Meeting Title	**Leicester, Leicestershire and Rutland (LLR) Integrated Care Board meeting** (meeting held in public)	**Date**	**Thursday, 11 April 2024**
Meeting no.	**14**	**Time**	**Confidential meeting: 8:30am – 8:55am** **Meeting in public: 9:00am – 9:45am**
Chair	**Simone Jordan** **Deputy Chair, ICB**	**Venue / Location**	MSTeams

REF	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
ICB/24/22	Welcome and Introductions	To receive	Simone Jordan (ICB Deputy Chair)	**Verbal**	9:00am
ICB/24/23	Apologies for Absence: • Mark Andrews, Rutland County Council (Kim Sorsky deputising)	To receive	Simone Jordan (ICB Deputy Chair)	**Verbal**	9:00am
ICB/24/24	Notification of Any Other Business	To receive	Simone Jordan (ICB Deputy Chair)	**Verbal**	9:00am
ICB/24/25	Declarations of interest relating to agenda items *Members are reminded of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of the NHS LLR ICB*	To receive	Simone Jordan (ICB Deputy Chair)	**Verbal**	9:00am
ICB/24/26	To consider **written questions received in advance** from the Public in relation to items on the agenda	To receive	Simone Jordan (ICB Deputy Chair)	**Verbal**	9:05am
ICB/24/27	Minutes of the meeting held on 8 February 2024	To approve	Simone Jordan (ICB Deputy Chair)	**A**	9:10am
ICB/24/28	Matters arising and actions following the previous meeting.	To receive	Simone Jordan (ICB Deputy Chair)	**B**	
ICB/24/29	Update from the Chair	To receive	Simone Jordan (ICB Deputy Chair)	**Verbal**	9:15am
STRATEGY AND SYSTEM PLANNING					
ICB/24/30	LLR ICB Board Assurance Framework 2023/24 and 2024/25	To approve	Robert Toole (ICB Chief Finance Officer)	**C**	9:20am
OPERATIONAL					
ICB/24/31	Equality, Diversity and Inclusion Annual Report	To approve	Alice McGee (ICB Chief People Officer)	**D**	9:25am
ICB/24/32	LLR ICB Finance Report	To receive	Robert Toole (ICB Chief Finance Officer)	**E**	9:30am
ICB/24/33	Emergency Preparedness, Resilience and Response (EPRR) Assurance Update	To receive	Rachna Vyas (ICB Chief Operating Officer)	**F**	9:35am
GOVERNANCE					
ICB/24/34	LLR ICB Register of Interests and Register of Gifts and Hospitality 2023/24	To approve	Robert Toole (ICB Chief Finance Officer)	**G**	9:40am
ICB/24/35	LLR ICB Board Forward Planner 2024/25	To approve	Robert Toole (ICB Chief Finance Officer)	**H**	

REF	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
ASSURANCE – FOR INFORMATION					
ICB/24/36	Assurance report from the Finance Committee	To receive	Jeff Worrall (ICB Finance Committee Chair)	**I**	--
ICB/24/37	Assurance report from the System Executive Committee	To receive	Caroline Trevithick (ICB CEO)	**J**	
ICB/24/38	Assurance report from the Quality and Safety Committee	To receive	Pauline Tagg (ICB Non-Executive Member)	**K**	
ICB/24/39	Assurance report from the Audit Committee	To receive	Darren Hickman (ICB Non-Executive Member)	**L**	
ICB/24/40	Assurance report from the Health Equity Committee	To receive	Prof Azhar Farooqi (ICB Non-Executive Member)	**M**	
FOR INFORMATION					
ICB/24/41	Delegation of Specified Specialised Acute Services	To receive	Sarah Prema (ICB Chief Strategy Officer)	**N**	--
ICB/24/42	LLR Delivery Partnership – Delivery of the LLR one- and five-year plans	To receive	Rachna Vyas (ICB Chief Operating Officer)	**O**	--
ICB/24/43	Operational Planning 2024/25 update	To receive	Sarah Prema (ICB Chief Strategy Officer)	**verbal**	--
ANY OTHER BUSINESS					
ICB/24/44	Items of any other business and review of meeting	To receive	Simone Jordan (ICB Deputy Chair)	**Verbal**	9:45am

The next regular meeting of the LLR Integrated Care Board meeting will take place on **Thursday 13 June 2024**, 9:00am to 11:30am, meeting to be held in public via MSTeams.

Where applicable *- motion for private session - the Chairman to move, that members of the public be excluded from the remainder of the meeting, owing to the confidential nature of the business to be transacted, which is related to the commercial affairs of the ICB.*

A

Minutes of the NHS LLR Integrated Care Board ("the ICB" or "the Board")
Held in Public, Thursday 8 February 2024
9:00am – 10:55am, via MS Teams

Members present:

Mr David Sissling	NHS LLR ICB Independent Chair and Chair of the meeting
Ms Caroline Trevithick	Chief Executive, NHS LLR ICB
Ms Kay Darby	Chief Nursing Officer, NHS LLR ICB
Dr Nil Sanganee	Chief Medical Officer, NHS LLR ICB
Mr Robert Toole	Chief Finance Officer, NHS LLR ICB
Mr Ket Chudasama	Deputy Chief Strategy and Planning Officer, NHS LLR ICB *(deputising for Ms Sarah Prema)*
Ms Alice McGee	Chief People Officer, NHS LLR ICB
Ms Rachna Vyas	Chief Operating Officer, NHS LLR ICB
Mr Darren Hickman	Non-Executive Member – Audit and Conflicts of Interest, NHS LLR ICB
Ms Simone Jordan	Non-Executive Member – Remuneration and People, NHS LLR ICB
Ms Pauline Tagg	Non-Executive Member – Safety, Performance and Transformation, NHS LLR ICB
Prof Azhar Farooqi	Non-Executive Member – Inequalities, Public Engagement, Third Sector and Carers, NHS LLR ICB
Sir Mayur Lakhani	Clinical Executive Lead, NHS LLR ICB
Mr Simon Barton	Deputy Chief Executive Officer, University Hospitals of Leicester NHS Trust *(Deputising for Mr Richard Mitchell)*
Ms Angela Hillery	Partner Member - community/mental health sector representative (Chief Executive, Leicestershire Partnership NHS Trust)
Mr Mike Sandys	Partner Member – local authority sectoral representative (Director of Public Health, Leicestershire County Council)
Mr Mark Andrews	Partner Member – local authority sectoral representative (Chief Executive, Rutland County Council)
Dr Nainesh Chotai	Primary Care Sector representative

Participants:

Dr Janet Underwood	Chair, Healthwatch Rutland
Ms Harsha Kotecha	Chair, Healthwatch Leicester and Leicestershire
Cllr Sarah Russell	Chair of Leicester City Health and Wellbeing Board
Cllr Diane Ellison	Chair of Rutland Health and Wellbeing Board
Cllr Louise Richardson	Chair of Leicestershire Health and Wellbeing Board

In attendance:

Prof Mick Steiner	Deputy Chief Medical Officer, NHS LLR ICB *(for item ICB/24/10)*
Ms Carly McDonald	Research Manager, NHS LLR ICB *(for item ICB/24/10)*
Ms Wendy Hope	Head of Quality and Safety, NHS LLR ICB
Mrs Daljit Bains	Head of Corporate Governance, NHS LLR ICB
Ms Charlotte Gormley	Corporate Governance Officer, NHS LLR ICB (minute taker)

Eight members of the public attended to observe the meeting.

ITEM		LEAD RESPONSIBLE
ICB/24/01	**Welcome and Introductions** Mr David Sissling welcomed colleagues and members of the public to the meeting. The meeting was held in public and confirmed as quorate.	

ITEM		LEAD RESPONSIBLE
ICB/24/02	**Apologies for absence from Members and Participants:** • Ms Sarah Prema, Chief Strategy Officer, NHS LLR ICB • Mr Richard Mitchell, Partner Member - acute sector representative (Chief Executive, University Hospitals of Leicester NHS Trust) • Mr Laurence Jones, Partner Member – local authority sectoral representative (Strategic Director, Social Care & Education, Leicester City Council) • Mr Richard Henderson, Chief Executive, East Midlands Ambulance Service	
ICB/24/03	**Notification of Any Other Business** No additional items of business had been notified.	
ICB/24/04	**Declarations of Interest on Agenda Items** No specific declarations were noted on agenda items. The register of interests was published on the ICB website and reviewed on a regular basis.	
ICB/24/05	**Consider written questions received in advance from the Public in relation to items on the agenda** No written questions had been raised in advance of the meeting.	
ICB/24/06	**Minutes of the meeting held on 14 December 2023 (Paper A)** The minutes of the ICB Board meeting held on 14 December 2023 were confirmed as an accurate record. **It was RESOLVED to:** • **APPROVE** the minutes of the ICB Board meeting held on 14 December 2023.	
ICB/24/07	**Matters Arising and actions for the meeting held on 14 December 2023 (Paper B)** Progress made against actions was noted and the request to close specific actions was supported. **It was RESOLVED to:** • **RECEIVE** the update and progress made in relation to the actions.	
ICB/24/08	**Update from ICB Chair** Mr Sissling announced that he would be stepping down from his role as Chair of LLR ICB. The process to identify a successor had commenced and would be subject to national approval. Mr Sissling confirmed the appointment of Ms Jordan as Deputy Chair. **Moreover, with three interim positions currently held within Executive Team, it was agreed that an appropriate risk assessment would be completed.** Mr Sissling commented on the excellence of the research activities taking place across the Integrated Care System (ICS). As Chair of the LLR Research Strategy Group, he particularly noted the progress made in non-medical research and research relating to primary care. Additionally, Mr Sissling advised that the LLR Health and Wellbeing Partnership had recently met and held excellent discussions regarding children's services, the opportunities available to Anchor Institutions, and specific initiatives such as the Workwell Programme. **It was RESOLVED to:** • **RECEIVE** the update.	**Caroline Trevithick**

ITEM		LEAD RESPONSIBLE
ICB/24/09	**Update from ICB, Acute Sector and Mental Health and Community Sector** Ms Trevithick highlighted the ongoing pressures within Urgent and Emergency Care (UEC) which had resulted in long waits for patients. A critical incident had been declared on 23 January 2024 and stood down on 25 January 2024. On behalf of LLR ICB, Ms Trevithick expressed thanks to all partner organisations for their efforts to jointly manage risks during across the UEC pathway. Ms Trevithick also acknowledged the support provided by partner organisations to the families affected by the flooding following the recent storms. This included support from mental health services for adults and children. Finally, pending the release of national planning guidance, Ms Trevithick provided assurance that operational planning for 2024/25 would continue based on previously advised planning assumptions. Ms Hillery observed that the occupancy rate in LPT's mental health beds remained high despite additional bedded capacity being opened. She noted that work continued with partner organisations to manage and respond to risks. Additionally, Ms Hillery shared that LPT was performing in the top quartile against a number of metrics in line with the latest NHS Oversight Framework. Improvements had been noted in dementia and perinatal care. Ms Hillery thanked partners for their collaborative efforts, advising that a set of key objectives for forthcoming year would be developed and fed back to the Board. An update was provided following recent unannounced visits by the Care Quality Commission (CQC) to mental health acute and psychiatric wards, intensive care, and community services. It was noted that initial feedback had been encouraging regarding staffing and culture. A draft report was anticipated within the next month and outcomes would be shared with all partners. Finally, Ms Hillery highlighted National Apprentice Week and advised that a Health and Care careers event would take place on 9 March 2024. In his update regarding the acute sector, Mr Barton advised that feedback was anticipated shortly following CQC visits to maternity and emergency care services. He noted the improvements in ambulance handover times in recent months, but acknowledged that the current winter had been difficult due to increases in demand particularly for admissions. Mr Barton highlighted the positive system response to the pressures and also drew attention to the positive impact of additional capacity which had been opened. UHL had been recognised for the significant progress made in elective activity despite the impact of industrial action. Mr Barton, finally, commented on a range of wider work being taken forward by UHL. This included opportunities associated with developing as an anchor organisation and initiatives to contribute to enhancing prevention and reducing inequity. Mr Sissling thanked members for their updates and drew the Board's attention to the Quarterly System Review Meeting (QSRM) that had taken place on 26 January 2024. He informed that discussion with NHS England had been	

ITEM		LEAD RESPONSIBLE
	positive with progress against a number of priorities being recognised. In particular LLR was commended in respect of improvements in elective care, mental health and learning disability services, and the system's approach to equity and diversity. However concerns and challenge had been raised by NHS England in relation to urgent care and finance. On behalf of the Board, Ms Trevithick thanked Mr Sissling for his contributions, support, and leadership to LLR ICB. She reflected on the positive legacy he would be leaving and wished him all the best for the future. **It was RESOLVED to:** • **RECEIVE** the updates.	
ICB/24/10	**Research update and Annual Report (Paper C)** Dr Sanganee introduced the item and assured the Board that LLR ICB was meeting its statutory duties with regards to research. He noted that key areas of focus included the facilitation and promotion of research and the application the evidence from research in service design and procurement. Furthermore, he highlighted the success of the Patient Recruitment Centre and the ongoing focus on increasing the diversity of the population taking part in research. Dr Sanganee observed that organisations active in research were considered to provide a higher quality of care and better outcomes for patients. Additionally, he confirmed to the Board that work was underway to update the Research Strategy and develop associated delivery plans. He confirmed that the aim was to embed research activity into service redesign and transformation programmes from the outset. Members welcomed the update, noting that LLR was in a strong position in terms of research with progress in cross-sector and partnership working. Further updates to the Board would be provided periodically. **It was RESOLVED to:** • **RECEIVE** for information.	
ICB/24/11	**Operational Planning 2024/25 update (Paper D)** Mr Chudasama introduced the item, advising that guidance required the ICB and partner Trusts to complete a review of the 5-Year Plan (5YP) before the start of each financial year, with the option to revise in-year if necessary. However, it had been agreed locally that the annual operational planning round should appropriately inform the 5YP refresh. As national guidance was yet to be released and the planning round would not be complete before the new financial year, it was proposed to carry over the existing 5YP into 2024/25 with a refresh to take place during Quarter 1, following submission of the Operational Plan. Finance and delivery plans would also align to the Operational Plan. He also provided an update regarding the 2024/25 Operational and Financial Plan, which had been discussed in detail at the System Executive development session held in January 2024. Significant challenges had been identified in terms of finance and affordability. LLR was not an outlier in this regard. It was	

ITEM		LEAD RESPONSIBLE
	anticipated that the Board would receive a draft version of the Operational Plan for comment in March 2024, followed by the final version for approval in May 2024. It was noted that these timelines may alter depending on the content of national planning guidance which was yet to be released. Members supported the proposal to complete a planned refresh of the 5YP in Quarter 1 of 2024/25, following submission of the Operational Plan. There was currently no indication as to when national planning guidance would be released, however local plans were being developed on the basis of assumptions carried forward from 2023/24. Members noted the importance of aligning short-term actions with the long-term goals as identified within the 5YP. It was also expected that opportunities for transformational change would be pursued over the short, medium, and long-term. Further updates would be provided at each Board meeting. **It was RESOLVED to:** • **APPROVE** the arrangements set out for the revision of the LLR ICB 5-Year Plan • **APPROVE** the inaugural LLR ICB 5YP is being maintained for 2024/25 • **NOTE** the 2024/25 Operational and Financial Plan update	
ICB/24/12	**Gender Pay Gap report (Paper E)** Ms McGee introduced the item, advising that all public sector organisations employing 250 or more staff were required to annually publish their gender pay gap information. Previously, the three LLR Clinical Commissioning Groups were not required to report this information as each organisation had less than 250 employees. The LLR ICB was required to report on the gender pay gap as it exceeded the 250-employee threshold. It was noted that LLR ICB did not meet the threshold required to publish an equal pay report. The report identified a Mean Pay Gap of 19.6% in favour of men. Although significant statistically, the difference of average hourly pay was relatively and driven predominantly by medical pay rates. It was noted that the majority of apprenticeships and senior medical positions were held by men. Analysis did not indicate, furthermore, that an equal pay problem exists. It was agreed that the People Board would develop a series of actions to encourage a workforce representative of the population, attract males and females into all roles, and address gender stereotypical perceptions of roles. Members approved the draft Gender Pay Gap Report 2023 for publication, noting the ICB's ambition to further understand and close the gap identified within the report. **It was RESOLVED to:** • **Approve** the Gender Pay Gap Report 2023 for publication on the ICB Website.	

ITEM		LEAD RESPONSIBLE
ICB/24/13	**Delegation of Specified Specialised Acute Services briefing paper (Paper F)** Mr Chudasama introduced the item and advised that NHS England was planning to delegate responsibility for 59 specialised acute services from 1 April 2024. He provided assurance to the Board in respect of the due diligence being undertaken by various working groups to ensure a safe transition. The Board was advised that a final suite of documents would be presented for the Board's approval on 14 March 2024. Dr Trevithick added that much discussion and consideration had been taking place across the region with leads supporting the programme from a clinical, quality, governance and finance perspective to ensure the risks associated with the delegation were fully understood and evaluated. Furthermore, the proposal was for all 11 Midlands ICBs to now agree to receive the delegated functions based on common governance and relevant supporting arrangements. Members received assurance that the ICBs would work closely with and receive support from NHS England during a transitional year. A discussion ensued and it was highlighted that the proposed arrangements would offer a range of positive outcomes. For example, resources for specialised services would to be brought closer to local populations to enable inequities to be addressed. There would also be opportunities to refine and improve pathways by identifying financial and clinical efficiencies. The Board noted the proposed alignment of the governance arrangements with those established for pharmacy, ophthalmic and dental (POD) services across the East Midlands. It was agreed that Board would benefit from a more detailed understanding of the services to be delegated, potentially through a series of deep dive sessions in the near future. **It was RESOLVED to:** • **RECEIVE and NOTE** the Delegation of Specified Specialised Acute and Services Briefing and associated appendices and provide feedback as required.	
ICB/24/14	**LLR Delivery Partnership – Delivery of the LLR one- and five-year plans (Paper G)** Ms Vyas introduced the item, providing the Board with an update on progress against the LLR Operational Plan and the LLR five-year plan at Month 9 of 2023/24. She highlighted the system's response to eight recent emergency resilience challenges, including industrial action, storms, and road traffic accidents. The multi-agency response to these incidents had provided positive results for patients with service continuity being maintained. Ms Vyas described areas of strong performance including improvements in elective, diagnostic and cancer access. She also highlighted the positive performance of many Mental health and Learning disability services. She however referenced the continuing challenges in relation to urgent care.	

ITEM		LEAD RESPONSIBLE
	Ms Trevithick drew the Board's attention to the critical incident declared in January 2024 in response to the significant challenges in UEC and described the robust actions taken to de-escalate the situation as swiftly as possible. She advised that the demand for bedded capacity had exceeded modelled levels, resulting in operational pressure and a requirement for further investment in resources. Transformational pathway work had resulted in improved year on year conveyance times for East Midlands Ambulance Service (EMAS). However delays caused by a shortage in Non-Emergency Patient Transport (NEPTS) capacity remained problematic and were affecting discharge arrangements. During Board discussion, it was noted that ongoing issues with ambulance response times to category 1 calls in Rutland had been flagged with EMAS. Members received assurance that plans were being developed to address the issues. Concerns were also raised regarding messaging from Urgent Care Centres in Oakham about evening and weekend opening hours. It was confirmed that same day access had been commissioned over winter and messaging would be addressed. It was agreed that a focussed discussion of UEC would be scheduled for a future Board development session. **It was RESOLVED to:** • **RECEIVE and NOTE** the full contents of the report. • **NOTE** the increasing risks within the UEC pathway and the risk this poses to the H2 plan.	
ICB/24/15	**LLR ICB Finance Report (Paper H)** Mr Toole informed the Board that the LLR system was reporting a year-to-date deficit at month 9 of £(66.6)m which represented a £(43.3)m adverse variance to the final agreed plan. UHL were reporting a £(47.3)m deficit and the ICB a £(18.8)m deficit. LPT were reporting a small year-to-date deficit of £(0.5)m. The system had forecast a revised year-end deficit of £(61.1)m, which was £(51.1)m adverse to the plan. This excluded any impact of Industrial Action during December 2023 and January 2024 and other arising issues. The drivers of the deficit included pay inflation, prescribing growth, UEC pressures, and workforce growth. The ICB was however declaring achievement of the Mental Health Investment Standard (MHIS) and running costs targets. In response to queries, Mr Toole clarified that the pressures associated with the delivery of urgent care services were particularly significant. This was driving a requirement to fund additional capacity and staffing levels. There had been an increase in the number of admitted patients and acuity levels were often quite severe. Board members acknowledged this challenge but emphasised the requirement for rigorous planning and control processes, particular for the management of workforce. The Board expressed concerns regarding the revised year-end deficit and emphasised the requirement for any further risks to delivery to be effectively mitigated. Members also supported necessary rapid work to develop an affordable and sustainable plan for 2024/25	

ITEM		LEAD RESPONSIBLE
	It was RESOLVED to: • **RECEIVE and NOTE** the financial position as at month 9 and the forecast performance. • **RECEIVE** for assurance.	
ICB/24/16	**Assurance report from the Finance Committee (Paper I)** Ms Simone Jordan (Deputy Chair of the Committee) introduced the report. She advised that the Committee had identified significant challenges and risk in all key areas. This was reflected in the risk rating. Relevant matters had been remitted to Executives for further action. **It was RESOLVED to:** • **RECEIVE** the report for assurance.	
ICB/24/17	**Assurance report from the System Executive Committee (Paper J)** Dr Trevithick highlighted that oversight of operational planning had been the key focus of the Committee alongside preparatory work in respect of the delegation of specialised acute services. She also confirmed that provider segmentation scores at Quarter 3 remained unchanged with LPT at NOF level 2 and UHL at NOF level 4. No items had been identified for escalation to the Board. **It was RESOLVED to:** • **RECEIVE** the report for assurance.	
ICB/24/18	**Assurance report from the Quality and Safety Committee (Paper K)** Ms Tagg advised that UEC had been highlighted as an area of risk over the winter months. The Committee had received assurance that the Winter Plan and escalations in place were appropriate. **It was RESOLVED to:** • **RECEIVE** the report for assurance.	
ICB/24/19	**Assurance report from the Audit Committee (Paper L)** Mr Hickman introduced the report, drawing the Board's attention to the focus on completing the Audit Plan and implementing audit actions in a timely manner. **It was RESOLVED to:** • **RECEIVE** the report for assurance.	
ICB/24/20	**Assurance report from the Health Equity Committee (Paper M)** Professor Farooqi highlighted the actions in place to reduce Board Assurance Framework (BAF) risk 2 through partnership working and investment aligned to health equity. It was highlighted that UHL and LPT had introduced a Social Value Framework and Health Inequality Charter respectively. Concerns had been noted regarding the discontinuation of the tier 2 weight management service and the poor performance of dental services throughout	

ITEM		LEAD RESPONSIBLE
	LLR. Deep dives into these areas would be held. Robust plans were also required regarding appropriate investment and prevention. A detailed update regarding vaccination programmes would be received at the next meeting and a report returned to the Board in due course. **It was RESOLVED to:** • **RECEIVE** the report for assurance.	
ICB/24/21	**Items of any other business and review of the meeting** There were no items of further business. The meeting closed at 11:01am.	
Date and Time of next meeting: The next meeting of the NHS LLR Integrated Care Board would take place on **Thursday 11 April 2024,** 9:00am to 11:30am via MS Teams.		

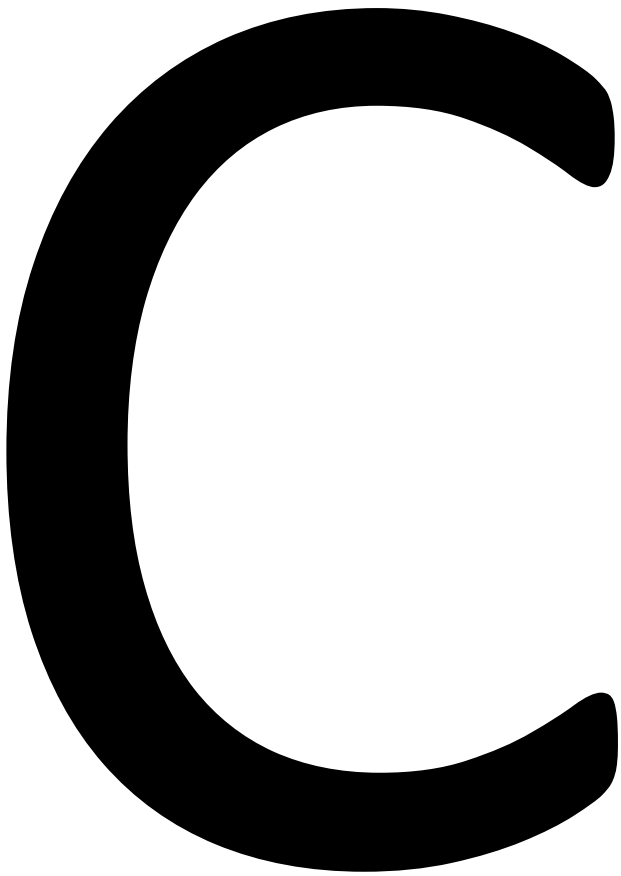
B

NHS Leicester, Leicestershire and Rutland (LLR) Integrated Care Board

Action Log

Key		
Completed	On-Track	No progress made

Minute No.	Meeting Date	Item	Responsible Officer	Action Required	To be completed by	Progress as at April 2024	Status
ICB/23/119	12 October 2023	Primary Care Access Recovery Plan - LLR System-level Access Improvement Plan	Dr Nil Sanganee (ICB Chief Medical Officer)	The Board requested a plan of actions with measurable indicators and outcomes.	~~January 2024 / February 2024~~ April 2024	It was agreed by the Board on 14 December 2023 that an update would be provided in April 2024 along with the results of the patient experience survey. **Item deferred to June 2024.**	**Amber**
ICB/23/153	14 December 2023	ICB Board Assurance Framework (BAF)2023/24 review	ICB Executive Team	Executive Team would consider the inclusion of the prevention agenda, particularly in terms of investment and sustainability, within the BAF.	End February 2024	Updated BAF on the Board agenda for April 2024. **Action complete**	**Green**
ICB/24/08	8 February 2024	Update from ICB Chair	Ms Caroline Trevithick (ICB Chief Executive)	In acknowledgement of the three interim positions currently held on the LLR ICB Executive Team, it was agreed that an appropriate risk assessment would be completed.	April 2024	A review has been undertaken by the Executive Management Team and an operational risk has been considered and included on the corporate governance risk register. **Action complete**	**Green**



Name of meeting:	**Leicester, Leicestershire and Rutland ICB Board (public)**		
Date:	11 April 2024	**Paper:**	**C**
Report title:	**ICB Board Assurance Framework 2023/24 and 2024/25**		
Presented by:	Robert Toole, Chief Finance Officer		
Report author:	Daljit Bains, Head of Corporate Governance		
Executive Sponsor:	Robert Toole, Chief Finance Officer		

To approve ☒	**For assurance** ☒	**To receive and note** ☐	**For information** ☐
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Recommendations:

The LLR ICB Board is requested to:

- **APPROVE** the de-escalation of BAF risk 8 (workforce) and for this to be replaced by BAF risk 9 (workforce).
- **APPROVE** the end of year closing position of the ICB Board Assurance Framework 2023/24 (as at Appendix 1).
- **APPROVE** the 2023/24 end of year position as the new ICB Board Assurance Framework for 2024/25.

Purpose and summary of the report:

This report aims to provide the Board with assurance that the risk management arrangements across the organisation continue to be fit for purpose and that the ICB's Board Assurance Framework (BAF) continues to be reviewed in line with agreed processes.

The BAF captures a snapshot of the ICB's risk profile at a point in time and the content of the BAF will continue to be reviewed by the Executive Management Team on at least a bi-monthly basis to ensure it remains up to date. Subsequently, the strategic risks within the BAF are also assessed and scrutinised through the Board Committees.

The BAF illustrates the changes made to the following risks:
- BAF risk 5 – quality and safety
- BAF risk 6 – EPRR
- BAF risk 7 - cyber
- BAF risk 8 – workforce – it is requested that this risk be de-escalated or closed and replaced by BAF risk 9.
- BAF risk 9 – new workforce risk proposed.

The residual risk scores across the remaining strategic risks have remained consistent over the last couple of months. Key highlights in relation to the BAF are captured in paragraph 14 of the report.

Appendices:	• Appendix 1 – LLR ICB BAF 2023/24 and new BAF for 2024/25
Report history (date and committee / group the	• 23 March 2023 – proposal presented for consideration and discussion at the Board development session.

content has been discussed / reviewed prior to presenting to this meeting):	• 3 April 2023 – EMT further considered the proposal for ICB BAF 2023/24. • April 2023 – July 2023 – each of the Board Committees have received and commented on the BAF • July – November 2023 - all Board Committees received the BAF at agreed intervals following review by EMT. • October 2023 – EMT reviewed the BAF and agreed content. • December 2023 – EMT reviewed the BAF and agreed content. • 14 December 2023 – LLR ICB Board approved the updated BAF. • 13 February 2024 – ODG reviewed the BAF and directorate level risk profiles and supported the proposal that BAF 9 is a new risk and BAF 8 be de-escalated. Proposal for onward consideration by EMT. • February – March 2024 – EMT and Board Committees.

The report is helping to deliver the following strategic objective(s) – *please tick all that apply***:**		
1. Improve outcomes	Improve outcomes in population health and healthcare.	☒
2. Health inequalities	Tackle inequalities in outcomes, experience and access.	☒
3. Value for money	Enhance productivity and value for money.	☒
4. Social and economic development	Help the NHS support broader social and economic development.	☒
5. NHS Constitution	Deliver NHS Constitutional and legal requirements.	☒

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	

Implications:	
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	Not having the fundamental governance and risk management arrangements could result in non-compliance with legal and statutory requirements.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	None specifically in relation to this report.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	None specifically in relation to this report.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	None specifically in relation to this report.
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	Not specifically in relation to this report, however the principles are contained with the Constitution and governance arrangements.

ICB Board Assurance Framework 2023/24 and 2024/25

Purpose

1. This report aims to provide the Board with assurance that the risk management arrangements across the organisation continue to be fit for purpose and that the ICB's Board Assurance Framework (BAF) continues to be reviewed in line with agreed processes.

2. The BAF captures a snapshot of the ICB's risk profile at a point in time and the content of the BAF will continue to be reviewed by the Executive Management Team on at least a bi-monthly basis to ensure it remains up to date. Subsequently, the strategic risks within the BAF are assessed and scrutinised through the Board Committees.

3. The residual risk scores across the remaining strategic risks have remained consistent over the last couple of months.

Governance arrangements and assurance

Risk Management Strategy and Policy

4. The ICB has adopted a risk management strategy and policy which is aligned to ISO 31000:2009 risk management systems and processes. The international standards (*ISO 31000:2009 Risk Management – Principles and Guidelines*) are recognised as good practice for risk management arrangements.

5. The Board has the responsibility to ensure appropriate risk management systems and processes are in place and are aligned to the ICB's Risk Management Strategy and Policy.

Executive and Committee responsibility

6. The Executive Management Team is responsible for the effective implementation of risk management arrangements and for ensuring adequate controls are in place to manage / mitigate risks. The Executive Management Team is also responsible for the regular review of the BAF in its entirety and evaluate strategic risks prior to escalation to the Board.

7. Each Board Committee is responsible for oversight of specific risks as assigned to it within the BAF and for providing appropriate assurance through the Committee assurance reports to the Board.

8. The Board will seek assurance from the Audit Committee in relation to the effectiveness of the risk management arrangements as part of the overall internal control arrangements of the ICB.

Consideration of system wide risk profile

9. Risks arising across the system will continue to be evaluated through the Committee structure to assess whether a risk solely relates to the ICB or whether there are implications for the ICB and other partner organisations. The Board agreed that it was key to identify the event that could potentially lead to a risk materialising and then identify which organisation would be responsible for managing and controlling this event. This would determine whether the risk is already being managed through existing risk management arrangements within partner organisations.

10. As alluded to in previous reports to the Board / Committees, the following principles continue to apply:

a. The ICB BAF will capture strategic risks that the ICB can influence and / or control relating specifically to the ICB (i.e. specific to the ICB as a statutory body) and
b. The ICB BAF will capture strategic risks that the ICB can influence and / or control where they collectively impact the ICB objectives and system objectives (categorise these as "system" risks). However, this element will continue to evolve as processes mature and develop.

Board Assurance Framework (BAF) updates

11. The ICB's Board Assurance Framework (BAF) continues to be aligned to the ICB's Strategic Objectives and Five Year Plan. The risk descriptions were agreed by the Board in April 2023 and amendments approved in July 2023. The ICB BAF is a live document and has therefore been updated to reflect change in controls, gaps identified, and action taken. In reviewing the BAF lead officers continue to consider the following:

    i. What are the key drivers for each strategic risk?
    ii. Are the key drivers sufficient and are they effective in mitigating the risk?
    iii. What further actions / mitigations are required to achieve the risk appetite score?
    iv. If the actions continue to be appropriate, how long will it take to reduce the residual risk and for it to align with the risk appetite?
    v. Are Executive Officers still confident that the actions being taken are the correct actions to mitigate the risks?

12. The Board approved the last iteration of the BAF in December 2023 and asked the Executive Management Team to consider whether the prevention agenda needs to be reflected in the organisation's risk profile.

13. The BAF has since been updated further. The updated BAF is as at **Appendix 1** with a high-level summary captured in **Table 1.** It is noted that the prevention agenda forms a key part of the ICB's operational plan and any risks in relation to the prevention agenda would be aligned to insufficient financial resources and also a potential risk of lack of partnership engagement and support. Therefore, the content of BAF risk 1 (partnerships), BAF risk 2 (health inequalities) and BAF risk 4 (finance) have been reviewed to capture any gaps in controls and assurances in relation to the prevention agenda. This will be kept under review in subsequent iterations of the BAF.

14. The Board's attention is drawn to the following **specific updates in relation to the BAF:**

    a) **Risk Owners** - have been updated across the BAF to reflect recent executive appointments.

    b) **Risks with a high residual risk score are as follows:**
        i. BAF 2 - Health inequalities (residual risk score of 20) and
        ii. BAF 4 - finance (residual risk score of 20)
        iii. BAF 5 - quality and safety (residual risk score of 16).

    c) **Change in residual risk scores**:
        - The residual risk scores across the strategic risks have not changed and have remained consistent over the last few months.

- For BAF risk 5 (quality and safety) – as discussed at the Quality and Safety Committee deep dive session in December 2023, it is anticipated that the actions will take at least 12 months to complete and embed before the residual risk score aligns with the risk appetite score.

d) **Updates against actions and mitigations** - detailed in Appendix 1.

e) Updates in relation to specific risks:

i. **BAF risk 2 – health inequalities** – in September / October 2023 officers undertook a detailed review of the actions required to reduce the residual risk score. The actions for completion over a 6 – 8 month period aim to focus on creating recurrent processes which endeavour to give all patients an equitable opportunity to access the full range of NHS care through the life course and to obtain good outcomes. This in turn will aim to affect, firstly, the likelihood of the risk materialising and, secondly (over a longer time scale), the impact of the strategic risk. The evidence that would provide that assurance will emerge over time.

ii. **BAF risk 4 – finance** – has been reviewed and detail contained in Appendix 1.

iii. **BAF risk 5 - quality and safety** – the Quality and Safety Committee carried out a deep dive into this BAF risk in December 2023 and as a result officers further updated the content of the BAF risk in January with further review in February/March 2024. The updates are highlighted in Appendix 1 including controls in place and the identification of critical actions required where gaps have been identified. One of the key actions identified relates to establishing quality metrics across the partnerships / collaborative.

iv. **BAF risk 6** – **emergency preparedness, resilience and response (EPRR)** - controls and assurances have been updated to reflect the positive assurance received from NHS England. The residual risk score remains positive, however the risk will continue to remain on the BAF given the potential impact of the risk on the organisation should the risk materialise.

v. **BAF risk 8 – workforce** and **BAF risk 9 (proposed <u>new</u> risk on workforce)** – the risk owner has reviewed BAF risk 8 following comments and observations made by the Remuneration Committee in November 2023. The Remuneration Committee members asked if the risk, as described in BAF 8, remains relevant and whether the "pressures" as referenced within the risk description need to be specified. In addition, it was noted that the residual risk score for BAF 8 remains at 12 and the risk appetite has been assessed as 8, which indicated that further actions may need to be considered to address the residual risk, however at the time no actions had been identified.

