding procedures and multi-agency working are now far stronger than they have been historically. Steps that have been taken include: increased staff awareness; improving information sharing across agencies; recognition and response, training; and shared learning; as well as better partnership working across the system at all levels. The upward trend in referrals to the CSE panel offers some assurance that victims are being identified and receiving an appropriate response.

2.0 Background

The Report was commissioned in 2018 by Telford & Wrekin Council following a high-profile police investigation (Operation Chalice) and prosecutions leading to a number of criminal convictions, most notably in 2013 when seven men were imprisoned for offences relating to young people between the ages of 13 and 16. A number of children were known to local authorities and had been deemed to be vulnerable.

The purpose of the Inquiry was to fully investigate and establish the facts of child sexual exploitation from 1989 to date, where there is a link to Telford. This includes the time period prior to the formation of Telford & Wrekin Council, whereby Shropshire County Council were the responsible body.

The successful prosecution of a small number of offenders for CSE raised awareness across the board and at all levels within partner agencies and with the public and media. CSE has not ended with the conclusion of Operation Chalice in 2013 and remains an on-going concern; the Inquiry Report, through its recommendations and intent to publish a follow-on report in 2 years' time, seeks to ensure that CSE is seen as a continuing priority in our local health economy.

3.0 NHS STW CCG role

To assist the inquiry, in November 2019 NHS Telford & Wrekin CCG, later NHS Shropshire, Telford & Wrekin CCG (collectively 'the CCG'), were asked to retain and provide any relevant documents and senior officers met directly with the Inquiry team as part of their information gathering. A legal hold was in place barring the destruction of any records held by the CCG to assist with the Inquiry. The CCG further assisted the Inquiry through meetings with GP practices/practice managers and other local NHS providers to elicit the required information submissions. Legal advice to the CCG was received from Mills and Reeve LLP.

4.0 Inquiry Findings

The four-volume Report is very detailed and runs to 1249 pages. The full Report can be accessed via: https://www.iitcse.com/

Volume 4, Chapter 7 (pp 998 – 1036) deals with Health Agencies specifically, however it should not be read in isolation. The Inquiry makes it clear that commissioners, including CCGs, had a legal duty to ensure staff and those delivering services were trained and competent and there were sufficient quality standards and assurances.

4.1 Areas of good practice

- The Inquiry Report noted that health services at commissioning level has real commitment to meet safeguarding obligations. The health contribution at strategic leadership level is strong and health is well represented by Named Nurses and safeguarding professionals who have been active, engaged and motivated.
- A number of independent inspections and reports (including CQC, Ofsted) over the period of the Inquiry gave positive assurance on the effectiveness of 'health' safeguarding arrangements, albeit with limited reference to CSE, and the Inquiry Report did not contradict these, nor comment that any recommendations arising from those reports were insufficiently acted upon.
- The Report also recognised areas where there have been improvements relating to CSE, for example, since 2015, specific training with an increase in health professional awareness of CSE; better referral pathways, policy and procedures and commissioning sexual health services have all improved.
- Whilst there is commentary that some provider services let victims down, the professionalism and tenacity of certain health professionals was recognised.

4.2 Areas of concern

- Although there was a recognition at strategic level this did not translate as quickly as it should have done into knowledge and action at delivery level was did not translate to services being received by those accessing them.
- Professionals across all agencies lacked recognition of a young person as a potential or actual victim of CSE, with adverse mention of some front line health services, specifically GP and sexual health services. The Report noted some of this was in part reflective of the legal language and framework of the time eg 'child prostitute' v child exploited. Examples of concerning attitudes towards children included: use of derogatory language in clinical records; references to 'lifestyle choices' and normalising of sexualised behaviour and pregnancy in under 16 year olds; and criminalizing behaviour (via the justice system).
- Lack of professional curiosity (no questions asked) when a young person presented to the GP for contraception, including repeated presentation for emergency contraception (a number of presentations in the same week) or when they accessed sexual health services, or displayed harmful or risky behaviour such as going missing and other indicators. Victims/survivors expressed dismay that professionals focused on behaviour rather than probing sensitively to elicit the underlying cause.
- In not recognising CSE, there was a consequent lack of counselling and emotional support offered to victims/survivors. [Authors note - this emotional impact stays with many today and indeed over an individuals lifetime; as a consequence, demand for CAMHs and adult mental health services (for example) may be seen].
- Specific CSE training was lacking initially and although did improve over time, there was a lack of real evidence to demonstrate translation of training into practice and thus making a difference to outcomes. The strategic focus was strong, but awareness of CSE at delivery level was slow to engage and implement changes.
- The numerous re-organisations of health services and complexity of commissioning arrangements was noted as contributing to lack of clarity when holding partners to account with a loss of documentation and corporate memory. Particularly noted was fragmented commissioning and delivery of sexual health services, with: no cohesive oversight; excessive workloads; absence of clinical supervision. This situation improved with the recommissioning of sexual health services in 2016. In light of the recent health re-organisation it is important to ensure that there is no corporate memory loss or loss of documentation on this occasion.
- Insufficient information sharing between health professionals, especially between the Council's CATE team (Children Abused Through Exploitation) and GP's, poor recording of CSE concerns on GP records and lack of a robust process for sharing information about concerns when a child moves GP practice.
- The insufficiency of information sharing was a theme running through the Report, which further commented on unacceptable delays of 9 months in offering screening to victims/survivors when a perpetrator was known to be HIV positive. Professional bodies and agencies differing views and legal advice on information sharing was a barrier, with no consensus for action, however health championed this and achieved resolution, albeit late. The Inquiry concluded there was nervousness and confusion about when information could be shared.

5.0 Inquiry Recommendations

The 47 recommendations are detailed in Volume 1, pp 124 – 136 and are included as an appendix to this briefing. Of these, **5 are specifically intended for NHS STW to action** (abridged):

- Rec 42. Improve the quality of CSE training delivered to NHS providers and practitioners to increase the likelihood of this translating into practice.
- Rec 43. (With NHSE - as commissioners of Tier 4 CAMHS) secure increased funding for improvements to trauma-related mental health services for victims and survivors.
- Rec 45. (With NHSE - as commissioners of Sexual Assault Referral Centres and PHE as commissioners of Sexual Health services) Review and keep under review guidance for sexual health clinics/all health providers responsible for giving sexual health advice.
- Rec 46. Consult with GP's to improve CSE data collection through an IT solution for flagging on health records.
- Rec 47. GP's to implement a review system to enable CSE notification between practices when a child moves GP.

A further **7 are joint agency recommendations which involve NHS STW** [authors commentary included].

- Rec 1. Establish a joint CSE Review Group (health to be an invited partner).
- Rec 6. Implement training on information sharing protocols and responsibilities [health partners should participate in this training].
- Rec 10. Children Abused Through Exploitation (CATE) pathway to be reviewed [the interface with GP's to be considered here].
- Rec 11. Implementation of an Adult Transition meeting where a CATE child transitions to adulthood [health providers should participate in these meetings; health commissioners should monitor attendance and escalations].
- Rec 18. Review CSE therapeutic services [directed at council commissioning responsibilities, but references commissioning MH services for victims/survivors].
- Rec 20. Review processes for information sharing relating to HIV risk.
- Rec 44. Increase capacity for health services to sexually exploited children [directed at council commissioning responsibilities, but an example of the complexity of commissioning arrangements].

The remaining recommendations are directed at other agencies, notably WMP and the Council (including education), relating in the main to arrangements for the joint CSE Review Group; CATE service arrangements; budgets for CSE and for counselling; licensing premises and taxi services; CSE processes in schools; training; complaints handling; processes for reporting concerns; and treating parents as partners.

Appendix 1 details the full TIICSE Report Recommendations.

6.0 Next Steps

NHS STW ICB will consider the Report in full and review the recommendations with safeguarding partners locally and regionally and also in association with partner commissioners of services in health and social care. We also have to look beyond the recommendations to elicit further learning that is not set in the recommendations themselves.

As stated, the ICB are the statutory health partner on the Telford & Wrekin Family Safeguarding Partnership Board and this is an opportunity to review our local system arrangements, looking wider than the Inquiry Report recommendations, to enable us to be assured we are delivering a real difference to our population.

The CNO, as ICB accountable executive, will lead the response to health recommendations, ensuring the delivery of all actions within the integrated plan, holding partners to account for robust and sustainable delivery of these. The Family Safeguarding Partnership Board and the newly recommended joint CSE subgroup hold multi-agency system safeguarding oversight and will approve the integrated action plan and provide progress assurance.

The above approach to governance aligns to STW Quality Governance via both the System Quality Group and the Quality & Performance Committee (which include both health and social care membership) and provides the formal assurance route to the ICB.

The Inquiry Report requires the new joint CSE group to publish an annual report within 18 months, including comparative performance data, and **there is intent for the independent author to publish a follow up report within 2 years**, which will detail progress made by all agencies in addressing the recommendations and will draw on the proposed CSE annual report as evidence of progress.

The necessary resources to ensure sustainable delivery of improvements of 'health' actions, and in discharging our safeguarding statutory responsibilities will be considered and presented separately for discussion and approval.

7.0 Support for victims/survivors and staff

We anticipate that more victims will come forward following publication of the Report and the details of how they can seek support have been shared in our staff briefing. Professionals are reminded that should the publication of this Report spark any professional concerns a safeguarding referral can be made in the usual way.

People who are currently employed by statutory safeguarding services will be able to access their employer's confidential support services.

Anyone else who may be affected by the contents of the Report, Telford & Wrekin Council has funded a confidential and independent support service which is publicised at the beginning of the Inquiry Report.

8.0 Recommendations

- The ICB is invited to note and debate the contents of this report and when available, agree an action plan and timeline for delivery of the recommendations.
- The ICB is further invited to note that a separate consideration of the resource required for health to deliver on its recommendations will be made and is recommended to support the allocation of resources accordingly.
- The ICB is invited to note that a second independent follow up report will be published in 2 years and approve an internal review of the recommendations within 12 months to ensure the ICB are on track when the Chair requests further information to support this follow-up review.

Appendix 1: TIICSE Report Recommendations

Recommendations

1. Establishment of a 'Joint CSE Review Group'

The **Council** and **WMP** should take the lead in establishing a joint group, and shall identify and include other key stakeholder authorities, to include education and health sectors and such third sector agencies as the Council and WMP as lead agencies deem appropriate. The Joint Group's function will be to meet every six months, in order to:

- Consider data and information gathered – such data to include: the incidence, trends and locations of CSE within the borough; missing persons/truancy data; referral numbers and investigations/complaints; licensing and night-time economy information; and any other data considered relevant;
- Analyse such data and information in order to provide a reliable set of statistics against which the threat/risk and prevalence of CSE can be measured, and any apparent increase or decrease in the number of CSE cases considered;
- Maintain minutes of each meeting, with appropriate action plans attached; and
- Publish a report setting out the results of the analysis and accounting to the public for the action being taken in response – as set out in **Recommendation 2**.

Relevant chapters: All chapters

2. 'Joint CSE Review Group' to publish an annual CSE Report

The **Council** and **WMP** should lead the 'Joint CSE Review Group' in publishing an annual report, titled "Joint CSE Review Group Annual Report" (or similar). This report should include, at a minimum:

- The output of the statistical analysis carried out in accordance with **Recommendation 1;**
- Current staffing numbers/caseload ratios within the WMP CE Team and the Council's CATE Team;
- The extent of collaboration and support sought from third sector organisations, including transparency about the level of funding ring-fenced for such support;
- Details of steps taken in relation to CSE training and awareness campaigns;
- Details of PCC funded resources and initiatives relevant to CSE;
- Statistics regarding the number of NRM referrals;
- Updates as to work undertaken to improve relevant services to children within the health and education sectors; and
- A summary of any complaints received by any of the member authorities regarding the handling of a CSE matter.

Each member organisation should publish a copy of the report on its website.

Relevant chapters: All chapters

Recommendations

3. **WMP to prepare mapping and prevalence data to be shared with the Joint CSE Review Group**

In line with **Recommendations 1 and 2:** in advance of each Joint CSE Review Group meeting, and for the purposes of its Annual Report, **WMP** should prepare the following:

- An analysis of the incidence of, and its response to, CSE within Telford (a "prevalence report"). Subject to the need to protect the integrity of ongoing investigations and policing tactics, this should include reference to the numbers of complaints, reports, investigations, arrests, charges and conviction rates, as well as geographical distribution of CSE 'hotspots' within Telford.
- A CSE activity analysis (a "mapping report") based on intelligence received from its own sources (including that collated via the 'Joint CSE Review Group'), in order to ensure that an ongoing and targeted approach to CSE is maintained.

Copies of the prevalence report and mapping report should also be shared with the PCC in line with **Recommendation 41.**

Relevant chapters: Chapters 2 and 5

4. **Council to prepare CATE data to be shared with the 'Joint CSE Review Group'**

In line with **Recommendations 1 and 2:** in advance of each 'Joint CSE Review Group' meeting, and for the purposes of its Annual Report, the **Council** should prepare the following:

- An analysis of its response to CSE within Telford & Wrekin to include numbers of CSE cases dealt with by Safeguarding processes, those dealt with by CATE processes, and to detail how many are new cases, how many are active, and how many have been closed.

Relevant chapters: Chapters 2 and 3

5. **Schools and colleges to prepare data to be shared with the 'Joint CSE Review Group'**

Secondary schools and colleges should prepare the following, in association with the **Council:**

- A six-monthly CSE statement (to be submitted prior to the six-monthly 'Joint CSE Review Group' meeting) giving details of specific children showing indicators which may be indicative of CSE (the "children at risk report"), whether or not that behaviour merits immediate referral to CATE or Safeguarding; and
- A further six-monthly report (to be submitted prior to the six-monthly 'Joint CSE Review Group' meeting) containing such information as may allow effective mapping of CSE ("school mapping report"), including but not limited to, ages of children involved, the place of exploitation where known, their general places of residence, and any information which may establish the identities of perpetrators.
- The above information should also include statistics and information relating to any missing from school episodes/ truancy records, in order to agree any steps that should be taken in relation to children that are shown to have regular difficulty attending school.

The children at risk report and the mapping report should be shared with the CATE Team, which in line with **Recommendations 1 and 2** will share the reports with the 'Joint CSE Review Group' meeting for the purposes of its Annual Report.

Relevant chapters: Chapter 3

Recommendations

6. **Information sharing training to be implemented in order to clarify responsibilities around confidentiality, information sharing and safeguarding**

All organisations with safeguarding responsibilities, to the extent it is not already in place, should:

- Implement an immediate programme of information sharing training for all those dealing with children, or in positions where referrals to Safeguarding is a possibility, to include at a minimum, police officers, PCSOs, social workers, CATE practitioners, youth workers, licensing officers, teachers, school counsellors and nurses, sexual health advisors, GPs, GP practice nurses, A&E doctors and nurses;
- Ensure such training sets out the principles of when information should not be shared and when it must be, including practical exercises; and
- Ensure that the above training is mandatory for any future recruits, and is repeated for existing team members no less than every two years, with training records to be made and retained.

Relevant chapters: Chapter 3, 5 and 7

7. **Ring-fencing of CATE Team resource**

- The **Council** should commit to the continued existence of the CATE Team within Telford at no less than its current strength in both numbers and budget (adjusted for inflation), for a period of no fewer than five years from the date of publication of this Report.
- Following the expiry of that period, in the event of no such further ongoing commitment, the Council should state publicly the reasons why, and the proposals for future management of children at risk of CSE.
- The Council should ensure that (i) CATE practitioners are protected from abstraction to cover other work; and (ii) practitioner caseload remains no higher than the current level.
- The Council should publish information regarding the resourcing and workloads of the CATE Team as part of the 'Joint CSE Review Group's' Annual Report.

Relevant chapters: Chapter 3

8. **Ring-fencing of WMP's CE Team resource**

- **WMP** should commit to the continued existence of the CE Team within Telford – at no less than its current strength in both numbers and budget (adjusted for inflation), for a period of no fewer than five years from the date of publication of this Report.
- Following the expiry of that period, in the event of no such further ongoing commitment, WMP should state publicly the reasons why, and the proposals for future management of CSE investigations within WMP.
- WMP should publish information regarding the resourcing and workloads of the CE Team as part of the 'Joint CSE Review Group's' Annual Report.

Relevant chapters: Chapter 5

Recommendations

9.	**Council should review its subgroups** • The **Council** should review the number, membership and remit of all groups and subgroups – internal and with partners - dealing with CSE. • Group membership should be limited, to ensure effective meetings, and be open to those most qualified to bring value - not be based simply on seniority. • Strategic meetings should always include a practitioner – someone working directly with children and their families. *Relevant chapters: Chapter 3*
10.	**CATE Pathway to be reviewed** • The **Council** should carry out an immediate and thorough review of the published CATE Pathway to ensure that it sets out, with clarity, the model of response, intervention and support to be expected where a child has been sexually exploited, or is considered at risk of future sexual exploitation, including the circumstances in which a child on the child protection pathway can obtain CATE support, and vice versa. • This review should include consideration of current research and national best practice. • The CATE Pathway should be reviewed annually to ensure that it remains fit for purpose. *Relevant chapters: Chapter 3*
11.	**Implementation of an adulthood transition meeting** The **Council** should commit to immediate implementation of an adulthood transition meeting as part of the CATE Pathway for cases where a CATE child transitions to adulthood. *Relevant chapters: Chapter 3*
12.	**Training of CATE Team and social workers** The **Council** should ensure that all CATE Team members and social workers in Safeguarding receive regular external training covering: • The concepts of risk and harm; and • The importance of rigorous recording of information (including detailing the exploitation suffered and naming children and perpetrators). *Relevant chapters: Chapter 3*

Recommendations

13.	**Case File Review/Audit** The **Council** should commit to an annual external audit of no fewer than ten randomly selected CATE case files and of no fewer than ten randomly selected Safeguarding case files relating to children who have been exploited or are at risk of exploitation, to ensure proper emphasis is established and maintained. The **Council** should also ensure that: • Safeguarding and CATE Team members focus appropriately on contextual safeguarding and not simply upon child behaviour modification; and • The extent and quality of information sharing is properly assessed. ***Relevant chapters: Chapter 3***
14.	**CATE's information sharing protocols with schools to be reviewed** The **Council** should review the information sharing protocols in place with schools, and update them as necessary to ensure that the CATE Team shares information with schools that identifies CSE threat levels, trends and groups as well as individuals; with a view to allowing schools to react, monitor and protect children better. ***Relevant chapters: Chapter 3***
15.	**Treating parents as partners** The **Council** should commit to treating parents as partners in CSE cases and should set out publicly what a parent is entitled to expect when their child is being supported by the CATE Team. ***Relevant chapters: Chapter 3***
16.	**Approach to victims/survivors as adults** The **Council** should undertake a review of social care cases to establish whether there is any identifiable bias in respect of parents who are victims/survivors of CSE and actions that have been taken in respect of safeguarding their children, and the reasons for such actions. If the review reveals any patterns, future policies should be reviewed and training provided to ensure no unconscious bias is applied. ***Relevant chapters: Chapters 3 and 9***
17.	**Counselling for victims/survivors** The **Council** should commit to the provision of contingency funding for continued access to counselling for affected victim/survivors and family members following the publication of this Report. ***Relevant chapters: Chapter 3***

Recommendations

18. **Council to review annually all CSE therapeutic support services**

The **Council** should annually review its CSE therapeutic support offering, to include services it provides directly and services it commissions, to ensure that:

- The offering is sufficiently broad in scope, encompassing mental health support and specialist trauma based support;
- The support is available for victims/survivors as children, when transitioning to adulthood, and ongoing support for victim/survivors in adulthood, including a focus on relationships and parenting;
- Such support is sourced from a range of providers, including national and local third sector groups;
- The support offering as a whole is clearly signposted to CSE victims/survivors and their families; and that
- The allocated budget is sufficient for need.

The review should be published annually as part of the 'Joint CSE Review Group's' Annual Report.

Relevant chapters: Chapters 3 and 9

19. **Youth support**

The **Council** should commit to collaborating with those bodies best able to offer replacement for community support services for children - for example, youth club provision - no longer provided by the Council.

Relevant chapters: Chapter 3

20. **Council, WMP and CCG to review processes relating to information sharing in respect of risk of HIV**

The **Council**, in association with the **CCG and WMP,** should review its processes relating to information sharing in the event of discovery of risk of exposure to HIV by a perpetrator of CSE and, if no such document exists, draft an infection protocol which makes clear:

- When information relating to risk of HIV exposure must be shared and with which bodies;
- The legal basis for that sharing, to avoid doubt; and
- Which body should take the lead on matters relating to information sharing, including identification of at risk contacts.

Furthermore the Council, WMP and the CCG should consider whether their existing individual and joint processes allow for the effective identification of risk of HIV exposure when a complaint is made of (particularly non-recent) exploitation; and if it is considered they do not, to amend those procedures, or to indicate why such procedures cannot be amended to allow such effective identification of risk

Relevant chapters: Chapter 3

Recommendations

21. **Council should refresh its system for reporting of concerns**

- The current website based system for reporting of concerns via Family Connect requires registration. This could serve as a barrier to reporting.
- The **Council** should institute and publicise a system whereby such concerns can be reported truly anonymously via a number of channels, whether by whistle-blowers or members of the public.

Relevant chapters: Chapter 3

22. **Council to review its CSE complaints procedure**

The **Council** should carry out a full review of its complaints process, insofar as this relates to the handling of CSE cases. This should include:

- Preparing and publishing a comprehensive complaints procedure for complaints relating to CSE which should be readily accessible and published on its website;
- Setting out a uniform process for dealing with all complaints relating to CSE, led by a named team within the Council;
- Establishing a suitable repository for all complaints relating to CSE, so that all documents relevant to a complaint including, ultimately, its outcome, are readily accessible;
- Ensuring that all staff, in particular CATE practitioners, are suitably trained so as to identify complaints, or feedback from service users which is not in the form of a complaint but which suggests cause for concern;
- Signposting to assistance which can support individuals with the process and substance of a complaint; and
- Publishing annually, as part of the Joint CSE Review Group's Annual Report, a summary of suitably anonymised CSE complaints and a review of complaints or concerns relating to CSE to include themes and lessons learned.

Relevant chapters: Chapter 3

23. **Licensing information sharing with neighbouring authorities**

The **Council** should seek to agree with its neighbouring authorities a stricter information sharing agreement, a joint enforcement protocol and a common licensing pricing structure.

Relevant chapters: Chapter 4

24. **Taxi driver training**

The **Council** has an established CSE training programme for taxi drivers; this course should be offered, at a cost, to drivers licensed elsewhere.

In the interim, the Council should publicise the high standards that Telford licensed taxis are already required to meet and raise awareness of how to recognise a locally licensed taxi.

Relevant chapters: Chapter 4

Recommendations

25. **Council to review and improve its complaints process for public complaints or concerns in relation to licensing and/or taxi drivers**

The **Council** should:

- Review the ways in which the public can report licensing complaints, to include consideration of instant reporting by way of text or online services;
- Publicise its role in taxi regulation, the need for the public to report concerns, and the ways in which concerns can be reported, to include prominent advertising in night-time economy 'hotspots' and a requirement for in-taxi notices; and
- Ensure a continuing programme of public awareness raising the requirement for licensed drivers to display their licence, so as to address 'badge-swapping'.