The risk owner has since reviewed the risk description and content. Rather than amending the risk description for BAF risk 8, it is proposed that BAF risk 8 be de-escalated to the relevant directorate risk register or closed as it is no longer relevant, and BAF risk 9 be approved as the current strategic risk in relation to workforce.

Table 1: High-level summary of the LLR ICB BAF 2023/24 (detail contained in Appendix 1)

Strategic risk	Residual risk score (trend) Dec 2023	Exec Lead	Committee oversight
BAF 1 – Partnership The ICB is unable to develop and sustain a culture of collaboration / partnership working and thus unable to improve outcomes in population health and healthcare.	**12**	**Chief Executive**	System Executive Committee / EMT
BAF 2 – Health Inequalities Failure to adequately address health inequalities due to a lack of investment and / or lack of partnership working, therefore unable to improve health equity and outcomes for the population of LLR.	**20**	**Chief Strategy Officer**	Health Equity Committee
BAF 3 – Demand and Capacity Demand could exceed capacity in commissioned services due to a variety of factors. This could result in patients not accessing services in the right place, at the right time, at the right level of care.	**12**	**Chief Operating Officer**	System Executive Committee
BAF 4 – Finance The financial viability of the local health economy (over the short, medium and long term) cannot be assured due to a lack of robust transformation processes and tested schemes, this could impact organisational reputation, incur possible financial penalties and result in closer regulatory scrutiny.	**20**	**Chief Finance Officer**	Finance Committee
BAF 5 – Quality and Safety Failure to maintain and improve the quality of services and meet the core standards could result in poor patient experience and potential harm and poor quality outcomes for patients.	**16**	**Chief Nursing Officer / Chief Medical Officer**	Quality and Safety Committee
BAF 6 – Emergency Preparedness, Resilience and Response Failure to have robust emergency preparedness, resilience and response (EPRR) processes in place due to lack of capacity and / or lack of partnership could result in inadequate response to major and / or business continuity incidents.	**8**	**Chief Operating Officer**	System Executive Committee / EMT
BAF 7 – Cyber A significant rise in new and unknown cyber-attacks (locally or nationally) could make access to IT services unavailable for extended periods of time. This may result in risks to the confidentiality of corporate or patient confidential data, disruption to organisational business continuity and to operational services.	**12**	**Chief People Officer**	Executive Management Team
BAF 8 – Workforce The ability to recruit and retain staff may be affected by the pressures and reduction in running costs impacting on enhancing productivity and delivering the ICB's strategic objectives.	**12**	**Chief People Officer**	Remuneration Committee / People Board
BAF 9 – Workforce (NEW) **The ability to retain staff, whilst delivering increasing workloads and priorities with a reduced capacity following a reduction in running cost allowance.**	**12**	**Chief People Officer**	Remuneration Committee / People Board

Board Assurance Framework 2024/25

15. It is proposed that the end of year BAF 2023/24 as at March 2024 be the opening BAF for 2024/25 as the strategic risks remain relevant. This would include the new BAF risk 9, which replaces the current BAF risk 8, as described above in paragraph 14, subject to Board approval.

Recommendations

The LLR ICB Board is asked to:

- **APPROVE** the de-escalation of BAF risk 8 (workforce) and for this to be replaced by BAF risk 9 (workforce).

- **APPROVE** the end of year closing position of the ICB Board Assurance Framework 2023/24 (as at Appendix 1).

- **APPROVE** the 2023/24 end of year position as the new ICB Board Assurance Framework for 2024/25.

Appendix 1

APPENDIX 1

Leicester, Leicestershire and Rutland Integrated Care Board

Board Assurance Framework 2023/24

(Version 12 as at March 2024)

To be read in conjunction with the LLR ICB Risk Management Strategy and Policy

CONTENTS **PAGE**

LLR ICB Strategic Objectives

LLR ICB Strategic Objective (Note: 1 – 4 are the national core purposes of an ICB)
1. Improve outcomes in population health and healthcare
2. Tackle inequalities in outcomes, experience and access
3. Enhance productivity and value for money
4. Help the NHS support broader social and economic development
5. Deliver NHS Constitutional and legal requirements

Summary of the strategic risks contained within the LLR ICB Board Assurance Framework

Strategic risk	Current / residual risk score	Exec Lead	Committee oversight	Risk aligned to the LLR ICB Strategic Objective(s)					Page
				1.	2.	3.	4.	5.	
BAF 1 – Partnership The ICB is unable to develop and sustain a culture of collaboration / partnership working and thus unable to improve outcomes in population health and healthcare.	**12**	**CT**	System Executive Committee / EMT	✓	✓	✓	✓	✓	
BAF 2 – Health Inequalities Failure to adequately address health inequalities due to a lack of investment and / or lack of partnership working, therefore unable to improve health equity and outcomes for the population of LLR.	**20**	**SP**	Health Equity Committee	✓	✓		✓	✓	
BAF 3 – Demand and Capacity Demand could exceed capacity in commissioned services due to a variety of factors. This could result in patients not accessing services in the right place, at the right time, at the right level of care.	**12**	**RV**	System Executive Committee		✓			✓	
BAF 4 – Finance The financial viability of the local health economy (over the short, medium and long term) cannot be assured due to a lack of robust transformation processes and tested schemes, this could impact organisational reputation, incur possible financial penalties and result in closer regulatory scrutiny.	**20**	**RT**	Finance Committee			✓	✓	✓	
BAF 5 – Quality and Safety Failure to maintain and improve the quality of services and meet the core standards could result in poor patient experience and potential harm and poor quality outcomes for patients.	**16**	**KD / NS**	Quality and Safety Committee	✓	✓			✓	
BAF 6 – Emergency Preparedness, Resilience and Response Failure to have robust emergency preparedness, resilience and response (EPRR) processes in place due to lack of capacity and / or lack of partnership could result in inadequate response to major and / or business continuity incidents.	**8**	**RV**	System Executive Committee / EMT	✓	✓			✓	
BAF 7 – Cyber A significant rise in new and unknown cyber-attacks (locally or nationally) could make access to IT services unavailable for extended periods of time. This may result in risks to the confidentiality of corporate or patient confidential data, disruption to organisational business continuity and to operational services.	**12**	**RT**	Executive Management Team	✓				✓	
BAF 8 – Workforce The ability to recruit and retain staff may be affected by the pressures and reduction in running costs impacting on enhancing productivity and delivering the ICB's strategic objectives. (propose to de-escalate to directorate risk register)	**12**	**AMcG**	Remuneration Committee / People Board	✓	✓			✓	
BAF 9 – Workforce The ability to retain staff, whilst delivering increasing workloads and priorities with a reduced capacity following a reduction in running cost allowance.	**12**	**AMcG**	Remuneration Committee / People Board	✓	✓			✓	

Principal / strategic risk:

BAF 1 – Partnership

The ICB is unable to develop and sustain a culture of collaboration / partnership working and thus unable to improve outcomes in population health and healthcare.

Date risk identified	ICB Executive lead (risk owner)	ICB Committee oversight	Risk category (✓ applicable category(ies))		ICB only or system risk (✓ one)		Risk rating (impact x likelihood = risk score)						Risk treatment *(i.e. state whether to terminate, treat, transfer, or tolerate the risk)*	If to be treated confirm frequency of review (e.g. monthly, quarterly)
					ICB	System								
March 2023	**Caroline Trevithick**	EMT / System Executive Committee	Clinical		✓		**Gross/inherent risk score**	4	x	4	=	**16**	Treat	**Quarterly**
			Organisational	✓			**Risk appetite score**	4	x	2	=	**8**		
			Financial				**Net/residual/ current risk score**	4	x	3	=	**12**		
			Information				**Residual / current risk score trend since last report:**						⟷ **February / March 2024** – risk assessed and no further changes required at present. Risk to be reviewed in April.	
							Next review date:						End April 2024	

Key controls in place and rationale for current / residual risk score	Internal and / or external assurances *Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?*		Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the ICB failing to gain evidence that the controls/systems are effective?*
	internal	**external**	
• ICB works with partners (i.e. LAs and NHS) to identify priority areas for joint working, development of joint strategies and plans (including plans for prevention and reducing health inequalities), reviews progress and resources, risks, issues and mitigations. • Committees in place include ICB Board, System Executive Committee, LLR Health and Wellbeing Partnership, Quality and Safety Committee, Health Equity Committee, Finance Committee and the Delivery Partnership. • Attendance at and joint working with other partnership forums including: Health and Wellbeing Boards across all three places, District councils' Health Leaders meetings, Integrated Systems of Care (ISOC) meeting (Leicester), Joint Integrated Commissioning Board (Leicester) Staying Healthy Partnership meetings (Leics.) Community Safety Partnership meetings, ICB-VCS Alliance regular meetings, regular meetings with Healthwatch across all three places, Collaborative meetings, Patient Participation Information and Assurance Group, LLR Research Strategy Board.	• Outcomes and progress following these meetings are reported through the ICB Board and respective ICB Committee. • Staff survey results • 360-degree evaluations of system, ICB, system maturity matrices • Complaints/disputes	• NHSE Quarterly System Review meetings • NHSE Regional Coordination Centre Daily calls • NHSE feedback on submissions such as Annual Operational plans, Joint Five Year Plan, Integrated Care Strategy, Better Care Fund Plans, Fuller Stocktake updates.	• There is room for more formal soliciting of partner evaluations of the state of our relationships and culture.

Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *What actions are required to bridge the gaps in controls and/or assurance?*	**Action to be completed by (date)**	**Will the action reduce impact of risk score or likelihood or both?**			**Progress on action(s)** *Brief note on updates/progress where appropriate and confirm when action completed.*
		Impact	Likelihood	Impact and likelihood	
a) Identify tool to measure partners' assessment of collaboration to provide structured feedback to ICB on their perception of our performance. If a suitable one can be identified – request system partners to complete and evaluate response.	~~30 August 2023~~ End March 2024			✓	NHS England partnership governance review undertaken and presented to the ICB Board in October 2023. ICB Board supported the content. **ACTION COMPLETE**

Principal / strategic risk:

BAF 2 – Health Inequity

Failure to adequately address health inequalities due to a lack of investment and / or lack of partnership working, therefore unable to improve health equity and outcomes for the population of LLR.

Date risk identified	ICB Executive lead (risk owner)	ICB Committee oversight	Risk category (✓ applicable category(ies))		ICB only or system risk (✓ one)		Risk rating (impact x likelihood = risk score)						Risk treatment *(i.e. state whether to terminate, treat, transfer, or tolerate the risk)*	If to be treated confirm frequency of review (e.g. monthly, quarterly)
					ICB	System								
20 March 2023	**Sarah Prema**	**EMT / System Executive Committee**	Clinical	✓		✓	**Gross/inherent risk score**	5	x	5	=	**25**	Treat	Bi-monthly
			Organisational	✓			**Risk appetite score**	5	x	3	=	**15**		
			Financial	✓			**Net/residual/ current risk score**	5	x	4	=	**20**		
			Information				**Residual / current risk score trend since last report:**						 **March 2024** – risk assessed and no further changes required at present, likely to take until April / May 2024 before impact of actions affect the residual risk score.	
							Next risk review date:						End April 2024	

Key controls in place and rationale for current / residual risk score	Internal and / or external assurances *Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?*		Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the ICB failing to gain evidence that the controls/systems are effective?*
	internal	**external**	
• Senior Leaders in Health Equity (including an Executive and Non-Executive ICB lead) have been appointed. • ICB Health Equity Committee in place and provides assurance to the Board regarding the effectiveness of programmes of improvement to reduce health inequity. • A Health Inequalities Framework (Better Care for All) and delivery plan have been agreed. • System-wide training for aspirant clinical and managerial health inequality leaders in place. • LLR Health Inequalities Support Unit (LLR HISU) has been established with dedicated analytical resource for the next 15 months. Workplan and strategic focus set by a Steering Group. Purpose is to support the Collaboratives/Partnerships in undertaking intelligence-led improvement projects to reduce health inequity. • An innovative new model of primary care funding has been developed which has improving health equity as a core purpose. • The ICB is participating in Wave 2 of the NHSE Core20 Connectors programme – working with three VCS partners across Leicester and Leicestershire 2022-24 on cancer, respiratory and cardiovascular disease. • ICB has invested £1.6M in a three-year Health inequalities Improvement programme with public Health in Leicester 2022-25. • ICB has invested £1.1M (2022-24) in a fuel poverty and health programme in Leicester. • Each PCN has nominated a HI Lead as part of the national reducing Health Inequalities in Neighbourhoods DES.	• Assurance reports from Health Equity Committee to the ICB Board. • Metrics on clinical performance in ICB Performance dashboard/ ICB Health Inequalities Dashboard. • LeDeR reviews. • Complaints/complements from patients and families • "Reducing Health Inequalities In Neighbourhoods" DES – activity reports. • Health Equity payment for 2024-25 included within the LLR GP Funding Model and approved in March 2024 by the ICB's Strategy Commissioning Group. • LLR Workforce and Public Sector Equality Duty reports to the ICB Board.	• Feedback from NHSE at QSRMs and to HI Operational plan and HI Stocktake submissions to NHSE. • Inequality data from the Elective waiting list. • LLR Maternity Services reports. • Joint Strategic Needs Assessments from Public Health - especially for PLUS groups	• Quality and completeness of ethnicity coding in primary care is still relatively poor. This must be addressed as a fundamental platform for equity improvement. • (Dependent on necessary improvements in ethnicity coding over time) More regularly analyse access, experience of care and outcomes data by ethnicity and postcode to identify health equity improvement opportunities. • Develop the existing information governance and data processing framework to support population health management and Risk stratification (in light of new NHSE requirements). • Develop a culture that empowers staff to address health inequalities (as discussed at the Health Equity Committee in June 2023). • Engage the communities most affected by health inequalities to raise awareness and co-produce solutions to challenges in understanding, accessing and benefitting from NHS services.

Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *What actions are required to bridge the gaps in controls and/or assurance?*	**Action to be completed by (date)**	**Will the action reduce impact of risk score or likelihood or both?**			**Progress on action(s)** *Brief note on updates/progress where appropriate and confirm when action completed.*
		Impact	Likelihood	Impact and likelihood	
Undertake a review of the quality of ethnicity coding in primary care and develop an improvement plan	September 2023			✓	Clinical coding deep dive completed and improvement plan being developed. **ACTION COMPLETE**
Establish re-current data processing to allow reports to be created for information and analysis enabling profiling of access, experience, and outcomes data by Ethnicity and postcode to support Health equity initiatives across all clinical specialties.	~~March 2024~~ May 2024			✓	Working on establishing a re-current process. A draft report on elective waiting lists completed.
Develop the information governance and data processing framework to support population health management and Risk stratification.	March 2024			✓	New Section 251 application for risk stratification submitted by ICB on 7 August 2023. In March 2024 National Clinical Advisory Group (CAG) approved processing of data for risk stratification purposes only. **ACTION COMPLETE** Processing of data for population health management being explored through other means e.g. NHS datasets.
Promote a culture within the organisation that enables staff to feel empowered to address health inequity.	~~October 2023~~ May 2024			✓	LLR Head of PHM and Health Equity has delivered a number of sessions across the organisation on the ICB's role in promoting health equity. For example, sessions delivered to two Integrated Neighbourhood Teams in August 2023, and to LPT Mental Health senior leadership. Application submitted for three-year MacMillan funding to resource a programme to reduce health Inequalities in Cancer in LLR.
Ensure health inequalities is integral to the Research Strategy and is more prominent in LLR research activities.	October 2023			✓	Meeting with LLR Research Group to discuss health inequalities in research took place in August and October 2023. **ACTION COMPLETE**

Engage the communities most affected by health inequalities to raise awareness and co-produce solutions to challenges in understanding, accessing, and benefitting from NHS services.	March 2024			✓	The ICB has supported partners in a range of engagement activities across various communities about how best to access screening and prevention offers. For example, 23 Somali bowel cancer champions recruited and trained at UHL in July via ICB funding and the annual Health Check programme for LD and SMI underway.
Continual exploration of commissioning / investment opportunities to support the reduction of health inequalities and support the prevention agenda.	May 2024		✓		Operational and Financial Plan 2024/25 under review includes detail on the respective areas. Submission of plan due on 2 May 2024.

Principal / strategic risk:

BAF 3 – Demand and Capacity

Demand could exceed capacity in commissioned services due to a variety of factors. This could result in patients not accessing services in the right place, at the right time, at the right level of care.

Date risk identified	ICB Executive lead (risk owner)	ICB Committee oversight	Risk category (✓ applicable category(ies))		ICB only or system risk (✓ one)		Risk rating (impact x likelihood = risk score)						Risk treatment *(i.e. state whether to terminate, treat, transfer, or tolerate the risk)*	If to be treated confirm frequency of review (e.g. monthly, quarterly)
					ICB	System								
March 2023	Rachna Vyas (Chief Operating Officer)	System Executive (operational oversight: LLR Delivery Partnership)	Clinical	✓		✓	**Gross/inherent risk score**	4	x	5	=	**20**	Treat	Quarterly
			Organisational	✓			**Risk appetite score**	3	x	3	=	**9**		
			Financial	✓			**Net/residual/ current risk score**	4	x	3	=	**12**		
			Information				**Residual / current risk score trend since last report:**						⟷ Reviewed in February 2024	
							Next risk review date:						End May 2024	

Key controls in place and rationale for current / residual risk score	Internal and / or external assurances *Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?*		Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the ICB failing to gain evidence that the controls/systems are effective?*
	internal	**external**	
Operational performance monitoring and review of metrics through various groups and Committees. This will primarily be led through the LLR Delivery Partnership, reporting into the System Executive Committee and escalating to Clinical Executive Group, & the Quality and Safety Committee as needed.	Assurance reports and mitigations plans reported to the ICB Board and relevant Committee.	NHS England Quarterly System Review meetings.	A set of metrics, against all facets of the LLR 2023/24 operational plan, have been developed by each partnership. These cover the 31 metrics in the NHS mandate and are mapped to the 5 Year Plan pledges.
Revised Terms of Reference and governance in place for 2023/24, with a focus on performance, activity, finance, equity and quality by each programme lead. Terms of reference strengthened following review at some of the Committees of the ICB.	Assurance reports and mitigations plans reported to the ICB Board and relevant Committee.	NHS England Quarterly System Review meetings.	N/A

Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *What actions are required to bridge the gaps in controls and/or assurance?*	**Action to be completed by (date)**	**Will the action reduce impact of risk score or likelihood or both?**			**Progress on action(s)** *Brief note on updates/progress where appropriate and confirm when action completed.*
		Impact	Likelihood	Impact and likelihood	
Development of an operational plan delivery dashboard detailing performance against the 31 nationally mandated indictors in the 2023/24 operational plan.	30 June 2023)			✓	Draft dashboard completed, trialled in April 2023. **ACTION COMPLETE**
Development of a single summary report for System Executive, detailing performance against all facets of delivery, with SMART escalations for action from either the clinical exec, system exec or quality group	via the internal ODG by 30 June 2023			✓	Draft report for April being trialled. **ACTION COMPLETE**
Strengthen accountability and understanding of where escalations should be made within system governance when any facet of 'value' is off track i.e. CIP or performance.	~~via the internal ODG by end November 2023~~ End April 2024			✓	New CEO and CFO delivery group established w/c 3 Oct 2023 to assess further escalations. Commissioning framework for each Partnership under development and initially reviewed at System Executive Committee in November 2023.

Principal / strategic risk:

BAF 4 – Finance

The financial viability of the local health economy (over the short, medium and long term) cannot be assured due to a lack of robust transformation processes and tested schemes, this could impact organisational reputation, incur possible financial penalties and result in closer regulatory scrutiny.

Date risk identified	ICB Executive lead (risk owner)	ICB Committee oversight	Risk category (✓ applicable category(ies))		ICB only or system risk (✓ one)		Risk rating (impact x likelihood = risk score)						Risk treatment *(i.e. state whether to terminate, treat, transfer, or tolerate the risk)*	If to be treated confirm frequency of review (e.g. monthly, quarterly)
					ICB	System								
Carried forward from 2022/23	**Robert Toole**	Finance Committee	Clinical			✓	**Gross/inherent risk score**	5	x	4	=	**20**	Treat	**Bi-monthly**
			Organisational	✓			**Risk appetite score**	4	x	2	=	**8**		
			Financial	✓			**Net/residual/ current risk score**	4	x	5	=	**20**		
			Information				**Residual / current risk score trend since last report:**						⟺ Reviewed in March 2024	
							Next risk review date:						End May 2024	

Key controls in place and rationale for current / residual risk score	Internal and / or external assurances *Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?*		Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the ICB failing to gain evidence that the controls/systems are effective?*
	internal	**external**	
System Financial Strategy refreshed following submission of the 2023/24 ICB Operational Plan and Financial Plan, and aligned to the LLR ICB medium term financial plan. Three-year Capital Plan reflecting the 2023/24 guidance approved by the ICB Board in April 2023. Proposes sustainable position at the end of the term.	Approval of the 5 Year Plan by the ICB Board.	Internal and External Auditor reports and findings are in progress (integrity of the General Ledger, Financial Systems Report and HFMA financial sustainability audit 2023/24).	• Significant transformation and efficiency schemes will be required over the next few years to bring about balance both in terms of organisational and system designed programmes. • There is a risk that some of the commitments included in five-year plan maybe unaffordable. This includes (but is not limited to) plans to make increasing levels of investment into prevention.
Long term capital programme developed to address infrastructure and IT risks.	Systemwide approach to reviewing and determining capital needs.		Three year capital envelopes may not be sufficient to deliver all partners' capital asks.
System Finance Team monitor the system position and provide monthly reports to LLR ICB Finance Committee.	Financial performance reports are reviewed monthly by the Finance Committee and assurance reports reviewed by the Board.		The 23/24 financial plans include a number of risks and pressures across ICS which will need to managed in year, including unmitigated planning risks which crystallise in year
			The level of pressure currently (and for a sustained period) on the urgent care system could lead to a necessary increase in costs
			Recruitment and retention are key to system transformation and financial recovery. There is limited workforce available within the area and a number of competing employers. Lack of workforce may cause schemes to slip or costs to rise due to agency usage. Recruitment to additional posts may cause financial pressures.
Monthly finance report to Finance Committee refreshed to cover POD delegation and raise visibility over risks given magnitude.	Financial performance reports are reviewed monthly by the Finance Committee and assurance reports reviewed by the Board.		Lack of financial control locally as decisions are taken at a Midlands and/or East Midlands level or nationally.
Internal and External Auditors conduct annual audits on financial systems to provide assurance that internal controls are effective.		Internal and external auditor reports and opinion. Unqualified opinion received	Year end governance processes for 2023/24 underway (i.e. Annual Report and Accounts).

		from the external auditors and satisfactory value for money report.	

Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *What actions are required to bridge the gaps in controls and/or assurance?*	**Action to be completed by (date)**	**Will the action reduce impact of risk score or likelihood or both?**			**Progress on action(s)** *Brief note on updates/progress where appropriate and confirm when action completed.*
		Impact	Likelihood	Impact and likelihood	
Implementation of NHSE Financial Controls	~~**July 2023**~~ ~~**September 2023**~~ ~~**December 2023**~~ **End March 2024**		✓		Audit of the key controls believed would have the most impact – update provided to finance committee in January. Final report requested by end of March 2024. Providers are strengthening controls to bring further improvement in bank / agency spend
Cost Improvement Plans to be established with credible schemes to enable financial targets for 2023/24 to be achieved.	~~**July 2023**~~ ~~**January 2024**~~ **End March 2024**		✓		CIP delivery still forecast to deliver although some risk at UHL given winter pressures.
Systemwide review of capital needs and risks vs three year capital allocation	~~**End April 2024**~~ **End June 2024**		✓		Work to prioritise strategic and operational schemes within envelope available for 2024/25 plan is nearing completion. Expected to be published in Q1
More comprehensive review of the financial impact of taking forward priorities in medium term plan to ensure they can deliver cost efficiencies and are affordable	~~**September 2023**~~ **End April 2024**			✓	Detailed review as we head into 2024/25 planning round through Planning process, Delivery Programme Board and partnerships /collaboratives.
Taking forward development of Lead Provider Framework approach for UEC to enable cost improvement plan of circa £17m to be achieved	~~**June 2023**~~ **June 2024**		✓		Discussion in progress through System Executive. External review of urgent and emergency care underway.
Ensure delivery of the financial plan for 2023/24 with an agreed deficit of £10m and an expectation from NHSE that we improve against that to deliver break even	**March 2024**		✓		Monthly finance reports, CIP scorecards and overview of risks to be received for scrutiny by Finance Committee, System Exec and ICB Board. Forecast of £64m deficit predicted at Month 11 following discussion with NHS England.

Principal / strategic risk:

BAF 5 – Quality and Safety

Failure to maintain and improve the quality of services and meet the core standards could result in poor patient experience and potential harm and poor quality outcomes for patients.

Date risk identified	ICB Executive lead (risk owner)	ICB Committee oversight	Risk category (✓ applicable category(ies))		ICB only or system risk (✓ one)		Risk rating (impact x likelihood = risk score)						Risk treatment *(i.e. state whether to terminate, treat, transfer, or tolerate the risk)*	If to be treated confirm frequency of review (e.g. monthly, quarterly)
					ICB	System								
March 2023	**Kay Darby / Dr Nil Sanganee**	Quality and Safety Committee	Clinical	✓		✓	**Gross/inherent risk score**	4	x	5	=	**20**	Treat	Bi-monthly
			Organisational	✓			**Risk appetite score**	4	x	3	=	**12**		
			Financial				**Net/residual/ current risk score**	4	x	4	=	**16**		
			Information				**Residual / current risk score trend since last report:**						⟷ Reviewed in February / March 2024	
							Next risk review date:						End May 2024	

Key controls in place and rationale for current / residual risk score	Internal and / or external assurances *Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?*		Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the ICB failing to gain evidence that the controls/systems are effective?*
	internal	**external**	
LLR Delivery Partnership meet monthly and produce monthly reports which include section on quality from each of the partnerships / collaboratives.	Assurance reports presented to the Quality and Safety Committee and System Executive.	NHSE Regional quality meeting and Quality Review System (QSRM) held quarterly.	Not all partnerships / have agreed quality metrics or report consistently to the System Quality Group.
ICB Quality and Safety Committee meeting takes place monthly: - receives assurance from the System Quality Group including risks and issues. - undertake deep dive / scrutiny into core areas bi-monthly.	Committee assurance reports presented to ICB Board.	NHSE Regional quality meeting and Quality Review System (QSRM) held quarterly.	N/A
LLR System Quality Group (SQG) meet monthly and review: - monthly updates from core providers: UHL, LPT and DHU, EMAS - workplan / schedule of reporting and presentations from partnerships. - Dynamic risk approach adopted with partner organisations.	Group assurance reports presented to Quality Safety Committee.	NHSE membership and attendance at SQG. NHS E Regional QSRM held quarterly.	N/A
LLR Clinical Executive provide clinical oversight to strategy and operational matters and supports in understanding system quality risks and issues.	Reports to System Executive Committee.		N/A
Policy and procedures in place to assess risk and impact including: - equality and quality impact assessment process - planning process agreed in 2023 ensures equality / quality impact assessments and clinical prioritisation as fundamental steps to inform decision making.	Where appropriate reports to the relevant committees and Board demonstrate equality / quality impact assessments have been completed and also clinical prioritisation (where appropriate).		
Partnerships / collaboratives use a self assessment tool to understand quality implications.			Confirmation of quality metrics used by each partnership / collaborative.

Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *What actions are required to bridge the gaps in controls and/or assurance?*	**Action to be completed by (date)**	**Will the action reduce impact of risk score or likelihood or both?**			**Progress on action(s)** *Brief note on updates/progress where appropriate and confirm when action completed.*
		Impact	Likelihood	Impact and likelihood	
Establish quality metrics across partnerships / collaborative – to be agreed by the Quality and Safety Committee and the System Quality Group.	**end May 2024**		✓		Work in progress
Undertake a confirm and challenge session across partnerships / collaborative to determine assessment of quality.	**end March 2024**		✓		
To undertake training and education to enable implementation of the equality and quality impact assessment tool.	**end March 2024**		✓		

Principal / strategic risk:

BAF 6 – Emergency Preparedness, Resilience and Response

Failure to have robust emergency preparedness, resilience and response (EPRR) processes in place due to lack of capacity and / or lack of partnership could result in inadequate response to major and / or business continuity incidents.

Date risk identified	ICB Executive lead (risk owner)	ICB Committee oversight	Risk category (✓ applicable category(ies))		ICB only or system risk (✓ one)		Risk rating (impact x likelihood = risk score)						Risk treatment *(i.e. state whether to terminate, treat, transfer, or tolerate the risk)*	If to be treated confirm frequency of review (e.g. monthly, quarterly)
					ICB	System								
July 2022	**Rachna Vyas**	System Executive / EMT	Clinical			✓	**Gross/inherent risk score**	5	x	4	=	**20**	~~Treat~~ Tolerate	**Quarterly**
			Organisational	✓			**Risk appetite score**	4	x	3	=	**12**		
			Financial	✓			**Net/residual/ current risk score**	4	x	2	=	**8**		
			Information				**Residual / current risk score trend since last report:**						**March 2024** - all actions completed from ICB perspective, no gaps identified therefore residual risk score remains the same. Risk remains on BAF as a strategic risk given the potential impact on the organisation.	
							Next risk review date:						End April 2024	

Key controls in place and rationale for current / residual risk score	Internal and / or external assurances *Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?*		Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the ICB failing to gain evidence that the controls/systems are effective?*
	internal	**external**	
LLR Incident Response Plan in place and Corporate Business Continuity Plan in place. Both have been updated and test exercise conducted on the Business Continuity Plan in June 2023.	• ICB checklist and evidence review. • Updates on EPRR core standards compliance presented to the ICB Board. • Internal Audit undertaken in 2022/23 providing "significant assurance". • ICB Major Incident Exercise to take place in December 2023. This will also test ICC arrangements and Comms EPRR Plan.	• Regular meetings with NHS England and LHRP. • NHS England reviews ICB's compliance with EPRR core standards.. ICB have achieved substantial compliance against the standards for 2023/24 with 89%. • 360 Assurance conducted an internal audit review providing significant assurance.	Plans to be reviewed to align responsibilities to Level 1 responder.
ICB Training Needs Assessment completed and DoC training plan in place.			N/A
ICS EPRR Work programme actions continue to be implemented and will be updated following the outcome of the Core Standards assessment.			N/A
Health Emergency Planning Operational Group (HEPOG) oversees actions from the LHRP meetings.			Testing of partner organisation plans underway and confirmation awaited.
Health EPRR Risk Management Group to assess local health risks and priorities and establish a system risk register for EPRR.			N/A
Testing of emergency planning takes place.			N/A
Strategic Control Centre and Incident Command Centre arrangements in place.			N/A
LRF Executive Board meetings in place quarterly.			N/A
Regular Director on Call lunch and learn sessions in place providing update on SCC functions, updates to ICB plans and policies and updates from ICS partners.			N/A
Planning for industrial action led by the ICB is in place. Debriefing in place to ensure learning from previous I.A is incorporated into future planning.	• Weekly Health Economy Tactical Coordinating Group meetings (HETCG). • Daily ICS GOLD (Strategic) Command meetings during Industrial Action.	• Regional Incident Management Meetings led by NHSE 3 x day during I.A. National Communications pack issued by NHSE National team.	Industrial Action can be affected by external factors including but not limited to, high demand for services, severe weather episodes and staffing shortages. Planning does cover these factors however due to the nature of these factors the risk remains.

	• Ability to stand up ICS Clinical Executive Group as required. • Enhanced SCC/UEC cover during I.A.		

Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *What actions are required to bridge the gaps in controls and/or assurance?*	**Action to be completed by (date)**	**Will the action reduce impact of risk score or likelihood or both?**			**Progress on action(s)** *Brief note on updates/progress where appropriate and confirm when action completed.*
		Impact	Likelihood	Impact and likelihood	
1. Table-top exercise yet to be arranged to test the Business Continuity Plans across LLR ICB. (Corporate Governance Team in conjunction with the EPRR team). 2. Review the ICB's Corporate Business Continuity Policy and Plan following NHS England's review of the EPRR core standards (Corporate Governance Team in conjunction with the EPRR team).	End June 2023 End August 2023			✓	• Directorate level risk registers in place across all directorates / functions and table-top test exercise carried out on 8 June 2023.**ACTION COMPLETE** • Feedback from NHS England's review of the core standards to inform the review of the Corporate Business Continuity Plan prior to testing the plan. Following which the Corporate Business Continuity Policy and Plan will be reviewed. **ACTION COMPLETE**

Principal / strategic risk:

BAF 7 – Cyber

A significant rise in new and unknown cyber-attacks (locally or nationally) could make access to IT services unavailable for extended periods of time. This may result in risks to the confidentiality of corporate or patient confidential data, disruption to organisational business continuity and to operational services.

Date risk identified	ICB Executive lead (risk owner)	ICB Committee oversight	Risk category (✓ applicable category(ies))		ICB only or system risk (✓ one)		Risk rating (impact x likelihood = risk score)						Risk treatment *(i.e. state whether to terminate, treat, transfer, or tolerate the risk)*	If to be treated confirm frequency of review (e.g. monthly, quarterly)
					ICB	System								
Carried forward from 2022/23	**Alice McGee (Chief People Officer)**	Executive Management Team	Clinical		✓		**Gross/inherent risk score**	4	x	4	=	**16**	Treat	**Quarterly**
			Organisational	✓			**Risk appetite score**	2	x	4	=	**8**		
			Financial	✓			**Net/residual/ current risk score**	3	x	4	=	**12**		
			Information				**Residual / current risk score trend since last report:**						⟷ Last reviewed in February / March 2024.	
							Next risk review date:						End May 2024	

Key controls in place and rationale for current / residual risk score	Internal and / or external assurances *Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?*		Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the ICB failing to gain evidence that the controls/systems are effective?*
	internal	**external**	
• Network boundary protection (firewalls) using multi-tiered approach. • Internal counter measures such as Advanced Threat Protection (ATP), Sophos Anti-Virus, Intercept-X anti-ransomware, 'honeypot' alerting system, etc. • Change controls and policy/procedure framework for operation of security platforms. • Alerting and intrusion detection systems in place. • Routine and cyclical technical security testing of network boundaries. • Independent assessment of security posture (e.g. Bitsight = top 10% of healthcare organisations). • Assurances through cyber security governance frameworks (e.g. ISO27001, Data Security Protection Toolkit, SPT, etc). • Established and tested incident response procedures • Continuity and disaster recovery plans in place. • Monitoring of security alerts and information published through credible routes (e.g. NHSDigital CareCERT, SANS). • LHIS has subscribed to the Police Cyber Alarm platform which provides alerts to potentially malicious activity on our network boundary. • Moved to NHS Mail • Subscribed to the NCSC Early Warning System which adds an additional layer of monitoring to our external network boundary. • Enrolment in NHSE Vulnerability Management Service (VMS) which monitors external boundary for malicious activity. • Review of NHSE secure boundary counter measures. • Web site security reviews being conducted.	• Active directory audit being planned • NCSC desktop simulations underway • Ransomware simulation being planned • LHIS continues to conduct security testing of various estate-wide services.	• External evaluation of security posture (e.g. Bitsight) • Audit reviews of security and governance frameworks (e.g. ISO27001, DSPT) (Internal Audit Review on DSPT 2022/23 underway). • Incident response to threats/attacks (i.e. was the attack successful) (assurance provided indicates controls are effective). • LHIS has attained a Cyber scheme penetration testing accreditation (positive assurance). • Externally commissioned technical security testing.	• Efficacy of local continuity plans for service provision in the event of a successful cyber-attack, preventing access to IT systems (including VPN) for an extended period (e.g., days). • IT service supply chain dependency which could have collateral impact on services. A number of recent high profile attacks on NHS IT service providers have highlighted this risk at a national level. • Reduction in ability to respond to cyber attacks outside of 'office hours'.

Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *What actions are required to bridge the gaps in controls and/or assurance?*	**Action to be completed by (date)**	**Will the action reduce impact of risk score or likelihood or both?**			**Progress on action(s)** *Brief note on updates/progress where appropriate and confirm when action completed.*
		Impact	Likelihood	Impact and likelihood	
Efficacy of local continuity plans for service provision in the event of a successful cyber-attack, preventing access to IT systems (including VPN) for an extended period (e.g., days).	End October 2023		✓		• Acquire assurance, through testing, that local service continuity plans are established and are operating as expected (i.e. service provision is not affected by outage). **ACTION COMPLETE**
Additional controls being considered to address risk (e.g. 3rd party monitoring of network estate Out of Hours, etc).	~~End January 2024~~ End June 2024		✓		• Work in progress.
Appointment of System Cyber Strategic Officer (shared with Northamptonshire ICB)	End June 2024		✓		• Focussed work underway to further reduce risks, understand the organisational interoperability impact on cyber attacks and links withs EPRR and business continuity plans.

Principal / strategic risk:

BAF 8 – Workforce

The ability to recruit and retain staff may be affected by the pressures and reduction in running costs impacting on enhancing productivity and delivering the ICB's strategic objectives.

Date risk identified	ICB Executive lead (risk owner)	ICB Committee oversight	Risk category (✓ applicable category(ies))		ICB only or system risk (✓ one)		Risk rating (impact x likelihood = risk score)					Risk treatment *(i.e. state whether to terminate, treat, transfer, or tolerate the risk)*	If to be treated confirm frequency of review (e.g. monthly, quarterly)
					ICB	System							
March 2023	**Alice McGee**	Remuneration Committee / People Board	Clinical		✓		**Gross/inherent risk score**	4	x	4	= **16**	Treat	**Bi-monthly**
			Organisational	✓			**Risk appetite score**	4	x	2	= **8**		
			Financial				**Net/residual/ current risk score**	4	x	3	= **12**		
			Information				**Residual / current risk score trend since last report:**					⟷ **December 2023 – risk reviewed and new risk BAF 9 on workforce identified. DE-ESCALATION OF BAF 8 IS PROPOSED.**	
							Next risk review date:					End February 2024	

Key controls in place and rationale for current / residual risk score	Internal and / or external assurances *Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?*		Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the ICB failing to gain evidence that the controls/systems are effective?*
	internal	**external**	
Regular workforce dashboard reports presented to the Executive Management Team and the People Board meetings to understand trends of leavers and sickness rates.	Trends are being tracked and there has been no rise in workforce metrics. Current turnover rate is c.2% and sickness rates remain below 3%. Staff Survey results.		No gaps identified at present.
Remuneration Committee terms of reference updated to include assurance reports on ICB workforce and the people plan.	Workforce dashboard presented to the Committee.		No gaps identified at present.
Participation and analysis of monthly, quarterly and annual staff survey.	Outcomes of staff survey shared with EMT and Remuneration Committee.		No gaps identified at present.
Regular staff briefings and communication about impact of Running Cost Allowance reductions.	Workforce reports presented to the Remuneration Committee at agreed intervals.		No gaps identified at present.
Analysis of exit interview questionnaires to understand any trends.	Analysis shared with EMT and Remuneration Committee.		No gaps identified at present.
Annual appraisals to manage workload and priorities.	Dashboard assurance report to be produced for Remuneration Committee and EMT		No gaps identified at present.

Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *(including What actions are required to bridge the gaps in controls and/or assurance?*	**Action to be completed by (date)**	**Will the action reduce impact of risk score or likelihood or both?**			**Progress on action(s)** *Brief note on updates/progress where appropriate and confirm when action completed.*
		Impact	Likelihood	Impact and likelihood	
No actions identified.					

Principal / strategic risk:
BAF 9 – Workforce (NEW)

The ability to retain staff, whilst delivering increasing workloads and priorities with a reduced capacity following a reduction in running cost allowance

Date risk identified	ICB Executive lead (risk owner)	ICB Committee oversight	Risk category (✓ applicable category(ies))		ICB only or system risk (✓ one)		Risk rating (impact x likelihood = risk score)						Risk treatment *(i.e. state whether to terminate, treat, transfer, or tolerate the risk)*	If to be treated confirm frequency of review (e.g. monthly, quarterly)
					ICB	System								
December 2023	**Alice McGee**	Remuneration Committee / People Board	Clinical		✓		**Gross/inherent risk score**	4	x	4	=	**16**	Treat	**Bi-monthly**
			Organisational	✓			**Risk appetite score**	4	x	2	=	**8**		
			Financial				**Net/residual/ current risk score**	4	x		=	**12**		
			Information				**Residual / current risk score trend since last report:**						N/A	
							Next risk review date:						End May 2024	

Key controls in place and rationale for current / residual risk score	Internal and / or external assurances *Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?*		Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the ICB failing to gain evidence that the controls/systems are effective?*
	internal	**external**	
Regular workforce dashboard reports presented to the Executive Management Team and the People Board meetings to understand trends of leavers and sickness rates.	Trends are being tracked and there has been no rise in workforce metrics. Current turnover rate is c.2% and sickness rates remain below 3%. Staff Survey results.		Dashboard to be presented to the EMT at agreed intervals.
Remuneration Committee reviews assurance reports on ICB workforce and the people plan.	Workforce dashboard presented to the Committee.		No gaps identified at present.
Participation and analysis of monthly, quarterly and annual staff survey.	Outcomes of staff survey shared with EMT and Remuneration Committee.		Staff survey results to be analysed and actions identified.
Regular staff briefings and communication about impact of Running Cost Allowance reductions.	Workforce reports presented to the Remuneration Committee at agreed intervals.		No gaps identified at present.
Analysis of exit interview questionnaires to understand any trends.	Analysis shared with EMT and Remuneration Committee.		No gaps identified at present.
Annual appraisals to manage workload and priorities.	Dashboard assurance report to be produced for Remuneration Committee and EMT		No gaps identified at present.

Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *(including* *What actions are required to bridge the gaps in controls and/or assurance?*	**Action to be completed by (date)**	**Will the action reduce impact of risk score or likelihood or both?**			**Progress on action(s)** *Brief note on updates/progress where appropriate and confirm when action completed.*
		Impact	Likelihood	Impact and likelihood	
2023 full staff survey results expected in February 2024 with analysis of results to understand pressures retention challenges.	**End May 2024**	4	3	12	Awaiting staff survey results.

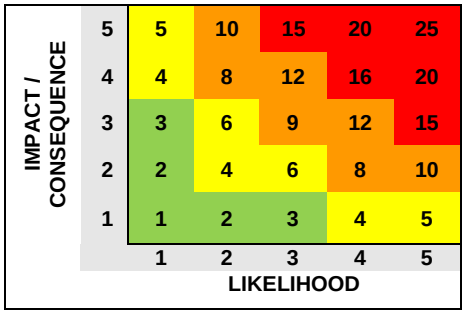
Appendix 1: Definitions and 5x5 Risk Matrix (as within the LLR ICB's Risk Management Strategy and Policy)

Areas	Definitions
Assurance	An evaluated opinion, based on evidence gained from review, on the organisation's governance, risk management and internal control framework. The more measurable, verifiable and objectives an assurance is the stronger the declaration and source of evidence it is. The assurance must also be up to date. Effective assurance needs to be at two levels, internal and external
Board Assurance Framework	The Board Assurance Framework provides evidence that the Board has systematically identified its objectives both strategically and operationally, and manages its risks to achieving them. The framework systematically provides a vehicle for the identification of assurances and controls to risks and their effectiveness.
Cause	The reason for the risk to potentially occur.
Consequence	The results should the risk materialise.
Control	A measure put in place to mitigate a risk from occurring i.e. to prevent. Different types of control can be preventative, detective, directive and corrective.
Description	The way of explaining risk to allow consistent understanding across the ICB in a single sentence where possible. Consider the 'x, y, z' approach as described in the Strategy and Policy ('x' could happen, because of 'y', resulting in 'z').
Gaps in controls/ assurances	Where the residual risk does not meet the risk appetite, gaps in the controls and the assurances must be identified in order to reduce the residual risk as close as possible to the risk appetite.
Gross / Inherent Risk	Inherent risk is the effect of something that might happen before taking account of controls in place to manage or mitigate it. The higher the score, the more attention the risk will require and the more likely the Board would seek assurance as to how it was being managed whether directly or via a committee of the Board.
Impact	A measurement of the effect the risk will have if it materialises.
Issue	Issue is something that has happened, as opposed to a risk which is something that could happen.
Likelihood	A measurement of the chance that a risk will materialise.
Mitigation Actions	These are the actions the risk owners take to reduce the risk or where this is not possible limit the impact of the risk.
Net risk	The measurement in terms of likelihood and impact on a risk after controls are considered to mitigate the risk. Also referred to as 'residual risk'.
Objective	The context in which risks are assessed i.e. ICB Aims/Objectives

Areas	Definitions
Operational risks	Operational risks are by-products of the day-to-day running of the ICB and includes a broad spectrum of risks including clinical, fraud, security, financial and legal risks arising from employment law of health and safety.
Owner	Either the owner of the risk (risk owner i.e. Director) or owner of an action (action owner i.e. the completer on the assigned action by the risk owner).
Principal risk	Principal risks are defined as those that threaten the achievement of the ICB's principal objectives.
Register	A tool to capture and report on the risks identified at project / programme level, Directorate level or Corporate level.
Residual Risk	Another term for net risk.
Risk	ISO 31000:2009 defines risk as the "effect of uncertainty on objectives" and states that "risk is often expressed in terms of a combination of the consequences of an event and associated likelihood of occurrence"
Risk Appetite	An expression of the nature and quantum of risk or uncertainty which the organisation is willing to take or accept to achieve its strategic objectives. Risk appetite score may be a different for different objectives and / or different risk categories.
Risk Management	Risk Management is the process by which an organisation identifies risks, assesses their relative importance, determines the appropriate control mechanisms and ensures that the agreed action is taken. Risk management may involve judgement as well as data.
Risk Management Process	The systematic application of management policies, procedures and practices to the tasks of establishing the context, identifying and analysing, evaluating, treating, monitoring and communicating risk.
Risk Matrix	The tool used to as accurately as possible identify the measurement of likelihood and impact of the risk identified.
Risk Tolerance	The threshold level of risk exposure which, when exceeded, will trigger an escalation.
Strategic risks	Strategic risks are those that represent major threats to achieving the ICB's strategic objectives or to its continued existence. Strategic risks will include key operational service failures, for example, failure to meet key targets or provision of poor-quality care would be very damaging to the ICB's reputation.

5 x 5 Risk Assessment Matrix (Risk Management Strategy and Policy)

IMPACT / CONSEQUENCE		LIKELIHOOD	
1	NEGLIGIBLE	1	RARE
2	MINOR	2	UNLIKELY
3	MODERATE	3	POSSIBLE
4	MAJOR	4	LIKELY
5	CATASTROPHIC	5	ALMOST CERTAIN



This will result in risks being rated in one of the following four categories

Risk score	Category
1 – 3	Low risk (green)
4 – 6	Moderate risk (yellow)
8 – 15	High risk (orange)
15 – 25	Extreme risk (red)

Key for Executive Directors:

CT = Caroline Trevithick, Chief Executive
AM = Alice McGee, Chief People Officer
RT = Robert Toole, Chief Finance Officer
KD = Kay Darby, Chief Nursing Officer
NS = Dr Nil Sanganee, Chief Medical Officer
RV = Rachna Vyas, Chief Operating Officer
SP = Sarah Prema, Chief Strategy and Planning Officer

D

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board (LLR ICB) public**		
Date:	**11 April 2024**	**Paper:**	**D**
Report title:	**Draft LLR ICB Equality, Diversity and Inclusion (EDI) Annual Report (with equality objectives) 2023-2024**		
Presented by:	Shaun Cropper, Equality, Diversity & Inclusion Business Partner		
Report author:	Shaun Cropper, Equality, Diversity & Inclusion Business Partner		
Executive Sponsor:	Alice McGee, Chief People Officer LLR ICB		

To approve ☒	**For assurance** ☐	**To receive and note** ☐	**For information** ☐
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Recommendations:

The Leicester, Leicestershire and Rutland Integrated Care Board (LLR ICB) are asked to:

- **Approve the Draft EDI Annual Report (with Equality Objectives) for publication on the ICB Website.**

Purpose and summary of the report:

1. The purpose of the Equality, Diversity & Inclusion (EDI) Annual Report is to demonstrate how Leicester, Leicestershire & Rutland ICB is complying with the Equality Act 2010, the Public Sector Equality Duty (PSED) 2011 and NHS Mandated Standards.

2. The EDI Annual Report also includes many initiatives that the ICB has undertaken organisationally and with LLR system partners over the past 12 months. The report demonstrates how we embed equalities and work to reduce inequalities in everyday work with communities, staff and stakeholders.

3. The Public Sector specific duties require the ICB to publish equality information annually that sufficiently demonstrates how we are thinking about equality across the services we provide and/or commission and our employment of staff. The aim of our EDI Annual Report is to demonstrate how we meet these duties.

   The annual information must include:

   - Information relating to employees who share protected characteristics (for public bodies with 150 or more employees)
   - Information relating to people who are affected by the public body's policies and practices who share protected characteristics.

4. ICBs are also required to publish one or more equality objectives, which should be specific and measurable at least every four years.

5. In addition to these requirements, the specific duty regulations contain an obligation for public bodies with 250 or more staff to publish gender pay gap information each year. This duty to publish will apply to ICBs from 30 March 2024, however the published data will cover our workforce profile as of 31 March 2023.

6. The Equality & Human Rights Commission (EHRC) recently reviewed all the ICBs websites for compliance with the PSED. They provided some general feedback at a meeting with EDI ICB leads in November and met with the Chief People Officer, Associate Director of Systems Leadership and OD and the EDI Business Partner in February. Their views are picked up in the points below.

Progress

7. With reference to paragraph 4 above, although the ICB does have Equality Objectives which have been linked to the new Equality Delivery System we have been working to ensure that they are now specific (relating to a protected characteristic/s) and have measurable outcomes. We have also chosen to update them annually which was supported by the EHRC.

8. With reference to paragraph 3, the EHRC would like to see more data on pay bands relating to employees protected characteristics where possible. This has been included in the draft EDI Annual Report. The EHRC acknowledged that the ICB are already comparing their workforce profile to the local demographic based on the 2021 census.

9. With reference to commissioned services (also relating to paragraph 3) the EDI Annual Report now contains data relating to the protected characteristics of people/service users who have responded to our engagement exercises as well as some examples in the health inequalities section around the Core 20 most deprived communities. This was included following the general feedback to all ICBs in November.

10. The EHRC have been assured with our current proposals for this year's annual reporting and workforce information. However, they would like to see more protected characteristic data (on the ICB's website) relating to service users/patients/public with this golden thread running through our performance data/strategies/plans/polices/ engagement and access/satisfaction surveys.

11. One of the main ways we consider 'due regard' for both employees and service users/patients is through our Equality Impact Assessments (EIAs). Completion rates have increased exponentially since the introduction of a new EIA/QIA policy, stronger governance around clinical policies, training on the new 'Inclusive Decision-Making Framework' assessment template, and reiterating EIAs importance around financial decisions.

12. The gender pay gap report (as per paragraph 5) is complete and was assured by Operational Development Group and RemCom. The report was approved at the ICB Board meeting on the 8th February 2024. This has been published on the ICB website and uploaded to the Government website.

13. The Modern Slavery Act Statement is also up to date and currently being reviewed for the next financial year.

14. All mandatory duties have been met with the Workforce Race & Disability Equality Standard reports being approved on 14th December 2023. These standards were undertaken on a voluntary basis as they were not a mandated requirement for ICBs this year. However, the report's action plan is linked to the new Equality Delivery System and will require the grading results from 'Domain 1: Commissioned or Provided Services'. This is being led at a system level and will be presented as a separate item.

Appendices:	**Appendix 1 - Draft EDI Annual Report 2023-24**
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	Approved by ODG 12/03/24 and EMT 18/03/24

The report is helping to deliver the following strategic objective(s) – *please tick all that apply*:		
1. Improve outcomes	Improve outcomes in population health and healthcare.	☒
2. Health inequalities	Tackle inequalities in outcomes, experience and access.	☒
3. Value for money	Enhance productivity and value for money.	☐
4. Social and economic development	Help the NHS support broader social and economic development.	☐
5. NHS Constitution	Deliver NHS Constitutional and legal requirements.	☒

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	
Implications:		
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board		N/A

Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	No
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	No
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	No
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	The Equality and Inclusion Annual report demonstrates due regard to the Public Sector Equality (specific) Duty which requires public bodies to publish relevant, proportionate information demonstrating their compliance with the Equality Duty.

Appendix 1

NHS
Leicester, Leicestershire and Rutland
Integrated Care Board

Public Sector Equality Duty

Equality, Diversity and Inclusion (EDI)

Annual Report - April 2024

A proud partner in the:

Leicester, Leicestershire and Rutland
Health and Wellbeing Partnership

Accessibility Statement

If you would like information in another format, such as another language, Braille, audio or large print, please let us know by calling 07795 452827 or emailing LLRICB-LLR.beinvolved@nhs.net to discuss your requirements.

Or you can write to us at:
Freepost Plus RUEE–ZAUY–BXEG
LLR ICB, G30, Pen Lloyd Building,
Leicestershire County Council, Leicester Road
Glenfield, Leicester, LE3 8TB

अगर आपको इस दस्तावेज में शामिल जानकारी समझने में सहायता चाहिए तो कृपया 0116 295 2110 पर फ़ोन कीजिए।

ਜੇਕਰ ਤੁਹਾਨੂੰ ਇਸ ਦਸਤਾਵੇਜ਼ ਦਾ ਵਿਸ਼ਾ ਵਸਤੂ ਸਮੱਝਣ ਲਈ ਮਦੱਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕ੍ਰਿਪਾ ਕਰਕੇ ਇਸ ਨੰਬਰ ਤੇ ਟੈਲੀਫੋਨ ਕਰੋ 0116 295 2110.

જો તમને આ દસ્તાવેજમાં આપેલ માહિતી સમજવા માટે મદદ જોઇતી હોય તો મહેરબાની કરીને 0116 295 2110 પર ફોન કરો.

এই ডকুমেন্ট'এর কোন বিষয় বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয়, তাহলে অনুগ্রহ করে 0116 295 2110 নাম্বারে টেলিফোন করুন।

Hadii aad u baahantahay in lagaa caawiyo fahmida qoraalka ku qoran documintigaan fadlan nagala soo xiriir telefoonkaan 0116 295 2110.

Jeśli potrzebujesz pomocy w zrozumieniu treści tego dokumentu prosimy o telefon pod numer 0116 295 2110.

"اگر آپ کو اس دستاویز کے مشمولات کو سمجھنے میں مدد کی
ضرورت ہو تو براہ کرم ہمیں 0116 295 2110 پر فون کریں۔"

Caso pretenda ajuda para compreender o conteúdo deste documento, por favor ligue para o 0116 295 2110.

如果您在理解本文档的内容时需要任何帮助，请致电 0116 295 2110.

Jei norėtumėte, kad kas nors padėtų suprasti šį dokumentą, skambinkite tel. 0116 295 2110. Ja jums nepieciešama palīdzība, lai saprastu šī dokumenta saturu, lūdzam zvanīt uz 0116 295 2110.

Contents

Welcome to our second Equality, Diversity and Inclusion Annual Report as an ICB

NHS Integrated Care Boards (ICBs) are statutory bodies established from 1 July 2022, replacing Clinical Commissioning Groups (CCGs).

This report sets out how we, as an ICB, fulfil our responsibilities arising from the Equality Act 2010 and other NHS mandated requirements. The Equality Act requires all ICBs to publish appropriate information which demonstrates how we are meeting the Public Sector Equality Duty 2011 (PSED, specific duties) and addressing any significant gaps which may adversely impact on local people who are protected by equalities law.

The Equality and Human Rights Commission have recently monitored all the ICBs websites for compliance with the PSED. The feedback on what we already have done and what we have planned for this year's annual reporting is largely positive. The one area we will be working on to improve is providing more data on our website around the protected groups in our other published plans, policies, strategies, performance data, satisfaction surveys and engagement exercises.

This Annual Report covers the period April 1st 2023 to 31st March 2024.

Foreword by Alice McGee, Chief People Officer

We are pleased to publish our second Integrated Care Board's, Equality, Diversity and Inclusion (EDI) Annual Report. As an organisation, we are dedicated to developing an organisational culture that promotes inclusion and embraces diversity, ensuring that the focus on EDI is maintained not only within the ICB but as part of the wider Integrated Care System. One of our Strategic Plan pledges is to make Leicester Leicestershire and Rutland (LLR) health and care, a great place to work and volunteer, which includes our commitment to inclusion and diversity.

LLR has some of the most diverse communities and it is important to the ICB and the wider system that the diversity of our population is mirrored in the diversity of our workforce. Across Health and Social care, we employ over 76,000 staff, of which current health workforce data suggests 42% are from a Black, Asian and Minority Ethnic (BAME) background, reflecting the diverse race profiles of our population.

Our Integrated Care System aims to deliver a health and care system in LLR that tackles inequalities in health and improves the health, wellbeing and experiences of local people and provides value for money. We can only achieve this through our people and our unwavering commitment to supporting the people that work for health and social care. Our commitment to ensure the work we do has the focus on equality, diversity and inclusion will ensure that the care we deliver to our population will achieve the purpose and aims of the Integrated Care System.

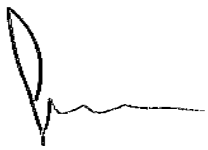
We have a clear purpose:

'To work together for everyone in LLR to have healthy, fulfilling lives.'

We have four main priorities:

To achieve these priorities, we will ensure that success will be seen on the ground with quicker diagnosis, care closer to home in improved facilities, higher quality services, earlier intervention in long-term conditions, improved wellbeing, more digital healthcare options where appropriate, and greater integration between healthcare providers so patients have seamless care between organisations.

By working with partners, we aim to reduce the unfair and avoidable health inequalities which exist in our community and improve health equity relative to need.

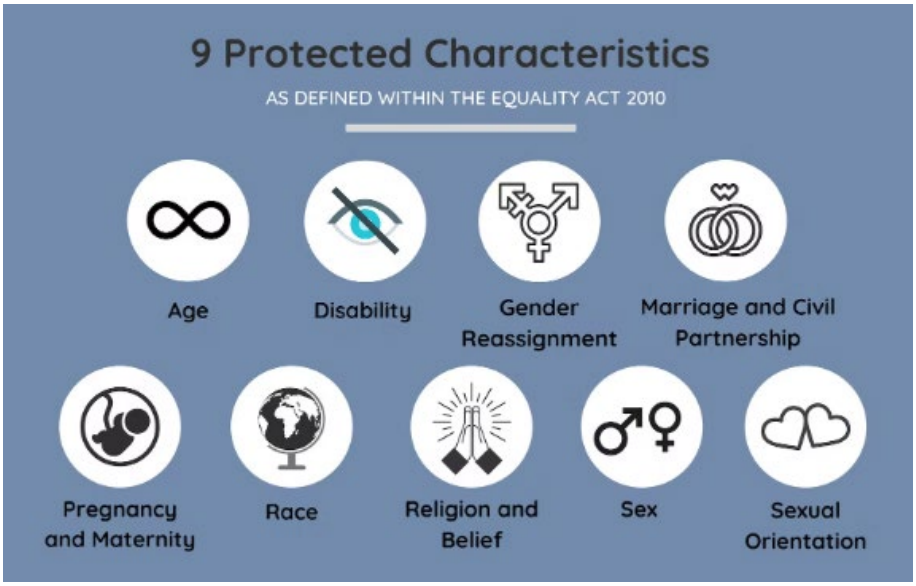


Alice McGee

Chief People Officer

Legal Duties for Equality, Diversity and Inclusion

The Equality Act 2010 protects people from unfavourable treatment, making it unlawful to discriminate, harass or victimise an individual due to a reason related to one of the following nine protected characteristics. Click here for more information: Protected Characteristics



Other Vulnerable Groups (Inclusion Health Groups)

In addition to the nine protected characteristic groups, we also recognise that there are additional groups that experience health inequalities and face disadvantage in society. These include (but are not limited to):

Carers	Rural and Farming communities
Armed forces veterans and their families	Asylum Seekers and Refugees
People experiencing Homelessness	People experiencing Deprivation
Looked after children and young people	Gypsy, Roma and Traveller communities
People in contact with the justice system	People with poor literacy and/or health literacy
People affected by addiction and/or substance misuse	Sex workers

Public Sector Equality Duty (PSED) 2011

Section 149 of the Equality Act 2010 applies to public sector organisations and bodies delivering public services, and requires the LLR ICB to address the following duties:

1. Eliminate unlawful discrimination, harassment, victimisation, and other prohibited conduct.
2. Advance equality of opportunity between people who share a protected characteristic and those who do not.
3. Foster good relations between people who share a protected characteristic and those that do not.

The Equality Act explains that the second aim involves, in particular, having due regard to the need to:

- Remove or minimise disadvantages suffered by people due to their protected characteristics.
- Take steps to meet the needs of people with certain protected characteristics where these are different from the needs of others.
- Encourage people with certain protected characteristics to participate in public life or in other activities where their participation is disproportionately low.

Specific Duties Under the PSED

LLR ICB have specific duties under the Public Sector Equality Duty (PSED) to:

- Publish information annually to demonstrate their compliance with the equality duties, including information relating to employees who share protected characteristics (for public bodies with 150+ employees), and information relating to people who are affected by the public body's policies and practices who share protected characteristics.
- Set equality objectives, at least every four years. (These can be found in this Annual Report on page 24).

Our EDI Annual Report is fulfilling the specific duty requirements.

Showing ‘Due Regard’ to the Public Sector Equality Duty

To commission high quality, and inclusive health services, we aim to ensure that protected groups have the same access, experiences, and outcomes as the general population, and where required, to focus on equity of service provision. This may mean that some of our protected groups have enhanced access to services.

We recognise that there are many things that influence this that we may not have complete control over, but we are committed to working with our communities and partners to ensure that our commitment to our equality duty is central to the work that we do and the decisions we make.

One of the ways that we demonstrate ‘due regard’ is though our Equality Impact Assessment (EIA) process. More on this can be found on page 17.

Human Rights Act 1998

The Human Rights Act 1998 sets out universal standards to ensure that an individual’s basic needs as a human being are recognised and met.

Public authorities have a mandated duty to ensure they have arrangements in place to comply with the Act.

It is unlawful for a healthcare organisation to act in any way that is incompatible with the Act. In practice, this means we must treat individuals with Fairness, Respect, Equality, Dignity and Autonomy known as the **FREDA** principles.

Modern Slavery Act 2015

The Modern Slavery Act 2015 applies to all organisations within the United Kingdom with a turnover of £36 million or above. A key element of the Act is the 'Transparency in Supply Chains' provision, which requires businesses above a certain threshold to produce a 'Slavery and Human Trafficking Statement' outlining what steps they have taken in their supply chain to ensure slavery and human trafficking is not taking place.

Slavery is a violation of a person's human rights. It can take the form of trafficking, forced labour, bonded labour, forced or servile marriage, descent-based slavery, and domestic slavery.

The ICB has zero tolerance for modern day slavery and breaches of human rights, so we ensure that this protection is built into the processes and business practices that we, our partners and our providers use.

To view our Modern Slavery Act Statement on our website, please click on to the following link: Modern Slavery Act Statement - LLR ICB

The Health and Social Care Act 2022

The ICB has a legal duty under the Health and Social Care Act 2022, to reduce inequalities between people in regard to their ability to access health services, and to reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services. The Act also places duties on the ICB to promote the NHS Constitution, to enable choice, and to promote patient, carer and public involvement in shaping health services.

To do this effectively, the ICB works with its partner organisations to reduce health inequalities and embeds this requirement into its commissioning strategies and policies. The ICB is also required to demonstrate how it provides culturally sensitive services and ensures all patients can exercise choice and be involved in decision making.

NHS England has a statutory duty under the Health and Social Care Act 2022, to conduct an annual assessment of ICBs. A single oversight framework called the NHS System Oversight Framework was introduced in 2019 for this purpose. This includes oversight metrics for reducing health inequalities and racial inequalities.

More information about the NHS System Oversight Framework for can be found at [NHS England » NHS Oversight Framework]

The Care Act (2014)

This sets out carers' legal rights to assessment and support and relates mostly to adult carers aged 18 and over who are caring for another adult. This is because young carers (aged 17 and under) and adults who care for disabled children can be assessed and supported under children's law.

The NHS Constitution

The NHS Constitution came into law as part of the Health Act in November 2009 and has recently been updated in January 2021. It contains seven principles that guide the NHS, as well as a number of pledges for patients and the public.

THE NHS CONSTITUTION
the NHS belongs to us all

Several of these, demonstrate the commitment of the NHS to the requirements of the Equality Act 2010 and the Human Rights Act 1998. For example, the first principle requires that the NHS "is available to all, irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status."

Meeting our Statutory Duties, NHS Mandated Equality Standards and other Equality-related Initiatives

Adoption of Inclusive Decision-Making Framework (IDMF)

In July 2020, a number of LLR System Equality, Diversity and Inclusion (EDI) priorities were identified by the Leicester, Leicestershire and Rutland (LLR) EDI Taskforce, including the creation and implementation of an Inclusive Decision-Making Framework.

The Inclusive Decision-Making Framework (IDMF) aims to enhance our decision-making processes and ensure they are not influenced by biases, and thoroughly consider the diverse needs of our patients, our service users, our workforce and the wider community.

Inclusive decision-making involves thorough consideration of equality, diversity, and inclusion when we are developing and implementing strategies, plans, programmes, projects, or commissioning or decommissioning and procuring services.

We have created the framework to support the embedding of equality, diversity and inclusion into our culture, so that it can enable transformation and innovation across the LLR System.

This means promoting inclusive and compassionate leadership so that we can create a diverse workforce which is able to deliver 21st Century care to all of the communities in LLR. The successful application of this framework ensures that we can integrate equality analyses into our decision-making to reduce health inequalities and attract, retain and develop diverse talent.

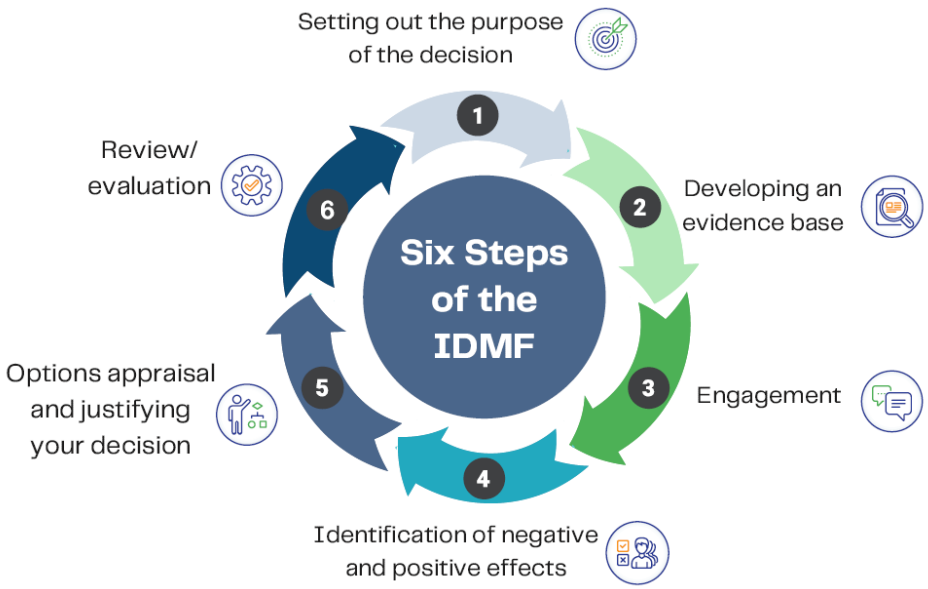
The Framework considers our role as anchor institutions whose long-term sustainability is tied to the health and wellbeing of the local community we serve. To facilitate effective implementation of the framework three key areas were identified to test the application of the framework in different contexts. These were:

- The Building Better Hospitals (Reconfiguration Programme)
- The implementation of the LLR Health Inequalities Framework
- LLR Clinical Design Group Planning
- Maternity Improvement and Redesign

The Inclusive Decision-Making Framework (IDMF) - The 6 steps

The Inclusive Decision-Making Framework consists of a 6-step process and a number of behavioural enablers which take into account the climate in which decision-making takes place and promote inclusivity in decision-making. Equally the Framework identifies the environmental barriers which can lead to sub-optimal biased decision-making. The IDMF recognises that equality is an expectation, diversity is a lived reality, and inclusion is a choice.

The figure below shows the six steps of the IDMF:



Step 1 Setting out the purpose of the decision

A robust assessment will set out the reasons for the change, how this change can impact on protected and inclusion health groups, as well as whom it is intended to benefit, and the intended outcome. Decision makers should also think about how individual proposals might relate to one another. This is because a series of changes to different services could have a severe impact on particular protected characteristics and inclusion health groups. Joint working with partners will also help us to consider thoroughly the impact of joint decisions on the people we collectively serve.

Step 2 Developing evidence base

It is important to consider the information and research already available locally and nationally. The assessment of the effect of a

change on equality and inclusion health groups should be underpinned by up-to-date and reliable information about the different groups of people that the change is likely to have an impact on. For example, workforce dashboard data and Public Health England dashboards reporting on health inequalities. A lack of information would not be a sufficient reason to conclude that there is no impact.

Step 3 Engagement

Engagement is crucial to assessing the effect of a change on equality and inclusion health groups. There is an explicit requirement to engage people under the duty to reduce health inequalities, and beyond the legislative imperative it will help our teams to improve the equality, diversity and inclusion information that they use to understand the possible effect of a change or service improvement on diverse groups. No-one can give better insight into how proposed changes will have an impact than the people who would be affected by change.

Step 4 Identification of positive and negative effects

It is not sufficient to state simply that a change will impact on everyone equally. There should be a more in-depth consideration of available evidence to see if particular protected characteristic and inclusion health groups are more likely to be affected than others. Equal treatment does not always produce equal outcomes, and sometimes organisations will have to take particular steps for certain groups to address an existing disadvantage or to meet differing needs. This could be using proportional universalism or positive action.

Step 5 Options appraisal and justifying your decision

The assessment should clearly identify the option(s) chosen, and their potential implications, and document the reasons for the decision(s).

Step 6 Review/Evaluation

Although assessments of the effect on of a change on equality and inclusion groups will help to anticipate the likely effect on different communities and groups, in reality the full impact of a decision will only be known once it is introduced. It is therefore important to set out arrangements for reviewing the actual impact of a change once it has been implemented.

During 2023, we embedded the IDMF into our Stage 2 Equality Impact Assessment/Analysis (EIA). The assessment incorporates the 6 steps noted above.

New Equality Impact Assessment/Analysis (EIA) incorporating the Inclusive Decision-Making Framework (IDMF)

Equality Impact Assessments/analysis enables the ICB to show 'due regard' to the Public Sector Equality Duty and ensures that consideration is given prior to any policy or commissioning decision made by the Governing Bodies (or other committees) that may impact upon people with protected characteristics, equality and human rights.

Most of our proposed services, polices and functions are subject to an EIA. This includes (but is not limited to) service and policy planning and review, projects and work programmes, performance management, (de) commissioning and procurement, budget planning and allocation, employee performance, development and relations.

The ICB use an Equality Impact Assessment (EIA) online platform called UAssure for stage one/screening purposes. This service is provided by the Inclusion Unit at NHS Midlands and Lancashire Commissioning Support Unit (MLCSU).

If a stage two (or part B) assessment is required, the ICB uses a more detailed word template called the **Inclusive Decision-Making Framework (IDMF) Equality Analysis.** This has been developed by Leicestershire Partnership Trust working in collaboration with the ICB with the aim of de-biasing the decision-making process. We are currently working to get other system partners on board.

The assessment also incorporates the Health Equity Assessment Tool (HEAT) and means that the equality analysis goes beyond the legal duties under the Public Sector Equality Duty by assessing the impact of proposals and decisions on groups in society who are more likely to experience health inequalities and/or poorer health outcomes due to wider determinants of health such as income, social and/or cultural status.

During the reporting period the ICB has developed **a joint Equality Impact Assessment and Quality Impact Assessment Policy** (EQIA) with links to relevant resources and templates.

Analysis of EIAs undertaken (or being considered) from 1st April 2023 to March 2024

Commissioning / Project
1. Community Health and Wellbeing Plans
2. Medicines Optimisation Framework
3. Fielding Palmer Hospital
4. Social Prescribing Platform
5. Direct Supply of Dressings in Nursing Homes
6. Primary Care Simple Switch Program
7. Care and Wellbeing Delivery Action Plan 2023 - 2025
8. Dementia Strategy
9. Review of FIN2 data to identify any anomalies
10. Care Package Reviews - CHC/Complex, AHP, S117 and Continuing Care for Children
11. Personal Health Budget Reconciliation
12. Review of LA Domiciliary Charges
13. Review of Shared Care

14. Review of Childrens Continuing Care
15. Breast Pain Pathway
16. Update to Covid Vaccination Programme
17. MSK
18. Stopping Gluten Free
19. Mutually Agreed Resignation Scheme
20. Proposal to redefine accreditation criteria for independent sector cataract providers
21. Long Clawson Surgery and Stackyard Surgery
22. EIA to assess the impact of not de-commissioning the current Community Pharmacy Service for urgent supply of End of Life medicines and IV antimicrobial medicines due to lack of funding.
23. Continuous Glucose Monitoring CGM - children and young people
24. Decommissioning Extended Access to Primary Care
25. H Pylori Service Provision
26. Specialised GP Services – Asylum Seeker Patients
27. Specialised GP Services – Homeless Patients
28. Specialised GP Services – Special Allocation Scheme (SAS)
29. All Age Online Counselling

30. Ophthalmology Pathway
31. Commissioning the Eclipse BOOMERANG Digital Platform for Select Inhaler Changes.
32. Integrating Primary and Secondary Care in LLR Through Primary Care Paediatric Hubs (PCPH)
33. Ear Irrigation Service
34. Alcohol Care Team (ACT) Funding Continuation
35. Brain Cancer Triage
36. Fit4Surgery Cancer Prehabilitation
37. Bowel Testing/Screening - FIT Project – to increase the use of Faecal Immunochemical Test as a diagnostic tool in patients aged 18 and over.
38. Additional Investment to Personalised Commissioning Contract 24/25
39. Health Inequalities Support Unit
40. Women's Health Hub
41. LLR Covid Medicines Delivery Unit
42. Learning Disabilities and Venipuncture
43. Adult Autism Assessment Service Optimisation
44. Home Enteral Nutrition Service (HENS) Adult Dietitians.
45. HENS Tube Changes

46. Primary Care Diabetes Enhanced Service
47. Co Production CYP
48. Palliative Care CYP
49. Asthma hubs
50. Milk Allergy Pathway
51. Early Intervention Therapy neonates
52. ADHD Medication Review
53. ASD Assessment Pathway
54. Tier 2 Weight Management
55. CPIPS (Cerebral Palsy Service)
56. SEND Integration Project
57. Fit4Surgery orthopaedic Prehabilitation
58. LUCID Programme Integrated Chronic Kidney Disease
59. Mental Health Cafes
60. Rezum Procedure (Urology)
61. CEIPS Calm Clinics – Calm Children Project 2024-2025 funding and City Early Intervention Psychology Support (CEIPS) Service

62. Diabetes Enhanced Care
63. S256 Historical Agreements Request for Continuation of Funding
64. Discretionary Grants to the voluntary sector
65. LLR Inequalities Hub
66. Newmedica clinic and surgical centre change of premises
67. Optum Accelerate Programme
68. Community Pharmacy Clinical Lead (CPCL)
69. PharmOutcomes
70. MicroGuide Antimicrobial App
71. Project Manager for development of a Central Appliance Hub 11/01
72. Getting Help in Neighbourhoods (GHiN) Mental Health Grant Scheme – Round 1 (year 3) Grant Awards for 2024-25
73. Acne Service

EIAs are available on request by emailing:

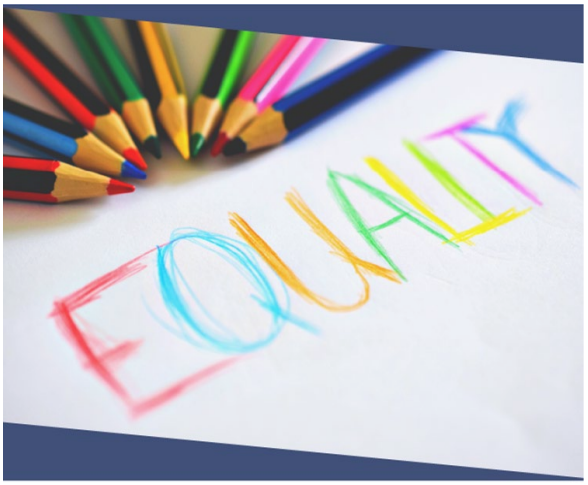
llricb-llr.enquiries@nhs.net

Additional EIA/Equality Analysis Training

Staff can access one-to-one training and support for completing Equality, Impact Assessments from the MLCSU Equality and Inclusion Business Partner upon request.

During the reporting year we delivered (in partnership Leicestershire Partnership Trust LPT) five two-hour workshops on the new IDMF EIA template to staff from our two organisations. We also produced a video resource for staff.

LLR CCG/ICB Equality, Diversity and Inclusion Strategy 2021-2025



The Equality, Diversity and Inclusion strategy is designed to cover the initial period of transition of the LLR CCGs becoming the new LLR ICB.

The current strategy was approved in May 2021 and sets out our strategic approach to delivering equality, diversity and inclusion for the benefit of the local population and staff in line with the aims and objectives of the Equality Act 2010, the Public Sector Equality Duty and NHS mandated duties.

Since its publication we have revised our equality objectives which fulfils our legal obligation. We will also be revising the strategy during 2024 for launch in 2025.

To view the EDI strategy, please click on the following link: EDI Strategy

Specific and Measurable Equality Objectives 2024-2025

In 2022 - 2023 the ICB aligned their overarching equality objectives to the three new Domains in the Equality Delivery System (EDS) 2022. The Domains consist of eleven outcomes which we assess against annually. This forms our overarching action plan. Following this year's EDS assessment and data analysis we have developed 3 specific and measurable objectives for the next reporting year **specific to the ICB**. There will also be some system wide equality objectives relating to Domain one 'Commissioned or Provided Services.'

In addition, we will be delivering a number of other actions noted in the EDS report: EDS Report as well as the Workforce Race and Disability Equality Standards (WRES/WDES) & the NHS EDI Improvement plan which are interlinked.

Protected Characteristic	Baseline	Our high impact actions	How will we know we've been successful	Who will lead on this work	When
Equality Objective 1 (Workforce) Disability, Race and Sexual Orientation	The following percentages of staff have not shared their protected characteristic (or it is not known) on ESR. • Race **12.4%** • Sexual Orientation **28%** • Disability **12.1% %**	We will deliver a campaign to increase recording on ESR of all staff but with a particular focus on the protected groups listed in the first column. This will help with workforce planning. **Action links to workstreams**	We will decrease the 'not known rates' for each protected characteristic by**:** • Race **100% to 0** • Sexual Orientation by **70% to 8.4%** • Disability by **90% to 1.2%**	EDI Business Partner/ Senior OD and Workforce Manager	March 2025

	(Data as of Sept 2023)	**WRES/WDES Action plan/NHS EDI Improvement plan and EDS Domain 2B)**			
Protected Characteristic	**Baseline**	**Our high impact actions**	**How will we know we've been successful**	**Who will lead on this work**	**When**
Equality Objective 2 (Leadership) Disability, Gender Identity, Race, Sex, Sexual Orientation, Religion & Belief	ICB Board Representation. 52.9% of voting board members did not register their ethnicity. 47% of voting members did not declare their disability status. Low levels of declaration are partly caused by the fact that not all ICB Board members are on the NHS Electronic Staff Record system.	To expand the characteristics declared beyond race/disability and improve the Board data collection by writing to members in a sensitive way. **Actions links to workstreams WRES/WDES Action plan/NHS EDI Improvement plan and EDS Domain 2B)**	a) All Members have completed their details relating to their protected characteristics to **100%.** b) To analysis the data around declaration/sharing rates to see if there are areas for improvement.	Alice McGee, Chief People Officer	March 2024 March 2025

Protected Characteristic	Baseline	Our high impact actions	How will we know we've been successful	Who will lead on this work	When
Equality Objective 3 (Commissioned Services) ICB specific Age Sex	• The one-year survival rate from lower GI (bowel) cancer in Leicester for males aged 55 + = 69% • Bowel Cancer Screening uptake in Leicester = 45%	Train a cohort of Somali Community Bowel Cancer Champions. Run a series of bowel cancer awareness events in specific areas where uptake of screening is low, and mortality is high. Produce a series of videos in different languages on successfully completing the bowel screening process.	• Increase one-year survival from lower GI Cancer in Men in Leicester from 69% to 72% by the end of 2024-5 • Increase Bowel screening up take from 45% to 50% in Leicester city by March 2025 • All Core 20 Connectors/Somali Health Champions and Social Prescriber Link Workers (SPLWs) to have accessed training on the screening programme.	Head of PHM and ICB Cancer Lead	March 2025 March 2025

			• A minimum of one health event with screening support held in 2024-5 in each of the low uptake PCNs. • Minimum of two Learning Disability-specific knowledge events held online/Face 2 Face during 2024-5 • Obtain Armed Forces Community agreement to host video on a website.		March 2025 March 2025

Website Accessibility Standard

The Public Sector Bodies (Website and Mobile Applications No. 2) Accessibility Regulations 2018 builds on existing obligations to make 'reasonable adjustments' under the Equality Act, and public sector bodies must make their websites and apps more accessible by making them 'perceivable, operable, understandable and robust'. This regulation also includes internal websites such as intranets.

The LLR ICB (and providers) websites should contain clear accessibility statements to ensure that the population can access information, resources and documents from the ICB in a format that meets their needs, for example via easy read or large print formats. Where possible, information resources and publications hosted on the ICB website are presented in plain and easy to understand language.

For a copy of the ICB website accessibility statement please click on the following link: Accessibility Statement - LLR ICB

Accessible Information Standard (AIS) 2016

The aim of the Accessible Information Standard (AIS) is to make sure that people who have a disability, impairment or sensory loss receive information in the best format for them and receive any communication support that they may require.

The AIS applies to service providers across the NHS and adult social care system, and effective implementation requires such organisations to make changes to policy, procedure, human behaviour and, where applicable, electronic systems.

Commissioners of NHS services and publicly funded adult social care must show due regard to this standard, to ensure that they enable and support compliance through their relationships with provider organisations. This standard is in all the ICBs NHS Standard Contracts and is monitored by Quality and Performance Key Performance Indicators (KPIs).

A copy of LLR ICBs AIS statement can by clicking on the following link: Accessible Information Statement

Provider Compliance Audit 2023-2024

NHS Midlands and Lancashire Commissioning Support Unit's Equality and Inclusion Team Business Partner conducts a desktop provider compliance check of commissioned service provider websites on the following equality-related legal duties and NHS Mandated Standards:

- Equality Objectives published on the provider's website (reviewed every 4 years)
- Published Equality information – e.g., Equality Compliance
- Equality Delivery System Grading and Report (on an annual basis)
- Workforce Race Equality Standard Report (on an annual basis)
- Workforce Disability Standard Report (on an annual basis)
- Up to date Modern Slavery Act 2015 Statement on website (for providers of £36 million and over – on an annual basis)
- Accessible Information Standard (AIS) and Website Accessibility Statement -– see above for more information on what these are.

The table below shows a summary of equality analyses carried out in December 2023. The following providers were reviewed:

- East Midlands Ambulance Service (EMAS)
- Leicestershire Partnership NHS Trust
- University Hospitals Leicester (UHL)

Where information wasn't displayed, we contacted the relevant people for an update.

Commissioned Provider	Equality Objectives	Published Equality Information	Undertaken EDS in 2022/23	Published WRES report	Published WDES report	AIS	Modern Slavery Act
East Midlands Ambulance Service (EMAS)	✓	✓	✓	✓	✓	✓	✓
Leicestershire Partnership NHS Trust	✓	✓	✓	✓	✓	✓	✓
University Hospitals Leicester (UHL)	✓	✓	✓	✓	✓	✓	✓

✓ In place ✓ In place but out of date/not dated

Our Workforce

As an employer we aim to build a great place to work. With a culture of inclusive and compassionate leadership, we strive to create a working environment where all our staff feel included, valued and can fulfil their potential.

The organisation has robust policies and procedures in place which ensure that all staff are treated fairly and with dignity and respect - some of which are included in the support for staff section. We are committed to advancing equality of opportunity for all current and potential employees.

People Plan

The NHS is made up of 1.3 million employees who care for the people of this country with skill, compassion, and dedication. People work in many different roles, in different settings, employed in different ways, and in a wide range of organisations.

The NHS People Plan was published in July 2020 and sets out actions to support transformation across the whole NHS now and in the future. It focuses on how we must all continue to look after each other and foster a culture of inclusion and belonging, as well as grow our workforce, train people, and work together differently to deliver patient care.

The NHS People Plan is set out in four broad themes:

- Belonging in the NHS
- New ways of working and delivering care
- Growing for the future
- Looking after our staff

The ICB continues to undertake many initiatives both organisationally, and with system partners, to advance the above aims.

The People Plan sets out what NHS staff can expect from leaders and each other and includes a focus on fostering *a culture of inclusion and belonging*. Some of the relevant actions are found in our Workforce Race and /Disability Equality Standard Action plan. The NHS People Plan includes a People Promise, which outlines the actions and behaviours staff should expect from their employers and colleagues, as part of improving the experience of working in the NHS for everyone.

The Inclusive People Promise

Equality, Diversity, and Inclusion run through the People Plan, changing the culture of NHS services to focus more on learning, belonging, recognition, work life balance, mental health and wellbeing and being the best place for people to work. Details of the inclusive people promise are shown below:

We are a team

- First and foremost, we are one huge, diverse and growing team, united by a desire to provide the very best we can.
- We learn from each other, support each other and take time to celebrate successes.

We work flexibly

- We do not have to sacrifice our family, our friends or our interests for work.

- We have predictable and flexible working patterns, and, if we do need to take time off, we are supported to do so.

We are always learning

- Opportunities to learn and develop are plentiful, and we are all supported to reach our potential.
- We have equal access to opportunities.
- We attract, develop and retain talented people from all backgrounds.

We are safe and healthy

- We look after ourselves and each other.
- Wellbeing is our business and our priority, and if we are unwell, we are supported to get the help we need.
- We have what we need to deliver the best possible care –from clean safe spaces to rest in, to the right technology.

We each have a voice that counts

- We all feel safe and confident to speak up.
- We take the time to really listen to understand the hopes and fears that lie behind the words.

We are recognised and rewarded

- A simple thank you for our day-to-day work, formal recognition for our dedication, and fair salary for our contribution.

We are compassionate and inclusive

- We do not tolerate any form of discrimination, bullying or violence.
- We are open and inclusive.
- We make the NHS a place where we all feel we belong.

The NHS Long Term Workforce Plan

The NHS Long Term Workforce Plan was published in June 2023 and identify three key themes of train, retain and reform to support the growth of the NHS workforce for the future.

Train

LLR ICB will work in conjunction with the Integrated Care System (ICS) to provide a pathway of Apprenticeships into Health & Social Care, Primary and Secondary Care, Voluntary, Community and Social Enterprise to ensure we engage local opportunities into health and care careers both clinical and non-clinical. Planned Higher Education Institute (HEI) commissioned clinical education programmes and higher clinical apprenticeships - foundation degree, degree and Master accredited courses.

Retain

The retention of our workforce to be healthy and well, within a culture that provides opportunity to be supported and provide educational competence and confidence, to meet the population health needs and improve access and minimise health inequalities.

Reform

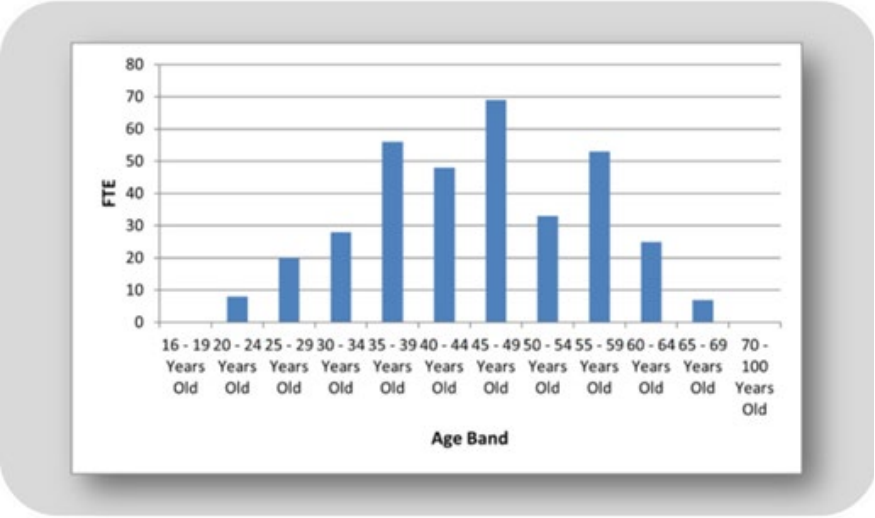
LLR ICB lead the Place and Neighbourhood approach to access, supply and quality of our workforce and how care is delivered to our population through the upskilling the workforce and have the supervision, coaching and mentorship.

From the three areas of workforce priorities, we will enable and influence positive progression across partnerships and maximising funding models, enriched with appraisal conversations, new models of workforce to meet the health needs of our population and the vision for LLR Integrated Care System (ICS) and Integrated Care Partnerships (ICP).

Workforce Profile

Our aim is to employ a diverse workforce that is representative of our local communities as we believe this will support our decision making in the development of health services.

This section illustrates the demographics of Leicester, Leicestershire and Rutland ICB workforce as of 30th September 2023, and compares the figures to Census 2021 local population data[1]. The ICB will use this data for future workforce planning.



Age

The age-band graph above shows that the largest proportions of the Leicester, Leicestershire and Rutland ICB workforce are between the ages of 45-49 (19.9%), 35-39 (16.1%), 55-59 (15.3%), and 40-44 (13.8%). Whilst at the other end of the scale, the lowest proportions of the Leicester, Leicestershire and Rutland ICB workforce are between the ages of 65-69 (2.0%) and 20-24 (2.3%).

Census 2021 data from the Office of National Statistics (ONS)[2], details that the largest proportions of the total resident population of Leicester, Leicestershire and Rutland local authority districts are between the ages of 20-24 (7.1%), 50-54 (6.8%), and 30-34 (6.7%), so although the ICB workforce figures for the latter two age bands do exceed those statistics, the 20-24 age band is much lower by comparison, so this is perhaps one age group that seems to be currently under-represented in the workforce demographic.

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[1] Where percentages are low (under 5%) and can result in staff being identified therefore, we have not presented the data for that particular protected characteristic. However, where this occurs, we have still shown these smaller portions without figures being attributed. This is because it is important to demonstrate that we have people from diverse protected characteristic groups working at the ICB.

[2] https://www.nomisweb.co.uk/

LLR Workforce Pay Band Cluster Table and Analysis

Age Band	% Headcount by Pay Band				
	Band 1 - 4	**Band 5 - 7**	**Band 8a - 9**	**Non-AfC**	**Grand Total**
16 - 19 Years Old	0.00%	0.00%	0.00%	0.00%	**0.00%**
20 - 24 Years Old	23.08%	Under 5%	0.00%	Under 5%	**Under 5%**
25 - 29 Years Old	15.38%	11.48%	Under 5%	0.00%	**5.76%**
30 - 34 Years Old	Under 5%	13.11%	5.41%	5.88%	**8.07%**
35 - 39 Years Old	7.69%	20.49%	14.19%	15.69%	**16.14%**
40 - 44 Years Old	11.54%	9.84%	16.22%	17.65%	**13.83%**
45 - 49 Years Old	11.54%	14.75%	27.03%	15.69%	**19.88%**
50 - 54 Years Old	11.54%	11.48%	6.76%	11.76%	**9.51%**
55 - 59 Years Old	7.69%	10.66%	20.95%	13.73%	**15.27%**
60 - 64 Years Old	Under 5%	5.74%	6.76%	13.73%	**7.20%**
65 - 69 Years Old	Under 5%	Under 5%	Under 5%	Under 5%	**Under 5%**
70 - 100 Years Old	0.00%	0.00%	0.00%	0.00%	**0.00%**
Grand Total	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

The figures shown in the table above illustrate that LLR ICB 20–24-year-olds and 25- 29-year-olds are predominately found in bands 1-4 at 23.08% and 15.38% respectively. There are also 11.48 % of 25-29 years olds found in bands 5-7.

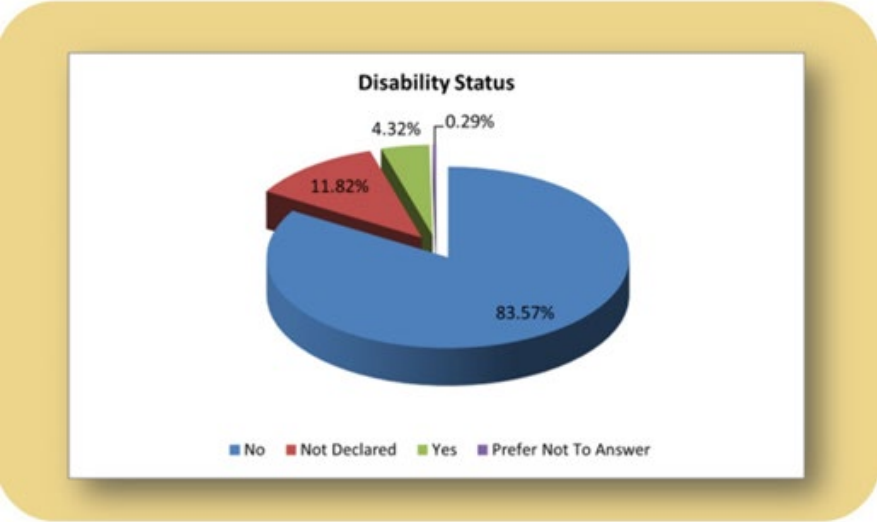
The highest proportion of those aged 30–34 and 35-39 are found in bands 5-7 at 13.11% & 20.49%.

The highest proportion of those aged 40–44 is found in the non AfC band at 17.65%.

The highest proportion of those aged 45 - 49 and 55-59 are found in bands 8a-9 at 27% and 20.95% respectively.

The highest proportion of 60–64-year-olds are found in the AfC band at 13.73%

Disability



The figures shown in the graph above illustrate that 83.6% of the LLR ICB workforce identify themselves as having no disability, 4.3% declare that they have a disability, and 12.1% opted not to disclose their disability status.

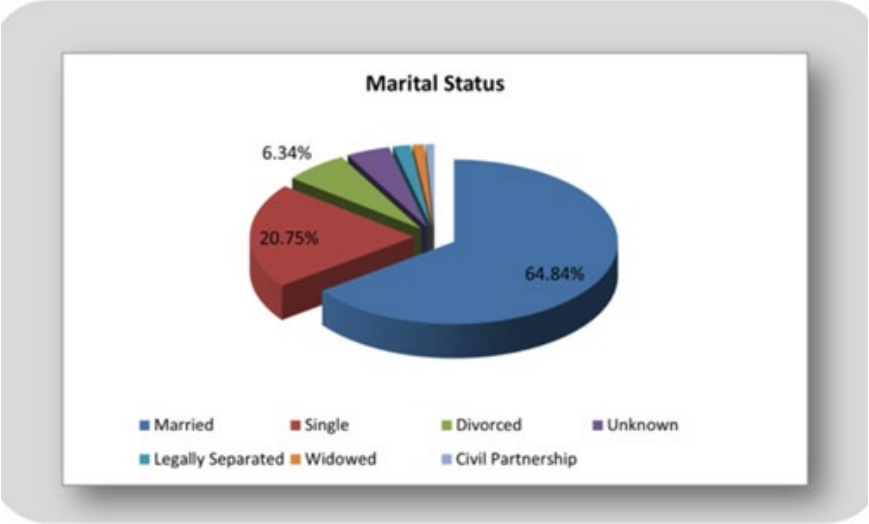
Census 2021 data from the Office of National Statistics (ONS), confirms that 83.8% of the resident population of LLR local authority districts view themselves as not being disabled under the Equality Act and 16.2% identify themselves as being disabled, so there appears to be a sizeable disparity between levels of disability in the ICB workforce compared to the local resident population as a whole.

LLR Workforce Pay Band Cluster Table and Analysis

Disability Status	% Headcount by Pay Band				
	Band 1 - 4	**Band 5 - 7**	**Band 8a - 9**	**Non-AfC**	**Grand Total**
No	84.62%	89.34%	89.19%	52.94%	**83.57%**
Not Declared	11.54%	Under 5%	5.41%	47.06%	**11.82%**
Yes	Under 5%	5.74%	Under 5%	Under 5%	**Under 5%**
Prefer Not To Answer	Under 5%	Under 5%	Under 5%	Under 5%	**Under 5%**
Grand Total	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

The figures shown in the table above illustrate that LLR ICB workforce has a consistent majority identifying themselves as having no disability across all pay bands, with the exception being the non-AfC cluster at 52.94%. The non-AfC cluster also has a very different proportion of staff

members opting not to disclose their disability status, with the figure for this pay band being considerably higher than the three other clusters at 47.06%.

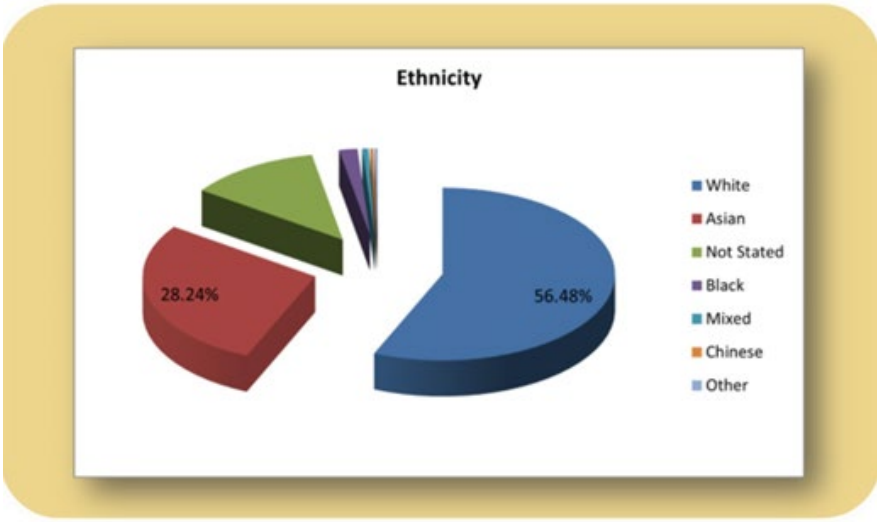


Marriage and Civil Partnership

The marriage and civil partnership graph above illustrates that 64.8% of the LLR ICB workforce identify themselves as being married. This is higher than the Census 2021 data for LLR local authority districts, which details that 47% of the total resident population aged 16 and above have listed themselves in the same category.

The proportion of the LLR ICB workforce who declare themselves to be single is 20.7%. This is lower than the Census 2021 figure for the same category, for LLR local authority district residents aged 16 and above, which is 36.5%.

Race



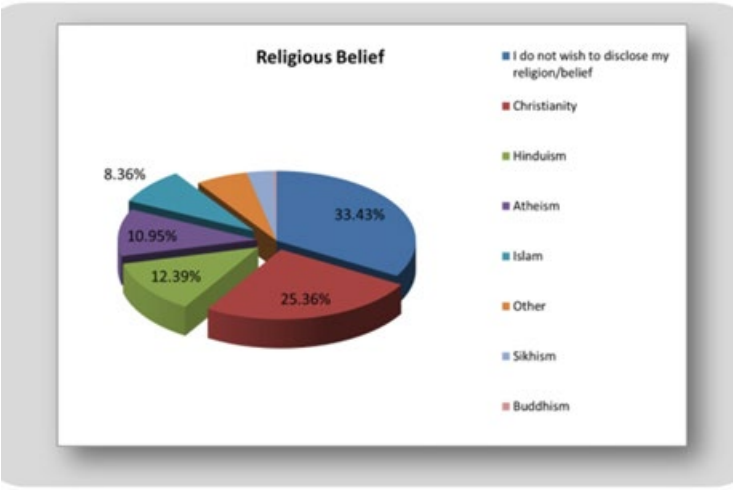
The figures shown in the graph above illustrate that 56.5% of the LLR ICB workforce identify themselves as White, and 28.2% identify as Asian. The total BAME population for the ICB workforce is 31.1%, yet 12.4% of staff have chosen not to declare their ethnicity, so this figure may be higher in actuality.

Census 2021 data from the Office of National Statistics (ONS), confirms results of 72.5% and 19.5% respectively, for the White and Asian ethnicity categories for the total resident population of LLR local authority districts and a total BAME population of 27.5%.

LLR Workforce Pay Band Cluster Table and Analysis

Ethnic Category	% Headcount by Pay Band				
	Band 1 - 4	**Band 5 - 7**	**Band 8a - 9**	**Non-AfC**	**Grand Total**
White	38.46%	55.74%	66.89%	37.25%	**56.48%**
Asian	30.77%	37.70%	22.30%	21.57%	**28.24%**
Not Stated	19.23%	Under 5%	8.11%	41.18%	**12.39%**
Black	11.54%	Under 5%	Under 5%	Under 5%	**Under 5%**
Mixed	Under 5%	Under 5%	Under 5%	Under 5%	**Under 5%**
Chinese	Under 5%	Under 5%	Under 5%	Under 5%	**Under 5%**
Other	Under 5%	Under 5%	Under 5%	Under 5%	**Under 5%**
Grand Total	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

The figures shown in the table above illustrate that despite the fact that 56.5% of the LLR ICB workforce identify themselves as White, the pay band clusters of 1-4, and non-AfC do have more evenly split proportions, with the percentages of Asian individuals listed as 30.77% and 21.57% respectively. The non-AfC cluster also has a very different proportion of staff members opting not to disclose their ethnicity, with the figure for this pay band being considerably higher than the three other clusters at 41.18%. Figures for Black, Mixed, Chinese and Other ethnicities are consistently low across all pay band clusters, with the exception of pay bands 1-4, which has 11.54% of Black members of staff.



Religion and Belief

The religion and belief graph above illustrates that 25.4% of the LLR ICB workforce identify themselves as being Christian, 8.4% identify as Muslim, and 12.4% as Hindu. The Christian and Muslim figures are lower than the 2021 Census, which gives results of 39.2% and 9.2% respectively, for the total resident population of LLR local authority districts. However, the number of Hindu employees is almost 5% higher than the total number of local residents identifying themselves in that category, which is 8.2%.

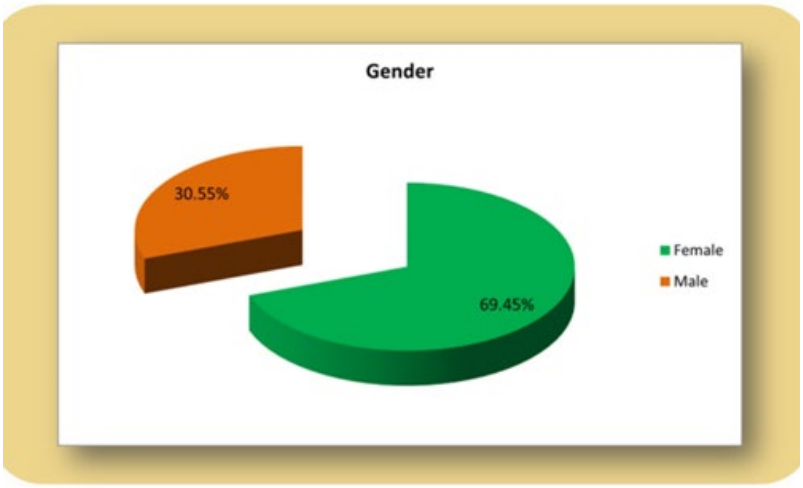
The proportion of the LLR ICB workforce who chose not to declare their religion is 33.4%. This is six times higher than the Census 2021 figure for the same category, for LLR local authority district residents, which is 5.5%.

LLR Workforce Pay Band Cluster Table and Analysis

Religious & Belief	% Headcount by Pay Band				
	Band 1 - 4	**Band 5 - 7**	**Band 8a - 9**	**Non-AfC**	**Grand Total**
I do not wish to disclose my religion/belief	23.08%	20.49%	29.73%	80.39%	**33.43%**
Christianity	19.23%	27.87%	29.05%	11.76%	**25.36%**
Hinduism	19.23%	17.21%	10.81%	Under 5 %	**12.39%**
Atheism	19.23%	7.38%	15.54%	Under 5%	**10.95%**
Islam	15.38%	13.11%	Under 5%	Under 5%	**8.36%**
Other	Under 5%	9.02%	6.08%	0.00%	**6.05%**
Sikhism	0.00%	Under 5%	Under 5%	0.00%	Under 5%
Buddhism	0.00%	Under 5%	0.00%	0.00%	Under 5%
Grand Total	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

The figures shown in the table above illustrate that the largest proportion of LLR ICB staff across all age bands chose not to disclose their religion or belief. The highest proportion being in the non AfC band at 80.39%. Staff working in bands 1-4 are evenly split between Christianity, Hinduism and Atheism at 19.23% each. The highest proportion of Christians are found in bands 8a -9 at 29.05%. The highest proportion of Hindus and those of Islamic faith are found in bands 1-4 at 19.23%. and 15.38% respectively. The highest proportion of atheists is found in bands 1-4 at 19.23%.