Relevant chapters: Chapter 4

26. **Council to collate data relating to complaints against taxi drivers**

The **Council** should publish annually, as part of the 'Joint CSE Review Group's' Annual Report, a taxi licensing review to include:

- How many complaints it has received about taxi drivers;
- How many of those complaints related to drivers licensed by the Council;
- How many complaints related to sexual behaviour, including use of sexualised language or harassment, and of those, how many related to complaints involving such behaviour towards children; and
- How many complaints resulted in action by the Licensing Team, and what action resulted.

Relevant chapters: Chapter 4

27. **Council to implement a protocol for the sharing of safeguarding information for the purposes of taxi licensing**

The **Council** should draft and publish within six months of this Report a protocol for the sharing of safeguarding information for the purposes of taxi licensing, setting out:

- The procedures by which, on receipt of a new application, renewal, or a complaint about a driver, information will be requested by the Licensing Team from Safeguarding, WMP, neighbouring local authorities and such others as are deemed appropriate; and
- The circumstances in which the Licensing Team will share information with Safeguarding, WMP, neighbouring local authorities and such others as are deemed appropriate, upon the receipt of a complaint and, if applicable, later imposition of a sanction against a taxi driver.

Relevant chapters: Chapter 4

28. **Council to explore implementation of CCTV in taxis**

- The **Council** should explore the possibility of installing CCTV in taxis. It should begin by carrying out a full consultation amongst interested parties, in the borough and in the region.
- The Council should consider any funding applications that may be available to assist in this regard.

Relevant chapters: Chapter 4

Recommendations

29. **WMP role in taxi licensing enforcement to be reviewed**

- **WMP** should carry out a review of its current involvement in joint taxi licensing enforcement exercises in order to ensure that the exercises are sufficiently regular and rigorous, and that any information or intelligence of concern relating to CSE activity is captured and acted upon.
- This should include considering which officers are involved in such enforcement exercises, and that those officers are of an appropriate rank and level of training.
- If not already in place, a named officer should be designated to liaise with colleagues in the Council's Licensing Team to ensure appropriate sharing of information relating to taxi drivers who may pose a risk/concern.

Relevant chapters: Chapter 4

30. **Council to review historic premises licences**

- The **Council** should take steps to ensure that appropriate conditions are applied in respect of any premises operating under a historic licence; and
- Whatever the terms of a historic licence, the Council should make clear its expectation that any nightclub should operate an '18 or over' entry policy.

Relevant chapters: Chapter 4

31. **Council to review its oversight of restaurant and take-away establishments**

- In association with its Night-Time Economy officer, Licensing Team and **WMP**, the **Council** should review information collection and sharing with regard to CSE concerns involving restaurants, takeaways, mobile food outlets and associated residential premises.

Relevant chapters: Chapter 4

32. **All schools and colleges to review and refresh training around CSE**

Where this is not already happening, **all schools and colleges,** in association with the **Council**, should:

- Commit to annual training of all teachers and staff in CSE awareness;
- Repeat such training at least every two years;
- Set out a programme of age-appropriate CSE awareness raising sessions for their pupils, whether that programme is delivered in the context of PSHE or otherwise; and
- Arrange a CSE awareness raising session for parents, no less frequently than annually, in the opening months of the academic year.

Where the school in question is a primary school, such CSE awareness should be aimed at pupils in Year 5 and above, or, if not felt appropriate, a letter should be sent to all parents explaining why such a programme is regarded as undesirable within the school, and enclosing written information on CSE awareness.

Relevant chapters: Chapter 3

Recommendations

33. **Schools and colleges to appoint a CSE Lead**

All **secondary schools and colleges** in Telford, in association with the **Council**, should designate a CSE Lead (who should not be the Designated Safeguarding Lead ("DSL")), but whose identity should be known to parents and children, and who must be easily accessible to children. The CSE Lead should compile the children at risk report and the mapping report (in accordance with **Recommendation 5**) in consultation with colleagues, including the DSL.

Relevant chapters: Chapter 3

34. **Schools to review CPOMS policy and systems for information sharing**

In association with the **Council, all schools and colleges** in Telford using the CPOMS system should ensure that:

- The school or college has a written policy in place to govern the recording of CSE-related information onto CPOMS;
- The policy sets out how information from CPOMS should be shared with partner agencies (namely WMP and Safeguarding) and considers the practicalities for doing so;
- All relevant information is routinely recorded on CPOMS;
- The information should include a statement of what the concerns are, what action was taken, and what follow up was thought to be needed; and that
- A six monthly review is carried out of the information logged on CPOMS, to ensure all relevant information (i.e. information which may have been identified as a possible indicator of CSE) is routinely recorded.

This process should be led by the DSL.

Relevant chapters: Chapter 3

35. **Schools and Colleges to carry out an annual review of site security**

In association with the **Council, all schools and colleges** in Telford should carry out an annual review to consider the adequacy of the school's site security provision, including arrangements for monitoring and recording any unauthorised access, to ensure that pupils are protected from potential perpetrators of CSE while at school, and to ensure appropriate liaison with WMP or Safeguarding where required.

Relevant chapters: Chapter 3

36. **WMP to review use of CSE marker system**

WMP should review the use of the intelligence marker system in CSE cases. The review should include:

- An assessment of the suitability of training, and of effectiveness of guidance and procedures for the application of CSE markers; and
- A historic search (to the extent possible) of CSE cases to ensure markers have been appropriately applied.

Relevant chapters: Chapters 2 and 5

Recommendations

37. Police officer and staff CSE training to be reviewed

WMP should ensure that:

- All its officers, PCSOs and public facing staff receive, as part of their initial induction and learning, training on CSE;
- All such staff should also receive regular refresher training and updates on CSE to include: the latest known trends around how CSE may be perpetrated; warning signs to look out for; and reminders as to the action to be taken in response to any concerns about CSE; and
- Any such training addresses the appropriate use of language and techniques to encourage victim disclosure and to avoid victim-blaming.

Relevant chapters: Chapter 5

38. Review of WMP complaints handling procedures required

- **WMP** should review its internal complaints handling procedures to ensure that any complaint raised in a CSE matter is acknowledged immediately and dealt with in a timely fashion. If there are any existing timescales for a response, the review should consider whether those timescales are being met, and if not, it must consider why not and how this should be rectified.
- WMP should also ensure that whenever a complaint is raised about an officer or staff member's conduct which relates to a CSE matter, consideration is given to whether any further training is required on the part of that individual, regardless of any other action that may be taken in relation to misconduct or performance issues.
- WMP should publish annually, as part of the 'Joint CSE Review Group's' Annual Report, a review of complaints or concerns relating to CSE to include themes and lessons learned.

Relevant chapters: Chapter 5

39. Multi-agency approach to NRM referrals to be reviewed

The **Council** and **WMP** should:

- Review and enhance the current NRM training provision to ensure that all staff who may deal with trafficked children are appropriately trained;
- Ensure that such training includes when a referral should be made, and the appropriate pathways and protocols to be followed in all NRM-qualifying cases.
- Liaise with one another to ensure that each organisation's protocols for NRM reporting is clear; that relevant information is shared; and agreement reached as to which authority should be responsible for making the referral, in circumstances where both authorities are involved.

Relevant chapters: Chapter 3, 5 and 6

40. PCC to commit to continued funding of CSE initiatives

The **PCC** should commit to continued funding of the following initiatives:

- Taxi Marshal scheme; and
- Street Pastors.

Relevant chapters: Chapter 4 and 6

Recommendations

41. **PCC Holding to Account ("HTA") Meetings to be improved**

The **PCC** and **WMP** should ensure that:

- The Chief Constable provides relevant data and statistics relating to CSE (including risk/threat analysis; case numbers; trends, and the information prepared for the 'Joint CSE Review Group' as per **Recommendation 3** above) and raises any related budgetary concerns at the HTA meetings;
- Any complaints or concerns reported to WMP relating to the handling of any CSE cases are shared with the PCC as part of the HTA meetings; and
- Minutes of the PCC and Chief Constable weekly meetings are to be maintained.

Relevant chapters: Chapter 6

42. **Quality of CSE training delivered to NHS providers and practitioners**

In respect of CSE training, in order to increase the likelihood of training translating into practice, the **CCG** needs to:

- Ensure that the training delivered to providers and practitioners includes training on effective ways of engaging with children and encouraging professional curiosity at every contact;
- Review the content and format of the training to ensure that it does not simply consist of the dissemination of written information;
- Ensure there is creativity in how the training is delivered; for example, practical exercises and/or tests to show understanding, including a minimum pass mark, to ensure the training is embedded in practice; and
- Review the method by which assurance is provided as to the percentage of providers/ practitioners that have completed the necessary training; for example, simply because a practitioner was on a distribution list is not sufficient assurance.

Relevant chapters: Chapter 7

43. **Improvements to trauma-related mental health services for victims and survivors of CSE in Telford & Wrekin**

CCG and **NHS England** should consider all avenues to secure an increase in funding for trauma-related mental health services, in particular for victims/survivors of CSE.

Relevant chapters: Chapter 7

44. **The Council to consider increasing capacity for health services to sexually exploited children**

The **Council** should review the current capacity (and ability to meet demand locally, compared to the average nationally) of the following services, and where possible commit to a further increase in capacity by 2024:

- Health visitors; and
- School nurses.

Relevant chapters: Chapter 7

Recommendations

45.	**Guidance for sexual health clinics/to all health providers responsible for giving sexual health advice to be reviewed** Current sexual health guidance issued to practitioners should be reviewed, and kept under review, by the **CCG** to ensure that it: • Reminds professionals of the need to consider the potential for CSE to be a reason that the child is seeking sexual health support; and • Clarifies the policies and referral pathways to follow, in the event they have a concern that a child may be being sexually exploited, or at risk of sexual exploitation. ***Relevant chapters: Chapter 7***
46.	**GPs in Telford & Wrekin to be consulted about CSE data collection** • The **CCG** should consult with GP practices in Telford & Wrekin to consider what can be done to implement a system for flagging CSE concerns on a child's medical records. • The **CCG** should seek to raise this issue at regional and national meetings, wherever possible. ***Relevant chapters: Chapter 7***
47.	**GPs to implement review system for children moving to a different practice** • The **CCG** should ensure that the GP practices within the borough introduce a system so that, when a child moves to a different GP practice, the patient records are reviewed and any concerns regarding CSE are flagged to the new GP practice. • **GP practices** within the borough will be accountable to the CCG to confirm it has a policy in place for such file reviews. ***Relevant chapters: Chapter 7***

Transition from CCG to ICB

Due Diligence Assurance – Final Update Report

Agenda item 28-09.029

SUBJECT TO THE PASSAGE OF THE HEALTH AND CARE BILL THROUGH PARLIAMENT

Introduction to the CCG Close Down and ICB Establishment Due Diligence Checklist v2

IMPORTANT - THIS CHECKLIST SHOULD ONLY BE USED ONCE YOU HAVE READ THE ICB ESTABLISHMENT GUIDANCE ENTITLED: 'DUE DILIGENCE, TRANSFER OF PEOPLE AND PROPERTY FROM CCGs TO ICBs AND CCG CLOSE DOWN' AND THE CONTENT OF THIS TAB.

The checklist has been co-produced by NHS England & NHS Improvement (from this point referred to as NHSEI), CCGs, ICSs, the Helathcare Financial Management Association (HFMA) and other stakeholders as a practical tool for use by CCGs and existing ICSs to provide evidence of due diligence in the transition from CCGs to ICBs. In all cases CCGs and ICSs must undertake an appropriate level of due diligence and it is recommended that this comprehensive checklist is used as the basis for the exercise. It is particularly important that the property list is sufficiently detailed for 'level 3' due diligence, where potentially property and liabilities are to be allocated between ICBs. V2 Completion of the full checklist is not itself mandated by NHSEI, however, the information on individual members of CCG staff must be provided by either completing the relevant tab in the checklist (ref 2.2) or in another form using the same data fields. The checklist may be used to reflect any work that has already been undertaken and adapted as necessary to suit local circumstances. It is recognised that some areas of the checklist will be more important than others - and the level of detail provided should be proportionate to local circumstances. The checklist is designed to be a live working document that can be updated as the due diligence process progresses.

It is for use by CCGs and existing ICSs to provide evidence of due diligence, and to be passed on to ICBs so that there is a clear picture of the people, property, liabilities, risks and issues that they are receiving on legal establishment. It will help as the basis on which the Accountable Officer of each existing CCG will formally confirm that an appropriate level of due diligence has been undertaken. This will support the legal transfer of people and property, close down of the CCG(s) and establishment of the ICB.

NHSEI regional system support teams will provide assistance with the due diligence process, including how to use this checklist - and they will also undertake 'light-touch' assurance to ensure that there is consistency of approach, for the benefit of CCGs, existing ICSs and the new ICBs (once established).

Note: the checklist includes reference to a number of activities to establish ICBs (shaded in grey), and some of these areas are subject to NHSEI guidance which is currently under development. The checklist currently includes a number of 'placeholders' and will evolve.

The checklist is colour coded to highlight key areas. The core checklist is tab 1 - this cross-references to further tabs which provide for further detail to be recorded if necessary. NOTE: The information on individual members of CCG staff MUST be provided either by completing tab 2.2, or in another form using the same data fields as outlined on tab 2.2, and adding local data fields as necessary.

The contents are as follows:

Introduction and guidance
Tab 1.0 - Core due diligence checklist
Tab 2.1 - HR / People due diligence checklist
Tab 2.2 - HR / People due diligence data - Supports tab 2.1 and provides a template to capture individual level staff information - **Refer to covering guidance**
Tab 3.1 - Financial due diligence checklist - Financial governance
Tab 3.2 - Financial due diligence checklist: Accounts and audit
Tab 3.3 - Financial due diligence checklist - Ledger, financial and cash management
Tab 3.4 - Financial due diligence checklist - Banking arrangements
Tab 3.5 - Financial due diligence checklist - Contracts
Tab 3.6 - Financial due diligence checklist - Assets
Tab 3.7 - Financial due diligence checklist - Liabilities
Tab 4.0 - IT assets, IT and records management due diligence checklist
Tab 5.0 - DSPT checklist - *to be included at a later point*
Tab 6.0 - ODS Reconfiguration checklist - *to be included at a later point*
V2 Tab 7.0 - Quality due diligence [please note that quality at handover is contained on the core diligence tab and a new tab has been added focussed on ICB set up]
Version changes log

Additional checklists will be included as required

Version Control

The current version of the Due Diligence Checklist is made available via the Hub / FutureNHS platform. Strict version control is being applied and the current version number and date of issue included below; any prompt changed / added is highlighted in yellow in column A on each tab, including the version in which the change took place; and the changes made logged V2 on the version control log tab.

V2	**Current version number**	V2
V2	**Date of current version**	10/14/2021
	Details of changes made	See Version Changes Tab

Comments Regarding Versions Released

V1 was released on 18.08.21

V2 provides an update as at 14.10.21 and the change log indicates all changes made to date

SUBJECT TO THE PASSAGE OF THE HEALTH AND CARE BILL THROUGH PARLIAMENT

1.0. CORE CCG DUE DILIGENCE CHECKLIST TO SUPPORT TRANSFER OF PROPERTY TO THE INTEGRATED CARE BOARDS (ICBs)

Name of ICB:	
Name of CCG(s):	
Date:	
Completed by:	
Contact details:	

Level of due diligence based on the level of complexity determined	**Select from drop down list below**
Level of complexity determined and the process as covered in section 1 below can be adjusted to respond to the level of complexity - select applicable option in column J	Level 1 - Single CCG to coterminous ICB and no boundary changes

Ref	Due Diligence Area for Review *A number of due diligence activities relate to ICBs, many of which are subject to NHSEI guidance under development and are included at this time as 'placeholders' only - they are shaded grey*	Comments	Initial Assessment: Person Responsible	Start Date	End Date	New ICB Timeline Due Date	RAG	Further action required (Yes / No)	Final Assessment: Action required	Due Date for Further Action	Page Ref
1.1	**Due diligence process**										
1.1.1	Due diligence process is fully documented and agreed at the Executive or Board	Due Diligence process approach was presented to CCG Governing Body and ICS Board in January 2021 for approval. Delegation to respective health committees also established.	Alison Smith	9/1/2021	9/29/2021		Green	No	N/A	N/A	Exa
1.1.2	DRD for due diligence for the CCG(s) agreed	Director of Corporate Affairs (TW CCG) agreed as SRO reporting to ICS Programme Director	Alison Smith	9/1/2021	9/29/2021		Green	No	N/A	N/A	Exa
1.1.3	Key dates for internal sign off for the overall due diligence process and staffing and property lists agreed	Plan for sign off outlined in the Due Diligence Process Approach report - AD signoff of Due diligence following final report to Audit Committee of CCG in mid May 2021	Alison Smith	3/1/2022	5/13/2022		Green	No	All sign off milestones have been met - no further action required.	N/A	Exa
1.1.4	Due diligence process risks considered and assessed	Initial assessment to be undertaken in November following first checklist reporting to CCG and ICS Audit Committees in preparation for peer assurance meetings in December. Further assessment will be undertaken at the end of March 2022.	Alison Smith	11/1/2021	3/31/2022		Green	No	None identified	N/A	Exa
1.1.5	Consideration given to the need for additional assurance / legal advice through the use of external / internal audit / consultancy / legal support. This should focus on high risk areas as identified through the assessment of risk	Due diligence approach report outlines a two day assurance panel that includes Lay members and CCI NEDs and CCG Internal Audit Director to review progress and areas of risk to provide assurance to Audit Committees meeting in January 2022. Further internal audit support has been identified for the handover process between CCG Directors and ICB Directors which is currently being scoped.	Alison Smith	11/1/2021	5/12/2022		Green	No	*Completed*	N/A	Exa
1.2	**Staff and Staff Benefits**										
1.2.1	Staff and Staff Benefits - HR / People Due Diligence Checklist is included at tab 1.2.	Lists of staff benefits is already held by the HR team which will be provided along with the checklist to the receiving organisation 28 days before the transfer.	Lisa Kelly/Alison Smith	10/1/2021	3/31/2022		Green	No	List of benefits is available to be made available as part of the employee liability information	3/31/2022	Exa
1.2.2	**A template is provided for senior organisations to provide employee liability information (ELI) and promote due diligence to facilitate the earth transfer or staff to receiving organisations. In the case ICBs, See covering guidance and tab 1.2 for the legal requirements - Template is included at tab 1.2**	Template has been uploaded into CSU workforce systems and will be used to pull together the employee liability information 28 days prior to transfer	Lisa Kelly/Alison Smith	10/1/2021	3/31/2022	31/5/22 (initial), 1/6/22 (final checkpoint)	Green	No	Employee liability information to be compiled 28 days before the date of transfer. Update ELI information has now been completed	2/28/2022	Exa
1.3	**Constitutional, Corporate and Regulatory Matters**										
1.3.1	Details of any concerns expressed by the Secretary of State, DHSC or NHSEI in relation to CCG actions	None identified to date - Processes are in place to identify these if & when they occur and to capture in the due diligence process	Alison Smith	10/1/2021	6/30/2022		green	No	*completed*	6/30/2022	Exa
1.3.2	Details of any concerns expressed by internal auditors, external auditors or the National Audit Office (concerning powers, rights or duties	External auditors have highlighted the CCG(s) failure to remain within its resource limit in its 2020/21 DAGM reports. Also the CCG's failure to address its underlying deficit is a recurrent theme in their annual reports.	Laura Clare	11/1/2021	11/1/2021		Green	Yes	*Copies of external auditors reports & VFM conclusion are available upon request*		Exa
1.3.3	Details of any disciplinary action taken by the CCG in relation to CCG Governing Body members, Directors or Officers relating to their acts or omissions relating to powers and duties of the CCG	None identified to date - Processes are in place to identify these if & when they occur	Lisa Kelly/Alison Smith	11/1/2021	6/30/2022		green	no	*completed*	6/30/2022	Exa
1.3.4	Details of any material breach of Public Procurement Regulations, Standing Orders or Standing Financial Instructions	None identified to date. Processes are in place to identify these if & when they occur	Laura Clare	11/1/2021	3/31/2022		Green	No			Exa
1.3.5	Details of any breach of the Code of Conduct, Code of Accountability or other equivalent guidance	None identified to date. Processes are in place to identify these if & when they occur	Alison Smith	10/1/2021	6/30/2022		Green	No	*Completed*	6/30/2022	Exa
1.3.6	Details of investigations by supervisory or regulatory bodies, statutory or government bodies, the Health and Safety Executive, the Environment Agency, the police, NHS Counter Fraud and Security Management Services (CFSMS), or any other circumstances, that would transfer	None identified for H&S, Environment Agency, Security Management Services. Processes in place to identify these if and when they occur. Counter Fraud investigations are reported on regularly to CCG Audit Committee.	Alison Smith/Laura Clare	10/1/2021	6/30/2022		Green	No	*completed*	6/30/2022	Exa
1.3.7	Current inspections by the Care Quality Commission (CQC) that would transfer	An internal Quality Directorate information checking process has confirmed that this information is contained within various quality monitoring processes and is up to date as of 14/04/22, and can be made available at the point of request.	Vanessa Whatley/Tracy Slater	Ongoing	6/30/2022		Green	No	Maintenance of records on-going.	3/30/2022	Exa
1.3.8	Total number of CQC warning notices (GP practices, Care Homes and NHS funded providers) in last 24 months	An internal Quality Directorate information checking process has confirmed that this information is contained within various quality monitoring processes and is up to date as of 14/04/22, and can be made available at the point of request.	Vanessa Whatley/Tracy Slater	Ongoing	6/30/2022		Green	No	Maintenance of records on-going.	5/31/2022	Exa
1.3.9	Total number of CQC inadequate inspection ratings (GP practices, Care Homes and NHS funded providers) in last 24 months	An internal Quality Directorate information checking process has confirmed that this information is contained within various quality monitoring processes and is up to date as of 14/04/22, and can be made available at the point of request.	Vanessa Whatley/Tracy Slater	Ongoing	6/30/2022		Green	No	Maintenance of records on-going.	4/1/2022	Exa
1.3.10	Open CQC action plans that would transfer	An internal Quality Directorate information checking process has confirmed that this information is contained within various quality monitoring processes and is up to date as of 14/04/22, and can be made available at the point of request.	Vanessa Whatley/Tracy Slater	Ongoing	6/30/2022		Green	No	Maintenance of records on-going.	4/1/2022	Exa
1.3.11	Open public consultations regarding service change / reconfiguration that would transfer	There is no plan to have any public consultations as we are not proposing any services changes in relations to becoming a statutory ICS. 2/12/21 No change	Chris Hudson/Edna Bonyongo	10/1/2021	6/30/2022		Green	No	No public consultation is being carried out that would require transfer to the ICB.	6/30/2022	Exa
1.3.12	Open learning points from past System Oversight Framework assessments that would transfer	All requirements for the SOF 4 process in relation to the agreed exit criteria are being followed and reported both directly and through the NCB ICB development work. This means that there is visibility of all open learning points that would transfer and no risk from the point of view of the DD handover.	Claire Skidmore	11/1/2021	6/30/2022		Green	No	*Transfer completed*	6/30/2022	Exa
1.3.13	Open risks that would transfer (provide risk register of all risks, including HR, financial / accounting, quality, risks, etc)	Risks at Board Assurance Level and Directorate Level are captured in regular bi-monthly risk reporting to the Audit Committee and Governing Body.	Alison Smith	10/1/2021	6/15/2022		Green	No	Open risks were reported to the CCG audit committee on the 15th June 2021 and which will form the information that has been transferred to the	6/15/2022	Exa
1.3.14	Open Memoranda of Understanding (MOUs) in place that would transfer	All contract owners will be contacted to identify leases held independently or within contracts. Once identified these will be added to the contract register workbook as a separate tab.	Kay Hodiand/Julie Garside	11/1/2021	3/31/2022		Green	Yes	HR active MoUs have been transferred to the 2022/23 contracts as a separate MoU / Grant Tab	5/31/2021	Exa
1.3.15	Clinical and non-clinical policies (provide policy register(s))	A significant amount of work to align policies has already been undertaken since the establishment of the new STW CCG to align the clinical and non-clinical policies of the former Shropshire and Telford & Wrekin CCGs. The majority of these policies have now been aligned and approved by the Governing Body or relevant Committee. Clinical policies are through Neo Policy Trackers, one held by Medicines Management for the clinical policies and the other by Tracy Eggby Jones for all other non-clinical policies. The Medicines Management Team (MMT) have prioritised (MG ratio) their policies and have a plan in place to review the Medicines Management policies. This is challenging due to the support they have been providing to the Covid pandemic response. Currently there are 2 documents on the MMT policy tracker to be completed, which relate to the Memorandum of Understanding (MoU) and Information Sharing Agreement (ISA) for the Prescription Ordering Direct (POD) service. This is in the process of being completed and subject to Information Governance approval. There is 1 policy on the corporate policy tracker yet to be approved. This is the HP policy and a significant amount of work has been undertaken to align the former two CCGs policies, which has included engagement work. The policy is due to be presented	Tracy Eggby Jones/Alison Smith	4/1/2021	5/27/2022	5/27/2022	Green	No	Policies aligned and adopted by ICB in 1st July 2022	7/1/2022	Exa
1.3.16	Where there are multiple CCGs in an ICS, assessment of risk posed by having different policies (e.g. IGP commissioning policy) and plan plan to consolidate all policies. This includes the need to agree the position and timescales for any 'high risk' policies not consolidated at the point of establishment of the ICB	June 21 update - Speaking in relation to the IGP Policy, which is due to be presented to the SCC meeting on 18 May 2022 for approval.	Tracy Eggby Jones/Alison Smith	10/1/2021	5/27/2022	5/27/2022	Green	No	Policies aligned and adopted by ICB on 1st July 2022	7/1/2022	Exa
1.3.17	Subject access requests (SARs) that would transfer (links to 5.15)	A SARs register is held by Tracy Eggby Jones, which identifies all SARs received, their current status with RAG rating. Any open SARs at 30.6.22 will transfer to the new ICB and responsibility notified.	Tracy Eggby Jones/Alison Smith	10/1/2021	6/30/2022		Green	No	Any open cases were transferred.	6/30/2022	Exa
1.3.18	Freedom of Information (FOIs) requests that would transfer (links to 5.16)	The process for overseeing FOI requests is managed by the Medicals & Lancashire CSU. They can provide a list of open FOIs at any point and relevant parties of those that are not concluded by 30 June 2022 will be notified of the transfer to the new ICB.	Tracy Eggby Jones/Alison Smith	6/30/2022	6/30/2022		Green	No	Any open cases were transferred.	6/30/2022	Exa
1.3.19	Open learning points from Emergency Preparedness, Resilience and Response (EPRR) that would transfer	Plans are in place to ensure that learning points will transfer to ICB as appropriate	Sam Tilley	11/1/2021	6/30/2022		Green	No	Plans for EPRR function for the ICB is in development with a draft being submitted to NHSEI on the 27/5/22 and learning points have transferred	6/30/2022	Exa
1.3.20	Details of any other material information relating to the constitution and governance of the CCG	None identified to date. Processes are in place to identify these if & when they occur	Alison Smith	10/1/2021	6/30/2022		Green	No	*Completed*	5/12/2022	Exa
1.3.21	Assess whether the ICB will need a new Economic Operators Registration and Identification (EORI) number	This will not apply to ICBs as they will not need this license					N/A	N/A		N/A	
1.3.22	Ensure that the Establishment Order is in place to create the ICB and dissolve the CCG(s) - *Note that this is to be undertaken nationally*	Relates to ICB set up - the creation of the Order will be done by NHSE	Nicky O'Connor/William Smith	4/1/2022	5/27/2022	5/27/2022	Green	No	*Completed*	5/26/2022	Exa
1.3.23	Ensure that the appropriate staff and property transfer schemes have been created and approved to transfer people and property from the CCG(s) to the ICB - *Note that this is to be undertaken nationally*	Relates to ICB set up - the creation of the schemes will be done by NHSE but informed by a list of staff to be provided by the CCG. Please refer to workstream 2.1 HR Due Diligence Checklist for detailed Action and Risk rating and commentary	Lisa Kelly/Alison Smith	5/1/2022	6/1/2022	6/1/2022	N/A	No	Milestones for information transfer to national team completed.		
1.3.24	New Constitution agreed for ICB - Model Constitution guidance currently under development	Relates to ICB set up. Model Constitution has been drafted. A re-amended version of the Model Constitution has been released on 11 February and amendments are currently being actioned. Final Constitution will be submitted to NHSE by deadline 20 May	Alison Smith	10/15/2021	5/12/2022	31/5/22 (initial), 15/3/23 (2nd draft), 22/4/22 (third draft), 30/5/22 (final)	Green	No	*Completed*	5/15/2022	Exa
1.3.25	Agree the new committee structure and develop terms of reference, as necessary. Committees may include: • Governing Body Committee; • Audit & risk committee; • Quality committee (following NQB guidance); • Finance committee; • Primary Care Commissing committee; • JFC; • Finance committee • Capital committee Consider committees that are an integral part of the governance structure or that are required due to the nature of the ICB. Agree their purpose, terms	Relates to ICB set up Terms of reference have been released by NHSCE to use. ICS already has committees in place which will be retained and added to. New ICB Interim Designate CE is in discussions with CCG and ICS Execs on changes to the Board Committee and governance structure. Work has started to review current ICS Committee TOR and align will developing thinking on new structure.	Alison Smith	2/1/2022	6/10/2022		Green	N/A	*Completed*	6/30/2022	Exa
1.3.26	Agree new logo, letter head, signage, harmonise all corporate documents, standard documents and inform staff where these can be accessed - for ICB	Relates to ICB set up Logo has been agreed and we are in the process of looking at all corporate templates. New NHS STW logo has been developed. Corporate stationery is being worked on and will be ready for circulation from mid-June. Website is in ICB set up.	Chris Hudson/Edna Bonyongo	10/22/2021	6/30/2022		Green	No	*Completed*	7/1/2022	Exa
1.3.27	New website for ICB	Website is live online, with the CCG site becoming the ICB website and the ICS site being decommissioned. There will be a section on the ICB site for CCG content. The planning for this change is under way.	Chris Hudson/Edna Bonyongo	10/1/2021	7/1/2021	7/1/2021	Green	No	*Completed*	7/1/2022	Exa
1.4	**Quality Governance**										
1.4.1	Infection control records	An internal Quality Directorate information checking process has confirmed that this information is contained within various quality monitoring processes and is up to date as of 14/04/22, and can be made available at the point of request. Data is shared with NHSEI on a quarterly basis. We have a system in place to escalate strength reporting in response to any changes to national guidance relating to Covid-19.	Jill Hassall/Vanessa Whatley	11/1/2021	6/30/2022		Green	Yes	Continued support to B&W CMO and IPC team and close monitoring of the progress of their IPC action plan. This is formally via SQG. System response to IPC guidance - on-going. Maintenance of records on-going.	6/30/2022	Exa
1.4.2	Open outstanding / ongoing complaints that would transfer (links to 1.4.2)	The CCG's Patient Services Team are able to run a report from Ulysses of all open complaints at any point. Any open cases at the point of transfer will be those that are not concluded by 30 June 2022 that their case will be transferred to the new ICB.	Tracy Eggby Jones	10/1/2021	6/30/2022	6/30/2022	Green	Yes	Completed - Patient Services Team have notified existing and new complaints cases that the CCG will transfer to the new ICB if it has not been resolved by 30 June 2022.	6/30/2022	Exa
1.4.3	Open Serious Incidents (SIs) that would transfer	An internal Quality Directorate information checking process has confirmed that this information is contained within various quality monitoring processes and is up to date as of 14/04/22, and can be made available at the point of request.	Vanessa Whatley/Tracy Slater	11/1/2021	6/30/2022		Green	No	Maintenance of records on-going.	6/30/2022	Exa
1.4.4	Open whistleblowing / PTSG cases that would transfer	Note identified. Annual reporting on freedom to speak up concerns to the Audit Committee	Alison Smith	10/1/2021	30/06/22		Green	No	*Completed*	6/30/2022	Exa
1.4.5	Open quality action / improvement plans that would transfer	An internal Quality Directorate information checking process has confirmed that this information is contained within various quality monitoring processes and is up to date as of 14/04/22, and can be made available at the point of request.	Tracy Slater/Zena Young	11/1/2021	6/30/2022		Green	No	*Completed.* Maintenance of records on-going.	6/30/2022	Exa
1.4.6	Personal Health Budgets held that would transfer	All of the PHB information is held on an electronic patient management system and the shared drive. It will be accessible in the same way as on 01/07/2022 as on 30/06/2022. No physical transfer required and software supplier has confirmed access will be in place. Plans have been developed and implemented on the transfer of checks and the wider finance system actions will ensure that system information and access transfers over.	Brett Tonn/Claire Parker	11/1/2021	6/30/2022		Green	No	*Completed.* Maintenance of records on-going.	6/30/2022	Exa
1.4.7	Open Individual Funding Requests or appeals that would transfer	Plans are in place to ensure that relevant information is transferred to the ICP. To convert to green on the 1st July as they are straight transfers.	Claire Stafford/Claire Parker	11/1/2021	6/30/2022		Green	No	Open IFR cases automatically transferred to the new organisation, the status of any outstanding IFR cases will not change and any required actions or panel meetings will take place as previously planned, any appeals will also transfer to the new organisation.		Exa
1.4.8	Deferred Individual Funding Requests that would transfer	Plans are in place to ensure that relevant information is transferred to the ICP. To convert to green on the 1st July as they are straight transfers.	Claire Stafford/Claire Parker	11/1/2021	6/30/2022		Green	Yes	Open IFR cases automatically transferred to the new organisation, the application will continue as per policy, a DB day deadline will still apply for the provision of further information to be provided and this will be continually reviewed in old and new organisation to ensure the policy is correctly applied.		Exa
1.4.9	Open independent investigations, including mental health homicide reviews and domestic homicide reviews that would transfer	An internal Quality Directorate information checking process has confirmed that this information is contained within various quality monitoring processes and is up to date as of 14/04/22, and can be made available at the point of request. SHRs: Details are provided on a quarterly basis of all open SHRs to NHSEI. Under local and legislative arrangements the oversight of these sits with the Community Safety Partnership and the ultimate governance rests with the Statutory Safeguarding Partnership arrangements. No issues have been identified.	Maria Hadley/Linda Salt (Interim lead)	11/1/2021	6/30/2022		Green	Yes	Maintenance of records on-going.	6/30/2022	Exa
1.4.10	Open safeguarding adults reviews that would transfer	An internal Quality Directorate information checking process has confirmed that this information is contained within various quality monitoring processes and is up to date as of 14/04/22, and can be made available at the point of request. Governance arrangements are in place and again Section 44 of the Care Act overarching accountability rests with the Safeguarding Adult Board. There are no concerns or challenges about CCG activity in support of ongoing SARs. Details are provided on a quarterly basis of all open SARs to NHSEI. Under local and legislative arrangements the oversight of these sits with the Statutory Safeguarding Partnership arrangements. No issues have been identified.	Maria Hadley/Linda Salt (Interim lead)	11/1/2021	6/30/2022		Green	No	Maintenance of records on-going.		Exa
1.4.11	Open serious case reviews / child safeguarding practice reviews that would transfer	An internal Quality Directorate information checking process has confirmed that this information is contained within various quality monitoring processes and is up to date as of 14/04/22, and can be made available at the point of request. Details are provided on a quarterly basis of all open CSPRs to NHSEI. Under local and legislative arrangements the oversight of these sits with the Statutory Safeguarding Partnership arrangements. No issues have been identified.	Maria Hadley/Linda Salt (Interim lead)	11/1/2021	6/30/2022		Green	No	Maintenance of records on-going.		Exa
1.4.12	Number of Looked After Children cases that would transfer	An internal Quality Directorate information checking process has confirmed that this information is contained within various quality monitoring processes and is up to date as of 14/04/22, and can be made available at the point of request.	Maria Hadley/Linda Salt (Interim lead)		6/30/2022		Green	No	Maintenance of records on-going.		Exa
1.4.13	Number of Deprivation of Liberty Safeguarding (DOLS) cases that would transfer	Legislation relating to the implementation of Liberty Protection Safeguards is due to be introduced during 2022/23 and the CCG safeguarding team are leading the system response to this. There is a risk recorded on the CCG risk register in relation to this (rated yellow).	Claire Parker/Paul Cooper	TBC	TBC		Green	Yes	The CCG safeguarding team provide on-going expertise to the CHC team to such cases.		Exa
1.4.14	Open mortality review reports / medical examiner referrals that would transfer - i.e. any cases being reviewed by the CCG, such as cases referred by a medical examiner which the CCG is following up on has an outstanding action for the CCG	An internal Quality Directorate information checking process has confirmed that this information is contained within various quality monitoring processes and is up to date as of 14/04/22, and can be made available at the point of request.	Zena Young	11/1/2021	6/30/2022		Green	No	Maintenance of records on-going.		Exa
1.4.15	Open Regulation 28 Coroner reports that would transfer	An internal Quality Directorate information checking process has confirmed that this information is contained within various quality monitoring processes and is up to date as of 14/04/22, and can be made available at the point of request.	Tracey Slater	11/1/2021	6/30/2022		Green	No	Maintenance of records on-going.		Exa
1.4.16	Enforcement notices (served on the CCG in the last 24 months) that would transfer	There are no such enforcement notices - the CQC does not regulate CCG's.	Zena Young	11/1/2021	6/30/2022		Green	No	NF as the CQC does not regulate the CCG		Exa
1.4.17	Open Learning Disabilities Mortality Review (LeDeR) cases that would transfer	An internal Quality Directorate information checking process has confirmed that this information is contained within various quality monitoring processes and is up to date as of 14/04/22, and can be made available at the point of request. Details are provided on a quarterly basis of all open LeDeR's to NHSEI.	Tracey Slater	11/1/2021	6/30/2022		Green	No	Maintenance of records on-going.		Exa
1.4.18	Open Eliminating Mixed Sex Accommodation (EMSA) cases that would transfer	Numbers of EMSA breaches form part of quality monitoring	Tracey Slater	11/1/2021	6/30/2022		Green	No	Monitored and tracked as part of SQG reporting.		Exa
1.4.19	Open learning points from patient surveys and feedback	Plans are in place to ensure that relevant information is transferred to the ICP	Edna Bonyongo/Zena Young	11/1/2021	6/30/2022		Green	No	Maintenance of records on-going.		Exa
1.4.20	Open learning points from clinical audits	This information is monitored as part of routine quality oversight of providers.	Tracey Slater		6/30/2022		Green	No	Maintenance of records on-going.		Exa
1.4.21	Open learning points from complaints, incidents, clinical audits, quality matters, etc. that would transfer	Cases are tracked as part of routine quality monitoring processes.	Zena Young		6/30/2022		Green	No	Maintenance of records on-going.		Exa
1.4.22	Establish approach for the transfer and retention of legacy organisation information on quality in accordance with Caldicott principles and share intelligence on quality, including safety (as per Quality Matrix)	An internal Quality Directorate information checking process has confirmed that this information is contained within various quality monitoring processes and is up to date as of 14/04/22, and can be made available at the point of request. Plans are in place with relevant quality leads. The Data Quality Matrix collection, sourcing, transfer and storing of records is underway and will be complete by 30/04/22	Zena Young	11/1/2021	4/30/2022		Green	No			Exa
1.4.23	Agree the approach to maintaining quality during the transition and improving quality following the establishment of the ICB as outlined in Position statement: https://www.england.nhs.uk/publication/national-quality-board-position-statement-on-quality-in-integrated-care-systems/ National Quality Board (NQB) Position statement on quality in integrated care systems - Quality Board guidance (Commissioner-to-quality/ Provider-to-quality/ Quality Board-to-Board)	Relates to ICB set up									
1.4.24	**Quality Checklist (relating to ICB set up) included at tab 7.0**	Relates to ICB set up									
1.5	**Claims, Litigation and Insurance**										
1.5.1	Outstanding claims / litigation that would transfer	The CCG has some current litigation in the Court of Protection which is likely to transfer to the ICB	Alison Smith	1/1/2021	6/30/2022		Green	No	Completed. Outstanding claims information transferred	6/30/2022	Exa
1.5.2	Pending claims / litigation (including any incidents that may become claims) that would transfer	No pending litigation identified for the purposes of reporting to NHS resolution. This will be kept under review up to 30/6/22.	Alison Smith	1/1/2021	6/30/2022		Green	No	*Completed. Pending claims information transferred*		Exa
1.5.3	Outstanding and pending claims / litigation under Environmental Information Regulations (EIR) that would transfer	None identified at moment. Regular reporting via NHS Resolution and CCG solicitors allows capture of data.	Alison Smith	1/1/2021	6/30/2022		Green	No	*Completed - none identified*	6/30/2022	Exa
1.5.4	Outstanding and pending claims / litigation under Data Protection Act (DPA) or General Data Protection Regulation (GDPR) that would transfer	None identified at moment. Regular reporting via NHS Resolution and CCG solicitors allows capture of data.	Alison Smith/Laura Clare	1/1/2021	6/30/2022		Green	No	*Completed - none identified*	6/30/2022	Exa
1.5.5	Details and copies of documents relating to insurance arrangements that the CCG(s) has in place	NHS Resolution provide insurance to the CCG and documentation setting out this arrangement is available	Tracy Eggby Jones/Alison Smith	1/1/2021	6/30/2022		Green	No	CCG documentation is in place and shared as this action is complete. NHS Resolution has confirmed that insurance will be in place for the ICB from 1 July 2022.	6/30/2022	Exa
1.5.6	Open learning points from litigation and claims that would transfer	None identified at moment. Regular reporting via NHS Resolution and CCG solicitors allows capture of data.	Alison Smith	1/1/2021	6/30/2022		Green	No	None identified.	6/30/2022	Exa
1.6	**Contracts, Leases and Commercial Agreements**										
1.6.1(i)	Contracts register: Ensure all contracts located and in place (clinical and non-clinical) - to include fields for clinical / non-clinical, contract terms, start dates, end dates, break dates, parties to contract, named leads and contact details for both parties of the contract including the name of the CCG lead for or on behalf of); etc. The contracts register should also include arrangements that are not formally documented as contracts but are still contracts	A list of all contracts, based on the contracts review undertaken as part of CCG merger exists, however contract holders will be contacted to check the accuracy of the information already captured.	Kay Hodiand/Julie Garside	10/30/2021	3/31/2022		Green	Yes	Procurement Oversight Group invitation is held on a monthly basis which now has a standing agenda for Goods & Services and the relevant contract holders are invited to attend and present updates.	3/31/2022	Exa
1.6.1(ii)	Cross check the contract register / schedule of contracts to the CCG's payments ledger to ensure that it is complete	Ensure all contract payments match the payments from the ledger	Kay Hodiand/Julie Garside	4/1/2022	5/31/2022		Green	Yes	Monthly validation of values to ensure contract register and ledger payments agree	6/30/2022	Exa
1.6.2	Ensure that all leases are listed to assist with work associated with IFRS 16 (this could be addressed by including all leases in the contracts register or by holding a separate list of all leases). To include all lease terms, start dates, end dates, break dates, parties to lease, CCG lead or on behalf of, etc.	All contract owners will be contacted to identify leases held independently or within contracts. Once identified these will be added to the contract register workbook as a separate tab.	Kay Hodiand/Julie Garside	10/30/2021	3/31/2022		Green	Yes	Procurement Oversight Group now covers the Goods & Services contract holders, so contract issues can be discussed and resolved at this forum.	3/31/2022	Exa
1.6.3	Agreements / service agreements in place	Currently no clinical agreements/service agreements in place Contract leads will be contacted to confirm this. Goods & Services	Kay Hodiand/Julie Garside	10/30/2021	3/31/2022		Green	Yes	Procurement Oversight Group now covers the Goods & Services contract holders, so contract issues can be discussed and resolved at this forum.	3/31/2022	Exa
1.6.4	Confirm which contracts are expiring at point of transfer or due for renewal in first quarter of 2022/23 and a clear plan in place to take forward each one	The contract register details expiry dates of contracts, the monthly procurement oversight group receives and discusses a expiring contracts tag for clinical services	Kay Hodiand/Julie Garside	1/30/2021	1/31/2022		Green	Yes	Discussion at Procurement Oversight Group on 19th May, paper to Strategic Commissioning Committee/Governing Body for agreement of	1/31/2022	Exa
1.6.5	Number of open tenders / procurements on the register	Currently no open clinical procurements on the register. Contract leads will be asked to confirm the number of open tenders/procurements for Goods & Services.	Kay Hodiand/Julie Garside	1/30/2021	3/31/2022		Green	Yes	All Active Procurements are discussed monthly at the Procurement Oversight Group. Also includes any procurements that are being planned	3/31/2022	Exa
1.6.6	Confirm contract with counterparties to contracts and clarify transfer of contracts / continuation of contracts if required (noting that this is likely to involve more than one contract to ensure that there is clarity)	Counterparties will be identified and contacted as appropriate and record of contact made noted in the comments section of the contract register	Kay Hodiand/Julie Garside	1/30/2021	3/31/2022		Green	Yes	Contract Register updated to new include details of counterparties to the contracts	6/30/2022	Exa
1.6.7	Confirm which contracts are 'legacy' services provided by independent sector providers that are not yet designated as Commissioner Requested Services. Further information via link below	Commissioning teams will work with commissioning team to consider if any action needs to be taken.	Kay Hodiand/Julie Garside	1/30/2021	3/31/2022		Green	Yes	Due to 'hard to replace' services have currently been identified that are provided by independent providers	6/30/2022	Exa
1.6.8	**Contract Checklist included at tab 1.3**										
1.7	**Real Estate, and Other Assets and Liabilities**										
1.7.1	Where CCGs are currently holding property which should be held by NHS provider organisations (e.g. buildings providing community services which have been historically mis-allocated to CCGs), they should take the opportunity now to make arrangements to transfer it to the relevant provider by the end of December 2021. This may will not be part of the property which is subsequently transferred to the ICB	This has been checked with both the CCG's legal advisors and with NHS Property Services and they have both confirmed that the CCG does not hold any property.	Alison Smith	11/1/2021	12/31/2021		Green	No	N/A	N/A	Exa
1.7.2	Confirm contract with counterparties related to real estate and other assets in this section as required	Counterparties will be identified and contacted as appropriate and record of contact made noted.	Kay Hodiand/Julie Garside	11/1/2021	3/31/2022		Green	Yes	N/A	N/A	
1.7.3	**Assets and Liabilities Checklists included at tab 1.4 and 1.7**										
	Real Estate										
1.7.4	Details of all properties owned by the CCG(s)	Not applicable - no properties are owned by the CCG	Alison Smith	N/A	N/A		Green	No	N/A	N/A	N/A
1.7.5	Details of all properties leased by the CCG(s)	List of property leased by the CCG exists and is based upon information received from NHS Property Services and one property leased from Shropshire Council.	Alison Smith	10/1/2021	3/31/2022	31/03/2022 (first draft), 6/5/22 (second draft), 20/5/22 (third draft)	Green	No	Information captured - complete	5/12/2022	Exa
1.7.6	Details of all legal charges on properties	List of property leased by the CCG exists and is based upon information received from NHS Property Services and one property leased form Shropshire Council. Further investigations with CCG legal advisors has not identified any legal charges within this portfolio.	Alison Smith	10/1/2021	3/31/2022	31/03/2022 (first draft), 6/5/22 (second draft), 20/5/22 (third draft)	Green	No	N/A	N/A	Exa
1.7.7	Details of all properties occupied by the CCG(s) and not included in the categories above	Not applicable to the CCG	Alison Smith	N/A	N/A	N/A	Green	No	N/A	N/A	N/A
	IT Assets, IT and Records Management										
1.7.8	Details of all IT systems, both clinical and non-clinical	List of systems and software collated System suppliers to be contacted once new name of organisation is confirmed	Sara Spencer/Laura Clare	11/1/2021	5/31/2022		Green	Yes	All systems suppliers to be contacted to detail the transfer to the new ICB once the official ICB name and invoice address is confirmed	5/31/2022	Exa
1.7.9	Details of any actual or potential disputes regarding IT systems	No disputes have been raised with the system suppliers	Sara Spencer/Laura Clare	11/1/2021	6/30/2022		Green	No	No action. Complete	N/A	Exa
1.7.10	Ensure that all IT equipment (apply a materiality approach)	Audit tech managed by the CSU IT team detail the hardware assigned to all staff and keep a full inventory.	Sara Spencer/Laura Clare	11/1/2021	5/31/2022		Green	No	No action. Complete		Exa
1.7.11	Ensure that the records management transition plans are in place - **See briefing paper providing records management guidance located on PulseHRS (link provided) is repeated on tab 1.0 to ensure that all prompts associated with records management are in one place.** For link to as follows: https://fusion.nhs.uk/CGUsersHome/searchresults/1+DRIVER	Organisations have been requested to review and cleanse the data held in the shared folders. A team is working with the departments to ensure that all information assets are mapped and arranged in one place on the shared drive. The shared drive merge is planned to be completed by end of May 2022.	Sara Spencer/Laura Clare	11/1/2021	5/31/2022	5/31/2022	Green	Yes	Regular meetings with the project team to ensure the progress stays within agreed timelines. Working with teams to understand the process to migrating the data. Weekly progress meetings in place with the project team.	4/30/2022	Exa
1.7.12	Ensure that processes are in place to review records (electronic and paper) to delete, archive or for carry forward to the ICB. Note that particular attention should be paid to retention of records which may be required for inquiries, including the forthcoming Covid Inquiry (this prompt is covered by a number of prompts on tab 6.0 to ensure that all prompts associated with records management are in one place - review tab 6.0 for full details)	A process is in place for the review of records and a policy for records management. All records have been reviewed. Records that are held as part of the stop notice have been retained.	Sara Spencer/Laura Clare	11/1/2021	5/31/2022	5/31/2022	Green	Yes	Data retention work due to complete by 31st May	5/31/2022	Exa
1.7.13	**Records Management, IT and IT Assets Checklist included at tab 4.0**		Sara Spencer/Laura Clare								
	Equipment										
1.7.14	Details of all other equipment, e.g. office equipment (apply a materiality approach)	List of equipment from CCG merger process in existence which as been reviewed and updated following an audit of equipment across two CCG sites	Alison Smith/Tracy Eggby Jones	12/1/2021	1/31/2022		Green	No	Action completed		Exa
1.8	**Environment**										
1.8.1	List and supply copies of all environmental licences, consents, permits and authorisations necessary of the operations of the CCG	Not applicable to