Sex

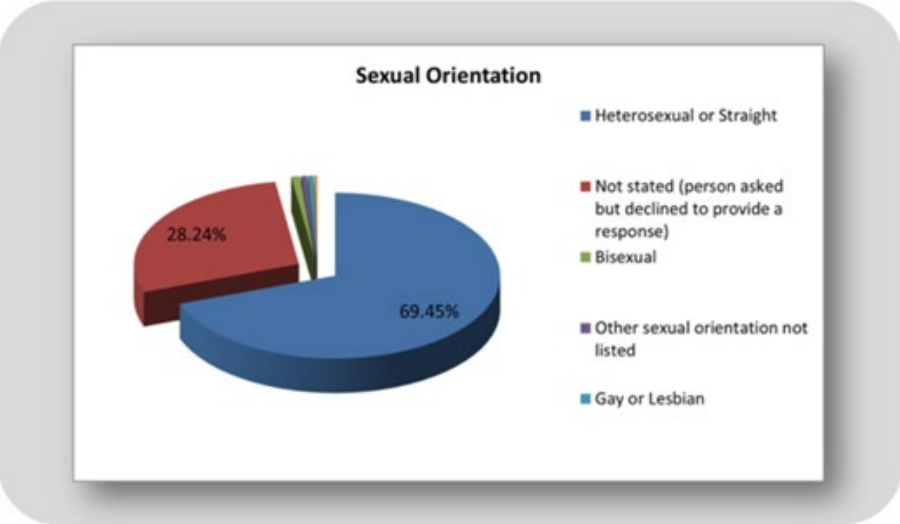


The graph above shows that 69.5% of the LLR ICB workforce are female and 30.5% are male. This reflects the latest available statistics from NHS Digital[3], which detail that the majority of the total NHS workforce are women at 76.7%.

In contrast, Census 2021 data from the Office of National Statistics (ONS) shows that 49.5% of residents in LLR local authority districts are male, and 50.5% are female. This also mirrors the data for both the East Midlands region and England as a whole. **The LLR Workforce Pay Band Cluster Table and Analysis for Sex/Gender can be found in the Gender Pay Gap Report.**

Gender Pay Gap Report

[3] https://www.england.nhs.uk/2021/03/nhs-celebrates-the-vital-role-hundreds-of-thousands-of-women-have-played-in-the-pandemic/



Sexual Orientation

The sexual orientation graph above illustrates that 69.4% of the LLR ICB workforce identify themselves as heterosexual or straight. This is lower than the Census 2021 data for LLR local authority districts, which details that 89.5% of the total resident population aged 16 and above have listed themselves in the same category.

As is shown above, 28.2% of the LLR ICB workforce chose not to declare their sexual orientation status. This figure is twenty percent higher than the Census 2021 data for LLR local authority districts, which details that 7.8% of the total resident population over the age of 16 chose not to answer this question on their census form.

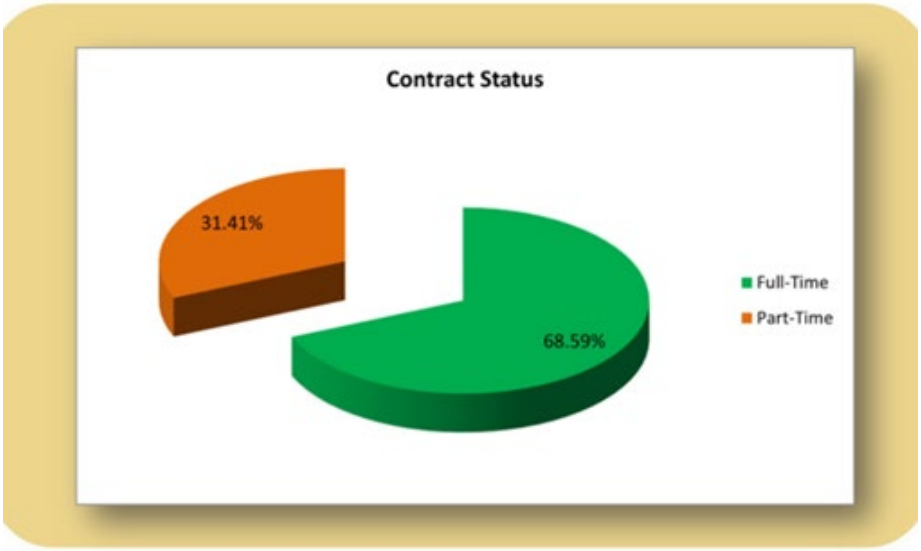
LLR Workforce Pay Band Cluster Table and Analysis

Sexual Orientation

	% Headcount by Pay Band				
Sexual Orientation	**Band 1 - 4**	**Band 5 - 7**	**Band 8a - 9**	**Non-AfC**	**Grand Total**
Heterosexual or straight	73.08%	82.79%	75.68%	17.65%	**69.45%**
Not stated	23.08%	13.93%	22.30%	82.35%	**28.24%**
Bisexual	Under 5%	Under 5%	Under 5%	Under 5%	**Under 5%**
Other	Under 5%	Under 5%	Under 5%	Under 5%	**Under 5%**
Gay or Lesbian	Under 5%	Under 5%	Under 5%	Under 5%	**Under 5%**
Undecided	Under 5%	Under 5%	Under 5%	Under 5%	**Under 5%**
Grand Total	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

The figures shown in the table above illustrate that the LLR ICB workforce has a consistent majority identifying themselves as being heterosexual or straight across all pay bands, with the exception of the Non-AfC cluster at 17.65%. The non-AfC cluster also has a very different proportion of staff members opting not to disclose their sexual orientation status, with the figure for this pay band being considerably higher than the three other clusters at 82.35%. Proportions of bisexual, other, gay or lesbian, and undecided members of staff are consistently low across all pay band clusters.

Contract Status



The contract status figures shown in the graph above illustrate that just over two thirds of the total LLR ICB workforce are employed on a full-time basis. This mirrors the Census 2021 data from the Office of National Statistics (ONS), which details that 69.3% of the total population of LLR local authority districts who are aged 16 and over and were in employment a week before the census, were contracted on a full-time basis also.

Workforce Race Equality Standard (WRES). Not a mandated requirement for ICBs in 2022-2023 and completed on a voluntary basis.

At present, Integrated Care Boards (ICBs) are not required to undertake the WRES or WDES assessments. However, we are committed to workforce equality and inclusion, and it is important we use this standard as part of our continuous EDI improvement journey. The ICB plays an active role in the development of Equality and Inclusion across the LLR system and needs to be an active in progressing and collaborating with partners on the standard. This is particularly important following the launch of the Workforce EDI NHSE Improvement Plan in June (noted below).

Please click on the following link: NHS EDI Improvement Plan

LLR ICB is **(usually)** required to demonstrate "due regard" (consideration) to the Workforce Race Equality Standard (WRES), and in meeting our requirements of the ICB Assurance Framework, which means monitoring and supporting NHS and other large provider organisations with progression of the Standard.

We aim to fully understand the diversity of our workforce to ensure non-discriminatory practice, work with staff and staff representatives. The Standard helps identify and eliminate barriers and discrimination in line with the Public Sector Equality Duty (PSED), the Equality Act 2010 and Employment Statutory Code of Practice. Ultimately, it is about ensuring an inclusive approach with regards to recruitment, training and promotion.

Since its introduction in 2015, the WRES has required NHS trusts and clinical commissioning groups to self-assess annually, on nine indicators of workforce race equality. These include indicators related to BME (black & minority ethnic) representation at senior and board level. **A copy WRES report and Action Plan can be found by clicking on the following links: Action Plan: WDES-WRES Action Plan**

WRES Report: WRES Report

Workforce Disability Equality Standard (WDES). Not a mandated requirement for ICBs in 2022-2023 and completed on a voluntary basis.

The Workforce Disability Equality Standard (WDES) was introduced in April 2019 as a mandated data collection for NHS provider trusts. The WDES is a collection of 10 metrics that aim to compare the workplace and career experiences of disabled and non-disabled staff. NHS Trusts and Foundation Trusts are required to report and publish data, on an annual basis, for each of these metrics.

A copy of WDES report and Action Plan can be found by clicking on the following links:

Action Plan: WRES and WDES Action Plan

WDES Report: WDES Report

The Gender Pay Gap Reporting

The specific duty regulations contain an obligation for public bodies with 250 or more staff to publish gender pay gap information each year. This duty to publish will apply to ICBs from 30 March 2024. **A copy of the report can be found by clicking on the following link:**
Gender Pay Gap Report

Training and Development Opportunities

Welcome sessions

The aim of these sessions is to welcome new starters to the LLR ICB and to provide them an overview of who we are, the system that we are operating in, what they can expect from working for us as well as signposting to useful information. The welcome sessions include an

EDI workshop exploring people's knowledge, and explaining the basic concepts, relevant legislation and organisational requirements.

EDI Mandatory training

LLR ICB staff are required to complete an on-line EDI training module every 3 years which is accessed via the Electronic Staff Record (ESR). The table below shows the level of compliance for all ICB staff including lay members as of January 2023:

Competency	All Workers		All Employees (Workers excluding GP / Lay Members)	
	Match	No Match	Match	No Match
NHS|CSTF| Equality, Diversity and Human Rights - 3 Years|	**86.67%**	**13.33%**	**90.40%**	**9.60%**

Details of other training and development can be found in the section working in collaboration with LLR System Partners.

Health and Wellbeing (looking after our workforce)

Included here are a few examples of the work we are doing to support the health and wellbeing of staff.

- **Employee Assistance Programme: Care First Counselling**
  Care first Lifestyle is available free of charge, offering immediate information, answers and advice on a range of workplace and personal issues. All access is confidential. Content is available as part of the Employee Assistance Programme. **www.carefirst-lifestyle.co.uk**

- **Event in a Box**
  Across our system we recognise that supporting our colleague's health and wellbeing is really important' To support getting resources out to colleagues across the system an 'event in a box' has been created and inside this box is a variety of resources to support colleagues' health and wellbeing.

- **Health and Wellbeing Partnership (LLR)** have recently updated the website to include some space specifically for the wellbeing of staff working in Health and Social Care in LLR.

  This was created to hold a wealth of information for our staff and it was launched with the Wellbeing Box and Make Time for More Good Days initiative. Staff have access to information relating to Financial and Mental Wellbeing on the webpage: Financial and Mental Wellbeing.

- **Financial Wellbeing** and pensions support can be provided through the Money Helper service – helping colleagues to understand the support available as well as the changes to the NHS Pension and how this might affect them.

- **Menopause, Coffee and Chat**
  The Midlands Leadership Academy hold a bi-monthly Menopause, coffee and chat session from 12.30pm to 13.30pm for any women wishing to go along have a chat with other Midlands NHS colleagues also going through the menopause.

- **Mental Health First Aiders**
  Across the ICB there are a number of staff who are accredited Mental Health First Aiders, which means they are equipped with the skills to support other colleagues in the workplace who may be feeling low, anxious, affected by the covid pandemic or anyone who has a general mental health and wellbeing worry.

- **National Pulse Survey and National Staff survey**
  The ICB takes part in the nation quarterly Pulse survey and the annual national Staff Survey they consistently have questions on health and wellbeing allowing the ICB to respond as needed.

- **People Information Board**
  Within the office environment a People Information board has been created which showcases initiatives internally, locally, regionally and nationally to support colleagues' wellbeing.

- **Freedom to Speak Up Champions**
  Across our ICB we have launched our network of Freedom to Speak Champions. The aim of our network is to encourage a range of colleagues to speak up – particularly groups who might find it more difficult to speak up with a strong focus on different service areas, professions, and protected characteristics.

Our champions are impartial and confidential, offering encouragement and signposting to the appropriate avenue for colleagues.

- **Listening into Action (LIA) – speaking up about discrimination and harassment**
  The ICB has been running events across LLR to understand the barriers that leaders face which prevent a safe speaking up culture and identify what is needed to support staff to feel free and able to speak out about inappropriate behaviours. We adopted Listening into Action methodology to engage with our people across LLR to try to understand what is hindering our leader's ability to provide psychologically safe environments that enable freedom to speak up. LIA has helped us to identify good (and bad) practices alongside lived experiences and case studies to help understand and then focus appropriate measures of support and plans for the future.

Looking after our Workforce (Policies)

We have several policies in place to support staff when they have a concern about abuse, harassment, bullying or violence. Equality Impact Assessments were recently undertaken on the following policies:

- Grievance Policy
- Harassment and Bullying at Work Policy
- Health & Wellbeing Policy
- Freedom to Speak up Policy.

Looking after our Workforce (Staff Networks)

- **LLR ICB People Forum**

In July 2023 the ICB ran its first People Forum (staff network meeting). The Forum represents all staff in the ICB with members from each directorate. The aims are:

- A place to discuss opportunities and challenges as well as providing feedback and having the opportunity to share views.
- Providing a safe space for discussion, sharing ideas and progressing key pieces of work.

- Building on direct feedback from colleagues as well as feedback from surveys.
- Role modelling the ICB values and provide positive energy to drive forward innovations.
- Working alongside other people groups to support and avoid duplication of work. An example of this is the appraisal champions. Network and people champions.

- **People Champions**

  At the time of writing and as part of the development of the ICB's commitment to make the organisation a great place to work the ICB are looking for staff to support and be a link between the people forum and directorates, to act as a role model for creating an open, honest, and transparent culture which values everyone has a voice.

  This is a voluntary role and is undertaken in addition to colleagues existing role in the ICB.

- **Appraisal Champions Network**

  In order to support staff development following on from previous staff survey results a network meeting has been established and supported by a Deputy Director to educate a number of employees and become “appraisal champions” to increase the uptake and recording of appraisals.

  A number of actions have been successfully completed in the last year to support an increase in our appraisal rates and also improve the quality of paperwork:

  - A new appraisal framework and supporting toolkit was launched on 1st April 2023 – including the requirement for all employees including senior leaders to have an EDI objective set as part of their appraisal objectives.

  - A number of training sessions have been held for champions to be able to promote the benefits of appraisals and also assist in recording data on the ESR system.

  - HR Business Partners team have supported a “deep dive” of the appraisal data to ensure data quality has improved.

As a result of this work the appraisal rate has increased significantly (by 20%) in Quarter 3.

- **Support for Managers**

We recognise that supporting our managers is important and we are committed to developing resources to support managers within the ICB.

The NHS is setting out expectations for its managers and phase one of our managers support is the launch of the new managers guide.

The guide has been created to support those who have line management/ supervisory responsibility within their role in the ICB. The purpose of the guide is to offer practical information, hints and tips, as well as signposting to further information to managers to support colleagues through their journey within the ICB.

An induction checklist has also been created to support managers induct new staff into the organisation.

Managers have been encouraged to attend NHS England 'A Kinder Manager' masterclass These sessions support managers to practice kinder management skills and learn about kinder cultural change.

Work will continue to support our managers.

Communication with Staff and Wider Communities

A variety of news and information is regularly issued via a range of communication platforms to inform, support and engage patients, communities and other key stakeholders, as well as our staff:

- LLR ICB website for patients, partners, stakeholders and communities
- Five for Friday – the ICB's stakeholder bulletin, featuring the week's top five articles for our partners and stakeholders.
- A conversation on…a series of face-to-face and online events inviting the public to have a conversation with the local NHS on key health issues.
- Social media (Facebook, Instagram, X (former Twitter), YouTube, LinkedIn and TikTok for instantaneous news and advice.
- LLR Connect – fortnightly staff newsletter.
- Regular ICS updates issued across the LLR health and care system.

- Campaigns and toolkits issued to ICS partners, MPs and wider stakeholders, including communities voluntary and community sector (VCS) to boost engagement and partnership working.
- Monthly staff briefings (virtual)
- Regular team meetings
- Ad-hoc online briefings for staff covering urgent important news.
- Directorate days/meetings
- Pulse Survey
- Annual Staff Survey
- Ad-hoc email communications to all staff
- Regular communication and support for Primary Care
- MP briefings
- People Information Board

Each month, we share equality awareness articles in our staff newsletters. The articles raise the profile of key equality related dates across the UK and allows us to draw attention to local awareness and celebration events.

During the reporting period the ICB has promoted a range of events that promote awareness and celebration of protected characteristics and other groups including (but not limited to):

- NHS 75 and Windrush anniversary – an exhibition at County Hall marking 75 years of the NHS and the contribution of BME NHS staff, including descendants of the Windrush generation. A comprehensive toolkit was also shared with partners to promote across LLR.
- Navratri, Vaisakhi, Ramadan and Eid – all featured in internal and external bulletins, as well as social media.
- Leicester's Diwali light switch-on ceremony to mark its 40-year anniversary in October plus video produced by Rachna Vyas and circulated in LLR connect, on social media and in Five for Friday.
- Black History Month October 2022 (Celebrating the Contribution of Nurses, Midwives and AHPs (of African origin) in the NHS a partnership event between UHL, LPT Northamptonshire ICB and LLR ICB)
- World Mental Health Day: 10 October 2023

Working in Collaboration with LLR system partners

The national direction regarding people development has provided LLR with an opportunity to collaborate and co-design people development practices that will enable our organisational and system workforces to be supported and developed with a cohesive and consistent approach. The cross-system development approach affords a valuable opportunity to share, design and deliver resource via the LLR Academy.

Working collaboratively, the LLR systemwide Equality, Diversity and Inclusion (EDI) Group have been working on a number of priority areas. A brief explanation and update on each area is provided below:

- **Reverse Mentoring** – seeks to pair a BAME, Disabled or LGBT+ member of staff with a senior NHS leader in a co-mentoring relationship. During the reporting period six participants were matched from the ICB.
- **The Inclusive Decision-Making Framework** – is a new way of embedding Equality, Diversity and Inclusion into our culture and addressing bias in decision making. **See page 13** this report for more information.
- **NHS Equality, Diversity and Inclusion Improvement Plan (undertaken on an organisational and system basis**) - sets out targeted actions to address the prejudice and discrimination – direct and indirect – that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce.

  It has been co-produced through engagement with staff networks and senior leaders.

  The plan:

  - Sets out why equality, diversity and inclusion is a key foundation for creating a caring, efficient, productive and safe NHS
  - Explains the actions required to make the changes that NHS staff and patients expect and deserve, and who is accountable and responsible for their delivery.
  - Describes how NHS England will support implementation.
  - Provides a framework for integrated care boards to produce their own local plans.

The EDI improvement plan supports the long-term workforce plan by improving the culture of our workplaces and the experiences of our workforce, to boost staff retention and attract diverse new talent to the NHS.

- **Active Bystander Programme (ABP)** – a pro-active organisational approach to address harmful behaviours, promote an inclusive and compassionate culture, and role model our system values and expectations. During 2023/4, the programme has been delivered to over 152 people working across our LLR health and care workforce. Our Active Bystanders form a supportive community of practice with the purpose of role modelling behaviours of civility and respect and promoting positive behaviour change in the workplace. A senior leader's module is being developed and line manager webinars are held to support Active Bystanders and ensure the programme is embedded.

  The ABP is being scaled up across the Midlands, with workshops delivered for key colleagues across the Nottingham, Derby and Northamptonshire health and care workforce with further interest from regional and national leaders. A comprehensive Train the Trainer programme has been developed to ensure sustainability for scaling the programme up.

  The LLR ABP has gained national recognition in its first pilot year and was awarded the National BAME Health and Care Outstanding Corporate Achievement Award in September 2023.

  LLR ICB are working with NHS England to pilot a Safe to Speak Up programme exploring the barriers to speaking up. Alice McGee – Chief People Officer LLR and Nil Sanganee – Chief Medical Officer LLR ICB spoke at:

- **Your Voice** – an online tool for LLR NHS staff is for reporting experiences of harassment, victimisation and discrimination. Signposting to available support will be part of the tool. The Your Voice platform will be launched as a pilot for the LLR ICB workforce in January 2024. The pilot, the first of its kind in the NHS, will last for 12 months and learning will be shared with LLR system partners. The Your Voice tool will support the LLR ICB Freedom to Speak Up Policy and will enable LLR ICB staff to report incidents online, at a time that suits them anonymously or named to the Freedom to Speak Up Guardians.

- **Cultural Competency Programme** - started in 2022 across the NHS LLR Integrated Care System alongside NHS England Midlands, with the support of a consultancy firm, ICECreates, the programme aims to continue to help people developing an appreciation for cultural diversity, coupled with the capability to accept and understand differences in the workplace and beyond. During 2023 a group of cultural competency enablers have been providing feedback to colleagues who have undertaken a 360 cultural competency feedback report. These colleagues alongside the enablers have been invited to community of practices to support their learning and to continue the development, skills and knowledge in this space.

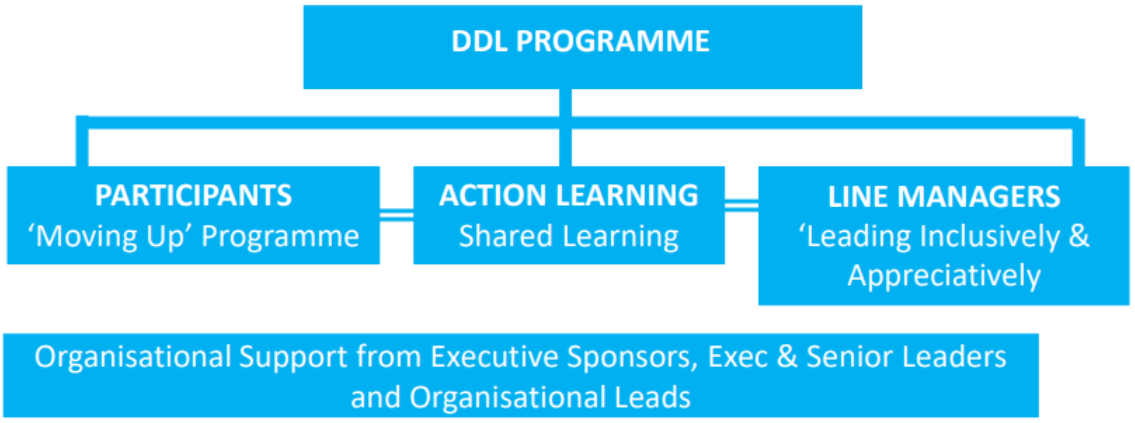
- **Developing Diverse Leadership Programme (DDL)**

LLR is focussed on creating and sustaining an inclusive culture for people working in, and people accessing our health and care system. To deliver great health and care across LLR, we know that it is important to encourage and support colleagues from diverse backgrounds to step into leadership roles. Whilst we have many success stories, our Workforce Race Equality Standard (WRES) data showed that there are differences around progression for nursing, Advanced Allied Professionals (AHP) and midwifery colleagues from BAME backgrounds compared to other ethnic groups.

The 'Developing Diverse Leaders (DDL)' tailor-made LLR pilot programme for aspiring black, Asian and minority ethnic leaders in the workplace, was designed and launched in October 2022, and was specifically aimed at Midwifery, Nursing and Allied Health Professionals AHP (Bands, 5-7) and their line managers.
The programme aims to support our leaders of the future, increase diversity at a leadership level - leading to better outcomes for colleagues and the communities we serve - and to offer opportunity and access to development and career progression to BAME colleagues.

The programme recognised that line managers can play a pivotal role in making a difference for BAME colleagues and the programme included them on this training to better understand how they can support BAME staff.

What does the programme look like?



Our purpose for this work - our 'why'.

- Developing our leaders of the future - increased diversity leading to better outcomes for colleagues & the communities we serve.
- Opportunity & access to development & career progression for people across LLR
- Deliver against our promise for #moregooddays
- A 'System of Choice & Belonging' - attract, develop, retain the best.

Who are Cohort 1?

- Cohort 1 was focussed creating opportunities for BAME colleagues.
- Blend of Band 5, 6, 7 nursing & AHP practitioners.
- x29 Participants (UHL)
- x6 Participants (LPT)
- x2 Participants (ICB/ LOROS)
- x36 Line Managers supporting their team members from across LLR

OVERALL KEY THEMES

Participants

- 96% of Participants said it is a programme they would recommend to other people - *"I (am) really thankful and glad that I am on this programme".*
- Attendance has had a positive impact on their confidence to – do their job; apply for new opportunities (& be successful); network; present & develop their careers.
- 72% reported a maintained or improved relationship/ ability to ask for career related conversations with their line manager.
- Increased confidence; Moving Up content; Career Anchors; Action Learning Sets were identified as key learning by Participants.

Line Managers

- 87% of Line Managers said it is a programme they would recommend to others
- 64% reported a maintained or improved relationship/ evidence of Participants asking for career related conversations with their line manager.
- Action Learning Sets; Understanding Culture; Unconscious Bias were identified as key learning by line managers.

IMPACT – why do more?

Some examples that we can share include:

- x3 Participants **promoted** whilst on the programme, & have shared that it is directly attributable to this opportunity.
- x2 Participants have achieved lateral career development whilst on the programme, & have shared that it is directly attributable to this opportunity.
- Significant shift/ improved levels of confidence; presentation skills demonstrated by the Participants at the Celebration Event.

An inspiring group of people are reporting that this programme has had a positive impact on their career/ lives.

Moving into 2024 we look forward to delivering the second DDL programme across the system and hope to also be developing a 'train the trainer' group of facilitators to sustain and embed the programme over the coming years.

- **Leicester, Leicestershire and Rutland Nursing, Midwifery and Allied Health Professionals (AHP) Inclusive Leadership Group**

The LLR Nursing, Midwifery and Allied Health Professionals (AHP) Inclusive Leadership Group brings together nursing, midwifery and AHP representatives from all levels of the ICS and will be responsible for developing and delivering system actions to address the historical inequity faced by minority ethnic nursing, midwifery and AHP staff in the NHS in order to have a representative and sustainable workforce.

The work is an integral part of the Equality and Diversity workstream led by the LLR People Board and is an important part of working together in more inclusive ways. In line with the LLR People's Board EDI Strategy the top priorities are to:

- Embed Equality, Diversity and Inclusion into our culture and address bias in decision making.

- Promote inclusive and compassionate leadership so we can create a diverse workforce which is able to deliver 21st century care for all of the communities in LLR.

- Enable transformation and innovation across the LLR System

The group will focus on the 4 areas of delivering the priority actions identified:

System intelligence and data
- Thematic analysis
- Gaps in our data and mechanisms to capture relevant data.

Recruitment
- Six high impact recruitment actions.

Engagement
- Understanding our staffs lived experiences.

Personal development

- Identify barriers to personal development.
- Develop a strategic approach to removing barriers and developing opportunities for personal development.

The group will report into the Nursing, Midwifery and AHPs Cabinet (ICB) group. There is also an expectation that the Chair or ICB CNO reports into the NHSE Strategic Regional Nursing and Midwifery Delivery Group and the Operation Expert Reference Group.

As a result of the work of this group the ICB has attracted the Developing Me: Developing You Talent Acceleration Programme.

- **Developing Me; Developing You – Midlands Cultural Change Talent Acceleration Programme.**

The DM;DU Cultural Change Talent Acceleration Programme was commissioned and funded by NHSE Midlands due the current success of the ICBs EDI work.

The programme is led by the ICB and draws BAME Nurses, Midwives and AHPs from across the LLR system focusing on band 8a and 8b and Allies at band 8c+.

The rationale for using this set of criteria for applications was based on analysis of what was available for this cohort of staff locally within each organisation in LLR ICB; what the ICB offered and what could be accessed across the region and national programmes.

Further analysis identified that there was little, or no development opportunities specifically designed for BAME Nurses, Midwives or AHPs above band 7 locally.

A limited number of places were available regionally. A national programme was aimed for those at Band 8c and above.

The BAME staff are matched with the Allies to form match pairs. We attracted and secured places for 14 matched pairs. This included staff from University Hospitals of Leicester, Leicestershire Partnership Trust, DHU and the ICB.

The programme commences with reverse mentoring before moving onto a sponsorship methodology. It was launched in October 2023 and is due to be competed at the end of March 2024.

What was different about this programme?

- Master Classes held to support candidates with applications.
- For both BAME Staff, and Allies.
- If there was difficulty in gaining line management support this was negotiated on their behalf.
- Independent psychologically safe space for both BAME staff and Allies.

Initial feedback:

- Attendance was 100% at the time of writing.
- Engagement, that is, feedback received was also high at 95%

Celebrating Success in December 2023, Asha Day BEM, Head of Nursing, Midwifery & AHPs Equalities at LLR ICB was awarded the Hidden in Plain Sight award (75 Gifted Ethnic Minorities 75 years of the NHS).

Other System/Collaborative Initiatives

The Looking After Our People workstream is represented by health and wellbeing leads/champions from across health (including primary care), social care, emergency services and charities. The work of the group is integral to delivering against the Long-Term Workforce Plan / Association of Directors of Adult Social Services in England (ADASS) Time to Act priorities centred around workforce retention and wellbeing. A few initiatives undertaken by this group are noted below. This is aligned to the NHSE Health & Wellbeing Framework

Menopause

15 menopause advocates (one from the ICB) were recruited and trained through Henpicked Menopause in the **Workplace Advocacy Programme**. Advocates have been delivering a series of system-wide menopause awareness raising sessions for colleagues and leaders starting January 2023, with a minimum of one virtual session per month. Advocates are also taking back learning to share internally within their own organisations and are delivering awareness raising sessions to their own teams and/or colleagues. As shown below, all partner organisations are engaged in this work and advocates are employed in a range of roles.

Systemwide Menopause Awareness Sessions in 2023 reached a total of 272 bookings which averages to 22.5 delegates per session. Delegates have been from organisations including, Leicestershire Partnership Trust, University Hospitals Leicester, ICB, Leicester City Council, Leicestershire County Council, Rutland County Council, Local Authority (District/ Borough Council), External Social Care Providers, Leicestershire Fire and Rescue Service, LOROS and other Voluntary Community and Social Enterprises (VCSE) sector colleagues.

Embrace Your Change - Menopause Psychological Support

Launched in October the Menopause Psychological support pathway delivered by LLR NHS Talking Therapies provides individual and group psychological support for those experiencing emotional distress or mental ill health in the context of the menopause. The pathway enables fast access to a psychological needs assessment (within 7 days) that will identify the correct modality of psychological support required. Support includes access to 1:1 evidence based psychological interventions (e.g. Cognitive Behaviour Therapy) and access to a 6-week course.

This course has been developed and informed by behaviour change and cognitive behavioural principles and focusses on practical implementation of coping strategies. There is opportunity for partners/carers/family to attend, workplace difficulty discussion and an overt focus on “Your Menopause” rather than “The Menopause” to account for cultural differences/gender expression in the experience of the menopause. The course was launched in January 2024.

Health Inequalities - Arts and Heritage Team at UHL

In support of the health inequalities agenda, we have been working with the Arts and Heritage team at UHL to deliver a series of uplifting and affirmative workshops for colleagues from ethnically diverse communities to create a poetry manifesto and inspire the artwork that will accompany the words, creating a collective voice on behalf of the system. The workshops were designed to provide a creative outlet to alleviate stress. The manifesto will be produced at large scale and displayed across the LLR system to inspire and unite our workforce and community. The poem has been created and was delivered at UHL’s NHS 75th anniversary celebration event- a video of this can be requested for personal viewing along with a copy of the poem. Strong common themes which were shared during the creation of the poem included:

- Taking time to learn how to pronounce colleagues’ names correctly- being confident to ask how.
- Celebrating culture all year round (not just focusing on it during a special event, e.g. Black History Month).
- Seeing representation of our diverse staff at senior levels across our organisations.

Community Engagement and Events

Winter Wellbeing Festival

Last year we held LLR’s Annual Winter Wellbeing Festival event, aimed to encourage all health and social care staff and volunteers in LLR to think about their health and wellbeing, enable engagement with our staff whilst providing them with wellbeing material for them and their colleagues. Improving access to wellbeing by helping them to find information they need. Led by the Health and Wellbeing lead at Leicestershire Partnership Trust, the event ran as an LLR wellbeing marketplace with interactive elements including games, a therapy dog and hot drinks. The event was hosted by LOROS free of charge as a

system initiative, at their Centre for Professional Development. We had over 100 delegates join us across the day and attending menopause taster sessions delivered by Talking Therapies.

Commissioning and Procurement

ICBs buy services for their local community from a range of service providers that meets NHS standards and costs – these could be NHS hospitals, social enterprises, voluntary organisations, or private sector providers. This means better care for patients, designed with knowledge of local services and commissioned in response to their needs.

As an ICB we commission a wide range of services including primary care, mental health services, urgent and emergency care, elective hospital services and community care.

Equality, Diversity and Inclusion (EDI) continues to play a significant role in procurement. During the procurement process EDI questions are designed and evaluated. The initial process requires all services to undertake an Equality Impact Assessment (EIA). During 2023-24 The ICB undertook the following procurement exercise:

- Digital All Age Mental Health Online Counselling Procurement
- Primary Care Procurement for Cossington Park Surgery
- Concluded the non-emergency patient transport service procurement in 2023/24.

Health Inequalities

Health inequalities are avoidable and unfair differences in health between different groups of people. Health inequalities concern not only people's health but the differences in care they receive and the opportunities they have to lead healthy lives.

Those living in the most deprived areas often have poorer health, as do some ethnically diverse groups and vulnerable/socially excluded groups. These inequalities are due to many factors, such as income, education and the general conditions in which many people are living. In addition, the most disadvantaged groups are not only more likely to get ill, but less likely to access services when they are ill.

Health Inequalities have been made worse by the Coronavirus pandemic, which has hit hardest the groups who already did not have the best health. The rate of people dying from the virus has been higher in more economically deprived areas and among some ethnically diverse communities and amongst disabled people. People in crowded housing, on low wages, unstable or frontline work have also experienced a greater impact from Covid 19.

The NHS contributes to tackling inequalities in health in three distinct ways:

1. **Influencing multi-agency action to address social determinants of health -** The role of integrated care systems (ICSs) working with local authorities and local communities is particularly critical here.

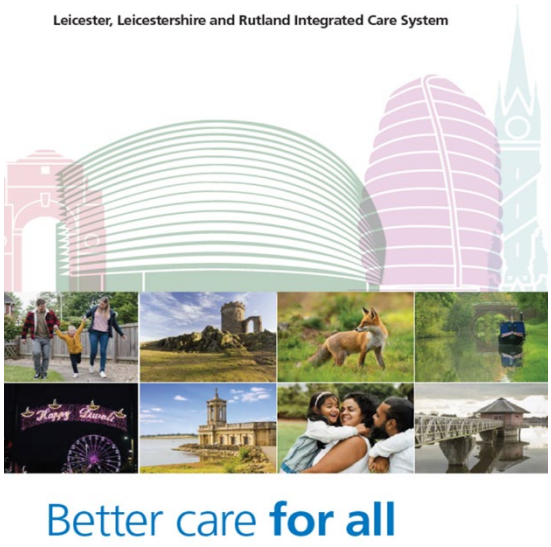
2. **The NHS is a significant economic actor in its own right -** The choices we make as an employer, a purchaser and a local ‘anchor institution’ can help moderate inequalities.

3. **Tackling inequalities in healthcare provision -** This is our direct responsibility and must be the prime focus of our action. The enduring mission of the NHS is high quality care for all. That means tackling the relative disparities in access to services, patient experience and healthcare outcomes.

Great work is happening across a number of organisations to address healthcare inequalities and we are committed to working with our partners to further enhance and accelerate this.

There is always going to be variation in health outcomes within a population, some variation is unavoidable, due to people’s age or genetics, but many differences in health are avoidable, unjust and unfair. It is because we are concerned about this that the LLR Health Inequalities Framework – Better care for all, has been developed.