SUBJECT TO THE PASSAGE OF THE HEALTH AND CARE BILL THROUGH PARLIAMENT

2.1 CCG HR DUE DILIGENCE CHECKLIST: STAFF TRANSFER, EMPLOYEE LIABILITY AND DUE DILIGENCE CHECKLIST

This document provides a checklist of due diligence activity that will support sender organisations and receiver organisations, in this case Integrated Care Systems, to prepare for the safe and effective transfer of their staff within the change and transition process. A people impact assessment should be completed to identify staff in scope of transfer. It is then a legal requirement under the Transfer of Undertaking (Protection of Employment) Regulations (TUPE) or those actions required under Cabinet Officer Statement of Practice (COSoP) guidance for employee liability information (ELI) to be provided to receiving organisations or all in scope staff at least 28 days prior to the transfer date, but organisations are asked to share anonymised data as early as possible to allow both parties to make preparations for transfer. A separate template to capture individual level staff information is provided on tab 2.2. Further details around the activities covered by this due diligence list can be found in the **HR Framework.**

2.1.1 Employee Liability Information - *the following information should be collated by sending organisations and provided to receiving organisations at least 28 days prior to transfer*		CCG Close	ICB Set Up	Person Responsible	Start Date	End Date	New ICB Timeline Due Date	Rag Rating	Comments	Risk
2.1.1.1	Complete a people impact assessment to identify individual staff in scope of transfer in line with the Employment Commitment and TUPE/COSOP, including those on fixed term contracts and secondments and in Board level positions	Yes	Yes	Lisa Kelly	10/1/2021	2/28/2022		Green	People impact assessment including identification of those on secondments and fixed term posts has been completed and is updated on a regular basis to reflect starters and leavers. All FTC and secondments have been reviewed to reflect the extended timescales **COMPLETE**	
2.1.1.2	Identity age of employees in scope of transfer	Yes		Lisa Kelly	10/1/2021	5/31/2022		Green	Those who are in scope of transferring have been identified as part of the people impact assessment and will be included in the employee liability information to be provided 28 days before transfer **COMPLETE**	
2.1.1.3	All the written information contained in the transferring employees contract of employment (written particulars)	Yes		CCG	10/1/2021	5/30/2022		Green	CCG are currently undertaking an audit of personnel files to ensure that contractual information is included in files **COMPLETE**	Risk is that action to adderss any issues coming out of the review are not concluded by the transfer date
2.1.1.4	Details of any formal disciplinary action being taken against transferring employees in the last two years	Yes		Lisa Kelly	10/1/2021	5/31/2022		Green	Information is currently collected and monitored by HR. Final position will be provided as part of the employee liability information. Template at 2.2 has been uploaded into ESR and will be populated by CSU by 31/03/2022. During April payroll will upload payroll fields. In May the HR team will upload manual elements and complete a series of checks to ensure that the data is complete before sharing with the ICB on 1 June 2022. **COMPLETE**	
2.1.1.5	Details of any formal grievances raised by the transferring employee in the last two years	Yes		Lisa Kelly	10/1/2021	5/31/2022		Green	Information is currently collected and monitored by HR. Final position will be provided as part of the employee liability information. Template at 2.2 has been uploaded into ESR and will be populated by CSU by 31/03/2022. During April payroll will upload payroll fields. In May the HR team will upload manual elements and complete a series of checks to ensure that the data is complete before sharing with the ICB on 1 June 2022. **COMPLETE**	
2.1.1.6	Details of any legal action brought, or that there is a reasonable belief may be brought, against the sending organisation by any transferring employee in the last 2 years	Yes		Lisa Kelly	10/1/2021	5/31/2022		Green	Information is currently collected and monitored by HR. Final position will be provided as part of the employee liability information. Template at 2.2 has been uploaded into ESR and will be populated by CSU by 31/03/2022. During April payroll will upload payroll fields. In May the HR team will upload manual elements and complete a series of checks to ensure that the data is complete before sharing with the ICB on 1 June 2022.**COMPLETE**	
2.1.1.7	Information about collective agreements that will have affect after the transfer	Yes		Lisa Kelly	10/1/2021	5/31/2022		Green	Information is currently collected and monitored by HR. Final position will be provided as part of the employee liability information. Template at 2.2 has been uploaded into ESR and will be populated by CSU by 31/03/2022. During April payroll will upload payroll fields. In May the HR team will upload manual elements and complete a series of checks to ensure that the data is complete before sharing with the ICB on 1 June 2022. **COMPLETE**	
2.1.1.8	Total number of temporary or agency workers working for the sender including details of the work they do	Yes		CCG	10/1/2021	4/30/2022		Green	Finance to provide details of any temporary and interim staff who are not engaged via the CCG's payroll and details of their term and work they do will be included as part of the information sent to the ICB. HR are currently in contact with finance to obtain this data. **COMPLETE**	No risks identified to date
2.1.2 Other due diligence Information to support the transfer of staff - *the following information should be collated by sending organisations to provide further helpful due diligence information about transferring employees that will support the safe and effective transfer of staff*		CCG Close	ICB Set Up	Person Responsible				Rag Rating	Comments	
2.1.2.1	Details of active employee benefit schemes and who participates (examples include lease cars, salary sacrifice schemes, etc - see tab 3.3 for more information)	Yes	Yes	Lisa Kelly	10/1/2021	4/30/2022		Green	Information is currently collected and monitored by HR. Final position will be provided as part of the employee liability information. Template at 2.2 has been uploaded into ESR and will be populated by CSU by 31/03/2022. During April payroll will upload payroll fields. In May the HR team will upload manual elements and complete a series of checks to ensure that the data is complete before sharing with the ICB on 1 June 2022.**COMPLETE**	
2.1.2.2	Details of ongoing training commitments/ funding and agreed time off to study for transferring employees	Yes		CCG/HR	10/1/2021	4/30/2022		Green	Information has been requested from line managers via a checklist with guidance on what information needs to be provided. Confirmation of information collected from each team will be sent back to line managers who will be asked to sign their submission off as correct for their team.**COMPLETE**	
2.1.2.3	Creation of a bank of active job descriptions	Yes		CCG/HR	10/1/2021	4/30/2022		Green	HR are currently undertaking an exercise of the job descriptions that they hold on behalf of the CCG. The data held will be sent to the CCG for them to formalise a final set of all job descriptions. **COMPLETE**	
2.1.2.4	Creation of a bank of employment policies identifying those that are contractual and non contractual	Yes		Lisa Kelly	10/1/2021	2/28/2022		Green	Work has been completed on contractual and non contractual policies and a final position will be provided as part of the employee liabiity information **COMPLETE**	
2.1.2.5	Details of any flexible working arrangements, whether contractual or custom and practice	Yes		CCG	10/1/2021	4/30/2022		Green	Information has been requested from line managers via a checklist with guidance on what information needs to be provided. Confirmation of information collected from each team will be sent back to line managers who will be asked to sign their submission off as correct for their team. **COMPLETE**	No risks identified to date
2.1.2.6	Any other custom and practice arrangements not already identified that transferring employees may reasonably believe will continue such as any variations to regular pay dates and agreements around annual leave accrual	Yes		CCG	10/1/2021	4/30/2022		Green	Information has been requested from line managers via a checklist with guidance on what information needs to be provided. Confirmation of information collected from each team will be sent back to line managers who will be asked to sign their submission off as correct for their team. **COMPLETE**	No risks identified to date
2.1.2.7	Identify individual pension arrangements including NHS Pensions and opt out provisions such as NEST. Pension providers will need to be informed of any changes of employer	Yes		Payroll	10/1/2021	5/31/2022		Green	Information is currently held by payroll and will be uploaded to the employee liability information during April when the payroll data is added **COMPLETE**	
2.1.2.8	Summary of accrued annual leave for transferring employees and agreements around carry forward (including the method of calculation)	Yes		CCG/HR	1/1/2022	5/31/2022		Green	Carry over is limited to 5 days only (pro rata) and is only allowed due to extenuating circumstances.. All carry over is reported to finance so information will be obtained directly from finance.**COMPLETE**	
2.1.3 Due diligence activity to support the transfer of staff - *the following activity will support sending and receiving organisations to prepare for*		CCG Close	ICB Set Up	Person Responsible				Rag Rating	Comments	
2.1.3.1	Develop a management of change business case in preparation for formal information and consultation with staff in scope of transfer	Yes		Lisa Kelly	4/4/2022	5/6/2022		Green	Document is complete and available to start consultation on 4 April 2022. Consultation incudes a process for communicating to all staff in scope including those ICB staff who are currently not engaged by the CCG. Those on maternity leave and long term sick leave will be identified and contacted directly by line maagers to ensure they recieve the same information as staff currently in work. **COMPLETE**	No risks identified
2.1.3.2	Identification of potential measures that ICS envisage making in relation to transferring employees. This could include, but is not limited to, anticipated base, line management or pay date changes, as well as Board level roles	Yes	Yes	Lisa Kelly	4/4/2022	4/29/2022		Green	Will be included in the consultation document **COMPLETE**	No risks identified
2.1.3.3	Schedule information and consultation activity with transferring staff and their representatives in good time prior to the date of transfer, ideally at the beginning of Q4 of 2022. This will include identifying employee representative and partnership working groups through which	Yes	Yes	Lisa Kelly	10/1/2021	6/30/2022	4/4/22 start and end 06/05/22	Green	Engagement with trade union represenatives has already started and will be ongoing until after the date of transfer. Revised dates for onsultation are from 4/4/2022 until 29/04/2022 **COMPLETE**	No risks identified
2.1.3.4	Conduct an initial equality impact assessment (EQIA) to assess the potential impact of the proposed changes on transferring staff groups, including those with protected characteristics	Yes	Yes	CCG/HR	10/1/2021	28/02/022		Green	**COMPLETE**	No risks identified
2.1.3.5	Conclude consultation with transferring staff prior to the transfer date	Yes	Yes	CCG	4/4/2022	5/6/2022	5/6/2022	Green	Consultation will concluded on 06/05/2022. **COMPLETE**	No risks identified
2.1.3.6	Determine current service providers for key people services for payroll, occupational health, expenses, employee assistance and whether they will roll forward or cease at the point of transfer	Yes	Yes	CCG	1/1/2022	3/31/2022		Green	Current contracts to transfer to the ICB. **COMPLETE**	No risks identified
2.1.3.7	Establish arrangements for the identification, transfer and retention of staff records in line with the NHS Records Management Code of Practice	Yes	Yes	CCG	10/1/2021	6/30/2022		Green	This work has largely been compleetd with some departments still to confirm full check of personnel files due to limited resources. Work will be completed by 31st August 2022	Risk is that capacity of line managers is limited
2.1.3.9	Complete the ESR IBM data collection template to identify the changes required within ESR to establish the ICS ESR VPD taking the existing CCG VPD structures into account. Submission will generate the allocation of a merge event within the IBM programme calendar from [see dates in the ICB Establishment Timeline] (also included on financial governance tab 3.1)	Yes	Yes	Jason Howle (MLCSU)/Maria Tongue	12/1/2021	5/31/2022		Green	Separate workforce / payroll group set up with the CCG to capture these elements **COMPLETE**	No risks identified
2.1.3.10	Produce a plan for payroll migration in line with the guidance on ESR transition for ICS to include plans to establish PAYE tax references for the ICS (also included on financial governance tab 3.1)	Yes	Yes	Jason Howle (MLCSU)/Maria Tongue	12/1/2021	5/31/2022		Green	Separate workforce / payroll group set up with the CCG to capture these elements **COMPLETE**	No risks identified
2.1.3.11	Ensure process in place to produce and submit end of year taxation returns (P11D and P60) (also included on financial governance tab 3.1)	Yes		Jason Howle (MLCSU)/Jane Boon	12/1/2021	3/31/2022		Green	Separate workforce / payroll group set up with the CCG to capture these elements **COMPLETE**	No risks identified
2.1.3.12	Agree a set of core employment policies and employment terms that will apply to new recruitment within the ICS. It is noted that existing contracts and HR policies for existing staff will transfer		Yes	Lisa Kelly	2/1/2021	6/30/2022			New set of policies to be created for the ICB	

SUBJECT TO THE PASSAGE OF THE HEALTH AND CARE BILL THROUGH

2.2 CCG HR DUE DILIGENCE CHECKLIST: STAFF TRANSFER, EMPLOYEE LIABILITY AND DUE DILIGENCE CHECKLIST
(Supports tab 2.1 and provides a template to capture individual level staff information - Note share anonymised data only)

This form provides a template for sender organisations to provide employee liability information (ELI) (and broader due diligence) to facilitate the safe transfer of staff to receiving organisations, in this case Integrated Care Systems. It is designed so that individual employee details can be populated below each field. It is a legal requirement under the Transfer of Undertakings (Protection of Employment) Regulations (TUPE) or those actions required under the Cabinet Officer Statement of Practice (COSoP) guidance for ELI information to be provided at least 28 days prior to the transfer date, but organisations are encouraged to share anonymised information as early as possible to enable both parties to make preparations for transfer.

NOTE: This information MUST be provided either by completing tab 2.2, or in another form using the same data fields as outlined on tab 2.2. and adding local data fields as necessary.

Name of ICB:	
Name of CCG(s):	
Date:	
Completed by:	
Contact details:	

| | 1. Employing Organisation | 2. Employee Relevant data | | | | | | 3. Contractual Terms | | | | | | | | | 4. Pay and Financial arrengements | | | | | | | | | | | | | | | 5. Job Info - Location / Line Manager | | | | | 6. Personal Data | | | | | | | | | | | | | | | 7. Pension Scheme | | 8. Other Data | | | | | | | | | | | | | | | 9. Other Leave Information | | | | |
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SUBJECT TO THE PASSAGE OF THE HEALTH AND CARE BILL THROUGH PARLIAMENT

3.1 FINANCIAL DUE DILIGENCE CHECKLIST: Financial Governance

The organisation needs to provide assurance to the Board and Audit Committee that appropriate arrangements are in place to closedown the accounts and financial systems of the entity by 30 June 2022.
The organisation should also ensure it has robust working papers for the new body. It should also ensure appropriate arrangements for archiving of financial and accounting records for the appropriate retention period.

V4

		Suggested Actions *A number of due diligence activities relate to ICBs, many of which are subject to NHSEI guidance under development and are included at this time as 'placeholders' only - they are shaded grey*	CCG close down	ICB setup	Person Responsible	Start Date	End Date	New ICB Timeline Due Date	RAG	Comments	Risk
Accounts	3.1.1	Identify the process / board / people (eg ICB Finance Director & Chief Executive) who will sign off the CCG accounts	Y	Y	Maria Tongue/Alison Smith	3/1/2022	4/30/2022		Green	Meetings scheduled for audit committee to review draft accounts in April and June and process established for full sign-off of audited accounts in June for 21/22 accounts. National guidance awaited re CCG 3 month accounts.	No risks identified
	3.1.2	Produce as many documents / briefings as practical which form part of the statutory accounts prior to the year end. As a minimum, this should include all Directors Statements, Governance Statement and an initial draft of the annual report.	Y		Maria Tongue/Alison Smith	12/2/2021	5/1/2022		Green	Plan shared with Audit Committee of sign off of accounts and draft accounts and annual report is being shared with the Audit Committee in April	No risks identified
	3.1.3	If key staff leave before the CCG(s) close, robust exit management arrangements should be employed to retain and manage vital business knowledge in relation to accounts preparation and assets and liabilities.	Y		Maria Tongue	11/1/2021	6/30/2022		Green	All staff will TUPE over to the new organisation on 1st April 2022 so risk is minimal. Any changes in staffing outside of this process will need to be addressed if & when they arise	2 members of FA team leaving Nov 21. Risk to month 9 & year-end accounts process.
Planning	3.1.4	Ensure the finance project plan is closely aligned to other transition project plans with interdependencies clearly identified.	Y	Y	Maria Tongue	10/1/2021	6/30/2022		Green	Plan aligns with ESR/payroll project plan and SBS (ledger) project plan & regular meetings have been set-up to monitor this.	No risks currently identified
	3.1.5	Ensure there are clear terms of reference for any local transition group	Y		Maria Tongue	10/1/2021	10/13/2021		Green	ToR outlined for SBS (ledger) project group which forms the majority of the work for finance	No risks currently identified
	3.1.6	Ensure each aspect of the closedown plan is risk assessed monthly and reported through local transition governance arrangements as well as the audit committee/finance committee	Y	Y	Alison Smith	11/1/2021	5/12/2022		Green	Feeds into overall due diligence plan and is reported to audit committees; there will be internal audit presence on the panel at planned due diligence panel dates	No risks identified
	3.1.7	Agree how all of the governing bodies involved will be informed of progress against the project plan so they can act in an integrated way. This may be through a committee structure or an individual post (for example, the chair, governing body secretary or company secretary)	Y		Alison Smith	11/1/2021	5/12/2022		Green	Completed. Only one CCG Governing Body involved therefore risk is significantly reduced. Due Diligence work feeds into overall due diligence plan and is reported to audit committees bi monthly and teh ICB Transition Steering group on a monthly basis; there will be internal audit presence on the panel at planned due diligence panel dates; audit committee and internal audit have seen and approved the due diligence proposal paper Progress reported to the CCG Govenring Body Infomal meeting in February 2022	No risks identified
	3.1.8	Agree and implement robust assurance arrangements including internal and external audit plans		Y	Laura Clare	12/1/2021	6/30/2022		Green	Internal and external audit plans approved at audit committee	Low risk around securing an external audit provider for the new organisation - procurement under way
V4 Audit Committee	3.1.9	Ensure that the audit committee meetings are scheduled in line with the requirements of the business, including one very close to the 30 June 2022 to provide an appropriate formal closure report. Schedule meetings for approval to submit draft and final accounts and report.	Y		Maria Tongue/Alison Smith	2/1/2022	4/30/2022		Green	Completed - see 3.1.1 above	No risks currently identified
Working files	3.1.10	The asset and liability handover process should • include set up of initial handover file, fully indexed that can hold information as soon as is relevant/is available; • include copies of original relevant documents and details of where originals are held; • identify future accounting/management requirements for the asset or liability; • include documentation of estimates, assumptions and judgements. Documentation should be held in accordance with guidance on retention of records.	Y		Maria Tongue	10/1/2021	6/30/2022		Green	Will be completed as part of work with SBS on the ledger transition. Process was robust for the CCG merger work and a similar process will be followed.	No risks currently identified
Payroll and ESR	3.1.11	Complete the ESR IBM data collection template to identify the changes required within ESR to establish the ICS ESR VPD taking the existing CCG VPD structures into account. Submission will generate the allocation of a merge event within the IBM programme calendar from May 2022 onwards (also included on HR tab 2.1)	Y	Y	Jason Howle (MLCSU)/Maria Tongue	4/1/2022	6/30/2022		Green	Regular meetings being held with HR to discuss progress & ensure key deadlines are met. First SR raised 1/4/22 in line with detailed plan.	No risks currently identified
	3.1.12	Produce a plan for payroll migration in line with the guidance on ESR transition for ICS to include plans to establish PAYE tax references for the ICS (also included on HR tab 2.1)	Y	Y	Jason Howle (MLCSU)/Maria Tongue	10/1/2021	7/1/2022		Green	Regular meetings being held with HR to discuss progress & ensure key deadlines are met. Indicative amended date for requesting PAYE number from HMRC is 1st July and deadline for re-registering for CT61 returns is 1st July.	No risks currently identified
	3.1.13	Ensure process in place to produce and submit end of year taxation returns (P11D and P60) (also included on HR tab 2.1)	Y	Y	Jason Howle (MLCSU)/Jane Boon (MLCSU)				Green	Separate workforce / payroll group set up with the CCG to capture these elements	No risks currently identified
Internal Audit	3.1.14	Ensure internal audit have representation on transition working groups.	Y	Y	Laura Clare/Alison Smith	10/1/2021	5/12/2022		Green	Completed	No risks currently identified
	3.1.15	Seek internal audit comment on the adequacy of transition plans. Internal audit plans should have some focus on the key risks associated with cessation, and verify that appropriate internal controls are in place. IA plan should specifically considers risks of fraud during transition and recommendations have been acted upon.	Y	Y	Laura Clare/Alison Smith	11/1/2021	3/31/2022		Green	Completed	No risks currently identified
Risk Management	3.1.16	Review, revise and agree a risk management strategy, policy and procedures. This must include an approach to setting an agreed risk appetite and identifying, evaluating and managing risks. Mechanism for risk share across organisations to be agreed.		Y	Alison Smith	11/1/2021	7/22/2022		Amber	Good Governance Institute will faciliatate two workshop sessions on risk management in an ICS, developing a risk appetite and Baord Assurance Framework in Autumn. With a Risk Management Policy being developed fro approval at Audit Committee in January 2023.	There is a risk around timeframes and capacity
Declarations	3.1.17	Establish transparent arrangements for declarations, including: - - register of gifts and hospitality - register of interests		Y	Alison Smith/Tracey Eggby Jones	10/1/2021	5/12/2022	9/30/2022	green	Completed. A register of interests for the ICS Board has already been developed and is presented to their Board meetings and publically available on their website. A Conflicts of Interest Policy and Standards of Business Conduct Policy have been agreed by the Board.	No risks currently identified
Business Plan	3.1.18	Assess the financial impact of the strategic objectives and business plan for the new ICB		Y	Claire Skidmore	11/1/2021	4/28/2022		Green	22/23 system financial plan submitted on 20th June 2022. Plan deadlines met but plan is not compliant with national guidance as £19m system deficit planned. Financial plan includes mapping financial implications of the system plan narrative and prioritisation of all cost pressures/investments. Next step is to refresh the longer term system plan that was presented to Boards in Sept 21 for the 22/23 update but also the next 3,5 and 10 years	Current risk as plan does not meet national expectation of break even. Risk around efficiency and system transformational plan delivery. ICB will inherit a deficit plan from CCG
Budgets	3.1.19	Budgets and contracts will need to be agreed for the ICB (essentially before the 1 July), agree how this will happen ensuring the required governance is in place. This should also be reflected on the risk register. [Note the need to agree budgets and contracts for the CCG before 1 April for 3 months and for the ICB before 1 July for 9 months]		Y	Claire Skidmore	11/1/2021	3/31/2022		Green	22/23 system financial plan submitted on 20th June 2022. Plan deadlines met but plan is not compliant with national guidance as £19m system deficit planned. Finance committee sign off of budgets in line with plan in April 2022 with subsequent issue to budget holders before M2 reporting (May 2022). Budget holders/directors actively involved in plan development. Work underway to map 22/23 budgets to new director portfolios but budget managers will not change immediately on transfer. ***Also see comments in submission from Contracts team***	Budgets will not be agreed and signed off until 1.5 months into the financial year due to the timing of the planning round
V4 CCG Functions	3.1.20	Map all existing CCG functions	Y	Y	Alison Smith	11/1/2021	2/28/2022		Green	Functions and duties map received from Browne Jacobson Solicitors to use by the CCG to capture as a full list.	No risks currently identified
V4	3.1.21	Map all existing CCG Statutory Duties	Y	Y	Alison Smith	11/1/2021	2/28/2022		Green	Functions and duties map received from Browne Jacobson Solicitors to use by the CCG to capture as a full list.	No risks currently identified
V4	3.1.22	Liaise through ENGLAND.SMTinfo@nhs.net to provide PCSE with the GP Pensions information and authorised user list ensuring aligned to organisational standard financial instructions			Maria Tongue	12/1/2021	5/31/2022		Green	Will be addressed as part of the SBS transition plan	No risks currently identified
	3.1.23	Liaise through ENGLAND.SMTinfo@nhs.net to provide PCSE with the GP Pensions information and authorised user list ensuring aligned to organisational standard financial instructions			Maria Tongue	12/1/2021	4/22/2022		Green	Initial information sent March 2022	No risks currently identified
V3 Stationery	3.1.24	Destroy old corporate stationery including blank cheques / blank POs. Retain evidence for audit purposes. Inform suppliers and users of address for invoices / queries. [this prompt is repeated on tab 4.0 to ensure that all prompts associated with records management are in one place]	Y		Maria Tongue/MLCSU	12/1/2021	5/31/2022		Green	Included within the transition plan with the CSU/SBS	No risks currently identified

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3.2 FINANCIAL DUE DILIGENCE CHECKLIST: Accounts and audit

The organisation needs to ensure the 2021/22 annual accounts are in a position to be produced and audited within given timescales and to a satisfactory level to provide information for the new organisation.

			Suggested Actions *A number of due diligence activities relate to ICBs, many of which are subject to NHSEI guidance under development and are included at this time as 'placeholders' only - they are shaded grey*	CCG close down	ICB setup	Person Responsible	Start Date	End Date	New ICB Timeline Due Date	RAG	Comments	Risk
	Annual report and Accounts	3.2.1	Produce and agree a timetable for completing all sets of annual report and accounts and the required resourcing of the process. This timetable should cover the whole of the process including the annual report, governance statement, accountable/ accounting officers' statements and audit as well as the preparation of the accounts. - Ensure key individuals are identified with appropriate knowledge and skills (assess the need for temporary staff) - Signing of the Accounts & Annual Report arrangements - continuing body sign off requirement (identify individuals) - Brief the Governing Body & Audit Committee of the demising organisation & new organisation on their responsibilities - AGM arrangements - Identification of assurances required for the new organisation from the demising organisation - Ensure that any necessary information is obtained to prepare final accounts (for example, information relating to pensions for the remuneration report). In particular, consider whether appropriate information is available relating to demising bodies and the members of their governing bodies Ensure that the resourcing of this process is agreed	Y	Y	Maria Tongue/Alison Smith	4/1/2022	6/30/2022		Green	Completed	No risks currently identified
		3.2.2	Review guidance from all appropriate regulatory bodies to ensure that all of the necessary documents are produced in the correct format. This includes: • the governance statement • the remuneration report • staff report • quality report	Y		Edna Boampong/Alison Smith	1/1/2022	4/20/2022		Green	Completed	No risks currently identified
	External Auditors	3.2.3	Consider whether external auditor contracts can and / or should be rolled over or whether the contract should be subject to tender. Agree handover arrangements between the outgoing auditors and the new auditors (re pre-ICB accounts / opening balances) - if required	Y	Y	Maria Tongue	11/1/2021	3/31/2022		Green	Tender process complete to appoint new auditors. Existing contract terminates 30/06/22 - new contract to be formally approved by meeting of ICB on 1st July 2022	No risks currently identified
		3.2.4	Ensure that links exist and work between external and internal audit	Y		Maria Tongue	11/1/2021	3/31/2022		Green	Teams have worked together over the last several years and links are well established. Re-tendering process for new external auditors included questions around liaison with internal audit.	No risks currently identified
		3.2.5	Discussion with the external auditors should include: - confirmation that the necessary work has been completed prior to the dissolution of the CCGs - what evidence they require from both the old and the new bodies	Y		Maria Tongue	1/1/2022	5/31/2022		Green	Discussed with external auditor as part of interim audit work in Jan/Feb 2022. Will be continued during main audit in April/May	No risks currently identified
		3.2.6	Agree an external audit schedule/plan and timetable for working papers production with the external auditors. The organisation should ensure that the pre-accounts interim audit focuses on areas that will reduce the workload during the final accounts audit.	Y		Maria Tongue	TBC	TBC		Green	Awaiting national guidance regarding timing of the audit of the CCG's 3 month accounts.	No risks currently identified
		3.2.7	Discuss with all auditors what third-party assurances they will require and arrange for those to be provided by the appropriate auditor. Ensure that appropriate external assurances (for example the service auditor report on SBS, ESR and local shared service providers) are received for any systems used prior to the establishment of the ICB by any of the bodies involved even if the system is not used by the new body/bodies	Y		Maria Tongue	1/1/2022	5/31/2022		Green	Process well established for receiving SARs in respect of ESR/GP payments/SBS/CSU and this will operate as normal for the 21/22 financial year. Awaiting national guidance regarding this for the CCG's 3 month accounts.	No risks currently identified
		3.2.8	Ensure that the external auditors for the dissolving CCG and establishing ICB are notified of the change in Accountable Officer and Finance Director			Maria Tongue	12/1/2021	3/31/2022		Green	Complete	No risks currently identified
	Internal Auditors	3.2.9	Consider internal audit work both before and after the establishment of the ICB in the light of the risks that it poses and adjust the nature and timing of work accordingly	Y	Y	Laura Clare	11/1/2021	3/31/2022		Green	Discussed regularly with inernal auditors as part of plan review in year, flex plans according to need	None identified
		3.2.10	Make arrangements for a Head of Internal Audit opinion to be signed in relation to all closing accounts	Y		Maria Tongue	2/1/2022	TBC		Green	HoIA process in place for CCG 21/22 accounts. Awaiting national guidance re completion of CCG 3 months accounts & AR	No risks currently identified
		3.2.11	Review outstanding Internal Audit actions and ensure that responsibility for their completion is transferred to the ICB	Y	Y	Maria Tongue	9/1/2021	6/30/2022		Green	Monitoring process already established	No risks currently identified
		3.2.12	Ensure that Internal Audit is involved in reviewing proposed new systems prior to implementation & that there is audit review of new systems once implemented	Y	Y	N/A				Green	N/A - systems will remain the same with data being transferred over	
V2	Fraud	3.2.13.1	Ensure the ICB has an accredited and nominated Local Counter Fraud Specialist (LCFS) with full access to NHS Counter Fraud Authority (NHSCFA) guidance, intelligence and case management systems.	Y	Y	Laura Clare	11/1/2021	3/31/2022		Green	IA contract incs counter fraud services and named LCFS. Contract will be novated to ICB	None identified
V2		3.2.13.2	Ensure appropriate handover arrangements are in place between CCG and ICB LCFSs to ensure: -continuity and progression of reactive work; including investigations, sanctions and recoveries -the ICB LCFS receives all relevant information from the CCG LCFS to inform ICB LCFS work plan	Y	Y	Laura Clare	11/1/2021	3/31/2022		Green	(see above)	None identified
V2		3.2.13.3	Ensure an agreed LCFS work plan is in place which should include (not exhaustive): -consideration of proactive work both before and after the establishment of the ICB in the light of the risks that it poses and adjust the nature and timing of work accordingly. -fraud risk assessment activity considering increased risk of fraud and asset loss during times of change (this is a major risk on reorganisation). -appropriate action to ensure compliance with the NHS Requirements of the Government Functional Standard GovS013 Counter Fraud	Y	Y	Laura Clare	11/1/2021	3/31/2022		Green	21/22 LCFS plan in place and available to view, will review 22/23 plan early in new financial year	None identified
		3.2.14	Set up account for National Fraud Initiative (NFI)		Y	Laura Clare	11/1/2021	3/31/2022		Green	Account will novate across - will check name change actioned etc	None identified
	Records	3.2.15	Establish arrangements for the identification, transfer and retention of financial and accounting records.	Y	Y	Maria Tongue	10/1/2021	6/30/2022		Green	All records are held on the secure, shared drive and this will still be in use in the ICB. The Finance team are working closely with IT & IG teams to ensure that any records to be archived are stored	No risks currently identified
V3		3.2.16	Ensure all appropriate records are kept, and emails are retained for any key staff that may leave during the transition period [this prompt is repeated on tab 4.0 to ensure that all prompts associated with records management are in one place]	Y		Maria Tongue	10/2/2021	6/30/2022		Green		No risks currently identified

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3.3 FINANCIAL DUE DILIGENCE CHECKLIST: Ledger, Financial and Cash Management

The organisation should put itself into a position to ensure all financial commitments and obligations are identified within budgets and appropriately accounted for within forecasts and the annual accounts.
The organisation should put itself into a position to ensure they have the required cash balances to meet creditor demands as they fall due and do not hold excessive cash balances at the year end.

			Suggested Actions *A number of due diligence activities relate to ICBs, many of which are subject to NHSEI guidance under development and are included*	CCG close down	ICB setup	Person Responsible	Start Date	End Date	New ICB Timeline Due Date	RAG	Comments	Risk
	Control Accounts	3.3.1	For all control accounts • All outstanding balances cleared (none greater than one month old wherever possible). • All accounts assigned to designated officer. • Supporting documents are attached to all items over one month old and clear, time-bound route to resolution identified. This should be reconciled to cash planning. Ensure all control account reconciliations have been completed. Document any reconciling balances in full so that they can be followed up	Y		Maria Tongue	4/1/2021	6/30/2022		Green	Control accounts completed monthly by CSU/SBS and reviewed by CCG Financial Accountant. 2nd review carried out quarterly by Associate Dir of Finance - Financial Accounting, Planning & Reporting	No risks identified
	Cashflows	3.3.2	Cash forecasts should be reviewed to ensure all constraints on cash have been factored, including any balance sheet items that may be expected to be cleared due to the closedown of the organisation. However, any change to cash requirements must be agreed. Prepare cash forecast for new entity.	Y	Y	Maria Tongue	4/1/2021	6/30/2022		Green	The CCG has a well established cash forecasting process. Cash forecast for April for ICB will be prepared in advance of the national deadline	No risks identified
		3.3.3	For cash purposes, consider any payments that may go out on the 30/06 or 01/07 to ensure fully factored into transitioning arrangements	Y	Y	Maria Tongue	10/1/2021	5/31/2022		Green	Consideration given & no payments identified. Will continue to be reviewed.	No risks identified
V4		3.3.4	Notify the NHSE cash funding team of the chief financial officer's name, the ICB's address and the GBS account number nhsenglandcash.management@nhs.net		Y	Maria Tongue	4/1/2022	4/29/2022	5/31/2022	Green	Will be submitted in line with national deadline	No risks identified
		3.3.5	Submit consolidated forecast for the new entity on a new CFF1 form nhsenglandcash.management@nhs.net		Y	Maria Tongue	6/1/2022	5/18/2022	5/18/2022	Green	Will be submitted in line with national deadline	No risks identified
		3.3.6	Appoint one cash manager with responsibility for overseeing cash management and establish systems to monitor implementation of cash action plan. Agree final reconciliation of bank accounts.	Y	Y	Maria Tongue	4/1/2021	6/30/2022		Green	Already established. Bank account recs completed by SBS.	No risks identified
	Working Papers	3.3.7	Establish arrangements to prepare full working papers with back up documentation	Y		Maria Tongue	4/1/2021	6/30/2022		Green	Already established.	No risks identified
		3.3.8	Reconcile opening balances to year end accounts		Y	Maria Tongue	TBC	TBC		Green	Awaiting national guidance re completion of 3 month CCG accounts	No risks identified
		3.3.9	For accruals, ensure that a full list of accruals carried forward from the CCGs has been documented and that all accruals are matched to the ICB's payment system so they can be written off as they are paid	Y		Maria Tongue	6/1/2022	7/31/2022		Green	Will be completed as part of the CCG 3 month accounts process	No risks identified
		3.3.10	For prepayments, undertake a detailed review and ensure robust working papers are in place (ensure the good/service which has already been paid for is received in the future)	Y		Maria Tongue	6/1/2022	7/31/2022		Green	Will be completed as part of the CCG 3 month accounts process	No risks identified
		3.3.11	For deferred income, undertake a detailed review and ensure robust working papers are in place	Y		Maria Tongue	6/1/2022	7/31/2022		Green	Will be completed as part of the CCG 3 month accounts process	No risks identified
		3.3.12	For provisions, and any contingent liabilities, undertake a detailed review and ensure robust working papers are in place	Y		Maria Tongue	6/1/2022	7/31/2022		Green	Will be completed as part of the CCG 3 month accounts process	No risks identified
		3.3.13	Review the annual leave accrual	Y		Maria Tongue	3/1/2022	6/30/2022		Green	Annual leave calculated and accrual amended for 21/22 year-end. Further guidance awaited for CCG 3 month accounts.	No risks identified
		3.3.14	Consider any need for a redundancy provision, early retirement provisions or ill health retirement provisions - this should include any clinicians covered by the 2019/20 pension annual allowance charge compensation policy	Y		Maria Tongue	6/1/2022	7/31/2022		Green	Review and calculations complete for 21/22 year-end. Further guidance awaited for CCG 3 month accounts.	No risks identified
		3.3.15	Review the losses and special payments schedule in detail. Try to identify any transactions which could result in a loss or special payment at an early stage	Y		Maria Tongue	6/1/2022	7/31/2022		Green	Review and calculations complete for 21/22 year-end. Further guidance awaited for CCG 3 month accounts.	No risks identified
		3.3.16	Undertake a detailed review of suspense codes and clear them as necessary	Y		Maria Tongue	4/1/2022	6/30/2022		Green	Control accounts completed monthly by CSU/SBS and reviewed by CCG Financial Accountant. 2nd review carried out quarterly by Associate Dir of Finance - Financial Accounting, Planning & Reporting	No risks identified
		3.3.17	Ensure that all closing balances are appropriately transferred and complete a reconciliation between closing and opening balances to ensure that no balances are 'lost'. Ensure robustness of working papers to support.	Y	Y	Maria Tongue	7/1/2022	7/31/2022		Green	Will be completed as part of SBS transition plan	No risks identified
		3.3.18	Where multiple CCGs are merging to then form the ICB, consider producing a consolidated position to provide financial history/audit trail	N	N	N/A				Green	N/A	
	Procedures	3.3.19	Develop procedures and policy for: - travel expenses - training expenses - relocation - excess travel - lease cars - telephones incl mobiles - long service awards		Y	Alison Smith for existing CCG policies Claire Skidmore for Lease Car policy	11/1/2021	6/30/2022		Green	Many of these policies will be inherited by the ICB from the CCG as this is a requirement as part of equivalent TUPE transfer of staff - Training expenses - The CCG have a learning and development policy which covers training expenses - Travel expenses- STW CCG Excess Mileage and Additional Travel Guidance for Managers in place - STW CCG Excess Mileage and Additional Travel Guidance for Managers in place - long service awards - STW CCG Long Service Award policy in place - telephones and mobiles - In draft form (IT) - Relocation - Not a HR policy in place for this but will use the national rate determined by HMRC - Lease cars - Not offered at the moment therefore no policy required	Where policies do not exist - lease cars there is a risk that a decision is not made to create one prior to the 1/7/22.
		3.3.20	Create financial procedures manual including losses and compensations register (& system to maintain). Issue to staff, train staff as required: - payroll - expenses - entering into off-payroll arrangements - creditors - receivables including debt recovery - losses		Y	Maria Tongue	11/1/2021	5/31/2022		Green	Current CCG procedures were refreshed in 20/21 & will be reviewed for use in the ICB	No risks identified
		3.3.21	Prepare scheme of reservation and delegation (SoRD) for the ICB		Y	Maria Tongue	3/1/2022	5/31/2022		Green	Draft financial scheme of delegation completed March 2022. To be finalised May 2022	No risks identified
		3.3.22	Prepare SFIs for the ICB		Y	Maria Tongue	11/1/2021	5/31/2022		Green	Draft SFIs completed March 2022. To be finalised May 2022	No risks identified
	VAT	3.3.23	Inform HMRC of organisational change, obtain new VAT registration and VAT number, arrange submission of pre-ICB establishment VAT returns Recalculate partial exemption		Y	Maria Tongue	2/1/2022	27/05/2022 & 12/08/2022		Green	VAT1 form to be submitted to HMRC by 27/5/22 for new VAT No. Deadline for informing national team of submission of final CCG VAT is 12/08/2022	No risks identified
		3.3.24	Ensure the correct VAT number appears on all relevant stationery		Y	Maria Tongue/Laura Clare		5/27/2022		Green	Included within SBS transition plan	
	Budget Holders	3.3.25	Budget holders: - Agree budget holders for ICB (accountability framework) - Agree format and content of budget holder reports - Agree process and timetable for establishing base budgets (both revenue and capital) - note this will need to be done ahead of 1 July 2022 - Review budgeting assumptions and consider if they are still valid following the establishment of the ICB - Ensure that budget holders are aware of their budget responsibilities and arrange training as necessary - Amend budgets to reflect any changes in activity and resources resulting from discussions with commissioners / providers - Obtain approval of base budgets from the governing body [Note the need to agree budgets and contracts for the CCG before 1 April for 3 months and for the ICB before 1 July for 9 months]		Y	Angus Hughes	1/1/2022	4/30/2022		Green	Budget setting process being developed as part of the 22/23 plan. Budgets will be issued to all budget holders before the end of March for sign off in line with the plan submission. Budget holders are actively engaged with finance on the development of the plan and the corresponding budgets.	Budgets will not be agreed and signed off until 1 month into the financial year due to the timing of the planning round
V4	Franking	3.3.26	Review franking machine requirements and ensure facilities are in place		Y					N/A		
	SBS	3.3.27	Ensure that the necessary arrangements for access to ISFE have been made (access will be required to CCG(s) as well as ICB's ledgers). Set up the users for the new system	Y	Y	Maria Tongue	3/1/2022	6/30/2022		Green	To be completed as part of SBS transition plan	No risks identified
		3.3.28	Minor Works Order Raised detailing cost directly chargeable to the CCG	Y	Y	N/A				Green	N/A - cost be bourne centrally by NHSEI	
		3.3.29	To set up BI Super User Licences applications to be submitted to england.oraclequeries@nhs.net		Y	Maria Tongue	1/1/2022	5/30/2022		Green	To be completed as part of SBS transition plan	No risks identified
		3.3.30	Chart of Accounts mapping	Y	Y	SBS				Green	To be completed as part of SBS transition plan	
	Reporting	3.3.31	Define and set up standard reports for budgetary, statutory and management reporting (for ICB with timescales)		Y	Claire Skidmore					CCG current reporting will transition into ICB as startpoint. System reporting also currently in place for ICS level financial reports to sustainability committee. These will transfer into ICB but with a development trajectory to improve both the streamlining of production of these reports and format as the organisation develops	No risks identified
	Systems	3.3.32	Ensure superseded system(s) are maintained to enable the production of annual accounts for the accounting period prior to establishment of the ICB	Y		Maria Tongue/SBS	10/1/2021	6/30/2022		Green	To be completed as part of SBS transition plan	No risks identified
		3.3.33	Establish control procedures (for example, passwords, journal input etc)	Y		Maria Tongue	1/1/2022	6/30/2022		Green	To be completed as part of SBS transition plan	No risks identified
	Interface	3.3.34	Evaluate ability to interface with other potential systems (for example, payroll, payables, receivables, personnel, BACS, contracting, supplies, capital systems)		Y	SBS				Green		
	Plans	3.3.35	Prepare and agree an ICB financial plan		Y	Claire Skidmore		17/3/22 (draft), 28/4/22 (final)		Green	22/23 system financial plan submitt4ed on 28th April 2022. Plan deadlines met but plan is not compliant with national guidance as £38m system deficit planned. Financial plan includes mapping financial implications of the system plan narrative and prioritisation of all cost pressures/investments. Next step is to refresh the longer term system plan that was presented to Boards in Sept 21 for the 22/23 update but also the next 3,5 and 10 years	Current risk as plan does not meet national expectation of break even. Risk around efficiency and system transformational plan delivery. ICB will inherit a deficit plan from CCG
		3.3.36	Prepare and agree place based budgets		Y	Laura Clare		3/31/2022		Red	Action is dependent on place partnership set up and delegation agreed - unlikely to have budgets delegated at place level until 23/24	Risk that place will not be sufficiently developed for place level budget delegation to operate in 22/23
		3.3.37	Review the cost improvement programmes and determine a new programme for the ICB		Y	Kate Owen	11/1/2021	1/20/2022		Amber	22/23 efficiency programme included as part of 22/23 financial plan submission. At point of submission £1m of plans unidentified and £0.7m running cost efficiency badged as high risk. System transformation plan savings also inlcuded within system plan submission with £2.9m unidentified gap currently held in CCG position.	Risk that full efficiency programmes and system transformation savings will not be identified which will contribute to financial deficit of organisation and system
		3.3.38	Agree financial framework for distributing allocations across the ICB		Y	Laura Clare	4/1/2021	9/30/2021		Green	Initial financial framework agreed across system at Sept 21 governing bodies and system committees. IFP arrangements also agreed in principle. Development of more sophisticated funding flows will develop with the creation of provider collaboratives and place based partneships	No risks identified
		3.3.39	Produce a team structure to meet its identified role within agreed management cost envelope		Y	Laura Clare	11/1/2021	31/03/022		Amber	DoF level discussions regarding teams working closer together across the system commenced with various workstreams set up led by system deputies to explore options. Initial CCG structure to lift and shift into ICB but will be reviewed to develop system wide finance structure as other areas develop	Risk around capacity within existing finance team in CCG to pick up all system wide work
		3.3.40	Consult with NHSEI to: • agree new control totals for ICB • determine performance against previously agreed control totals		Y	Laura Clare	11/1/2021	6/30/2022		Amber	22/23 planning guidance released 24.12.21. System worked through detailed 22/23 financial plan development for final submission in June	Risk that system transfomation and organisational efficiencies will not be fully identified in order to meet control total
	Archive	3.3.41	Identify archive requirements and ensure that data/information is extracted and stored in an easy to access format. This also applies to all feeder systems to the ledger. Documentation should be held in accordance with guidance on retention of records.	Y		Maria Tongue	12/1/2021	3/31/2022		Green	Data is held on secure shared drive. The Finance team are working closely with IT & IG teams to ensure the appropriate records are archived securely and in accordance with guidance	No risks identified
	Timetable	3.3.42	Produce a timetable for ledger close-down	Y		Maria Tongue/SB	01/03/22	31/05/22		Green	To be completed as part of SBS transition plan	No risks identified
	HMRC	3.3.43	Ensure that documentation (for example, copies of the HMRC checklist) relating to off-payroll arrangements is archived and available in case of an HMRC visit. Documentation should be held in accordance with guidance on retention of records.	Y		Maria Tongue	01/03/22	31/03/22		Green	Process established. Review will be carried out in March	No risks identified
	New ledger	3.3.44	ICB will be required to use ISFE and the standard chart of accounts		Y	Maria Tongue	11/1/2021	3/31/2022		Green	Cost centres provided to CCG. Code combinations will be set-up by SBS as part of transition plan	No risks identified
		3.3.45	Ensure arrangements are in place for the transfer of closing balances from the old to the new system	Y	Y	Maria Tongue	Duplicate of 3.3.17			Green		
	Seal	3.3.46	Destroy existing CCG seal, ascertain if need new seal	Y	Y	Alison Smith/Tracy Eggby Jones	7/1/2022	7/15/2022		Green	Plan in place for destruction - must wait for CCG to be dissolved before the seal is destroyed. A new seal for the ICB has been ordered.	The new seal for the ICB has been arranged. No risks identified.
	Functions	3.3.47	Determine the role and responsibilities of each of the new functions within the new management structure within the ICB, to include: - Corporate - Commissioning - Contracting - CHC/individual personal commissioning - Finance - Business intelligence		Y	Alison Smith/Nicky O'Connor	11/1/2021	5/12/2022		Green	ICB CE has released a structure showing new ICB Exec Director roles and how CCG functions will sit within each portfolio.	
	Capital	3.3.48	Agree a framework for capital prioritisation and allocation across the system		Y	Claire Skidmore		6/30/2022		Amber	Initial capital meeting due to be held August/early September; process of incorporating capital into overall prioritisation process (part of the evolution of the investment panel) is in place; infrastructure is in place and the prioritisation framework will be there in time for the planning round.	No risks identified
	CEfF	3.3.49	Consider arrangements for CEfF (Controlled Environment for Finance) to review detail on invoices https://www.england.nhs.uk/wp-content/uploads/2019/01/ccg-CEfF-compliance-statement-v1-4.pdf		Y	Maria Tongue/ ML CSU					Currently in operation through MLCSU	
	Costs	3.3.50	Keep track of all costs associated with the transition e.g. interim support costs, website etc	Y	Y	Mark Ward	9/1/2021	6/30/2022		Green	All costs are being recorded against a separate cost centre	No risks identified
	P2P	3.3.51	Purchase to Pay: - Supplier template - NHS supplies - Locations template - Purchasing Positions template - Catalogue template - Non PO rules template - Payment configuration form - Vendor notifications		Y	Maria Tongue/MLCSU/ SBS	11/1/2021	6/30/2022		Green		No risks identified
	O2C	3.3.52	Order to Cash: - Customer data - Receivable items - Receivable activities - Sales Person template		Y	Maria Tongue/MLCSU/ SBS	11/1/2021	6/30/2022		Green		No risks identified