The LLR Health Inequalities Framework



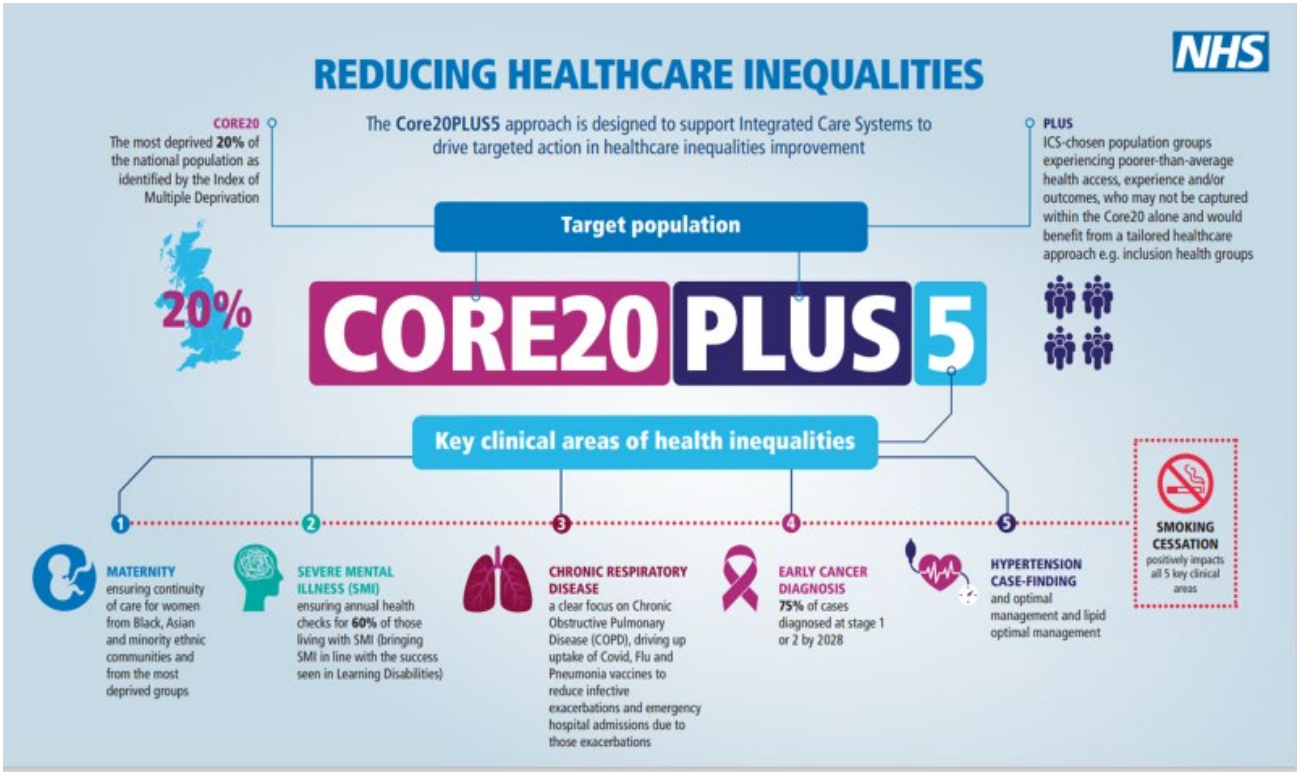
The LLR Health Inequalities Framework is the result of a collaboration of partners from across LLR, including the local NHS, Public Health, Health Watches and Local Authorities. It sets out our commitment to reducing health inequalities as a core purpose for the ICB, and for the future partnership which the Integrated Care System (ICS) represents.

The document sets out the principles we will work to, and the key actions we will take at system level to improve access to, experience of, and outcomes from local NHS services. This framework has been very positively received at regional and national levels.

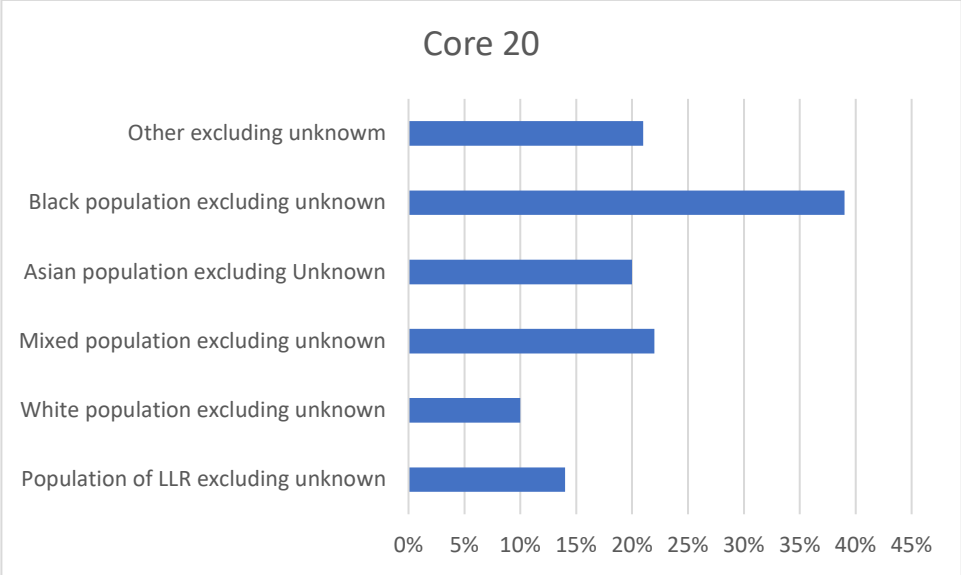
Core20PLUS5 Framework

The NHS focus on reducing healthcare inequalities is stronger each year. The LLR ICB will be working on this agenda using the CORE20Plus5 framework. The framework asks the NHS to have developed specific plans for how it will improve access, experience and outcomes for:

- people in the least affluent 20% of the population (**Core 20**)
- for locally identified additional vulnerable populations such as those who are homeless and those with a learning disability etc. (**Plus**)
- any of the following five key clinical areas of healthcare – cancer, severe mental illness, high blood pressure, pregnancy and birth, lung problems (**5**)



Core20 based on ethnicity.



The graph above looks at the Core20 most deprived communities based upon ethnicity. The largest proportion within this cohort are from the black ethnic group at 39% followed by people of mixed ethnic backgrounds at 22%.

Core20 relating to some long term conditions.

Condition	Prevalence in patients in Core20	Prevalence all LLR pop.	Relative Risk (RR) for patients in Core20
ASD	0.3%	0.2%	1.30
COPD	2.2%	1.8%	1.24
Diabetes	8.4%	7.3%	1.15

The table indicated that a relative Risk above 1 means there is a higher risk of having the condition if patients live in Core20 locations. Basically Core20 patients are 30% more likely to have ASD, 24% more likely to have COPD and 15% more likely to have Diabetes.

In November 2022, the Core20Plus5 framework was expanded to include children and young people in five different key clinical areas – Asthma, Diabetes, Epilepsy, Oral Health and Mental Health:

These frameworks emphasise that the detailed plans to reduce health inequalities in each of the three “places” in Leicester City, Leicestershire, and Rutland – will be led by the local Health and Wellbeing Boards, based on their knowledge of their population’s

needs. These plans will be published in each area as a refresh of their Health and Wellbeing Strategies.

Five National Key Priorities for Systems and Providers

There are also five national key priorities for systems and providers that we will focus on in LLR and they are as follows:

Priority 1: Restoring NHS services inclusively

NHS performance reports should be broken down by patient ethnicity and Index of Multiple Deprivation (IMD) quintile, focusing on:

- Under-utilisation of services (e.g., proportions of cancelled appointments)
- Waiting lists
- Immunisation and screening
- Late cancer presentations

Priority 2: Mitigating against 'digital exclusion'

- Ensure providers offer face-to-face care to patients who cannot use remote services.
- Ensure more complete data collection, to identify who is accessing face-to-face, telephone and/or video consultations (broken down by patient age, ethnicity, IMD quintile, disability status or condition)

Priority 3: Ensuring datasets are complete and timely

- Improve collection of data on ethnicity, across primary care, outpatients, A&E, mental health, community services and specialised commissioning.

Priority 4: Accelerating preventative programmes

- Flu and Covid vaccinations.
- Annual health checks for people with severe mental illness (SMI) and learning disabilities
- Continuity of maternity carers
- Targeting long-term condition diagnosis and management

Priority 5: Strengthening leadership and accountability

- System and provider health inequalities leads to access Health Equity Partnership Programme training, as well as the wider support offer, including utilising a new Health Inequalities Leadership Framework (to be developed).

Fair Allocation of Resources for GP Practices

The model, created by one of our ICB primary care doctors was developed during 2020-21 using local population health data. The new model aims to ensure that practices have a fair allocation of available funding based on the needs of our resident population. Practices in areas where health outcomes are poor will need greater resources to help bring these outcomes up to the level of the healthiest places in LLR. This model will help achieve that over time. This year we have undertaken a review of the model itself and of its impact to date. There are encouraging early data to indicate that the additional funding is having a positive effect on primary care provision where population needs are greatest. LLR was the first system in the country to do this and our work has received some very positive interest from NHS England as a possible model for primary care funding allocation.

Engagement

LLR ICB People and Communities Strategy (2022-2024)

2023-2024 has been a year of delivering the LLR ICB People and Communities Strategy (2022-2024). This collaborative strategy developed in 2022 with partners and stakeholders, sets out how the ICB works with people and communities.

The Strategy identifies seventeen priorities which collectively help to ensure that the voice of people and communities is embedded at all levels of the ICB.

The priorities are subdivided into key areas:

- Insights, experiences and business intelligence – ensuring that there is useful and relevant evidence of the voices of patients, carers, staff and stakeholders impacting on decision making, service design and delivery and it is representative of the socio-demographics of our population.

- Governance – ensuring that the patient voice influences at all levels of the ICB.
- Relationships Management – working collectively across the ICB to build relationships that influence services and improve the lives of the people we service.
- Infrastructure development and implementation – ensuring that all new infrastructure, whether at system, place or neighbourhood has inbuilt in processes to ensure that people and communities co-design and co-produce healthcare.
- Reducing health inequalities – ensuring that all projects and programmes of work align to our Public Sector Equality Duty and show evidence of adherence.
- Delivering our legal and statutory duties to involve and reduce inequalities – ensuring that service design and delivery is influenced by the patient/service user voice and experiences and 'Report of Findings' demonstrate satisfaction levels and ability to access services and are disaggregated by protected characteristics and published.

Voluntary, Community and Social Enterprise (VCSE) Alliance

The LLR Voluntary, Community and Social Enterprise (VCSE) Alliance is a formal, strong and mutually beneficial partnership with the sector, created to tackle health inequalities, empower communities and embed their voices into the heart of the health and care system. Co-designed with the sector, the Alliance moves us beyond a system of merely contracting in support as and when needed, to a place where we work in close and equal partnership, working collaboratively to find solutions that tackle health inequalities.

The Alliance, which was launched in November 2022, was born out of, and builds on the relationships formed both during the pandemic and during the large scale Building Better Hospitals public consultation. However, it started to take shape during a second large scale public consultation – Step up to Great Mental Health.

The core focus of the work of the Alliance is on:

- Health prevention
- Population health management
- Reduction in health inequalities

- Receiving evidenced base insights and business intelligence
- Delivering high quality communications and involvement

Since the VCSE Alliance launched on the 23 November 2022 we have:

- 511 VCSE subscribers to the online Alliance Forum representing communities with protected characteristics.
- 152 VCSE Alliance members who are signed up to the VCSE Directory and the Opportunities Hub representing communities with protected characteristics.

We have also invested circa £112,000 through the Opportunities Hub, via 32 VCSE organisations, supporting the delivery of ICB 5 strategic projects, some of which are included later in this report.

The next steps for development of the Alliance include:

- Developing in the partnership a Voluntary and Community Sector Strategy.
- Increase the number of subscribers.
- Increase the number and diversity of VCSE Alliance members.
- Evolve the Alliance at place and neighbourhood and through Primary Care Networks.
- Develop a direct route for the VCSE sector into the Insights, Behaviour and Research Hub.
- Enhance governance and implement stronger reporting of insights and output and outcomes from the VCSE sector.
- Enhance our training and development programme.
- Develop equal partnerships and secure long-term sustainable funding to maintain financial resilience VCSE sector.

Specialist Engagement and Consultation with Communities

In 2023-2024 we have undertaken engagement/consultation in five key areas. Our Report of Findings for all five projects are published on the ICB website.

We are committed to eliminating discrimination based on age, disability, gender, pregnancy & maternity, race, religion and belief, sex, sexual orientation or socio-economic disadvantage.

Prior to commencing any research project, we seek to understand the socio-demographics of the geographic area we are seeking to hear the voice of, if it is not a health system wide project. The Equality Impact Assessment along with a review of population health management data helps us to understand at the start of the research project the people and communities we need to engage.

To get the required assurance and clarity, in all engagement/consultation activities we ask equality questions across socio-demographics and protected characteristics. At the end of the research, this information gives us clarity on whether we have involved people who are statistically and demographically representative and helps to assure whether the insights are in tune with the attitudes of the entire population and meets the pre-determined quota.

Together with the insights gathered, this information is used to make commissioning decisions and influence how and what services are provided. This helps to ensure that accessible care and treatment is delivered in a way that respects the needs of each individual and does not exclude anyone.

We recognise that the ICB is not always best placed to gather insights and intelligence from all communities. For some time now we have worked in partnership with the voluntary and community sector through the Alliance. Through an Opportunities Hub we commission this sector to work within their communities to gain experiences from individuals and communities to understand what matters to them on a range of services. These insights are then fed into the overall Report of Findings.

- **Maternity and Neonatal Services**

Under the remit of 'Improving Equity in Maternity Care' the local Maternity and Neonatal Voices Partnership (MNVP) undertook a maternity survey across LLR targeting mothers, birthing people and parent.

450 people responded to the survey which ran from 31 May to 31 July 2023. Participation was encouraged from a wide range of socio-demographic groups by using a range of mechanisms including online listening events, face-to-face listening events and an online survey. People running the events spoke various languages to support people where English wasn't their first language.

50% of the responses were received from people from Minority Ethnic backgrounds.

The valuable insights and experiences, which are already informing service planning through the Local Maternity and Neonatal System (LMNS), show that while overall there appears to be positive statements about the care received throughout the journey, respondents who were from Asian population, identified as Muslim, or spoke another language, posted fewer positive statements and more negative ones.

Respondents who were from the Asian population, identified as Muslim, or spoke another language, posted fewer positive statements and more negative ones.

Issues (not exclusive) ranged from 'not being listened too', poor postnatal care, and pressured into making decisions.

In future, we will host a permanent survey which will seek experiences of maternity and neonatal services on an ongoing basis. This will launch in early 2024. It will report quarterly to the LMNS and will a continuous pipeline of insights, used to monitor improvements to services.

- **Improving Hinckley Community Health Services**

The Report of Findings shows that there has been engagement with people and communities in Hinckley and Bosworth Districts to understand the impact of proposed changes and improvements to the Hinckley and District Hospital.

2,004 people responded to the engagement in 2023.

Most age groups were well represented, although only **10%** were aged under 35. A total of **41%** respondents to the engagement were aged 65 or over.

(88%) of responses were from respondents who consider their ethnic origin to be White and a small minority of responses **(4%)** were from people form minority ethnic back.

49% taking part in the engagement identified with or followed the Christian religion.

25% said that they identify with no religion.

15% preferred not to say what their religion is, while **8%** of all respondents taking part in the engagement provided no information about this issue.

22% considered themselves to have a disability or suffer from poor health. The most common condition was a physical or a long-standing illness or condition.

A small minority **3%** of respondents had a sexual orientation that is not straight or heterosexual**.**

11% preferred not to say what their sexual orientation was.

12% of all respondents taking part in the engagement provided no information about this issue.

The majority of those taking part in the engagement (63%) were either married, in a civil partnership or living with a partner.

Overall, 25% provide care for someone – the most common care provided is for an older person aged over 50 (16% - 325 respondents).

A small minority said that they had served in the Armed Forces.

In general, the statistical representative aligned with the socio-demographics of the Hinckley and Bosworth District.

- **Youth Voice on GP Remote Consultations**

The Report of Findings from the qualitative research demonstrates that 43 young people took part in the engagement ranging from 8 to 20 years old, providing more understanding of their remote access to primary care services. The young people cohort included those with autism, ADHD, long term heath conditions, care experienced young people, young carers and unaccompanied asylum-seeking child/young people.

The views of the young people were compiled and presented to Leicester Partnership NHS Trust's Youth Advisory Board, who then came up with recommendations to be put to various ICB groups and committees.

The valuable insights and experiences have been shared with the Primary Care Transformation Board, the Primary Care Quality Group, Children and Young People's Collaborative and the system Quality and Safety Group to influence service delivery.

- **Asylum Seekers and Homeless**

Both the Report of Findings, produced in January 2024, for asylum seekers and the homeless shows clear engagement with both groups. The data shows their experiences of primary care services and seeks to gain an understanding of what matters most to them.

We had 207 homeless and 258 asylum seekers participating either through a survey, focus groups and one-to-one interviews. The focus groups and one-to-one interviews were supported by interpreters.

When given the option of providing equality data in the survey, 20% of both asylum seekers and homeless preferred not to answer all questions. For some equality questions this statistic was higher, as certain questions people preferred not to answer.

- **Asylum Seekers**

There were **22** different languages that asylum seekers identify as being their preferred language.

The top 5 were English, Arabic, Kurdish (including Badini, Sorani), Persian/Farsi and Eritrean/Tigrynya.

The ethnicity of asylum seekers was **9%** White (i.e. British, Irish, any other white background).

21% Asian or Asian British

13 % Black or Black British ((i.e. Caribbean, African, or any other Black background)

3% Mixed (i.e. White & Black Caribbean, White & Black African, White & Asian and any other Mixed background)

Of the respondents who answered, the majority were male and the top three age groups were: 25% were aged between 25 and 34, 11% aged between 16 and 24 and 10% were aged between 35 and 44.

52% of asylum seekers said they identified as the gender they were assigned with at birth. **6%** said they didn't.

18% said that they provided care for someone, this was spread across young people under 24 years of age, adult 25 to 49 and older people aged 50 and over.

6% of asylum seekers who answered the question said they had a disability and **11**% said they were in poor health.

3% said they were either pregnant or had given birth in the last 26 weeks.

5% of people who answered had served in the Armed Services.

The majority identified as Heterosexual/straight, **2%** identified as Bisexual and **1%** Gay or Lesbian.

Their relationship status where given was in the main single **(21%)** and married/civil partnership **(24%).**

- **Homeless**

12 languages were identified by homeless people, but 85% preferred English.

The ethnicity of the homeless was:

11% from the BAME community.

66% White (i.e. British, Irish, any other white background).

20% no information available.

Of the respondents who answered, the majority were male and the main ages ranged from 25 to 64, with 4% who answered saying they were between 65 and 74 years old.

72% of homeless said they identified as the gender they were assigned with at birth.

10% said they didn't.

17% preferred not to say or didn't answer this question.

In addition, 9% said that they provided care for someone, this was spread across young people under 24 years of age, adult 25 to 49 and older people aged 50 and over.

22% of homeless who answered the question said they had a disability and **25%** said they were in poor health.

1% said there were either pregnant or had given birth in the last 26 weeks.

4% of people who answered had served in the Armed Services.

Their relationship status was in the main single (52%), married/civil partnership 8%, 7% Separated or Divorced or Partnered/Living with a partner.

The majority identified as Heterosexual/straight, but 3% identified as Bisexual.

This data along with the insights has shaped the commissioning of primary care services for these populations.

Insights, Behaviour and Research Hub

As an Integrated Care Board (ICB) we are an organisation who are rich with data and insight. In September 2023 we launched the Insights, Behaviour and Research Hub as a central point to access this insight from all key system partners, which can aid our collaboratives, design groups, workstreams and commissioning and provide staff.

The implementation of this systematic and structured hub is supporting ICB partners to work more efficiently, as well as making it easier for staff to ensure that the patient and community voice impacts all that they do.

The objectives of the Insights, Behaviour and Research Hub are to:

- Provide information and aid in identifying gaps to help to promote understanding of what people need (including our most vulnerable groups) from local NHS services.
- Support the Integrated Care System (ICS) teams and delivery groups to interpret, utilise and identify gaps from the data in planning and decision-making processes.
- Provide the system Quality and Safety Committee with robust data that supports them to provide assurance to the ICB Board with regard to the safety and quality of care to the population we serve.
- Enable patterns of poor quality to be identified and reported to the Quality and Safety Committee and other appropriate committees.
- Tackle health inequalities by helping to ensure that we are involving a true representation of our population.
- Encourage collaboration with delivery groups to identify the impact of intelligence and articulate clearly, the difference it has made.

- Promote collaboration between the ICB, Leicestershire Partnership Trust (LPT) and University of Hospitals Leicester (UHL) and Healthwatch Leicester and Leicestershire and Healthwatch Rutland. In the longer term it will also support joint working with local authorities and voluntary and community organisations.
- Provide and encourage data sharing securely across organisations which encourages financial savings by developing joint systems and processes that reduce duplication.
- Feedback to people and communities so that they can see how their voice has impacted services.
- Allow information provided by partners to be accessible in the hub.
- Ensure that the information is structured by place and communities that aligns with the ICB strategy.

Work continues through 2024 to support continued co-design of the hub with the VCSE sector following a presentation with them at a meeting in November 2023, which attracted great interest. We hope that the sector will have full access to the Hub, for mutual benefit early in 2024.

Conclusion

The LLR ICB continues to demonstrate compliance to our legal and mandated equalities duties. We continue to embed equality considerations into decision making. This includes commissioning decisions that impact our communities and also internal workforce changes which directly or indirectly impact on our workforce.

END

This report was produced by Leicester, Leicestershire and Rutland ICB in conjunction with the Inclusion Team, NHS Midlands and Lancashire Commissioning Support Unit. If you have any feedback about the content of this report, please email inclusion.unit@nhs.net

Action Plan Update April 2023 – End March 24

In 2022 - 2023 the ICB aligned their overarching equality objectives to the three new Domains in the Equality Delivery System (EDS) 2022. The Domains consist of eleven outcomes which we assess against annually. This forms our overarching action plan. Following this year's EDS assessment & data analysis we have developed 3 specific and measurable objectives for the next reporting year specific to the ICB **see page 24**. There will also be some system wide equality objectives relating to Domain one 'commissioned or provided Services.

In addition, we will be delivering a number of other actions noted in the EDS report as well as the Workforce Race and Disability Equality Standards (WRES/WDES) and the NHS EDI Improvement plan which are interlinked.

A separate link to the EDS Report can be found here: EDS Report

E

Name of meeting:	**Leicester, Leicestershire, and Rutland Integrated Care Board (public)**		
Date:	11 April 2024	**Paper:**	**E**
Report title:	**Finance Report Month 11 2023/24**		
Presented by:	R D Toole Chief Finance Officer		
Report author:	Spencer Gay, Deputy Director of Finance (System).		
Executive Sponsor:	R D Toole Chief Finance Officer		

To approve ☐	**For assurance** ☒	**To receive and note** ☒	**For information** ☐
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Recommendations:

The Leicester, Leicestershire and Rutland Integrated Care Board is asked to:

- **RECEIVE and NOTE** the financial position as at month 11 and the forecast performance.
- **RECEIVE for assurance.**

Purpose and summary of the report:

The overall year-to-date (YTD) system position at month 11 is a deficit of £(58)m which is a £(53.9)m adverse variance to plan.

UHL have reported a YTD deficit of £(45.6)m which is a £(41.7)m adverse variance against plan, whilst LPT have reported a YTD deficit of £(0.2)m, which is break even against their YTD plan.
The ICB have reported a £(12.2)m YTD deficit against a break-even plan.

The system is forecasting a year-end deficit of £(64.9)m, which is also the variance from plan now that NHSE have provided funding (revenue and cash) for the original £10m planned deficit. This can be broken down as; UHL £(49.3)m deficit, LPT breakeven, and ICB £(15.6)m deficit.

However, this £10m is non-recurrent funding and will need to be repaid in future years and so on a like for like basis the out-turn is £(74.9)m. In comparison to the NHSE forecast commitment of £(61.1)m in November this is a £(13.8)m adverse movement.

Now that industrial action funding has been received, LPT and the ICB have returned to reporting in line with the NHSE agreed positions. UHL's reported forecast has deteriorated due to £2m residual industrial action costs and pressures now included in the position which were previously flagged as risks: £5.3m Urgent Care pressures, £4m workforce cost pressures, and £2.5m depreciation funding shortfall.

Appendices:	• N/A
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• CFOs • Finance Committee • System Execs

The report is helping to deliver the following strategic objective(s) – *please tick all that apply*:		
1. Improve outcomes	Improve outcomes in population health and healthcare.	☐
2. Health inequalities	Tackle inequalities in outcomes, experience and access.	☐
3. Value for money	Enhance productivity and value for money.	☒
4. Social and economic development	Help the NHS support broader social and economic development.	☐
5. NHS Constitution	Deliver NHS Constitutional and legal requirements.	☒

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	

Implications:	
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	This aligns with the financial sustainability risk.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	Yes as the report focuses on the financial position.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	N/A
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	N/A
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	N/A

Finance Report Month 11 2023/24

11th April 2024

Month 11 System Financial Position

1. Dashboard:
   The system dashboard is shown below:

System KPI Dashboard	YTD £'000			M1-12 £'000		
	Target	Actual	Rating	Target	FOT	Rating
System Delivery of planned surplus/(deficit)	(4,091)	(57,949)		(2)	(56,061)	
System Revenue expenditure not to exceed income	4,993,494	5,051,443		5,440,679	5,496,740	
System Capital expenditure not to exceed allocations	104,456	75,442		130,472	121,407	
System Operates within Cash Reserves	101,984	98,036		115,305	71,208	
ICB Running Costs Allocation not to be exceeded *(included within system position)*	18,686	16,556		20,385	18,138	
ICB Primary Care Co-Commissioning Allocation not to be exceeded *(included within system position)*	185,617	186,569		200,848	202,181	
ICB Newly Delegated Allocation not to be exceeded *(included within system position)*	89,136	86,239		97,997	87,550	
System CIP delivery	120,636	121,230		142,569	146,693	
System Better Payment Practice code % NHS invoices paid within target (£)	95%	95%		95%	95%	
System Better Payment Practice code % NHS invoices paid within target (number)	95%	92%		95%	92%	
System Agency spend within ceiling				45,392	64,368	
ICB MHIS spend requirement to meet target				189,313	189,431	

Revenue

2. **The system is reporting a year-to-date (Month 11 February 2024) deficit of £(58)m which is £(53.9)m worse than plan**, (UHL £(41.8)m adverse variance and ICB £(12.2)m variance against plan). The position reflects pressures relating to unfunded inflation, prescribing growth, and urgent & emergency care and other demand pressures.

3. Following work in conjunction with NHSE colleagues to provide an assessment of a realistic forecast outturn (FOT) of £(61.1)m for the year, agreement was reached in November giving a £(51.1)m variance to plan. However, since then further movements have been identified as illustrated by the table below. This includes; pressures previously flagged as risks now included in the position (£5.4m UEC, £4m workforce costs, £2.5m depreciation funding); £2m residual industrial action costs as the funding received has not covered all expenditure incurred; and £10m funding from NHSE to cover the original planned deficit.

	£m
Planned Deficit	(10.0)
Reforecast Variance	(51.1)
Deficit Funding Received	10.0
Net Industrial action costs	(2.0)
Urgent Care pressure	(5.4)
Workforce Costs	(4.0)
Depreciation funding shortfall	(2.5)
M11 Forecast Position	(64.9)

4. Although the £10m additional funding is reducing the deficit in year, it is artificially doing so; according to NHSE business rules when assessing the level of deficit within the system (for repayment in future years) it will not be considered and therefore **the repayable deficit will be viewed as £(74.9)m.**

5. Work undertaken recently to highlight and confirm efficiency plans and offsetting non-recurrent support in place means we are forecasting full delivery by the end of the year. This is reflected in the M11 position which forecasts delivery of £146.7m against a plan of £142.5m.

Capital

6. Operating capital spend is currently below plan by £7.1m with a year-to-date actual spend of £39.5m, the underspend is due to an IFRS 16 lease revaluation and shortening exercise, the impact will continue into M12.

7. National capital schemes have been impacted by issues outside of the systems control ie planning permission causing an underspend to be flagged to region.

Other Indicators of note

8. **Agency spend** remains above target. The position has been impacted by additional costs with Emergency and Specialist Medicine and Nursing vacancies across a number of specialities and encompassing both main providers.

9. **Better Payments Policy** expectation across all public sector organisations is to pay creditors in a timely manner (within 30 days):-

   ICB is achieving the cumulative standard of 95% of invoices (both in value and volume).
   UHL is cumulatively at 83% in relation to the numbers of NHS invoices (non-NHS at 95%)
   LPT is cumulatively at 93% in relation to the numbers of NHS invoices (non-NHS at 97%).

10. The **cash** position remains positive across the system. Now that the forecast deficit position has been agreed, the implications for cash balances are clearer, and we expect cash balances to reduce as the year continues, this will be monitored closely.

11. The ICB receives funding for specific elements of spend within its allocation. **Better Care Fund, Primary Care Co-Commissioning, Mental Health Investment**, **Running Costs** and the newly delegated **Pharmacy, Ophthalmic & Dental** are examples of these. The ICB has committed funds in line with allocations in all these areas and is forecasting to spend more in

relation to Primary Care Co-commissioning and Mental Health Investment and has taken action to ensure underspend against Running Costs.

Conclusion

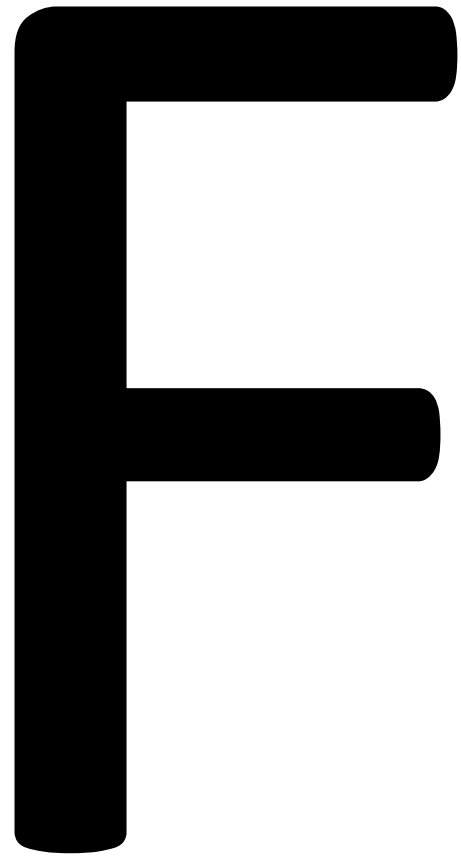
12. As a system, at Month 11, we have reported an in-year deficit of £(58)m and a year-end deficit revised forecast of £(64.9)m against revenue budgets.

13. Operational capital spending is forecasting an underspend of £7.1m with National programme capital spend forecasting to underspend by £2m.

14. The ICB are declaring achievement of the Mental Health Investment Standard and Running Costs targets.

Recommendations:
The Leicester, Leicestershire and Rutland Integrated Care Board is asked to:

- **RECEIVE and NOTE** the financial position as at month 11 and the forecast performance.
- **RECEIVE for assurance.**



Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board** (public)		
Date:	11 April 2024	**Paper:**	**F**
Report title:	**Emergency Preparedness, Resilience and Response (EPRR) Core Standards Update**		
Presented by:	Rachna Vyas, Chief Operating Officer & Deputy Chief Executive		
Report author:	Amita Chudasama, Acting Head of EPRR		
Executive Sponsor:	Rachna Vyas, Chief Operating Officer & Deputy Chief Executive		

To approve ☐	**For assurance** ☒	**To receive and note** ☐	**For information** ☐
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Recommendations:

The Leicester, Leicestershire and Rutland Integrated Care Board is asked to:

- **RECEIVE for ASSURANCE** the results of the core standards process 2023/24 for LLR.

Purpose and summary of the report:

1. The EPRR workstream supports the ICB and other health organisations to meet their responsibilities as Category 1 or 2 responders under the Civil Contingencies Act (2004) (CAA) and NHS England's Core Standards for EPRR which are audited on an annual basis.

2. This report provides the ICB with the mandatory annual update against the ICB EPRR Core Standard self-assessment process to help ensure the ICB and ICS is well prepared to respond to any disruptive challenge or emergency and serve LLR patients and communities irrespective of any adverse circumstances the ICB/ICS face.

3. In the 2023-24 assurance process the ICB and LPT were assessed as substantially compliant, UHL were partially compliant, and HTG were non-compliant. Mitigating action plans are in place.

Appendices:	
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• LLR System Executive Committee November 2023

The report is helping to deliver the following strategic objective(s) – *please tick all that apply***:**		
1. Improve outcomes	Improve outcomes in population health and healthcare.	☐
2. Health inequalities	Tackle inequalities in outcomes, experience and access.	☐

3. Value for money	Enhance productivity and value for money.	☐
4. Social and economic development	Help the NHS support broader social and economic development.	☐
5. NHS Constitution	Deliver NHS Constitutional and legal requirements.	☒

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	

Implications:	
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	This report provides assurance of mitigations in place to support risks relating to EPRR and business continuity and risks are escalated accordingly in line with the risk management processes. EPRR is Risk 6 on the BAF. The residual risk was reduced in January 2024 due to controls in place.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	No specific resource implications identified as this is a report providing assurance.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	No specific quality and patient safety implications identified as this is a report providing assurance. Support's quality and patient safety objectives of the ICS
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	Not required in relation to this report
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	Not specifically required in relation to the production of this report.

Emergency Preparedness, Resilience and Response (EPRR) Core Standards

11th April 2024

Background

1. NHS England requires all NHS organisations to annually assess their ability to meet their Emergency Preparedness, Resilience & Response (EPRR) statutory obligations. This assurance is sought annually, and this paper provides the ICB Board with the compliance rating for the LLR ICB for 2023/24.

Compliance with NHS England Core Standards for EPRR 2023/24

2. The NHS Core Standards for EPRR are the minimum standards which all NHS organisations and providers must meet to comply with the requirements of the Core Standards Framework, the NHS Contract, and the Civil Contingencies Act 2002.

LLR System Summary for EPRR Assurance 2023/24

3. The Local Health Resilience Partnership (LHRP) provide a strategic forum for local healthcare organisations to facilitate preparedness and planning for health emergencies at a system and LRF level. Part of the remit of the group is to oversee EPRR assurance for the system. An annual summary of core standards is presented to the LHRP for sign off based on the preparedness to respond to incidents. The LHRP assessed LLR system compliance as **Substantial** based on 2 organisations (ICB and LPT) rated as substantial compliance, 1 organisation (UHL) rated as partial compliance with HTG playing a limited role in incident management.

4. Overall LLR was assessed as having good working partnerships in place across health organisations and the LRF with full engagement in the resilience structures. All health organisations are an integral part of the LRF and work in collaboration to ensure the progression of health and LRF workstreams, plans and policies. There are also a number of joint training opportunities which allow multi-agency working and the ability to build better working relationships.

5. NHSE identified a number of good practices across LLR health organisations, a few are detailed below:

    - ICB Consultation tracker
    - ICB EPRR Comms Desktop Exercise
    - LPT HCID action card
    - LPT SBAR involving a partial lockdown
    - UHL EPRR work programme which covers many different aspects in one single document.
    - UHL VIP plan

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Regional Assurance Report 2023/24

5. Compliance ratings across the region were reviewed by ICBs and NHSE Midlands EPRR team during a process of confirm and challenge meetings. Areas of concern were raised with organisations and a finalised position was agreed based on discussions at the compliance meeting.

6. Direct comparison of 2022 to 2023 shows an improving picture across the Midlands region for all organisations, however it was noted that improvements have been slower due to the challenges of industrial action. Diagram 1 below shows the final position comparisons.