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3.4 FINANCIAL DUE DILIGENCE CHECKLIST: Banking Arrangements

The CCG should look to close all bank accounts and open a new Government Banking Service Account for the new organisation

			Suggested Actions *A number of due diligence activities relate to ICBs, many of which are subject to NHSEI guidance under development and are included at this time as 'placeholders' only - they are shaded grey*	CCG close down	ICB setup	Person Responsible	Start Date	End Date	New ICB Timeline Due Date	RAG	Comments	Risk
V4	Bank Accounts	3.4.1	Ensure plans are in place to list and close all CCG bank accounts and set up new account for ICB. Obtain closing of bank account in writing. Write to RBS/Government Banking Service (GBS). Arrange for redirections to be in place.	Y	Y	Maria Tongue	12/1/2021	4/30/2022		Green	Existing CCG bank account will be renamed and become ICB bank account. Letter sent to GBS 24/03/22 in line with national deadline	No risks identified
		3.4.2	Identify all GBS accounts and list authorised signatories. Ensure that arrangements in place to manage transfer. Complete new bank mandates.		Y	Maria Tongue	12/1/2021	7/31/2022		Green	(see above) Bank mandates have been reviewed & updated where applicable.	No risks identified
		3.4.3	The issue of all cheques from CCG accounts to cease no later than 30 June 2022 (agree treatment of outstanding cheques, POs etc)	Y		Maria Tongue	3/1/2022	6/30/2022		Green	Will be covered in SBS transition plan	No risks identified
		3.4.4	Ensure continuity of existing BACS and transition to new BACS arrangements - identify payment run dates (especially GP payments)	Y	Y	Maria Tongue	1/1/2022	6/30/2022		Green	Covered in SBS transition plan and payment run dates have been fixed for 22/23 to include GP payments	No risks identified
		3.4.5	Inform any non-NHS bodies which pay electronically of the new bank details		Y	Maria Tongue	1/1/2022	6/30/2022		Green	Will be covered in work with SBS/CSU	No risks identified
		3.4.6	Inform suppliers of change in organisational structure and new payment arrangements (experience shows that this process should be started early and at least two letters should be sent). Inform suppliers that any debts will be pursued by the new organisations and balances will be paid by the new organisation		Y	Maria Tongue	1/1/2022	6/30/2022		Green	Will be covered in work with SBS/CSU	No risks identified
		3.4.7	Inform suppliers of the final date for sending invoices to the CCG(s)	Y		Maria Tongue	1/1/2022	4/30/2022		Green	Will be covered in work with SBS/CSU	No risks identified
		3.4.8	Contact customers who pay by standing order to request pay to new bank account	Y		Maria Tongue	1/1/2022	5/31/2022		Green	Will be covered in work with SBS/CSU	No risks identified
		3.4.9	Check for any payments which currently interact directly into the ledgers, such as Personal Health Budgets (PHB) payments, and flag to SBS	Y		Maria Tongue	1/1/2022	5/31/2022		Green	Will be covered in work with SBS/CSU	No risks identified
		3.4.10	Contact suppliers submitting invoices electronically via Tradeshift to ensure connections are made to the new organisation. Liaise with SBS e-invoicing team - SBS-W.e-invoicingqueries@nhs.net to ensure a smooth transition	Y	Y	Maria Tongue	1/1/2022	5/31/2022		Green	Will be covered in work with SBS/CSU	No risks identified
		3.4.11	Agree a final date for paying invoices from the 'old' CCG(s) bank accounts	Y		Maria Tongue	1/1/2022	4/30/2022		Green	Will be covered in work with SBS/CSU	No risks identified
		3.4.12	Check any direct debits are set up for the new bank account and also any standing orders. Cancel existing direct debits the existing bank account and reissue for the new bank account.		Y	Maria Tongue	1/1/2022	4/30/2022		Green	Will be covered in work with SBS/CSU	No risks identified
		3.4.13	Ensure any payments driven by systems have been changed to the new bank account. For example AP, the faster payments and CHAPS in the Oracle system.		Y	Maria Tongue	1/1/2022	4/30/2022		Green	Will be covered in work with SBS/CSU	No risks identified
V4	Petty Cash	3.4.14	Ensure arrangements are in place to bank all petty cash by 3o June 2022 and close accounts where relevant. Determine petty cash floats for the new organisation & make arrangements	Y	Y	N/A				Green	N/A - no petty cash held	
	Payment Cards	3.4.15	Identify all payment cards held by the organisation - close down payment cards for the old organisation - identify requirements for payment cards in the new organisation - identify categories and spending limits for payment cards - set up payment cards in the new organisation	Y	Y	Maria Tongue	12/1/2021	4/30/2022		Green	Existing payment cards will be novated/transferred to the ICB. Allpay to be contacted to formally confirm.	No risks identified
V3	Stationery	3.4.16	Destroy old corporate stationery including blank cheques / blank POs. Retain evidence for audit purposes. [this prompt is repeated on tab 4.0 to ensure that all prompts associated with records management are in one place]	Y		Maria Tongue/MLCSU	4/1/2022	7/31/2022		Green	No manual cheques or paper POs. held - cheques are produced on demand when a cheque run is actioned and all PO's are electronic	No risks identified
		3.4.17	Ensure new stationery (e.g. payable orders (POs) and cheques) is ordered and received with name of the ICB and safe arrangements for storage made. To include new VAT number and GBS / bank account details		Y	Maria Tongue	4/1/2022	5/31/2022		Green		

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3.5 FINANCIAL DUE DILIGENCE CHECKLIST: Contracts

The organisation should identify all clinical and non-clinical contracts, the date that the contract is due to end and, where necessary, review the terms. The organisation should assess the potential cost to the NHS of contract termination and develop plans that minimise these.

		Suggested Actions *A number of due diligence activities relate to ICBs, many of which are subject to NHSEI guidance under development and are included at this time as 'placeholders' only - they are shaded grey*	CCG close down	ICB setup	Person Responsible	Start Date	End Date	New ICB Timeline Due Date	RAG	Comments	Risk
Contracts	3.5.1	Core tab outlines the requirements for the contracts register, ensure that the following are included (where appropriate): - Primary care contracts - CHC contracts - Placement contracts - PHB contracts - NHS contracts for healthcare services - independent sector, NHS organisations, D2A beds, patient transport, Medical support to assessment beds, etc - Non healthcare service contracts, e.g., IT contracts	Y	Y	Kay Holland	10/31/2021	1/31/2022		Green	Contract register is in place and updated regularly.	Oversight of contracts not held/managed by the Contract Management Team (e.g. Medicines Management contracts) needs to be stronger
	3.5.2	Identify any other material matters relating to contracts and commercial agreements, including: - Open contract management actions - Open contract notices - Open contractual financial incentive schemes (eg revenue sharing for outsourced pharmacy provision)	Y		Kay Holland	10/31/2021	1/31/2022		Green	Directors and Senior Managers contacted	28 rebate contracts to be updated to new organisaton
	3.5.3	Ensure that the review of contracts in place includes negotiation with suppliers so the ICB is able to buy at the best price given to the CCG(s)	Y	Y	Kay Holland	10/31/2021	1/31/2022		Green	Directors and Senior Managers contacted	28 rebate contracts to be updated to new organisaton
	3.5.4	Outline any PFI agreement, NHS LIFT or other Public Private Partnership arrangements or equivalent DHSC initiative in place	N/A	N/A	N/A	10/31/2021	1/31/2022		N/A	Not applicable no PFI, NHS LIFT or other Public Private Partnership arrangements in place	
	3.5.5	Agree approach to contracts in ICB, payment mechanism, aligned incentive, risk share etc.	N/A	Y	Kay Holland	10/31/2021	1/31/2022		Green	Task & Finish Group in place chaired by Jill Robinson and reporting to Directors of Finance to develop an Intelligent Fixed Payment contracting model with SaTH, RJAH and SCHT; Paper submitted to Directors of Finance in December; Discussions on-going	
	3.5.6	Develop new s75/s256/s76 agreements for the ICB (and arrange for the appropriate governance/sign off) or revise existing ones for ICB		Y	Claire Parker/Tracey Jones	10/31/2021	1/31/2022		Green	Awaiting final confirmation from LA colleagues and that this expected to be able to be confirmed as our statement by the 4th MAY deadline 1) We have a current signed section 75 in place regarding BCF budgets with both Shropshire and Telford LA 2) That these arrangements can transfer over into the ICB under the wordings of successor organisations as was confirmed when we moved from two CCGs into one CCG 3) We have a process for agreeing the updates to the BCF that may be required on release of national planning guidance for BCF expected end of quarter 1 22/23 The latest variation on the BCF section 75 is currently awaiting Claire Skidmore's signature and Alison smith to apply the seal.	
Provisions	3.5.7	Ensure appropriate provisions have been made for any early contract termination penalties (if applicable).	Y		Kay Holland	10/31/2021	1/31/2022		Green	Directors and Senior Managers contacted to date no early contract termination penalties identified	
Disputes	3.5.8	Ensure that all contractual disputes are documented and have appropriate ownership prior to the establishment of the ICB (determine the arrangements in the ICB for resolving all disputes, including those carried forward from the CCG(s)	Y	Y	Kay Holland	10/31/2021	1/31/2022		Green	No contractual disputes identified	
Risk share	3.5.9	Identify all risk share / gain share arrangements which are in place prior to the establishment of the ICB to ensure that they are either terminated or continued	Y	Y	Kay Holland	10/31/2021	1/31/2022		Green	Any risk/gain share arrangements will be continued	
Joint working	3.5.10	Identify all joint working arrangements - ensure that they have been appropriately accounted for	Y	Y	Kay Holland	10/31/2021	1/31/2022	5/27/2022	Green	Directors and Senior Managers contacted	
Grants	3.5.11	Identify and charitable or government grants	Y	Y	Kay Holland	10/31/2021	1/31/2022		Green	Grants are listed on the contract register	

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3.6 FINANCIAL DUE DILIGENCE CHECKLIST - Assets

The organisation should put itself into a position to identify all assets and make arrangements for each asset to be transferred to the new organisation with comprehensive backing information.

		Suggested Actions *A number of due diligence activities relate to ICBs, many of which are subject to NHSEI guidance under development*	CCG close down	ICB setup	Person Responsible	Start Date	End Date	New ICB Timeline Due Date	RAG	Comments	Risk
Assets	3.6.1	Establish baseline audit of existing state of the fixed asset register (FAR)	N	N					N/A	The CCG does not hold fixed assets	
	3.6.2	Reconciliation of inventory (if applicable) and establish any write offs. Review of any inventory below the capitalisation limit	N	N					N/A	The CCG does not hold fixed assets	
	3.6.3	Reconciliation of FAR (where possible, physically verify all plant and equipment. Where this is not possible, consider whether write- offs are required). Assets include those 'non accountable' assets below the capitalisation threshold	N	N					N/A	The CCG does not hold fixed assets	
	3.6.4	Intangible assets - review with ICT team to ensure that asset is in use, functional and will be transferred new organisation	N	N					N/A	The CCG does not hold fixed assets	
	3.6.5	Determine which equipment is under warranty or has a service contract and ensure that the necessary documentation is identified and appropriately filed or archived	N	N					N/A	The CCG does not hold fixed assets	
	3.6.6	Ensure that if the asset register is not integrated, it interfaces with the ledger system		Y	Maria Tongue	11/1/2021	3/31/2022		Green	The CCG does not currently hold fixed assets but does have access to a fully integrated asset system provided by SBS if required.	
	3.6.7	If different asset registers are maintained, agree a date when they will be merged onto one system	Y	Y					N/A	The CCG does not hold fixed assets	
	3.6.8	Review capitalisation policies, particularly around IT equipment and staff costs, and determine approach	Y	Y	Maria Tongue	1/1/2022	3/31/2022		Green		No risks identified
Working Capital	3.6.9	Working capital • Establish, if not in place already, an internal escalation framework to resolve disputes based on the age and size of the balance. Where disputes can not be resolved via normal payment or debt collection processes, disputes should be escalated to the Deputy Director of Finance (DDoF). If the dispute can not be resolved at DDoF level, it should be escalated to the Director of Finance and if they are unable to resolve the dispute, to the Chief Executive to engage with their counterparts. • Report balances over 90 days old to the Audit Committee and Transition Board (or equivalent) to ensure senior leadership is aware of the issues and can provide oversight of the process. Executives should be engaged in resolving disputes. • Encourage budget-holders to review and resolve queries with greater frequency and haste. • Ensure the finance team regularly report on and discuss aged balances with budget-holders. • Ensure settling balances is a high priority and monitored regularly by the Director of Finance and Senior Management Team. • Build and maintain relationships with key contacts within counter-party organisations in order to facilitate resolution of contentious issues. • Balances under 30 days should be resolved primarily through normal dispute and approval processes. Any disputed or	Y		Maria Tongue/MLCSU/SBS	12/1/2021	3/31/2022		Green	Process already well established and will continue in ICB	No risks identified
Invoicing	3.6.10	Do not delay in raising sales ledger invoices relating to 2022/23		Y	Maria Tongue	11/1/2021	3/31/2022	Raised between 18/04/22 to 20/05/22	Green	Action noted & built into M12/M1 planning	
Offices	3.6.11	Determine office requirements for the new organisation, including the need to assess impact on current office space, end lease / continue lease etc. Where a new accommodation is commissioned, ensure that NHS digital access is in place.		Y	Sam Tilley/Alison Smith	11/1/2021	2/28/2022		Green	CCG merger has already undertaken a consolidation of accommodation so no further changes will be forthcoming. **COMPLETED**	No risks identified
Debtors	3.6.12	Review and, where appropriate, write off irrecoverable debts. This should be done in detail on a balance by balance basis. If the debt cannot be written off, consider whether any impairment is necessary. Ensure that any write offs are documented in the losses and special payments register.	Y		Maria Tongue	3/1/2022	6/30/2022		Green	Aged debtors will be reviewed regularly as part of transition plan with SBS/CSU	No risks identified
	3.6.13	Agree post-ICB establishment debt recovery service if via more than one external supplier		Y	N/A					N/A	
	3.6.14	Review debtor balances and manage down so that no debts remain at year end that are over 1 month	Y		Maria Tongue/MLCSU/SBS	1/1/2022	6/30/2022		Green	Aged debtors will be reviewed regularly as part of transition plan with SBS/CSU	No risks identified
	3.6.15	Clear unallocated cash balances where possible. Applying to sales invoices, AP refunds or coding direct cash payments to I&E	Y		Maria Tongue/MLCSU/SBS	1/1/2022	6/30/2022		Green	Included within SBS transition plan	No risks identified
Policy	3.6.16	Prepare new receivables policy for credit terms, recovery, legal action, write-off, de minimis levels etc		Y	Maria Tongue	2/1/2022	6/30/2022		Green	Existing CCG policy will be utilised with name change since well established process	
Leases	3.6.17	Consider IFRS16 finance leases (the standard is effective from 1 April 2022 as adapted and interpreted by the FReM)	Y	Y	Maria Tongue	1/1/2022	3/31/2022		Green	Leases identified - core data passed to SBS for inclusion in FMIS system which will be utilised from 1/7/22	No risks identified
	3.6.18	Identify all contracts with NHS Property Services Ltd and Community Health Partnerships.	Y		Wendy Wood/Alison Smith	10/1/2021	6/30/2022		Green	Process already well established. **COMPLETED**	N/A
	3.6.19	Identify any leases which are held at a peppercorn rent	Y		N/A				Green	N/A	
	3.6.20	Ensure that all lease documentation is properly filed and archived. Inform lessors of equipment of the transfer to ICB. Review all existing leases and terminate/ renegotiate as necessary (including mobile phones / pagers, photocopiers, lease cars)	Y	Y	Kay Holland	11/1/2021	31/06/2022		Green	Contracts register does contain some lease information but more work to be undertaken. All lease/contract owners contacted and asked to update register - work ongoing	

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3.7 FINANCIAL DUE DILIGENCE CHECKLIST: Liabilities

The organisation should put itself into a position to ensure that any balances remaining at 30 June 2022 are minimal and disputes have been resolved with both NHS and non-NHS organisations. The organisation should ensure arrangements are in place for each liability to either be approved for payment or have a clear route to authorisation (including those to be transferred to the new organisation with comprehensive backing information).
All creditor control accounts will be fully reconciled with no balances awaiting clearance unless they are longer term transactions.

			Suggested Actions *A number of due diligence activities relate to ICBs, many of which are subject to NHSEI guidance under development and are included at this time as*	CCG close down	ICB setup	Person Responsible	Start Date	End Date	New ICB Timeline Due Date	RAG	Comments	Risk
	Working Files	3.7.1	Ensure that all liabilities can be analysed by the ICB with appropriate working files	Y	Y	Maria Tongue/MLCSU/SBS	12/1/2021	6/30/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified
V4	Invoices	3.7.2	Ensure communication and ordering arrangements are in place to minimise the chance of invoices arriving late (i.e. post 30 June 2022)	Y		Maria Tongue/MLCSU/SBS	12/1/2021	5/31/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified
	Disputes	3.7.3	Prioritise and resolve any outstanding disputes	Y		Maria Tongue/MLCSU/SBS	12/1/2021	6/30/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified
V4	Expenses	3.7.4	Establish arrangements to manage staff expenses down so only claims relating to the end of June 2022 remain	Y		Maria Tongue/MLCSU/SBS	12/1/2021	6/30/2022		Green	Not material - minimal claims being made	No risks identified
	Credit Notes	3.7.5	Review all outstanding credit notes and monitor resolution	Y		Maria Tongue/MLCSU/SBS	12/1/2021	6/30/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified
		3.7.6	Ensure all credit notes are applied. If appropriate re-raise but as a debtor	Y		Maria Tongue/MLCSU/SBS	12/1/2021	6/30/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified
V4	Suppliers	3.7.7	Ensure supplier list up to date. Suppliers in respect of those with balances will need to be transferred to new organisation post 1 July 2022	Y	Y	Maria Tongue/MLCSU/SBS	12/1/2021	6/30/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified
		3.7.8	Write to inform suppliers of changes	Y		Maria Tongue/MLCSU/SBS	4/1/2022	5/31/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified
	Authorisations	3.7.9	Clear lines of authorisation and availability of authorising officers • Keep scheme of delegation under regular review to ensure any staff departures are recognised and addressed appropriately. • Ensure sufficient cover to address staff leaving. • Continually review authorisation processes to ensure proper processes are in place. • Ensure that authorising officers are at the correct seniority. • Ensure Governing Body approval for any changes	Y		Maria Tongue/MLCSU/SBS	3/1/2022	6/30/2022		Green	Financial scheme of delegation to be reviewed as part of transition	No risks identified
	Working Capital	3.7.10	Working capital • Aim to settle all invoices within 30 days in line with the better payment practice code. Ensure all Non PO & PO invoices are validated and paid where possible. • Establish, if not in place already, an internal escalation framework to resolve disputes based on the age and size of the balance. Where disputes can not be resolved via normal payment or debt collection processes, disputes should be escalated to the Deputy Director of Finance (DDoF). If the dispute can not be resolved at DDoF level, it should be escalated to the Director of Finance and if they are unable to resolve the dispute, to the Chief Executive to engage with their counterparts (or equivalent). • Report balances over 90 days old to the audit committee and transition board (or equivalent) to ensure senior leadership is aware of the issues and can provide oversight of the process. Executives should be engaged in resolving disputes. • Encourage budget-holders to review and resolve queries with greater frequency and haste. • Ensure the finance team regularly report on and discuss aged balances with budget-holders. • Ensure settling balances is a high priority and monitored regularly by the Director of Finance and Senior Management Team. • Build and maintain relationships with key contacts within counter-party organisations in order to facilitate resolution of contentious issues. • Balances under 30 days should be resolved primarily through normal dispute and approval processes. Any disputed or unapproved items over 30 days should be reviewed by Finance and discussed with budget-holders. • The finance team should contact their counterparts to resolve disputes. • Following a concentrated effort during Quarter Three to resolve aged debt, balances approaching 60 days should be escalated to the DDoFs of both parties for resolution and beyond.	Y		Maria Tongue/MLCSU/SBS	4/1/2021	6/30/2022		Green	Process already well established and will continue in ICB	No risks identified
	GRNI	3.7.11	Clear all goods received not invoiced balances (GRNI) as soon as the invoice is paid. Investigate any outstanding balances. Contact suppliers to issue invoices where GRNI balances are being accrued	Y		Maria Tongue/MLCSU/SBS	12/1/2021	6/30/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified
V4	Payments	3.7.12	Determine frequency of payments and establish timetable to operate from 1 July 2022. Harmonise payment dates if operating with two or more systems	Y	Y	Maria Tongue/MLCSU/SBS	2/1/2022	5/31/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified
		3.7.13	Determine how any payables carried forward from CCG(s) are going to be cleared in the ICB's accounts		Y	Maria Tongue/MLCSU/SBS	12/1/2021	6/30/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified
		3.7.14	Review payables, decide on reference methodology and eliminate redundant/duplicated references	Y	Y	Maria Tongue/MLCSU/SBS	12/1/2021	6/30/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified
		3.7.15	Specify requirements for payments and determine if time constraints will force a period of dual running	Y	Y	Maria Tongue/MLCSU/SBS	12/1/2021	6/30/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified
		3.7.16	Ensure bank details are obtained and reviewed for payables paid by BACS		Y	Maria Tongue/MLCSU/SBS	3/1/2022	4/30/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified
		3.7.17	Ensure compatibility with ordering and goods received systems		Y	Maria Tongue/MLCSU/SBS				N/A	No work required - continuation of existing ISFE system	
		3.7.18	Ensure payables payment system interfaces with ledger accounting		Y	Maria Tongue/MLCSU/SBS				N/A	No work required - continuation of existing ISFE system	
		3.7.19	The CCG(s) should ensure it has established who has responsibility for the settlement of balances and communication with creditors	Y		Maria Tongue/MLCSU/SBS	12/1/2021	4/30/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified
V2		3.7.20	Non PO invoices on hold to be released and paid where possible once verified as appropriate	Y		Maria Tongue/MLCSU/SBS	12/1/2021	6/30/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified
V2		3.7.21	PO Notifications to be actioned and holds released to ensure invoices can be paid once verified as appropriate	Y		Maria Tongue/MLCSU/SBS	12/1/2021	6/30/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified
		3.7.22	Clear Prepayment Status Report Invoices	Y		Maria Tongue/MLCSU/SBS	12/1/2021	6/30/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified
		3.7.23	Ensure every effort is taken to recover any outstanding incorrect or duplicate supplier payments	Y		Maria Tongue/MLCSU/SBS	12/1/2021	6/30/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified
	Staff	3.7.24	Identify key purchasing staff and ensure that they can continue to order supplies during the transition period	Y	Y	Maria Tongue/MLCSU/SBS	12/1/2021	6/30/2022		Green	Included as part of transition plan with SBS/CSU	No risks identified
	Other contracts	3.7.25	Identify ongoing service contracts (small contracts such as milk delivery, window cleaning as well as the more obvious such as servicing of medical equipment) and decide whether these contracts need to be terminated/extended	Y	Y	Kay Holland	12/1/2021	3/31/2022		Green	These contracts were reviewed and update by the Contract owner on the merger of Shropshire and Telford & Wrekin CCGs - contract owners to confirm and take necessary steps for new organisation	
		3.7.26	Review services provided and see if there are consolidation opportunities. Ensure that processes for tender/quotation for services are followed (combined services may change the required procedure under SFIs). Agree / confirm ICB's new tender / quotes limits	Y	Y	Kay Holland	12/1/2021	3/31/2022		Green	These contracts were reviewed and update by the Contract owner on the merger of Shropshire and Telford & Wrekin CCGs - contract owners to confirm and take necessary steps for new organisation	
	Processes	3.7.27	Review supplies team processes and ensure they are amended as required	Y	Y	Kay Holland	12/1/2021	3/31/2021		Green	Supplies team processes reviewed	
	Insurance	3.7.28	Determine insurance requirements for the ICB and ensure portfolio of required cover is in place, contact NHS Protect to inform them of NHS body affected by reorganisation so that all insurance cover and claims can be amalgamated and new reference numbers allocated		Y	Maria Tongue	4/1/2022	5/31/2022		Green	NHS Protect will be contacted to inform them of change	No risks identified
V2	Legal	3.7.29	Ensure that the ICB has access to all of the CCG(s) claims history (see also core tab 1 - section 1.5)	Y	Y	Alison Smith	01/11//2021	5/30/2022		Green	Claims and litigation information is held.	No risks identified
V2		3.7.30	Identify any ongoing legal cases, clear working files for new entity (see also core tab 1 - section 1.5)	Y	Y	Alison Smith	01/11//2021	5/30/2022		Green	Held and updated monthly.	No risks identified
	Pension/Ill Health Provisions	3.7.31	Consider any need for a redundancy provision, early retirement provisions or ill health retirement provisions - this should include any clinicians covered by the 2019/20 pension annual allowance charge compensation policy	Y	Y	Duplicate of 3.3.14				Green		

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4.0 IT ASSETS, IT AND RECORDS MANAGEMENT CHECKLIST

V4 The organisation puts arrangements in place for the effective management of financial data transfer between the CCG and the ICB and that access to systems will be maintained post 30 June 2022. This should cover the annual accounts production and audit process and also any post June 2022 reporting requirements.

			Suggested Actions *A number of due diligence activities relate to ICBs, many of which are subject to NHSEI guidance under development and are included at this time as 'placeholders' only - they are shaded grey*	CCG close down	ICB setup	Person Responsible	Start Date	End Date	New ICB Timeline Due Date	RAG	Comments	Risk
V4	Licensing	4.1	System and software licensing arrangements are reviewed to ensure that financial data can be accessed after 30 June 2022. Licences for existing systems should be extended (pending a national decision on historic data archiving)	Y	Y	Sara Spencer	11/1/2021	3/31/2022		Green	List of systems suppliers collected, software to continue to be in place post 30/06/2022	No risk identified
		4.2	Identify all software licences held are transferred to the ICB, identify any early termination penalty clauses, rationalise licences	Y	Y	Sara Spencer	11/1/2021	3/31/2022		Green	All software licences can be transferred to the ICB, no penalty clauses of rationalisation of licences	No risk identified
	Access	4.3	Access to buildings for legacy staff is enabled in whatever way is most appropriate. It is not sensible to exit data centres for example without a clear transition plan in place for data and records archiving.	Y	Y	Tracy Eggby-Jones	N/A	N/A		N/A	Access to buildings needs to be removed from the tab and assigned to the right person No data centres will be exited as a result of the ICB	No risk identified
	Security	4.4	Key business security systems are maintained and regularly checked (e.g. back up procedures and business continuity arrangements) to protect management and audit trails	Y		Sara Spencer	11/1/2021	6/30/2022		Green	Back-up process in place for all data storage servers as part of the CSU contract for IT.	No risk identified
V3		4.5	Single prompt replaced by new suite of prompts 4.23 to 4.34 inclusive - see version control log. Prompt number retained but not reused to prevent renumbering confusion		Y	Sara Spencer	11/1/2021	3/31/2022				
		4.6	Ensure all hardware is identified and staff holder mapped	Y		Sara Spencer	11/1/2021	3/31/2022		Green	Asset lists available from the MLCSU IT department	No risk identified
		4.7	Evaluate and compare existing systems against ICB's requirements. Compare to other systems if appropriate	Y	Y	Sara Spencer	11/1/2021	6/30/2022		Green	All systems meet with the ICBs requirements, the ICB transition will not affect the systems or software	No risk identified
		4.8	Review the spine end points (e.g. EMIS) which may have Spine endpoints affected	Y	Y	Sara Spencer	11/1/2021	3/31/2022		Green	Spine endpoints have been reviewed no actions reported	No risk identified
V3	Risk	4.9	Prompt moved to 4.29 and wording revised - see version control log. Prompt number retained but not reused to prevent renumbering confusion	Y		Sara Spencer	11/1/2021	3/31/2022				
	Policy	4.10	Develop a policy on use of work computers and communicate the new policy to employees		Y	Sara Spencer	11/1/2021	6/30/2022		Green	Review of policies to identify if this is in place. New draft to be adopted by the new ICB	No risk identified
	Hardware/Software	4.11	Identify and dispose of surplus equipment securely (risk of old IT kit not being wiped properly)	Y		Sara Spencer	11/1/2021	3/31/2022		Green	There is a contract in place for the safe disposal of IT equipment with MLCSU; This is complete, all old IT equipment is returned to the CSU IT Team and is securely destroyed.	No risk identified
		4.12	Identify hardware needs, standardise and purchase new equipment		Y	Sara Spencer	11/1/2021	6/30/2022		Green	Hardware needs identified, standard hardware offer has been agreed for the future ICB	No risk identified
	Dual Running	4.13	Specify requirements for each material system and determine if time constraints will force a period of dual running after establishment of the ICB		Y	Sara Spencer	11/1/2021	3/31/2022		Green	All systems will not require dual running for the ICB transition, all systems in place and delivering to ICB requirements	No risk identified
	Smart Card	4.14	Review the smart card users. Take action to reconcile the smart card list with the Care Identity Service	Y	Y	Sara Spencer	11/1/2021	3/31/2022		Green	Smartcard / RA service has been contacted to identify if a process of transfer is needed, the ODS code is not changing, just a name change is expected	No risk identified
V3	Records Retention	4.15	Single prompt replaced by new suite of prompts 4.23 to 4.34 inclusive - see version control log. Prompt number retained but not reused to prevent renumbering confusion	Y	Y	Sara Spencer	11/1/2021	3/31/2022				

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6.0. ODS RECONFIGURATION TOOLKIT

V2	The current codes used to identify STPs will be changed to identify ICBs.
V3	
V4	The ODS Reconfiguration Toolkit has been reviewed and released previously. Please follow the link below to the Future NHS Platform:

Please Note: this document does not contain an exhaustive list of impacts, actions or people. CCGs will need to consider fully their own uses for ODS codes.

Purpose of this form

Some key systems, services and reporting functions known to be impacted by ODS changes are listed below, but note this is not an exhaustive list. Organisations affected by an organisational change must identify all systems, services and reporting platforms they utilise their current CCG codes (where a CCG is impacted by a boundary change) or names within, via their own internal impact assessment. A recommended approach towards an impact assessment can be found on the IA tab. This Reconfiguration Checklist tab may be used as a 'starting point' for identifying impacted areas; i.e. non-impacted areas may be removed or additional impacts identified added at your discretion.

No New ODS codes will be issued and Shropshire and Telford and Wrekin CCG/STP will be automatically be renamed in line with the changes below.

Integrated Care Boards (ICBs)

Current active STP codes will be renamed
A new organisation name suffix will be shown as 'Integrated Care Board' - e.g. 'NHS Devon Integrated Care Board'
All 42 STP codes will be retained and will remain legally active within the data infrastructure (no end dates will be applied)
The primary role against STP codes will remain unchanged, this is 'Strategic Partnership'

Non Primary Roles

The non primary role against the 42 STP codes currently ('Sustainability and Transformation Partnership') will be end dated 31/03/2022
A new non primary role will be applied to all 42 codes, start dated 01/04/2022, to denote the point at which they became a legal entity
The new non primary role name will be '**Integrated Care Board**'
All entities currently linked to or from an STP code in ODS data will remain unchanged in the transition year (apart from those impacted by ICB Boundary changes)

Clinical Commissioning Groups (CCGs)

Renaming

Current active CCGs will be renamed
The current CCG ODS code will be displayed in the Sub ICB location name to represent the geographic area - e.g. "15N" represents Devon CCG
Using Devon as an example, the renaming will result in the following, Sub ICB Location Name: "NHS Devon ICB" and the current ODS CCG code "15N".
e.g. NHS Devon ICB - 15N.
No end dates will be applied to CCG codes during transition year 2022/23.
ODS has two concepts of organisation start/end dates - a legal view and an operational view. All current CCG codes will remain 'legally' and 'operationally' open in ODS data due to wider NHS system constraints/implications.

Non Primary Roles

A new non primary role will be applied to all active CCG codes, start dated 01/04/2022

The new non primary role name will be 'Sub ICB Location'.

The primary role (organisation type) will remain unchanged e.g. Clinical Commissioning Group (RO99)
All active Commissioning Hub codes will remain unchanged during transition year (currently coded as a CCG entity with a Commissioning Hub non primary role)
All entities currently linked to or from a CCG in ODS data will remain unchanged in the transition year (apart from those impacted by the ICB Boundary changes)

This will mean it automatically change from

Pre April 2022

CCG Code	CCG Name	CCG Non-Primary Role Name and Code	STP Code	STP Name	s-Primary Role Name ar	NHSE Region Code	E Region N
M2L0M	NHS SHROPSHIRE, TELFORD AND WREKIN CCG	N/A	QOC	SHROPSHIRE AND TELFORD AND WREKIN STP	SUSTAINABILITY AND T	Y60	MIDLANDS COMMISSIONING REGION

To

From April 2022

Sub ICB Location ODS Code	Sub ICB Location Name	Sub ICB Location Non-Primary Role	ICB Code	Integrated Care Board Name	ICB Non-Primary Role	Region Code	Region Name
M2L0M	NHS SHROPSHIRE, TELFORD AND WREKIN ICB - M2L0M	SUB ICB LOC	QOC	NHS SHROPSHIRE, TELFORD AND WREKIN INTEGRATED CARE BOARD	INTEGRATED CARE BC	Y60	MIDLANDS COMMISSIONING REGION

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7.0 QUALITY DILIGENCE CHECKLIST - ICB SET UP

The 'Core Due Diligence Checklist' (tab 1) contains a number of quality related areas, including governance, external reviews and the summary of numbers of complaints, SIs etc. This tab builds on the contents of tab 1 and contains a number of prompts related to the set up of the ICB.

V4

7.1 Strategic Quality - approach to maintaining quality during the transition and improving quality following the establishment of the ICB		CCG Close	ICB Set Up	Person Responsible	Start Date	End Date	New ICB Timeline Due Date	Rag Rating	Comments	Risk
7.1.1	Identify the nominated executive lead for quality within the ICS		Yes	Simon Whitehouse	11/11/2021	31/2/22		Green	The Chief Nurse is the nominated lead. A susbstantive appointment has been made from June 2022.	
7.1.2	Develop a clear and credible strategy for improving quality (experience, safety and effectiveness) and reducing unwarranted variation and inequalities. This includes details on transformation and embedding of cultures to empower staff and enable sustained improvement.		Yes	Zena Young	11/11/2021	31/2/22	Jul-22	Green	We have an ICS Quality Strategy, approved by the ICS Board in June 2021. System partners have contributed to developing this and it is currently undergoing refresh in light of changing guidance and our emerging approach to system governance. It includes Quality Improvement capability and capacity. The draft is to be presented at teh System Quality Group 04/05/22	
7.1.3	Ensure a defined governance and escalation process is established for quality which ensures that risks are identified, mitigated and escalated effectively through System Quality Groups (SQG) and links to Regional NHSEI quality oversight and reports to the ICB. This will link to the broader ICS risk management strategy, policy and procedures (see 3.1.13). The System Quality Group will serve as, or align with any Quality Committee (see 1.3.24).		Yes	Zena Young			Jun-22	Green	In accordance with National Quality Board (NQB) and NHSEI published guidance, we have set up our local quality governance, implementing a structure and function in accordance with the needs of our system. We are awaiting a further NQB publication which will inform the approach to Place-based quality governance. As part of our emergent system-level governance arrangements, we are reviewing how risks to quality are captured, escalated and managed effectively to ensure that our future system risk arrangements reflect our development as an ICS. We are awaiting the NQB guidance on risk escalation and will adopt this when published. We do not yet have a complete shared view of system quality risks, however providers publication of their Quality Accounts by the end of June 22 will inform this work. The system approach to risk appetite needs to be confirmed along with consideration of adopting a unified risk scoring system / matrix as a number of different ones are in use in the system. The NED chair of the QPC has yet to be announced.	
7.1.4	Agree the SQG (or equivalent name) structure and develop Terms of Reference. The NQB Position Statement [located on FutureNHS] sets out guidance on suggested structure for an SQG and includes: o membership o quoracy arrangements, o guidance on managing conflicts		Yes	Zena Young	11/11/2021	3/31/2022		Green	Completed and embedded. We have received feedback from membership eg CQC that our approach is at an advanced stage and is to be commended.	
7.1.5	Develop a plan to ensure that quality is measured consistently, using nationally and locally agreed metrics triangulated with professional insight and soft intelligence. Includes local quality metrics and national metrics (e.g Quality Toolkit, System Oversight Framework) aligned with section 1.4 of the core checklist.		Yes	Zena Young	11/11/2021	3/31/2022	Jun-22	Green	A task & finish group with system representatives is established to finalise the format and content of reporting requirements to the various quality forums. We have a prototype report which incorporates all of the requirements of the NQB toolkit (the minimum requirement) as well as some localised priority metrics. Metrics at Place are also under development, but do exist at a population health level. Our reporting metrics report format will undergo further development over the next few months. There is system Business Intelligence Support identified for this and good system engagement to progress this work.	
7.1.6	Agreed way to transfer and systematically store and retain legacy information (following Caldicott principles) [note that this links to section 1.4.19 of the core checklist]	Yes	Yes	Zena Young	11/11/2021	3/31/2022		Green	The data cleanse exercise, securing, transfer and storing of records is completed	
7.2 Operational Quality - Ensure the ICB recognises its statutory duties for quality, setting up systems and processes to enable effective delivery and oversight (where relevant) of:		**CCG Close**	**ICB Set Up**	**Person Responsible**	**Start Date**	**End Date**	**New ICB Timeline Due Date**	**Rag Rating**	**Comments**	**Risk**
7.2.1	**Quality Systems and Assurance:** Independent Investigations (including Mental Health Homicides); Regulation 28 reports; Judicial reviews; Controlled Drugs Assurance and Oversight; Complaints; Whistleblowing and Freedom to Speak Up; Review of provider Quality Accounts; Learning from Deaths; Medical Examiners; Infection Prevention and Control (IPC); Antimicrobial Resistance (AMR); HealthCare Acquired Infections (HCAI).		Yes	Zena Young	11/11/2021	3/31/2022		Green	Plans are in place to enable the ICS to assess which schemes will be ongoing post transfer. The list of relevant information relating to this item is updated and changes frequently within month. A number of these requirements are also reported regionally - eg safeguarding, IPC.	
7.2.2	**Experience:** Patient surveys and unpaid carer feedback including FFT; Embedding experience of care in improvement and transformation programmes including coproduction with people with lived experience; Enabling engagement and coproduction; Staff surveys and feedback.		Yes	Zena Young	11/11/2021	3/31/2022		Green	Plans are in place to enable the ICS to assess which schemes will be ongoing post transfer. QPC receives quarterly reports on a number of these schemes. As a system we are considering our approach to hearing and improving patient experience and will be developing a pathway and feedback route as part of our Quality Roadmap.	
7.2.3	**Patient Safety:** Serious Incident Framework or Patient Safety Incident Response Framework processes (or Patient Safety Incident Response Framework, PSIRF, oversight if the ICB includes an Early Adopter); Incident reporting to the Learn from Patient Safety Events service (and former NRLS, StEIS); Support for the commissioning of patient safety incident investigations including arrangement for regional or national escalation as appropriate; Compliance with national patient safety alerts; supporting safety improvement programme; Identifying Patient Safety Specialists and recruiting two or more Patient Safety Partners.		Yes	Zena Young	11/11/2021	3/31/2022	Jun-22	Green	We are awaiting NHSEI to approve the timing for roll-out of the PSIRF (part of the NHS Patient Safety Strategy) to all systems including STW. STW CCG has a system Patient Safety Specialist who is leading this work with Patient Safety Specialists from our NHS providers and other experts. We have established a specific system-wide Patient Safety Forum with the brief of implementing the NHS Patient Safety Strategy and PSIRF consistently within our system and are engaged in national learning forums to ensure we are taking an aligned approach to implementing PSIRF. The CCG GB paper January 2022 provides an update on progress with implementing the Patient Safety Strategy.	
7.2.4	**Effectiveness:** National Clinical Audits; NICE Health and Care guidance, Quality Standards and Technology Appraisals; Getting it Right First Time (GIRFT) reports.		Yes	Zena Young (owner)/Julie Garside				Green	This requirement is a shared responsibility and the named directors have been updated accordingly. Plans are in place to enable the ICS to assess which schemes will be ongoing post transfer.	
7.2.5	**Safeguarding:** Executive accountability/ownership for the Safeguarding Accountability and Assurance Framework across their partnerships (including safeguarding children and adults system leadership; Children in Care/ Looked After Children; Child Death responsibilities and Overview Panel).		Yes	Zena Young			Jun-22	Green	All of these responsibilities are incorporated into the forward quality governance arrangements and accountabilities. We submit a separate return to regional NHSE on safeguarding readiness to operate and have received positive feedback from our submissions. We have live action plans to address learning points identified in the CCG Internal Audits for Adult and Child Safeguarding. An update will be provided to the May 22 CCG Audit Committee - at present all actions are progressing satisfactorily, with the exception of the recommendation relating to the Designated Doctor for child safeguarding. We have part funding for this post which needs to be increased and a business case has been developed. The current post-holder has resigned from this post at short notice from the provider and there is a current gap in service.	
7.2.6	**Transformation and Quality Improvement:** Local transformation and improvement priorities; the NHS Long Term Plan programmes (e.g. Maternity, Learning Disabilities and Autism, Screening Programmes, Continuing Healthcare, Personal Health Budgets, Infection Prevention and Control, digital transformation programmes; clinical pathways).		Yes	Zena Young (owner)/Claire Parker				Green	Transformation schemes will carry forward into the ICS, being incorporated into the wider governance architecture for our system as this is under development for the sub structure of reporting within the ICS. Transformation schemes are subject to regional NHSEI reporting requirements. There is a robust assurance and reporting mechanism for maternity - relating to recommendations arising from the Ockenden reports.	