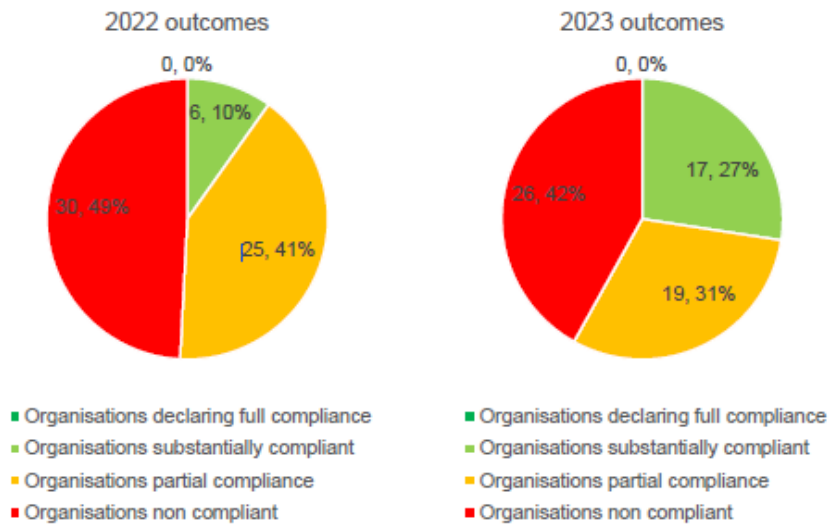


Diagram 1: 2022 to 2023 final position comparison

7. The regional report showed that compliance issues are spread across all organisations, ICBs showed the greatest overall improvement in position, and this can be attributed to being newly formed in 2022 and therefore not having all the appropriate plans and policies in place for the 2022-23 round of Core Standards. Diagram 2 below shows regional breakdown of overall compliance by organisation type.

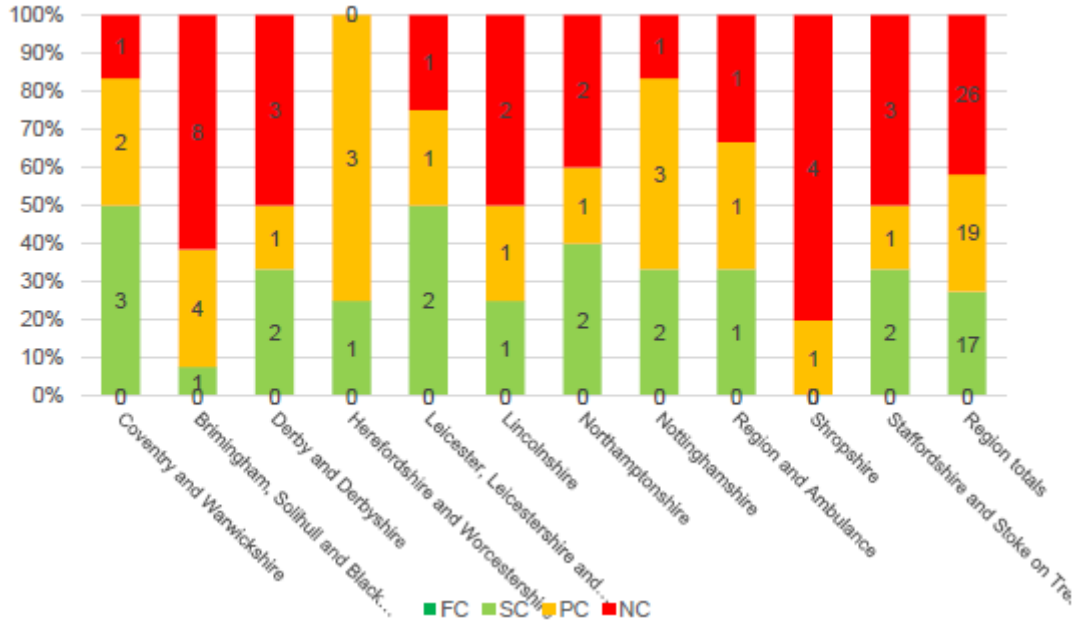


Diagram 2: Final reported positions by LHRP

8. A number of standards were identified as areas of concern across the region.

- Core Standard 12 (Infectious disease) - there was a mixture of arrangements which were not always well documented in accordance with EPRR requirements. Most plans across the region for High Consequence Infectious Disease (HCID) were specific and therefore didn't cover procedures for dealing with viral haemorrhagic fevers (VHFs) or specific diseases like Monkeypox.

Fully Compliant - ICB, LPT and UHL have plans in place in line with current guidance and legislation and organisations have arrangements in place to respond to an infectious disease outbreak covering a range of diseases. LPT and UHL were asked to make some minor changes to their plans.

Partially Compliant - HTG were asked to include government HCID guidance in their plans and include the definitions and process for transferring patients including use of PPE and IPC processes.

- Core Standard 13 (New and emerging pandemic) – organisations across the region have been reluctant to fully review pandemic plans as they are still awaiting updated national guidance, therefore learning from COVID is not yet fully embedded.

  Fully Compliant - ICB, LPT, and UHL have plans in place in line with current guidance and legislation.

  Partially Compliant - HTG were asked to review their plan and include learning from COVID-19.

- Core Standard 14 (Mass Countermeasures) – there has been an improvement in compliance from 2022 however further alignment of plans in required across systems especially focussed on acute distribution plans.

  Fully Compliant - ICB, LPT, and UHL have plans in place in line with current guidance and legislation. UHL's plan was with overall roles and set up plan in place was highlighted as an example of good practice.

  Partially Compliant – HTG, though this standard is not directly applicable HTG were asked to ensure countermeasures is mentioned in their Major Incident Plan and staff are aware of what countermeasures are and how HTG may be asked to support the system.

- Core Standard 50 (Business Continuity Monitoring) – KPIs are being established across systems to monitor BC, however organisations need to set up monitoring processes to measure against KPI's and ensure these are being reported to their Board meetings. For example how many BC plans are in place, how many have been updated in the last year etc.

  Fully Compliant - ICB, LPT, and UHL have BC monitoring and evaluation processes in place, however refinement around KPI's was required.

  Partially Compliant – HTG were partially compliant and needed to make changes proportionate to the role and size of their organisation.

- Core Standard 53 (Assurance of service providers) – this is a challenge for most organisations, whereby they either have undocumented processes or have copies of provider BC plans but do not assess them to see if they are fit for purpose.

  Partially Compliant – ICB, LPT, UHL and HTG were partially compliant and needed to add clarity to their processes and how they would track provider BC plans and review them. All organisations have met with NHSE to gain further understanding of what is required for this standard.

- Core Standard 66 (CBRN exercising) – this is a new standard and was reflected in lower compliance scores as many organisations have not exercised or tested their CBRN capability and capacity.

  Fully Compliant – UHL and LPT had Hazmat and CBRN plans and arrangements in place and exercising is incorporated in to EPRR training and testing programmes. This standard was not applicable to the ICB and HTG.

Next Steps

9. Focus is now on the 2024-25 Core Standards Assurance process. NHSE hold monthly meetings with the ICB to track progress against the core standards for the ICS. There is also a workstream programme in place with 11 different subjects led by each ICB within the Midlands region. LLR ICB is leading the Exercising workstream. Further webinars will be put in place by NHSE to walk through the requirements for this year.

10. All LLR health organisations have action plans in place to address partial and non-compliant standards and will contribute to the overall ICS EPRR work Programme led by the ICB EPRR Team.

Recommendations:

The Leicester, Leicestershire and Rutland Integrated Care Board is asked to:

- **RECEIVE for ASSURANCE** the results of the core standards process 2023/24 for LLR.

Name of meeting:	**Leicester, Leicestershire and Rutland ICB Board meeting (public)**		
Date:	11 April 2024	**Paper:**	**G**
Report title:	**ICB Register of Interests 2023/24 and Register of Gifts and Hospitality 2023/24**		
Presented by:	Robert Toole, Chief Finance Officer		
Report author:	Daljit K. Bains, Head of Corporate Governance		
Executive Sponsor:	Robert Toole, Chief Finance Officer		

To approve ☒	**For assurance** ☒	**To receive and note** ☐	**For information** ☐
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Recommendations:

The LLR ICB Board is asked to:

- **APPROVE** the ICB's Register of Interests 2023/24 as at 31 March 2024 (Appendix 1), subject to any further amendments / additions identified during the meeting.

- **APPROVE** the gifts and hospitality register 2023/24 as at March 2024 (Appendix 2).

Purpose and summary of the report:

Purpose:

1. The purpose of this report is to assure the Board that:

    - the ICB is compliant with the legal requirement to have in place statutory registers to record individual interests; and
    - these systems and processes demonstrate transparency and compliance with the ICB's governance arrangements, particularly in the management of conflicts of interest as outlined within the ICB Constitution and conflicts of interest policy.

2. The Board is requested to approve the year-end statutory registers.

Introduction

3. All Board members and employees, in particular employees involved in decision making processes, have a legal obligation to act in the best interests of the ICB. They have a duty to conduct NHS business with probity demonstrating high standards of corporate and personal conduct including impartiality, integrity and objectivity in the execution of their roles and responsibilities. There is a requirement to adhere to the standards of probity outlined in the *'Seven Principles of Public Life'* (i.e. the Nolan Principles).

4. The *Code of Accountability for NHS Boards* and the ICB's *Conflicts of Interest, Gifts and Hospitality and Sponsorship Policy*, which is aligned to NHS England's guidance, set out the requirement that all Board members and staff should declare any conflict of interest that arises in the course of conducting NHS business.

5. A conflict of interest occurs where an individual's ability to exercise judgement or act in one role is, or could be, impaired or otherwise influenced by his or her involvement in another role or relationship. This could be actual or perceived. Interests fall into four categories outlined below. A benefit may arise from the making of a gain or the avoidance of a loss:

a. **Financial interests:** where an individual may get direct financial benefits from the consequences of a commissioning decision.
b. **Non-financial professional interests:** where an individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their professional reputation or status or promoting their professional career.
c. **Non-financial personal interests:** where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit.
d. **Indirect interests:** where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision.

6. All persons referred to within the scope of the ICB's Policy must declare all interests. Declarations of interest should be made as soon as reasonably practicable and by law within 28 days after the interest arises (this could include an interest an individual is pursuing).

7. Some staff, Board and committee members are more likely than others to have a material influence on the use of taxpayers' money because of the requirements of their role.

8. Key decision-making staff may also include management, administrative and clinical staff who have the power to enter into contracts on behalf of the ICB; and / or are involved in decision making concerning the commissioning of services, purchasing of goods, medicines, medical devices or equipment and formulary decisions.

Register requirements

9. As a minimum, the ICB is required to publish the register of interests, and register of gifts and hospitality of decision making staff, Board and committee members at least annually in a prominent place on the ICB website.

10. The Accountable Officer is responsible for an annual review of the Register of Interests. A review of the content of the register has been undertaken ahead of this report being presented to the Board and members are proactively reminded and invited to review their entries and ensure the content is current.

11. The ICB's Board level Register of Interests is appended at **Appendix 1** and published on the ICB website. This register is maintained by the Head of Corporate Governance.

12. The register containing conflicts declared by decision-making staff is also maintained by the Corporate Governance Team and is also published on the ICB website.

Register for Gifts and Hospitality

13. A 'gift' is defined as any item of cash or goods, or any service, which is provided for personal benefit, free of charge or at less than its commercial value.

14. All gifts of any nature offered to ICB staff, Board and committee members by suppliers or contractors linked (currently or prospectively) to the ICB business should be declined, whatever their value. The person to whom the gifts were offered should also declare the offer to the Head of Corporate Governance so the offer, which has been declined, can be recorded on the register.

15. The register is maintained by the Head of Corporate Governance and updated on a regular basis. The current register has been reviewed and is as at **Appendix 2.**

Internal Audit review

16. The Internal Auditors will be conducting an annual audit on the ICB's conflicts of interest

arrangements to provide assurance to the Audit Committee and the Board that effective systems are in place. This audit review is currently taking place.	
Appendices:	• Appendix 1 – LLR ICB Register of Interests as at March 2024. • Appendix 2 – LLR ICB Gifts and Hospitality Register as at March 2024.
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• N/A

The report is helping to deliver the following strategic objective(s) – *please tick all that apply*:		
1. Improve outcomes	Improve outcomes in population health and healthcare.	☒
2. Health inequalities	Tackle inequalities in outcomes, experience and access.	☒
3. Value for money	Enhance productivity and value for money.	☒
4. Social and economic development	Help the NHS support broader social and economic development.	☒
5. NHS Constitution	Deliver NHS Constitutional and legal requirements.	☒

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	

Implications:	
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	Not having the fundamental governance arrangements could result in non-compliance with legal and statutory requirements.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	None specifically in relation to this report.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	None specifically in relation to this report.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	None specifically in relation to this report.
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	Not specifically in relation to this report, however the principles are contained with the Constitution and governance arrangements.

Appendix 1

NHS LEICESTER, LEICESTERSHIRE AND RUTLAND INTEGRATED CARE BOARD

Declarations of Interest - 2023 - 2024 (v5, 31 March 2024)
N.B. including dates "to", "from" or both as per guidance relating to the interest where new or circumstances have changed through the year.

Name	Job Title / Role	Financial Interests	Non-financial professional interests	Non-financial personal interest	Indirect Interests	Actions to be taken to mitigate the risks (see Conflicts of Interest Policy for details)
Mr David Sissling	Chairman (until 31 March 2024)	Wife is a manger at University Hospitals of Leicester NHS Trust (current as at end March 2024).	N/A	N/A	N/A	Appropriate actions to be taken as necessary during system-wide meetings and during conduct of business, particularly in relation to matters concerning UHL. Action will be taken dependent on the nature of the conflict.
Dr Caroline Trevithick	Chief Executive (interim) (from 27 November 2023) (previously Chief Nursing Officer until 26 November 2023)	N/A	Royal College of Nursing Nurse & Midwifery Council. Awarded the title and status of Honorary Doctorate of Science from Loughborough University.	N/A	N/A	Appropriate actions to be taken as necessary and dependent on the nature of the conflict.
Mr Andy Williams	Chief Executive (until 24 November 2023)	N/A	Chair and Trustee of Brap - charity working in the rights and equality field. Director of Jupiter Phase 3 Management Company (not remunerated) - residents property management. .	Warden of Birmingham Cathedral - non remunerated position. Foundation Governor of St Matthews Primary School, Smethick - non remunerated position.	Wife is Acting Director at Dudley and Walsall Mental Health Partnership NHS Trust.	Appropriate action would be taken during procurement processes. Interests are non-financial in the main. However, if a direct potential or actual conflict of interest arises then appropriate action to be taken in line with the Policy.
Ms Kay Darby	Chief Nursing Officer (interim) (from 11 December 2023)	N/A	N/A	N/A	N/A	N/A
Mr Robert Toole	Chief Finance Officer (interim) (from 23 October 2023)	N/A	N/A	N/A	N/A	N/A
Ms Caroline Gregory	Interim Chief Finance Officer (from 1 August 2022 - 31 October 2023)	N/A	Member of the Chartered Institute of Public Finance & Accountancy (CIPFA).	Parish Councillor on Hook Norton Parish Council (from May 2020 - May 2024)		Appropriate will be taken if necessary, although limited action required as the Council is outside of the geographical area of LLR.
Mrs Alice McGee	Chief People Officer	Chief People Officer for Northamptonshire ICB (interim position 1 February 2023 - December 2023).	N/A	N/A	N/A	N/A

Name	Job Title / Role	Financial Interests	Non-financial professional interests	Non-financial personal interest	Indirect Interests	Actions to be taken to mitigate the risks (see Conflicts of Interest Policy for details)
Mrs Rachna Vyas	Chief Operating Officer	N/A	Awarded the title and status of Honorary Lecturer at the University of Leicester from 19 July 2021 to 18 July 2024.	Trustee on the Board of a national charity called Growing Points, helping refugees and those from disadvantaged backgrounds into professional careers.	Registered as a patient at Evington Medical Centre a Practice in LLR. No financial interest in Practice.	Note that interest in GP Practice is not a direct financial interest for the individual, and as a member of the Executive Management Team it may not be possible for the individual not to participate in the decision-making process in committee meetings relating to this Practice. However, if a direct potential or actual conflict of interest arises then appropriate action to be taken in line with the Policy.
Ms Sarah Prema	Chief Strategy Officer	Local Public Sector Director at Leicester LIFT Co.	N/A	N/A	Registered as a patient at Birstall Medical Practice which is a Practice in LLR. Son is employed by Boots in Leicester working as a trainee Pharmacist Assistant. Mother-in-law in receipt of funded nursing care.	Appropriate actions to be taken as necessary and dependent on the nature of the conflict.
Dr Nilesh Sanganee	Chief Medical Officer	GP Partner - Principal at Castle Medical Group. Trustee of Friends for Castle Medical Group - Registered Charity. Practice is a member of the LLR Provider Company Castle Medical Group is a member of the North West Leicestershire GP Ltd. Director of Sangco Ltd, a residential property letting company (from 25 June 2022 to current). Practice has a contractual relationship with Derbyshire Health CIC, note also that DHU CIC and the LLR Provider Company have an affiliation.	Professional Membership Details - British Medical Association (BMA). Professional Membership Details - Royal College of General Practitioners. Professional Membership - General Medical Council. Professional Membership Details - Medical Defence Union. Senior Fellow of the Faculty of Medical Leadership and Management.	N/A	Indirect interest in respect of discussions and decisions made relating to GP Practice property relating to Practice premises, which is under a lease from a third party.	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individual can be involved in, or not involved with at all etc. For other declarations, appropriate actions to be taken as necessary in line with the Policy, dependent on the nature of the interest declared and whether a conflict arises.

Name	Job Title	Financial Interests	Non-financial professional interests	Non-financial personal interest	Indirect Interests	Actions to be taken to mitigate the risks (see Conflicts of Interest Policy for details)
Mr Darren Hickman	Non-Executive Member - Audit	Non-Executive Director & Risk Chair, Earl Shilton Building Society (Nov 20 to present) Non-Executive Director of Northampton Children's Trust (Sept 2020 to December 2023). Non-Executive Director and Audit Chair of BHSF Ltd (an insurer based in Birmingham). Will commence on 1 April 2024. Director of D&JH Services Ltd a consultancy and property managemnet company (July 2021 to Present).	N/A	N/A	N/A	Appropriate actions to be taken as necessary in line with the Policy, dependent on the nature of the interest declared and whether a conflict arises.
Ms Simone Jordan	Non-Executive Member - People and Remuneration	Managing Director - Simone Jordan & Associates Ltd (from 2015 to date) Vice Chair - Royal Orthopaedic Hospital NHS Foundation Trust: Associate NED from 2017-2020, and Vice-Chair from 2021 to present. Non-Executive Director and Chair of Audit Committee - George Eliot Hospital NHS Trust (from 2018 to present)	Member of Chartered Institute of Personnel and Development	N/A	N/A	In relation to financial interests, to ensure individual does not participate in the decision-making process (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individuals can be involved in, or not involved with at all etc. For other declarations, appropriate actions to be taken as necessary in line with the Policy, dependent on the nature of the interest declared and whether a conflict arises.
Ms Pauline Tagg	Non-Executive Member - Quality, Performance and Transformation	Co-owner of Approved Fire Protection Ltd. Chair of East Midlands Ambulance Service NHS Trust (ended 31 July 2022).	Chair of VISTA (sight loss charity and care home provider).	N/A	N/A	In relation to financial interests, to ensure individual does not participate in the decision-making process (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individuals can be involved in, or not involved with at all etc. For other declarations, appropriate actions to be taken as necessary in line with the Policy, dependent on the nature of the interest declared and whether a conflict arises.

Name	Job Title	Financial Interests	Non-financial professional interests	Non-financial personal interest	Indirect Interests	Actions to be taken to mitigate the risks (see Conflicts of Interest Policy for details)
Prof Azhar Farooqi	Non-Executive Member - Health Inequalities, Public Engagement, Third Sector and Carers	GP Partner at East Leicester Medical Practice and part owner. Director of A Farooqi Limited which provides clinical research and quality service. Part owner and share-holdings exceeding 25%. GP Practice (East Leicester Medical Practice) is a member of the LLR GP Provider Company with less than 1% ownership. Honorary Professor, Department of Health Sciences at University of Leicester and Clinical Director Centre of Ethnic Health Research University of Leicester. East Leicester Medical Practice in receipt of NHS England research funding via National Institute of Healthcare Research. East Leicester Medical Practice acts as the lead practice for Across Leicester Academy (a consortium of 7 city practices) providing undergraduate medical teaching to a number of medical schools. Practice was a member of the Aegis Primary Care Network (1 July 2019 - August 2021). From 1 September 2021 Practice is a member of Salutem Primary Care Network. National and international presentations and lectures as part of research or academic and postgraduate education roles including non-promotional educational activity sponsored by charities and pharmaceutical companies. East Midlands Clinical Research Network - Clinical Director appointef from 1 June 2021, Division 5, East Midlands Clinical Research Network hosted by University Hospitals of Leicester NHS Trust on behalf of the National Institute of Health Research (position is remunerated). Co-director of Regional Diabetes and Vascular Clinical Network, NHS England Midlands. Son, Dr Imran Farooqi, is a partner at the East Leicester Medical Practice.	Fellow of the Royal College of General Practitioners. Member of the British Medical Association. Member of the Leicester Medical Society.	N/A	Indirect interest in respect of discussions and decisions made relating to GP Practice property, however does not own the Practice premises as these are leased from NHS Property Services.	In relation to financial interests, to ensure individual does not participate in the decision-making process (e.g to absent themselves from meetings at the relevant point on the agenda); if involved in procurement processes then individual to seek advice to clarify if they can / cannot be involved and at what stage. For other declarations, appropriate actions to be taken as necessary in line with the Policy, dependent on the nature of the interest declared and whether a conflict arises.
Mr Mark Andrews	Partner Member - Local Authority Sectoral representative	Chief Executive of Rutland County Council.	N/A	N/A	Spouse is a Director for Worldwide Clinical Trials, a Contract Research Organisation (from July 2022).	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individual can be involved in, or not involved with at all etc.

Name	Job Title	Financial Interests	Non-financial professional interests	Non-financial personal interest	Indirect Interests	Actions to be taken to mitigate the risks (see Conflicts of Interest Policy for details)
Mr Martin Samuels	Partner Member - Local Authority Sectoral representative (until 30 November 2023)	Strategic Director, Social Care & Education, Leicester City Council	N/A	N/A	N/A	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individual can be involved in, or not involved with at all etc.
Mr Laurence Jones	Partner Member - Local Authority Sectoral representative (from 1 March 2024)	Strategic Director, Social Care & Education, Leicester City Council	N/A	N/A	N/A	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individual can be involved in, or not involved with at all etc.
Mr Mike Sandys	Partner Member - Local Authority Sectoral representative	Director of Public Health for Leicestershire County Council and Rutland County Council.	N/A	Chair and Board Member - Active Together. Board member - Active Partnerships.	N/A	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individual can be involved in, or not involved with at all etc.
Mr Richard Mitchell	Partner Member - Acute Sector representative	Chief Executive, University Hospitals of Leicester NHS Trust. Occasional consultancy work (less than £500 per year).	Chair East Midlands Cancer Alliance (work with NHS England / Improvement). Board Member NHS Impact - NHS Improvement Board. Chair Midlands Leadership Board (work with NHS England / Improvement). Chair Midlands East pathology Network. Deputy Chair Cancer Alliance Leadership Forum.	N/A	N/A	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individual can be involved in, or not involved with at all etc.

Name	Job Title	Financial Interests	Non-financial professional interests	Non-financial personal interest	Indirect Interests	Actions to be taken to mitigate the risks (see Conflicts of Interest Policy for details)
Ms Angela Hillery	Partner Member - Community and Mental Health Sector representative	Joint Chief Executive for Northamptonshire Healthcare NHS Foundation Trust (NHFT) and Leicestershire Partnership NHS Trust (LPT). Transition to role within LPT commenced on 8 July 2019 and accountability for LPT role from 15 July 2019). Director of 3Sixty Care Partnership on behalf of NHFT.	National NHS Providers Board member. Executive Reviewer for Care Quality Commission. Member of the Royal College of Speech and Language Therapists. Member of the Board of NHS Northamptonshire Integrated Care Board. Member of other ICB fora and LLR partnership forums. Midlands region CEO representative for National Mental Health working group. Member of East Midlands Alliance - Mental Health. Member of National Mental Health Programme Board. Member of NHS Employers workforce policy board.	N/A	Sister is employed by William Blake House charity which operates several residential homes for people with learning disabilities. Husband is a property surveyor. Daughter is a teacher in Northants. Son and nephew are in the Northants Police Force.	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individual can be involved in, or not involved with at all etc.

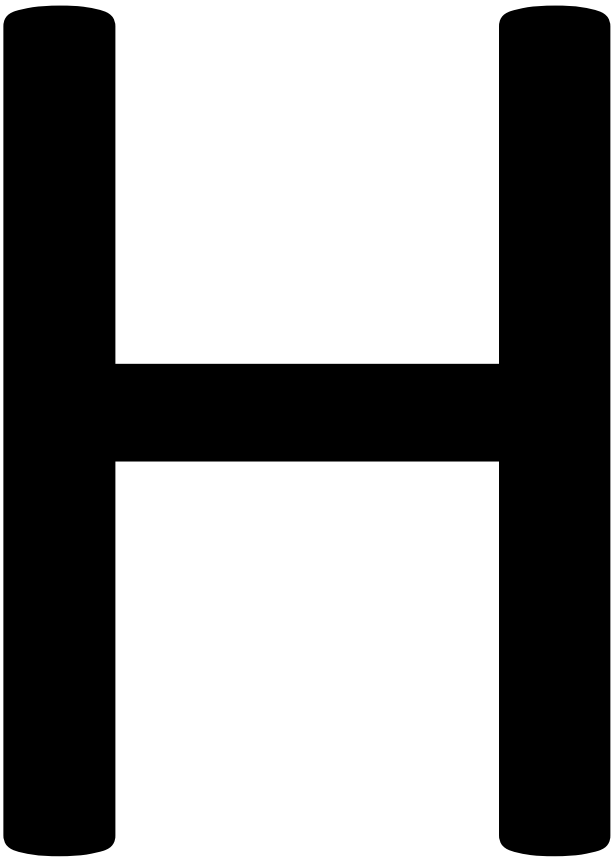
Name	Job Title	Financial Interests	Non-financial professional interests	Non-financial personal interest	Indirect Interests	Actions to be taken to mitigate the risks (see Conflicts of Interest Policy for details)
Dr Nainesh Chotai	Partner Member - primary care sector representative (from September 2022)	GP Partner at Glenfield Surgery and Groby Surgery. Director of G&G Surgery Ltd, company providing general medical practice activities (since May 2017). Clinical Director of G3 Primary Care Network. Director and shareholder in Glenfield Pharmacy Ltd. GP Practice is a member of the LLR GP Provider Company. Director of Southmeads Properties Ltd. Director of Southmeads Professional Services & Investments Ltd. (since March 2013). Providing management consultancy activities other than financial management.	N/A	N/A	Wife is a franchise holder in Wigston, Oadby and Blaby Specsavers Opticians.	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individual can be involved in, or not involved with at all etc.
Prof Mayur Lakhani	Clinical Executive Lead	Chair – FMLM Faculty of Medical Leadership & Management Company Director – The office of Dr Mayur Lakhani CBE Limited Undergraduate teaching - University of Leicester & Nottingham. GP Principal Highgate Medical Centre GMS contract Independent contractor at Highgate Medical Centre (GP), GMS practice Highgate Medical Centre is part of Charnwood Federation and Soar Valley PCN (July 2019). Highgate Medical Centre is a member of LLR Provider Company Visiting Professor, Division of Health Sciences, University of Leicester (Honorary) Spouse is a Practice Manager and non-clinical partner at Highgate Medical Centre and director of Charnwood GP Network Ltd. Honoraria to be received from LuminaDx and Pulse Magazine (CRP/D-Dimer Testing, point of care (undertaken as a GP and not in ICB capacity). Chair, Session on Lipid Management and secondary prevention, Sanofi (undertaken as a GP and not in ICB capacity). Panel Member of a (national) GP Consultancy (GPCA) – ad hoc work. Undertaken as a GP not in ICB capacity. Clinical Advisor, Arden and GEM CSU. (undertaken as a GP and not in ICB capacity).	Professional Membership Details Royal College of General Practitioners Professional Membership Details British Medical Association Professional Membership General Medical Council Professional Membership Details Medical Defence Union Professional Membership Details Royal College of Physicians Edinburgh Professional Membership Details Royal College of Physicians London Professional Membership Details Fellow of Royal College of GPs Professional Membership Details Member of the Faculty of Medical Management & Leadership. Professional Membership Details Medical Examiner trained and Medical Examiner member of Royal College of Pathologists Clinical Lead, UHL, non-site specific cancer pathway, and Cancer Board.	N/A	N/A	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individual can be involved in, or not involved with at all etc.

Appendix 2

LEICESTER, LEICESTERSHIRE AND RUTLAND INTEGRATED CARE BOARD

Register of Gifts & Hospitality 2023-24 (v1 reviewed January 2024)

Ref	Name of receipient and job title	Date of offer / receipt of gift / hospitality	Description of gift / hospitality	Estimated Value £	Supplier / Offeror Name and Nature of Business	Details of Previous Offers or Acceptance by this Offeror/ Supplier	Details of the officer reviewing and approving the declaration made and date	Declined or accepted and date	Reason for declining or accepting	Other Comments
1	Rachna Vyas, Chief Operating Officer	22 September 2023	LPT Awards dinner and event	Unknown	LPT event, sponsored by Dunhelm and Tilbury Douglas	None	Andy Williams, Chief Executive December 2023	Accepted December 2023	Accepted in line with policy.	
2	Rachna Vyas, Chief Operating Officer	23 September 2023	Gift bag - 3 x spa gifts	£17	Dunhelm (sponsor of above event)	None	Andy Williams, Chief Executive December 2023	Accepted December 2024	Accepted in line with policy.	
3	Caroline Trevithick, Chief Nursing Officer	24 September 2023	LPT Awards dinner and event	Unknown	LPT event, sponsored by Dunhelm and Tilbury Douglas	None	Andy Williams, Chief Executive December 2023	Accepted December 2023	Accepted in line with policy.	
4	Caroline Trevithick, Chief Nursing Officer	25 September 2023	Gift bag - 3 x spa gifts	£17	Dunhelm (sponsor of above event)	None	Andy Williams, Chief Executive December 2023	Accepted December 2024	Accepted in line with policy.	



Name of meeting:	**Leicester, Leicestershire and Rutland ICB Board meeting** (public)		
Date:	11 April 2024	**Paper:**	**H**
Report title:	**ICB Board forward planner**		
Presented by:	Robert Toole, Chief Finance Officer		
Report author:	Daljit K. Bains, Head of Corporate Governance		
Executive Sponsor:	Caroline Trevithick, Chief Executive		

To approve ☒	**For assurance** ☒	**To receive and note** ☐	**For information** ☐
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Recommendations:

The Leicester, Leicestershire and Rutland Integrated Care Board is asked to:

- **APPROVE** the updated ICB Board forward planner for 2024/25.

Purpose and summary of the report:

1. The ICB Board forward planner is updated at regular intervals, in conjunction with the Executive Management Team and Board members, to ensure that it remains current. The forward planner captures key strategic aspects of business reserved for the Board, including assurance reports on functions delegated to officers and / or committees of the Board.

2. The Board is asked to approve the forward planner on an annual basis. The section containing the proposed topics for future Board development sessions will be kept under review and prioritised in conjunction with the ICB Chair.

3. The updated version for 2024/25 is at Appendix 1.

Appendices:	• Appendix 1 – ICB Board forward planner 2024/25
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• N/A

The report is helping to deliver the following strategic objective(s) – *please tick all that apply*:		
1. Improve outcomes	Improve outcomes in population health and healthcare.	☒
2. Health inequalities	Tackle inequalities in outcomes, experience and access.	☒
3. Value for money	Enhance productivity and value for money.	☒
4. Social and economic development	Help the NHS support broader social and economic development.	☒
5. NHS Constitution	Deliver NHS Constitutional and legal requirements.	☒

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	

Implications:	
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	Not having the fundamental governance arrangements could result in non-compliance with legal and statutory requirements.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	None specifically in relation to this report.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	None specifically in relation to this report.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	None specifically in relation to this report.
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	Not specifically in relation to this report, however the principles are contained with the Constitution and due regard is considered in the development of the strategies and policies of the organisation.

Appendix 1

NHS LLR ICB meeting forward planner

LLR INTEGRATED CARE BOARD meeting work programme / forward planner 2024/25 (v1 April 2024)	Responsible officer	2024/25 (meetings to be held bi-monthly and development sessions in intervening months)											
AGENDA ITEMS		**April**	**May (dev.)**	**Jun**	**July (dev.)**	**Aug**	**Sept (dev.)**	**Oct**	**Nov (dev.)**	**Dec**	**Jan (dev.)**	**Feb**	**Mar (dev.)**
Welcome and introductions	ICB Chair	✔		✔		✔		✔		✔		✔	
Apologies for absences	ICB Chair	✔		✔		✔		✔		✔		✔	
Declarations of interest on agenda items	ICB Chair	✔		✔		✔		✔		✔		✔	
Receive questions from the public relating to items on the agenda	ICB Chair	✔		✔		✔		✔		✔		✔	
Minutes of the previous meeting - to approve	ICB Chair	✔		✔		✔		✔		✔		✔	
Matters arising: update on actions from the meeting	ICB Chair	✔		✔		✔		✔		✔		✔	
Notification of Any Other Business	ICB Chair	✔		✔		✔		✔		✔		✔	
Chair's Overview	ICB Chair	✔		✔		✔		✔		✔		✔	
Chief Executive's Overview	Chief Executive	✔		✔		✔		✔		✔		✔	
Sharing case studies and patient stories	EMT	✔		✔		✔		✔		✔		✔	
STRATEGY AND SYSTEM PLANNING													
5-year Forward Plan - to review / approve (for 2024/25 forms part of the Operational Planning reports)	Chief Strategy Officer	✔									✔	✔	✔
Joint commissioning arrangements including delegation of NHS England commissioning functions (updates and / or for approval) *(as required)*	Chief Strategy Officer	✔											
Sustainable Development Strategy / The Green Plan (and annual reports / updates) - to review and approve (to go through System Executive in the first instance)	Chief Strategy Officer (in conjunction with lead officer in UHL)			✔									
System level business cases (above resepctive committee delegation) - as required	EMT												
Thematic reviews e.g. estates, system flow etc (as required)	EMT												
Equality and Inclusion Strategy and Policy and Equalities Objectives - to approve	Chief People Officer	✔											
Research and development - updates via the System Executive Committee - as required	System Executive												
OPERATIONAL													
Progress reports from the LLR Delivery Partnership (this includes ICB and system operational performance i.e. progress against the Operational Plan and against the 5 Year Plan)	Chief Operating Officer	✔		✔		✔		✔		✔		✔	
Finance monthly report on ICB and system position.	Chief Finance Officer	✔		✔		✔		✔		✔		✔	
Performance assurance briefings from UHL and LPT to be received a couple of times a year.	UHL / LPT (Head of Corporate Governance to assist coordination)					✔				✔			
The 2024/25 Operational Plan and Financial Plan - to review and approve	Chief Strategy Officer / Chief Finance Officer	✔											
The 2025/26 Operational Plan and Financial Plan - to review	Chief Strategy Officer / Chief Finance Officer							✔		✔		✔	
Winter Plan 2024/25 - for approval	Chief Operating Officer					✔							
Update on system leadership, People Plan and recruitment	Chief People Officer							✔					
Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) reports	Chief People Officer									✔			
Gender Pay gap report	Chief People Officer											✔	
Update on people plan and workforce (as required)	Chief People Officer							✔					
Emergency Planning, Resilience and Response assurance report	Chief Operating Officer	✔										✔	
ASSURANCE													
Assurance Report from the Audit Committee	Chief Finance Officer	✔		✔		✔		✔		✔		✔	
Assurance Report from the Remuneration Committee *(as required, to be presented in confidential meetings)*	Chief People Officer												
Assurance Report from the System Executive Committee	Chief Executive	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Assurance Report from the Finance Committee	Chief Finance Officer	✔		✔		✔		✔		✔		✔	
Assurance Report from the Health Equity Committee	Chief Strategy Officer	✔		✔		✔				✔			
Assurance Report from the Quality and Safety Committee	Chief Nursing Officer	✔		✔		✔		✔		✔		✔	
Briefings following meetings of the Health Inequalities Advisory Group (as required)	Chief People Officer												
Research Group Annual Report	Chief Medical Officer											✔	
Assurance reports from joint commissioning meetings as and when available and / or once arrangements have been approved	EMT												
GOVERNANCE ARRANGEMENTS													
ICB Constitution to review (including the Standing Orders) (as required)	Chief Finance Officer												
ICB Constitution to approve (as required)	Chief Finance Officer												
ICB Scheme of Reservation and Delegation (SoRD) - review and approve	Chief Finance Officer			✔									
Standing Financial Instructions - to review and approve	Chief Finance Officer			✔									
ICB Governance Handbook - to review and approve	Chief Finance Officer			✔									
Standards of Business Conduct Policy / Conflicts of Interest - to review and approve	Chief Finance Officer (in conjunction with Head of Corporate Governance)			✔									
Functions and decision map - to review and approve	Chief Finance Officer (in conjunction with Head of Corporate Governance)			✔									
Audit Committee Terms of Reference - to approve (statutory committee)	Chief Finance Officer (in conjunction with Head of Corporate Governance)			✔									
Remuneration Committee terms of reference - to approve (statutory committee)	Chief People Officer (in conjunction with Head of Corporate Governance)			✔									
System Executive Committee terms of reference - approve (locally established)	Caroline Trevithick (in conjunction with Head of Corporate Governance)			✔									
Finance Committee terms of reference - to approve (locally agreed committee)	Chief Finance Officer (in conjunction with Head of Corporate Governance)			✔									
Health Equity Committee terms of reference - to approve (locally agreed committee)	Chief Strategy Officer (in conjunction with Head of Corporate Governance)			✔									
Quality and Safety Committee terms of reference - to approve (locally agreed committee)	Chief Nursing Officer (in conjunction with Head of Corporate Governance)			✔									
ICB Board Assurance Framework 2023/24 - end of year version to be approved and closed.	Chief Finance Officer (in conjunction with Head of Corporate Governance)	✔											
ICB Board Assurance Framework 2024/25 - opening version to be approved	Chief Finance Officer (in conjunction with Head of Corporate Governance)	✔											
Review of Board Assurance Framework.	Chief Finance Officer (in conjunction with Head of Corporate Governance)	✔						✔					
Register of Interests and Register of Gifts and Hospitality - end of year approval	Chief Finance Officer (in conjunction with Head of Corporate Governance)	✔											
Corporate Policies for approval (as and when required)	EMT												
ICB forward planner - for review and approval	ICB Chair	✔											
Undertake effectiveness review of the governance arrangements	EMT / Committee Chairs (in conjunction with Head of Corporate Governance)					✔							
Proposed development session topics for 2023/24 (once agreed timescales will be confirmed):													
Constitution, governance and risk management	EMT						✔						
Board/Team Development (Values, behaviours, criteria for success, Cohesion)	Chief People Officer												
Financial challenges	Chief Finance Officer				✔		✔						
Collaboratives	Chief Strategy Officer												
Place and Integration	Chief Operating Officer												
Addressing Health Equity	Chief Strategy Officer						✔						
Transformation and service development	Chief Operating Officer		✔				✔						
Urgent and emergency care pathway (as agreed in February 2024)	Chief Operating Officer												
People and Communities	Chief People Officer												
People Plan and workforce	Chief People Officer												
Safeguarding Adults and Children	Chief Nursing Officer												
Children and Young People	Chief Nursing Officer												
Medicines Safety	Chief Nursing Officer / Chief Medical Officer												
ANNUAL GENERAL MEETING	ICB Chair						✔						

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	**11 April 2024**	**Paper:**	**I**
Report title:	**Assurance Report from the ICB (System) Finance Committee**		
Presented by:	Jeffrey Worrall, Non-Executive Director, University Hospitals of Leicester NHS Trust		
Report author:	Imran Asif, Corporate Governance Officer, LLR ICB		
Sponsor:	Robert D Toole, Chief Financial Officer, LLR ICB		

To approve ☐	**For assurance** ☒	**To receive and note** ☒	**For information** ☐
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Recommendations:

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.