VERSION CONTROL - LOG OF CHANGES

Date of Change	Version Change	Tab Number	Ref	Original Drafting	Revised Drafting	Comment Regarding Change
Version 1 released 18 August 2021						
Version 2 released 14 October 2021 - Changes shown below						
10/14/2021	V2	Introduction	Para 1 Line 7	Completion of the full checklist is not itself mandated by NHSEI	**Completion of the full checklist is not itself mandated by NHSEI**	There is no change to the wording, but the statement regarding the checklist not being mandated has been changed to blue bold type to make this important point clearer. Nb tab 2.2 is required.
10/14/2021	V2	Introduction	Line 28	N/a	Reference to a new tab - line added	The 'Core Due Diligence Checklist' (tab 1) contains a number of quality related areas, including governance, external reviews and the summary of numbers of complaints, SIs etc. A new 'Quality Due Diligence Checklist' tab (tab 7.0) has been added which builds on the contents of tab 1 and contains a number of prompts related to the set up of the ICB.
10/14/2021	V2	Introduction	Line 34	Version Control The current version of the Due Diligence Checklist will be made available via the Hub. Strict version control will be applied and the current version number and date of issue will be included below; and the changes made will be logged at tab 7.0	Version Control The current version of the Due Diligence Checklist is made available via the Hub / FutureNHS platform. Strict version control is being applied and the current version number and date of issue included below; any prompt changed / added is highlighted in yellow in column A on each tab, including the version in which the change took place; and the changes made logged on the version control log tab.	Added reference to the Future NHS platform. Added any prompt changed / added will be highlighted in yellow in column A on each tab, including the version in which the change took place - this is to make it easier to see the changes. The version control log tab is no longer called 'tab 7' to allow for additional tabs to be added - but will always be located at the end.
10/14/2021	V2	Introduction	Line 36 / 37	V1 18/08/21	V2 14/10/21	Latest version release
10/14/2021	V2	Introduction	Line 40	N/a	Comments Regarding Versions Released V1 was released on 18.08.21 V2 provides an update as at 14.10.21 and the change log indicates all changes made to date	Added to provide confirmation of all versions released
10/14/2021	V2	1 Core	1.4.21	Further prompts relating to the necessary arrangements to support the establishment of processes for robust quality management are being developed and will be added in a later update via version control (these prompts will be either added on the core list at this point, or as a separate tab)	Quality Checklist (relating to ICB set up) included at tab 7.0	The 'Core Due Diligence Checklist' (tab 1) contains a number of quality related areas, including governance, external reviews and the summary of numbers of complaints, SIs etc. A new 'Quality Due Diligence Checklist' tab (tab 7.0) has been added which builds on the contents of tab 1 and contains a number of prompts related to the set up of the ICB.
10/14/2021	V2	1 Core	1.7.12	Ensure that processes are in place to review records (electronic and paper) to delete, archive or for carry forward to the ICB	Ensure that processes are in place to review records (electronic and paper) to delete, archive or for carry forward to the ICB. **Note that particular attention should be paid to retention of records which may be required for the forthcoming Covid Inquiry**	Added reference to the Covid Inquiry.
10/14/2021	V2	2.2 HR Due Diligence Data	Line 17 - and multiple columns	N/a	Drop down functionality removed	A number of columns appeared to have a drop down option but nothing was contained in the drop down menu. These were blank as there was no intention to be prescriptive regarding the drop down options but the drop down functionality has now been removed.
10/14/2021	V2	2.2 HR Due Diligence Data	Columns G, H, I, AH, AI	N/a	Added columns for: Professional Registration Body - column G Professional Registration Unique Identifier - column H Professional Registration Expiry Date - column I Department - column AH Staff Group - column AI	Added five columns / data fields required
10/14/2021	V2	3.2 Accounts & Audit	3.2.13	Ensure that there is a Local Counter Fraud Specialist (LCFS) and an agreed plan in place. Ensure that LCFS and senior Ensure Ensure that management work plans cover the increased risk of fraud and asset loss during times of change (this is a major risk on reorganisation). Ensure that the LCFS is involved in fraud and risk assessment for the ICB	3.2.13.1 Ensure the ICB has an accredited and nominated Local Counter Fraud Specialist (LCFS) with full access to NHS Counter Fraud Authority (NHSCFA) guidance, intelligence and case management systems. 3.2.13.2 Ensure appropriate handover arrangements are in place between CCG and ICB LCFSs to ensure: -continuity and progression of reactive work; including investigations, sanctions and recoveries -the ICB LCFS receives all relevant information from the CCG LCFS to inform ICB LCFS work plan 3.2.13.3 Ensure an agreed LCFS work plan is in place which should include (not exhaustive): -consideration of proactive work both before and after the establishment of the ICB in the light of the risks that it poses and adjust the nature and timing of work accordingly. -fraud risk assessment activity considering increased risk of fraud and asset loss during times of change (this is a major risk on reorganisation). -appropriate action to ensure compliance with the NHS Requirements of the Government Functional Standard GovS013 Counter Fraud	The initial prompt included at 3.2.13 has been revised and also expanded from one to three prompts.
10/14/2021	V2	3.7 Liabilities	3.7.20	Non PO invoices on hold to be released and paid where possible	Non PO invoices on hold to be released and paid where possible once verified as appropriate	Revised wording
10/14/2021	V2	3.7 Liabilities	3.7.21	PO Notifications to be actioned and holds released to ensure invoices can be paid	PO Notifications to be actioned and holds released to ensure invoices can be paid once verified as appropriate	Revised wording
10/14/2021	V2	3.7 Liabilities	3.7.29	Ensure that the ICB has access to all of the CCG(s) claims history on the NHS Protect's extranet	Ensure that the ICB has access to all of the CCG(s) claims history (see also core tab 1 - section 1.5)	Removed reference to NHS Protect and cross referenced to the core tab and section 1.5
10/14/2021	V2	3.7 Liabilities	3.7.30	Identify any ongoing legal cases, clear working files for new entity	Identify any ongoing legal cases, clear working files for new entity (see also core tab 1 - section 1.5)	Cross referenced to the core tab and section 1.5
10/14/2021	V2	4 IT Assets, IT and Records	4.16	N/a	Ensure that processes are in place to review records (electronic and paper) to delete, archive or for carry forward to the ICB. **Note that particular attention should be paid to retention of records which may be required for the forthcoming Covid Inquiry**	Added reference to the Covid Inquiry.
10/14/2021	V2	5 DSPT	Tab 5	N/a	NHS Digital is in the process of reviewing and updating the DSPT Toolkit to ensure that it is fit for purpose for the establishment of ICBs. The aim is to confirm by 31 October 2021 when the DSPT Toolkit will be released with an indicative release date of mid-November 2021.	The DSPT Toolkit is not yet available for release but a new entry has been made on tab 5.0 as outlined in column G.
10/14/2021	Vs	6 ODS Reconfiguration	Tab 6	N/a	The current codes used to identify STPs will be changed to identify ICBs. NHS Digital is in the process of reviewing and updating the ODS Reconfiguration Toolkit to ensure that it is fit for purpose for the establishment of ICBs and takes account of the use of STP codes for ICBs as opposed to an application for, and receipt of, a new ICB code. Once complete the ODS Reconfiguration Toolkit will be released by NHS Digital and also via this Due Diligence Checklist. The aim is to confirm by 31 October 2021 when the ODS Reconfiguration Toolkit will be released with an indicative release date of mid-November 2021.	The ODS Reconfiguration Toolkit is not yet available for release but a new entry has been made on tab 6.0 as outlined in column G.
10/14/2021	V2	7 Quality	Tab 7	N/a	New tab added The new tab includes a number of prompts and these are 7.1.1 to 7.1.6 and 7.2.1 to 7.2.6 (inclusive)	The 'Core Due Diligence Checklist' (tab 1) contains a number of quality related areas, including governance, external reviews and the summary of numbers of complaints, SIs etc. A new 'Quality Due Diligence Checklist' tab (tab 7.0) has been added which builds on the contents of tab 1 and contains a number of prompts related to the set up of the ICB.
Version 3 released 24 November 2021 - Changes shown below						
11/24/2021	V3	Introduction	Line 36 / 37	V2 14/10/21	V3 24/11/21	Latest version release
11/24/2021	V3	Introduction	Line 40	Comments Regarding Versions Released V1 was released on 18.08.21 V2 provides an update as at 14.10.21 and the change log indicates all changes made to date	Comments Regarding Versions Released V1 was released on 18.08.21 V2 provides an update as at 14.10.21 and the change log indicates all changes made to date V3 provides an update as at 24.11.21 and the change log indicates all changes made	Latest version release
11/24/2021	V3	1 Core	1.3.7	Current investigations by the Care Quality Commission (CQC) that would transfer	Current inspections by the Care Quality Commission (CQC) that would transfer	Investigations corrected to inspections
11/24/2021	V3	1 Core	1.4.12	Open medical examiner reports that would transfer	Open mortality review reports / medical examiner referrals that would transfer – ie any cases being reviewed by the CCG, such as cases referred by a medical examiner which the CCG is following up or has an outstanding action for the CCG	A number of queries have been received about this prompt and it has therefore been updated to provide clarity
11/24/2021	V3	1 Core	1.4.20	Agree the approach to maintaining quality during the transition and improving quality following the establishment of the ICB as outlined in: Shared Commitment to Quality: https://www.england.nhs.uk/publication/national-quality-board-position-statement-on-quality-in-integrated-care-systems/ Position statement: https://www.england.nhs.uk/publication/national-quality-board-shared-commitment-to-quality/	Agree the approach to maintaining quality during the transition and improving quality following the establishment of the ICB as outlined in: Shared Commitment to Quality: https://www.england.nhs.uk/publication/national-quality-board-position-statement-on-quality-in-integrated-care-systems/ Position statement: https://www.england.nhs.uk/publication/national-quality-board-shared-commitment-to-quality/ See the Quality section on the FutureNHS platform under ICS Guidance - Quality. This includes a briefing note to support handover	Included reference to a new handover briefing note
11/24/2021	V3	1 Core 4 IT Assets, IT and Records	1.7.11 4.17	Ensure that data and records management transition plans (including a clear sub section for historic financial data) are in place	Ensure that records management transition plans are in place See briefing paper providing records management guidance located on FutureNHS [this prompt is repeated on tab 4.0 to ensure that all prompts associated with records management are in one place]	Removed reference to data as guidance provided that the two should not be combined. Original prompt at line 1.7.11 split into two prompts on tab 4.0 - 4.17 & 4.18. Extended narrative to link to records management guidance briefing paper and to group all associated prompts into one place in the due diligence checklist
11/24/2021	V3	1 Core 4 IT Assets, IT and Records	1.7.11 4.18	Ensure that data and records management transition plans (including a clear sub section for historic financial data) are in place	Ensure that records management transition plans for historical financial records are in place	Original prompt at line 1.7.11 split into two prompts on tab 4.0 - 4.17 & 4.18.
11/24/2021	V3	1 Core	1.7.12	Ensure that processes are in place to review records (electronic and paper) to delete, archive or for carry forward to the ICB. Note that particular attention should be paid to retention of records which may be required for the forthcoming Covid Inquiry	Ensure that processes are in place to review records (electronic and paper) to delete, archive or for carry forward to the ICB. Note that particular attention should be paid to retention of records which may be required for the forthcoming Covid Inquiry [this prompt is covered by a number of prompts on tab 4.0 to ensure that all prompts associated with records management are in one place - review tab 4.0 for full details]	Extended prompt to redirect the user to tab 4.0 which provides a more comprehensive set of prompts related to records management.
	V3	3.1 Financial	3.1.24	Change Request raised: NHS Digital for new ODS codes	~~Change Request raised: NHS Digital for new ODS codes~~	Removed as there is no need to raise a change request for new codes
11/24/2021	V3	3.1 Financial	3.1.27	Destroy old stationery. Evidence for audit purposes Inform suppliers and users of address for invoices / queries	Destroy old corporate stationery including blank cheques / blank POs. Retain evidence for audit purposes	Clearer description
11/24/2021	V3	3.2 Accounts & Audit	3.2.16	Ensure appropriate records are kept, and emails are retained for any key staff that may leave during the transition period. This is likely to include the need to review policy. Documentation should be held in accordance with guidance on retention of records.	Ensure all appropriate records are kept, and emails are retained for any key staff that may leave during the transition period.	Added the word 'all' - ie Ensure all appropriate records are kept… Second element split from this prompt as repeated. See 4.22
11/24/2021	V3	4 IT Assets, IT and Records	4.5	Devise new records management arrangements for the ICB: - electronic file structure - policy & procedures relating to records management - corporate and clinical - physical record storage arrangements: on site and archive arrangements		Single prompt replaced by new suite of prompts 4.23 to 4.34 inclusive shown below
11/24/2021	V3	4 IT Assets, IT and Records	4.9	The organisation should put arrangements in place to assess and respond to the increased risk to the confidentiality, integrity and availability of data from the reorganisation. Ensure that documentation is stored on shared rather than local drives.	A procedure to deal with the increased risk to records that result from a re-organisation (such as potential loss or accidental disclosure)	Revised wording

Action to collate inforamtion required as part oif Due Diligence process - RAG ratings

Red	not started or at risk
Amber	plans in place and/or ongoing
Green	completed
N/A	This specific action in the due diligence checklist does not apply to STW CCG
Yes	
No	

Level 1 - Single CCG to coterminous ICS and no boundary changes
Level 2 - Multiple CCGs to coterminous ICS and no boundary changes
Level 3 - Boundary changes requiring confirmation of transfer arrangements for staff and property

Property and Asset Risk to ICB - RAG ratings

Red	High or extreme risk related to identified property or asset but no mitigation in place
	High or extreme risk related to identified property or asset but mitigated or only partially mitigated but remains high or extreme
Amber	Moderate risk related to the identified property or asset and has no mitigation in place
	Moderate risk related to the property or asset identified and has mitigation in place or partial mitigation in place but remains at moderate
Green	No risks related to property and assets identified
	Low or very low risks related to the property or asset identifed but are fully or partially mitigated
N/A	This specific action in the due diligence checklist does not apply to STW CCG

RISK MANAGEMENT MATRIX

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

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

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

Shropshire, Telford & Wrekin CCG Due Diligence Checklist- Ambers and Reds

Tab	Ref	Due Diligence Area for Review *A number of due diligence activities relate to ICBs, many of which are subject to NHSEI guidance under development and are included at this time as 'placeholders' only - they are shaded grey*	Comments	Person Responsible	Start Date	End Date	New ICB Timeline Due Date	RAG	Further action required (Yes / No)	Action required	Due Date for Further Action	Final RAG	Risk identified	Mitigating Action/Comments	Risk RAG
	1.4.11iii	Number of Deprivation of Liberty Safeguarding (DOLS) cases that would transfer	Legislation relating to the implementation of Liberty Protection Safeguards is due to be introduced during 2022/23 and the CCG safeguarding team are leading the system response to this. There is a risk recorded on the CCG risk register in relation to this (rated yellow).	Claire Parker/Paul Cooper	TBC	TBC		Green	Yes	The CCG safeguarding team provide on-going expertise to the CHC team in such cases.		Green	DOLS will cease to exist and it will be covered by new legislation under Liberty Protection Safeguards (LPS). . LPS introduction was delayed due to COVID and at present is still going through national consultation process, with an unknown implementation date. Legislation relating to the implementation of Liberty Protection Safeguards is due to be introduced during 2022/23	The CCG safeguarding team are leading the system response to this. This is a continuing action and an unknown risk impact - mainly financial. LPS is out to consultation and we await a national response/next steps before being able to make any further progress on this. This is recorded on the CCG CRR and handed over to the incoming ICS CNO	Amber
Risk Management	3.1.16	Review, revise and agree a risk management strategy, policy and procedures. This must include an approach to setting an agreed risk appetite and identifying, evaluating and managing risks. Mechanism for risk share across organisations to be agreed.	Good Governance Institute will faciliatate two workshop sessions on risk management in an ICS, developing a risk appetite and Baord Assurance Framework in Autumn. With a Risk Management Policy being developed fro approval at Audit Committee in January 2023.	Alison Smith	11/1/2021	7/22/2022		Amber				Moderate	There is a risk around timeframes and capacity	Agreed CCG Director of Corporate Affairs will take work forward with support from the good governance institute.	Moderate
Business Plan	3.1.18	Assess the financial impact of the strategic objectives and business plan for the new ICB	22/23 system financial plan submitted on 20th June 2022. Plan deadlines met but plan is not compliant with national guidance as £19m system deficit planned. Financial plan includes mapping financial implications of the system plan narrative and prioritisation of all cost pressures/investments. Next step is to refresh the longer term system plan that was presented to Boards in Sept 21 for the 22/23 update but also the next 3,5 and 10 years	Claire Skidmore	11/1/2021	4/28/2022		Green				High	Current risk as plan does not meet national expectation of break even. Risk around efficiency and system transformational plan delivery. ICB will inherit a deficit plan from CCG	Regular system discussions around plan development through DoFs, CEOs and system sustainability committee. IDB overseeing delivery of efficiency and system transformation. We have a risk here as we remain unable to reach a breakeven plan position. We have assessed the financial impact of our business plan but it does not meet planning requirements. Mitigating actions include the steps we are taking, working with system partners to both lower cost where possible and also bolster our delivery plans in order to lower risk of overspend against the plan. We are also in the process of designing a new system planning process which will improve our rolling planning programme and help us to better align finance, activity and workforce planning in the future.	High
Plans	3.3.35	Prepare and agree an ICB financial plan	22/23 system financial plan submitt4ed on 28th April 2022. Plan deadlines met but plan is not compliant with national guidance as £38m system deficit planned. Financial plan includes mapping financial implications of the system plan narrative and prioritisation of all cost pressures/investments. Next step is to refresh the longer term system plan that was presented to Boards in Sept 21 for the 22/23 update but also the next 3,5 and 10 years	Claire Skidmore		17/3/22 (draft), 28/4/22 (final)		Green				High	Current risk as plan does not meet national expectation of break even. Risk around efficiency and system transformational plan delivery. ICB will inherit a deficit plan from CCG	Regular system discussions around plan development through DoFs, CEOs and system sustainability committee. IDB overseeing delivery of efficiency and system transformation The risk here is the same as 3.1.18, we have yet to meet planning requirements to deliver a break even position.	High
	3.3.36	Prepare and agree place based budgets	Action is dependent on place partnership set up and delegation agreed - unlikely to have budgets delegated at place level until 23/24	Laura Clare		3/31/2022		Red				moderate	Risk that place will not be sufficiently developed for place level budget delegation to operate in 22/23	Place discussions continue across the system On the basis that our place arrangements are not fully mature we have not yet set place-based budgets. We do have a work plan for finance that focuses on what we want to develop over the next 6/12/18 months and this is on there.	Very low
	3.3.37	Review the cost improvement programmes and determine a new programme for the ICB	22/23 efficiency programme included as part of 22/23 financial plan submission. At point of submission £1m of plans unidentified and £0.7m running cost efficiency badged as high risk. System transformation plan savings also inlcuded within system plan submission with £2.9m unidentified gap currently held in CCG position.	Kate Owen	11/1/2021	1/20/2022		Amber				Moderate	Risk that full efficiency programmes and system transformation savings will not be identified which will contribute to financial deficit of organisation and system	Integrated Delivery board reviewing progress against both internal organisation efficiency plans and system transformration plans on a monthly basis	Moderate
	3.3.39	Produce a team structure to meet its identified role within agreed management cost envelope	DoF level discussions regarding teams working closer together across the system commenced with various workstreams set up led by system deputies to explore options. Initial CCG structure to lift and shift into ICB but will be reviewed to develop system wide finance structure as other areas develop	Laura Clare	11/1/2021	31/03/022		Amber				Moderate	Risk around capacity within existing finance team in CCG to pick up all system wide work	Structure being reveiwed across system around how can bring together existing resource across the system in a better way	Moderate
	3.3.40	Consult with NHSEI to: • agree new control totals for ICB • determine performance against previously agreed control totals	22/23 planning guidance released 24.12.21. System worked through detailed 22/23 financial plan development for final submission in June	Laura Clare	11/1/2021	4/28/2022		Amber				Moderate	Risk that system transfomation and organisational efficiencies will not be fully identified in order to meet control total	Integrated Delivery board reviewing progress against efficiency plans and system transformation projects on monthly basis	Moderate
Capital	3.3.48	Agree a framework for capital prioritisation and allocation across the system	Initial capital meeting due to be held August/early September; process of incorporating capital into overall prioritisation process (part of the evolution of the investment panel) is in place; infrastructure is in place and the prioritisation framework will be there in time for the planning round.	Claire Skidmore		6/30/2022		Amber				Very low	No risks identified		Very low