Purpose and summary of the report:

1. This report provides a summary of the key areas of discussion and outcomes following the meeting of the **ICB (System) Finance Committee** held on the **27 March 2024**.
2. A summary of the level of assurance provided by the Committee is detailed below.

Appendices:	None.
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• N/A

The report is helping to deliver the following strategic objective(s) – *please tick all that apply***:**		
1. Improve outcomes	Improve outcomes in population health and healthcare.	☒
2. Health inequalities	Tackle inequalities in outcomes, experience and access.	☒
3. Value for money	Enhance productivity and value for money.	☒
4. Social and economic development	Help the NHS support broader social and economic development.	☒
5. NHS Constitution	Deliver NHS Constitutional and legal requirements.	☒

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	No conflicts of interests were identified in relation to this report.
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	

☐	Conflict noted, conflicted party to be excluded from the meeting.	
Implications:		
a)	**Does the report provide assurance against a strategic risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc?** *If so, state which risk and also detail if any new risks are identified.*	Aligned to BAF financial sustainability risk.
b)	**Does the report highlight any resource and financial implications?** If so, provide which page / paragraph this can be found within the report.	Revenue and Capital risks highlighted for 2023/2024.
c)	**Does the report highlight quality and patient safety implications?** If so, provide which page / paragraph this is outlined in within the report.	None specifically in relation to this report.
d)	**Does the report demonstrate patient and public involvement?** If so, provide which page / paragraph this is outlined in within the report.	None specifically in relation to this report.
e)	**Has due regard been given to the Public Sector Equality Duty?** If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	Not specifically in relation to this report, however, the principles are contained with the Constitution and governance arrangements.

Assurance Report from the ICB (System) Finance Committee

1. The summary of the assurance level is as detailed in the table below:

Key area discussed at the Committee meeting	Level of assurance (RAG)	Rationale for level of assurance	Risk(s) / issue(s) to escalate where required
1. ICS System Financial Report for Month 11 2023/24 – Revenue, capital, efficiency schemes and POD	**RED**	The Finance Committee received the M11 ICS System Finance position including an update on revenue, capital, efficiency schemes and the POD delegation. The Finance Committee were not assured because of the emerging risks and overall YTD deficit of £(64.9)m which was an adverse variance of £(53.9)m against the plan. The system partner forecasts for the year are listed below: • UHL - £ (49.3)m; • LPT – reporting breakeven; and • ICB - £ (15.6)m. The committee were informed that variance from plan following NHS England providing funding (revenue and cash) against the original planned £(10)m deficit will result in a Like for Like outturn position of £(74.9)m, which is an adverse variance of £(13.8)m from the revised forecast commitment of £(61.1)m. The adverse variance was due to £(5.3)m UEC pressures, £(4)m workforce cost estimate, £(2.5)m depreciation funding shortfall and £(2)m industrial action costs in excess of funding.	There is a significant risk of the LLR system not achieving the year end plan out-turn.
2. ICB Finance Report Month 11 2023/24	**RED**	The Finance Committee received the M11 ICB financial position forecast which remained consistent with a deficit out-turn of £(15.6)m.	There is a significant risk of the ICB not achieving the original year end plan out-turn of break-even.
3. 2024/2025 Financial Plan Update	**RED**	The Finance Committee were presented with the LLR system financial plan summary to date. The LLR system have submitted to NHS England a revised £(99)m deficit total for the financial plan for 2024/2025 improved from c.£(138)m deficit. Engagement with NHS England representatives this month have highlighted expectations of the LLR system which are listed below: - • Emphasis on reducing planned deficit further; • Greater financial and operational control is required for workforce management; and • Deliver a 5% efficiency target through the cost improvement plan (CIP). A final plan will be submitted by the 2 May.	There is a significant risk of the ICS being unable to agree a balanced financial plan for 24/25.
4. 24/25 Joint Capital Resource Use Plan	**AMBER**	The committee were presented an update on the 24/25 joint capital resource use plan. It was reported that the LLR system have established a robust governance structure which	

		has enabled it to plan its utilisation of the allocated capital spending allowance for 2024/2025. The capital plan will be endorsed by the System Executives on the 24 April for approval by the ICB along with the Operational and financial Plan.	
5. LLR System Delivery Partnerships Month 11 Report	**RED**	The LLR System Delivery Partnership Report for M11 was taken as read and pertinent highlights were shared with the Committee. The committee requested that consideration was given to identifying several schemes for 2024/2025 which could enable significant transformation across the LLR system and have the largest impact to financial sustainability.	The LLR system are not able to capitalise on transformational opportunities that assist in reducing the financial challenge in 2024/2025.
6. Estates Assurance Report	**RED**	The Estates Assurance Report was received, and focus was placed on the implementation of the Estate Infrastructure Strategy. The committee were keen to understand the scope of the Estate across the LLR system with a view of receiving assurance that future projects would contribute to and achieve financial efficiencies.	
7. Digital Transformation Report	**RED**	The committee received an update on the digital transformation taking place across the LLR system. It was noted that the LLR system digital strategy had seven key themes of which there were 43 actions. The digital action plan was shared, and it was noted that of the 43 actions there were: - • 11 fully met/completed; • 8 on schedule; • 22 delayed; and • 2 not started. The committee re-iterated the need to focus efforts on identifying several schemes for 2024/2025 which could enable significant transformation and achieve financial targets.	
8. ICB Risks and Issues Log Month 11	**N/A**	The Finance Committee received the ICB Risks and Issues Log for M11, noting there were no risks closed and all risks had been reviewed and updated as appropriate.	

Key for level of assurance:

Green	**Assured:** there are no gaps and there are robust plans / controls in place.
Amber	**Partially assured:** there are some gaps in assurance, although assured that appropriate plans / controls are being developed to address the gaps.
Red	**Not assured:** there are significant gaps in assurance and not assured as to the adequacy of the plans / controls.

Recommendations

The LLR Integrated Care Board is asked to:

RECEIVE the report for assurance.

J

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	11 April 2024	**Paper:**	**J**
Report title:	**Assurance Report from the System Executive**		
Presented by:	Caroline Trevithick, Chief Executive LLR ICB and Chair of the System Executive		
Report author:	Tamara Hazell, Corporate Governance Officer Charlotte Gormley, Corporate Governance Officer		
Sponsor:	Caroline Trevithick, Chief Executive LLR ICB and Chair of the System Executive		

To approve ☐	**For assurance** ☒	**To receive and note** ☐	**For information** ☐
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Recommendations:

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.

Purpose and summary of the report:

1. This report provides a summary of the key areas of discussion and outcomes following the meetings of the System Executive Committee held on 23 February 2024, 15 March 2024, and 22 March 2024. The report also covers items for escalation and consideration by the Board ensuring that the Board is alerted to emerging risks and issues.

2. A summary of the level of assurance provided by the Committee is detailed in paragraph 15.

Appendices:	• N/A
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• N/A

The report is helping to deliver the following strategic objective(s) – *please tick all that apply***:**		
1. Improve outcomes	Improve outcomes in population health and healthcare.	☒
2. Health inequalities	Tackle inequalities in outcomes, experience and access.	☒
3. Value for money	Enhance productivity and value for money.	☒
4. Social and economic development	Help the NHS support broader social and economic development.	☒
5. NHS Constitution	Deliver NHS Constitutional and legal requirements.	☒

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	
Implications:		
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*		The focus is on mitigating strategic risks as identified in the BAF and to identify and evaluate risks on an ongoing basis.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.		Assurances received in relation to the financial plan.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.		None specifically in relation to this report.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.		None specifically in relation to this report.
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.		Not specifically in relation to this report, however due regard is considered within reports presented to the Committee.

Assurance Report from the System Executive

Introduction

1. This report aims to provide assurance to the Board and a summary of the key updates, decisions, and outcomes, aligned to the Committee's delegated authority, following the meetings of the System Executive Committee held on 23 February 2024, 15 March 2024 and 22 March 2024. The report also covers items for escalation and consideration by the Board ensuring that it is alerted to emerging risks or issues.

Operational performance assurance

2. **2024/25 Operational and Financial Planning Submission -** Members acknowledged the draft Operational and Financial Planning submission submitted on 27 February 2024. The draft planning submission included elements of the Operational Plan such as finance, activity performance, ambulance, and workforce. The slide pack would be further developed for consideration at a future LLR ICB Board Development Session before final sign off and submission in May 2024.

3. An extraordinary meeting of the System Executive Committee was held on 15 March 2024 with a focus on the **Operational and Financial Plan 2024/25.** A number of actions and next steps across organisations were agreed for completion ahead of the meeting with NHSE on 18 March 2024 and submission deadline of 21 March 2024.

4. The **2024/25 Operational Planning** submission to NHSE on 21 March 2024 included significant improvements in terms of workforce and the expected deficit. Risks however remained regarding delivery of the Cost Improvement Programme (CIP) and Urgent and Emergency Care (UEC). The System Executive would make recommendations to the Board on 11 April 2024.

5. The **Delegation of Specified Specialised Acute Services Briefing paper** outlined the ongoing discussions taking place with UHL and colleagues from the LLR ICB contracting team on the arrangements for delegated responsibility. A CEO timeout session had taken place on 23 January 2024 where an additional due diligence exercise was undertaken covering areas of risk identified in relation to quality, finance, contracting, workforce, and benefits / opportunities. The draft delegation report that was presented to the LLR ICB Board on 8 February 2024 was raised in relation to financial risk arrangements and queries relating to public communications. Governance documentation was developed underpinning the delegation of specialised commissioning services and taken to the Board on 14 March 2024 for formal approval.

6. The **Hinckley Community Diagnostic Centre and Capital Funding Risk Updates** identified that the cost of the project was currently forecasting £(3)m over budget. A number of actions had been agreed to bring the project back under budget within six days as no further capital would be made available. Delays to the project would have negative impact in terms of financial commitment, planned activity, equipment, and workforce.

7. The **LLR Delivery Partnership – February briefing** identified improvements in the areas of Mental Health, Learning Disabilities, Diagnostics and Primary Care. Out of Hours Service utilisation had increased to an average of 97% across January 2024 to date. Additional clinical resource would be provided to support walk-in demand at Oadby Urgent Treatment Centre (UTC) from 8 January 2024 to 31 March 2024. Work was underway to look at data delays impacting on some indicators received via the national team, but assurance was provided noting that local data had shown improved performance in areas such as hypertension.

8. The **LLR Delivery Partnership – March briefing** highlighted ongoing clinical risks in the Emergency Department and associated services, whilst increasing variation had been noted against all UEC metrics. LLR had however achieved the highest number of appointments in the region, with face-to-face appointments increasing to 85%, and ranked number one nationally for adult community mental health transformation.

9. An **Update on the ICB 2023/24 Financial Position at month 10 (January 2024)** identified that the system year to date (YTD) deficit at month 10 was £(75.5)m, which was an adverse variance from plan of £(56.9)m. All organisations were taking steps to minimise variation through strengthened financial controls and efficiencies. The system position included an updated estimate of the impact of the Junior Doctor Industrial Action in line with the recognised level of financial risk and an agreed revised forecasted position with NHSE of £(61.1)M deficit excluding industrial action costs.

10. An **Update on the ICB 2023/24 Financial Position at month 11 (February 2024)** identified that the system year to date (YTD) deficit at month 11 was £(58)m, which was an adverse variance from plan of £(53.9)m. The system was forecasting a year-end deficit of £(64.9)m, which was the equivalent of a £(74.9)m deficit given £10M of non-recurrent additional funding received mitigating the planned deficit. This support is repayable in future years according to NHSE business rules. Challenges related to risk shares across the region for Pharmacy, Optometry, and Dental (PODs) activity remained to be addressed.

11. The **Outcome Letter from the Quarterly System Review Meeting (QSRM)** that took place on 26 January 2024 was received, outlining key areas of discussion with many areas being evidenced as having continued positive improvement. The next QSRM was scheduled for 26 April 2024. An update would be provided to the System Executive on 12 April 2024 in advance of submission to NHSE by 19 April 2024.

12. The System Executive reviewed the **Outputs on 2024/25 Business Cases,** agreeing to recommendations from the Clinical Executive Group and Chief Finance Officers (CFOs). This included support for a short list of business cases and agreement that all disinvestments and potential business cases for 2024/25 undergo the prioritisation process before approval at Strategic Commissioning Group or System Executive. It was noted that the financial allocation for 2024/25 was yet to be agreed.

Other decisions including business cases, procurements and contracts:

13. Committee members considered and supported a number of decisions, all of which fall within the delegated authority of the Committee:

    a. The System Executive supported the **Reconfiguration Programme (Our Future Hospitals) Outline Business Case** for onwards approval by the Board.

    b. The **Lutterworth Consultation Findings Report** was received following the public consultation that took place between 23 October 2023 and 14 January 2024 regarding proposed changes to Feilding Palmer Hospital. The consultation had received 1398 responses, 86% of which agreed or strongly agreed with the proposed bed closures.

    c. The System Executive approved recommendations regarding **Continuation of the Clinical Navigation Hub (CNH) services and Home Visiting Services (HVS) provided by DHU LLR & Re-design of services post 1st April 2024.**

Assurance Reports for Information Only (including reports from sub-groups)

14. Regular assurance reports were received from the Strategic Commissioning Group and Clinical Executive Group.

Summary of assurance from the Committee

15. The summary of the assurance level is as detailed in the table below:

Key area	Level of assurance	Rationale for level of assurance	Risk(s) to escalate where required
1. Operational performance assurance	**Red**	• Draft Operational and Financial Planning submissions were submitted on 27 February 2024 and 21 March 2024. • Governance documentation for the Delegation of Specified Specialised Acute Services was taken to the Board on 14 March 2024 for formal approval. • A number of improvements were identified within the February and March Delivery Partnership briefings. Clinical risks had however been identified in a number of areas. • The system year to date (YTD) deficit at month 11 was £(58)m, which was an adverse variance from plan of £(53.9)m. • Challenges related to risk shares across the region for Pharmacy, Optometry, and Dental (PODs) activity remained to be addressed. • The estimated cost of the Hinckley Community Diagnostic Centre would be over budget. No further capital would be made available and delays to the programme would have negative impact on a number of areas. • Recommendations were approved on review of outputs from the 2024/25 Business Cases. The financial allocation for 2024/25 was however yet to be agreed.	N/A
2. Other decisions including business cases, procurements and contracts	**Green**	• The Reconfiguration Programme (Our Future Hospitals) Outline Business Case was supported for onwards approval by the Board. • A positive response was received from the public consultation regarding proposed changes to Feilding Palmer Hospital in Lutterworth. • Recommendations were agreed regarding the Clinical Navigation Hubs and Home Visiting Service to enable a redesign of the current model of care.	N/A
3. Information only	**Green**	• Assurance reports from sub-groups are regularly received, and issues and risks identified along with mitigations.	N/A

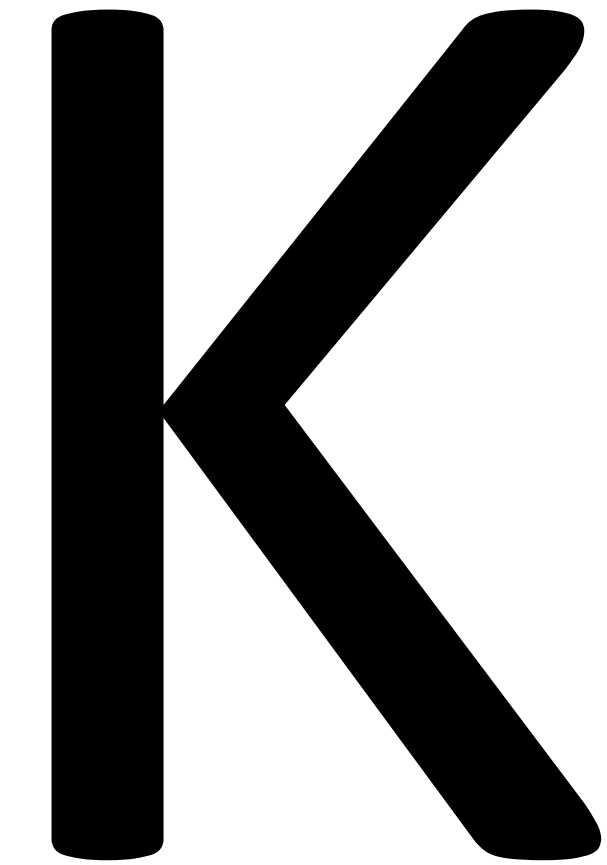
Key for level of assurance:

Green	**Assured:** there are no gaps.
Amber	**Partially assured:** there are some gaps in assurance, although assured that appropriate plans are in place / being developed to address the gaps.
Red	**Not assured:** there are significant gaps in assurance and not assured as to the adequacy of the plans.
Blue	Not considered at the meeting as item not due.

Recommendations

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.



Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board meeting**		
Date:	**11 April 2024**	**Paper:**	**K**
Report title:	**Assurance Report from the ICB Quality and Safety Committee**		
Presented by:	Pauline Tagg, Non-Executive Member - Quality, Safety and Transformation, LLR ICB		
Report author:	Imran Asif, Corporate Governance Officer, LLR ICB		
Sponsor:	Kay Darby, Chief Nursing Officer, LLR ICB		

To approve ☐	**For assurance** ☒	**To receive and note** ☒	**For information** ☐
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Recommendations:

The LLR Integrated Care Board is asked to:

- **RECEIVE** the Assurance Report from the ICB Quality and Safety Committee

Purpose and summary of the report:

1. This report provides a summary of the key areas of discussion and outcomes following the meeting of the ICB Quality and Safety Committee (QSC) held on **7 March 2024**. The report also covers any items for escalation and consideration by the Board ensuring that the Board is alerted to emerging risks and issues.

2. A summary of the level of assurance provided by the Committee is detailed below.

Appendices:	• N/A
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• N/A

The report is helping to deliver the following strategic objective(s) – *please tick all that apply***:**

1. Improve outcomes	Improve outcomes in population health and healthcare.	☒
2. Health inequalities	Tackle inequalities in outcomes, experience and access.	☒
3. Value for money	Enhance productivity and value for money.	☒
4. Social and economic development	Help the NHS support broader social and economic development.	☒
5. NHS Constitution	Deliver NHS Constitutional and legal requirements.	☒

Conflicts of interest screening		Summary of conflicts *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	No conflicts of interest identified in relation to this report.
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	

Implications:	
a) Does the report provide assurance against a strategic risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	Yes, assurance at pathway and provider level supporting improvements and input against the current risks of LLR BAF 05. This Committee will review risks associated with quality at design group / collaborative level on a quarterly basis.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	No.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	Yes. Quality and safety risks considered in the CNO/CMO Quality Assurance report and GP Quality report.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	Report from Chairman of PPIAG.
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	N/A

Assurance Report from the ICB Quality and Safety Committee

1. The summary of the assurance level is as detailed in the table below:

Key area discussed at the Committee meeting	Level of assurance (RAG)	Rationale for level of assurance	Risk(s) / issue(s) to escalate where required
ICB Chief Nursing Officer/ Chief Medical Officer Quality Assurance Report	**AMBER**	**Assure** **<u>Digital risks</u>** Committee were informed that digital risks related to patient letters from DHU/LPT to GPs was a cause for concern and further work is underway to mitigate risks. **<u>CQC visits to UHL and LPT</u>** Both LPT and UHL were visited by CQC in January 2024. Following inspections, immediate concerns raised by CQC have been mitigated. The final CQC reports are expected to be received April & May. **<u>Measles outbreak</u>** LLR has an ongoing live measle outbreak and assurance was provided that actions were taken to mitigate the risks such as the implementation of an Incident Management Team the Measles Elimination Project.	N/A
	AMBER	**Advise** **<u>CNO/CMO – UHL deprivation of liberties</u>** The CNO and CMO are working with system partners to put in place a process that enables efficient management of the UHL's Deprivation of Liberties applications. **<u>Medical examiner service rollout</u>** The committee were provided an update on the rollout of the medical examiner service due to start in April 2024. The ICB will be working with UHL to manage the demand to this service post April.	N/A
	RED	**Alert** **<u>Urgent and Emergency Care (UEC)</u>** The committee were informed that the pressures experienced in UEC were now reflected on the system quality risk log. **<u>Antimicrobial Resistance (AMR)</u>** The committee were made aware of risks in relation to AMR that are not currently captured within the ICS risk register or programmes of work. A paper will be prepared for SQG outlining the concerns, proposed mitigation and support required to manage these risks. **<u>Court of Protection</u>** The CNO is working with clinical colleagues to consider solutions to reduce the 140 community Court of Protection applications that are delayed in being processed. There is a clinical and reputational risk that the LLR system could be challenged about restricting individuals' liberties without authorisation.	N/A

Key area discussed at the Committee meeting	Level of assurance (RAG)	Rationale for level of assurance	Risk(s) / issue(s) to escalate where required
		Asylum Seekers The demands on health services, in terms of infection prevention and control, and safeguarding concerns associated with the Asylum seeker community were added to the Quality risk log. Further work is required to quantify the level of risk and adequacy of mitigations.	
System Quality Provider Updates	**AMBER**	**UHL** Nothing further to report. **LPT** Nothing further to report. **EMAS** The committee were informed that in January 2024 it was reported that 23,000 hours were lost outside hospitals. 30% which were at LRI. Three patient safety incidents were reported due to the delayed response times. **GP Report** The Committee received a summary update on the GP quality themes, identification of patient safety risks and associated assurance mechanisms for Quarter 3 (October 2023 to December 2023). It was noted that the quality assurance tool for Primary Care has been completed and this work has been recognised regionally and nationally as innovative.	
Specialised Services Delegation: Draft Quality Governance Framework	**RED**	The Committee were provided information on the acute specialist service delegation process due to be in place by the 1 April 2024. 59 specialised services will be delegated, the LLR system will have a one-year transition period. Clinical colleagues expressed their support of the delegation of specialised services as the benefits of developing new patient pathways outweighed any unknown quality risks.	N/A
CQC Maternity Services Survey Benchmark Report	**AMBER**	The Committee received the CQC Maternity Services Survey Benchmark Report undertaken by UHL. It was noted that the report highlighted good practice, areas for improvement and risks related to the maternity services. It was reported that staffing levels remained a concern and focus is being placed on workforce recruitment to mitigation this risk.	N/A
Instrumental Births Report	**AMBER**	The Committee were provided assurance that independent investigations had been undertaken following concerns raised that three midwife students had counted three instrumental births (one per student) as part of their facilitated birth numbers which was not compliant with the Nursing and Midwifery Council's (NMC) Standards.	N/A

Key area discussed at the Committee meeting	Level of assurance (RAG)	Rationale for level of assurance	Risk(s) / issue(s) to escalate where required
		Assurance was provided that there were no concerns related to clinical competency of newly qualified nurses/midwives following the investigation.	
Quality Assurance Scorecard	**AMBER**	The Committee received a focus and assurance report against one of the four themes outlined in the NHSE Maternity and Neonatal Services Delivery Plan. Theme 3 focused on – *"Developing and sustaining a culture of safety, learning, and support".* The Committee were assured of the positive work being undertaken to improve the culture of safety, learning and support within LLR. However, it was reported that there is a lack of short and medium-term performance measures in place to assist in providing consistent reporting across the region required by NHS England. The LLR system will be developing a suite of Key Performance Indicators (KPIs).	The Board to note that positive improvement is being made in developing a culture of safety, learning and support across the LLR system.
LLR Delivery Partnership Report	**AMBER**	The LLR system delivery report was presented for information. It was reported that for the Children and Young People Partnership it was necessary to develop a suite of KPIs to measure outcomes against specific areas such as therapy services.	LLR system to develop KPIs to assist in measuring outcomes.
Update from Public and Patient Involvement Assurance Group	**AMBER**	The Committee received an update from the PPIAG for the January 2024 meeting and the following points were highlighted: - **<u>Step up to Great Mental Health</u>** It was reported that the PPIAG had received positive feedback that there had been good engagement. It was highlighted that navigation of services required fine tuning; it would be important to raise awareness of mental health services for clinical staff to ensure patients are referred to appropriate services. **<u>Asylum Seekers and Homeless GP Service Consultation</u>** The committee were informed that the needs of the asylum seeker and homeless communities were specific with high level of clinical risks associated. The need for a deep dive was discussed and the CMO/CNO were asked to consider this further.	Asylum seeker and homeless communities have high levels of clinical needs which could lead to additional pressure on the primary care services. Executive team to consider further.
ICB Board Assurance Framework 2023/2024 update	**AMBER**	An updated version of the BAF was shared which included the escalation and de-escalation risk process. The Committee were informed that the BAF risk 5 (Quality and Safety) had an overall score of 16. It was noted that the risk score is expected to reduce over the next 12 months. The committee were concerned BAF risks 4 (Finance) could have an impact on several Long-Term condition transformational projects that were funded non recurrently.	N/A
LLR System Quality Risk Log	**AMBER**	The Committee received the System Quality Risk Log (SQRL).	The Board to be notified that the QSC were not

Key area discussed at the Committee meeting	Level of assurance (RAG)	Rationale for level of assurance	Risk(s) / issue(s) to escalate where required
		Discussions were focused on how the committee could be assured that all risks were captured at partnership level and across the system. It was noted that the ICB are reviewing the risk management processes to ensure a consistent approach is adopted across the LLR system.	assured that all risks at partnership level are being identified and escalated to the SQRL.

Key for level of assurance:

Green	**Assured:** there are no gaps and there are robust plans / controls in place.
Amber	**Partially assured:** there are some gaps in assurance, although assured that appropriate plans / controls are being developed to address the gaps.
Red	**Not assured:** there are significant gaps in assurance and not assured as to the adequacy of the plans / controls.

Recommendations

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	**11 April 2024**	**Paper:**	**L**
Report title:	**Assurance Report from the ICB Audit Committee**		
Presented by:	Darren Hickman, Non-Executive Member and Chair of Audit Committee		
Report author:	Tamara Hazell, Corporate Governance Officer Daljit Bains, Head of Corporate Governance		
Sponsor:	Darren Hickman, Non-Executive Member and Chair of Audit Committee		

To approve ☐	**For assurance** ☒	**To receive and note** ☒	**For information** ☐
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Recommendations:

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.

Purpose and summary of the report:

1. This report provides a summary of the key areas of discussion and outcomes following the meeting of the **ICB Audit Committee** held on **20 February 2024.** The report also covers items for escalation and consideration by ICB Integrated Care Board ensuring that it is alerted to emerging risks and issues.

Appendices:	N/A
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	N/A

The report is helping to deliver the following strategic objective(s) – *please tick all that apply*:		
1. Improve outcomes	Improve outcomes in population health and healthcare.	☒
2. Health inequalities	Tackle inequalities in outcomes, experience and access.	☒
3. Value for money	Enhance productivity and value for money.	☒
4. Social and economic development	Help the NHS support broader social and economic development.	☒
5. NHS Constitution	Deliver NHS Constitutional and legal requirements.	☒

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	No conflict identified in relation to this report.
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	
Implications:		
a) Does the report provide assurance against a strategic risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*		The remit of the Audit Committee is to provide assurance in respect of the ICB's risk management arrangements including the BAF.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.		Not in relation to this report.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.		Not in relation to this report.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.		Not in relation to this report.
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.		Not in relation to this report.

Assurance Report from the ICB Audit Committee

1. The summary of the assurance level is as detailed in the table below:

Key area discussed at the Committee meeting	Level of assurance (RAG)	Rationale for level of assurance	Risk(s) / issue(s) to escalate where required
1. External Audit Update	**GREEN**	The Audit Committee were advised of progress made in relation to planning for the 2023/24 audit and confirmed emerging issues had been discussed and resolved.	**None.**
2. Internal Audit	**GREEN**	The Audit Committee received the Internal Audit Progress Report for 2023/24 (covering period 13 December 2023 to 9 February 2024). Significant Assurance opinions were issues against financial audits. Remaining 2023/24 audits were underway and the output of these would be received in the Head of Internal Audit Opinion. The Committee approved for the postponement of the Healthcare Contract Management and Performance review from the 2023/24 Internal Audit Plan to be added into the 2024/25 Internal Audit Plan. The draft outline for the 2024/25 Internal Audit Plan was reviewed and formal approval would be given to the final version in April 2024.	**None.**
3. Annual Report and Accounts Timetable	**GREEN**	An overview of the timeline for submission of the draft and final versions of the LLR ICB's Annual Report and Accounts was received noting specific dates for the draft submission and submission of full audited annual reports and accounts in June 2024.	**None.**
4. Audit Follow-up Progress Report	**GREEN**	The Audit Committee were assured of the actions implemented following both internal and external audit reviews.	**None.**
5. Review Board Assurance Framework	**GREEN**	The Audit Committee received the current ICB BAF 2023/24 with an update on the ongoing review of risk management arrangements.	**None.**
6. Losses and Special Payments	**GREEN**	The Committee noted one loss incurred for period up to 20 February 2024.	**None.**
7. Waiver of Standing Orders	**GREEN**	There were no waiver of standing orders received for the period between 11 December 2023 and 13 February 2024.	**None.**
8. POD Delegation Checklist / Self-certification	**AMBER**	The Committee were informed of the POD Delegation Checklist and requirement to submit a self-certification. The inherited complaints backlog was noted as a potential concern although it was recognised that work was underway to address these issues.	**None.**
9. Medicines Optimisation Deep Dive	**GREEN**	The Audit Committee undertook a deep dive into Medicines Optimisation.	**None.**

Key for level of assurance:

Green	**Assured:** there are no gaps and there are robust plans / controls in place.
Amber	**Partially assured:** there are some gaps in assurance, although assured that appropriate plans / controls are being developed to address the gaps.
Red	**Not assured:** there are significant gaps in assurance and not assured as to the adequacy of the plans / controls.

Recommendations

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.

M

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board meeting**		
Date:	11 April 2024	**Paper:**	**M**
Report title:	**Assurance Report from the ICB Health Equity Committee**		
Presented by:	Professor Azhar Farooqi, Non-Executive Member - Health Inequalities, Public Engagement, Third Sector and Carers, LLR ICB		
Report author:	Daljit Bains, Head of Corporate Governance, LLR ICB		
Sponsor:	Sarah Prema, Chief Strategy Officer, LLR ICB		

To approve ☐	**For assurance** ☒	**To receive and note** ☐	**For information** ☒
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Recommendations:

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.

Purpose and summary of the report:

1. This report provides a summary of the key areas of discussion and outcomes following the meeting of the ICB Health Equity Committee held on **20 February 2024**. The report also covers any items for escalation and consideration by the Board ensuring that the Board is alerted to emerging risks and issues.

2. A summary of the level of assurance provided by the Committee is detailed below.

Appendices:	• N/A
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• N/A

The report is helping to deliver the following strategic objective(s) – *please tick all that apply*:		
1. Improve outcomes	Improve outcomes in population health and healthcare.	☒
2. Health inequalities	Tackle inequalities in outcomes, experience and access.	☒
3. Value for money	Enhance productivity and value for money.	☒
4. Social and economic development	Help the NHS support broader social and economic development.	☒
5. NHS Constitution	Deliver NHS Constitutional and legal requirements.	☒

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	
Implications:		
a) Does the report provide assurance against a strategic risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*		The Committee has oversight for the health inequalities risk on the Board Assurance Framework 2023/24.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.		None specifically in relation to this report.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.		None specifically in relation to this report.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.		None specifically in relation to this report.
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.		Not specifically in relation to this report, however due regard is integral to the remit of the Committee and is considered within reports presented to the Committee.

Assurance Report from the ICB Health Equity Committee

1. The summary of the assurance level is as detailed in the table below:

Key area discussed at the Committee meeting	Level of assurance (RAG)	Rationale for level of assurance	Risk(s) / issue(s) to escalate where required
1. ICB Board Assurance Framework Update Report	**AMBER**	Focusing on BAF risk 2 (health inequalities) the committee was assured that actions were in progress to mitigate the risk and supported the consideration of the prevention agenda within the overall risk profile of the ICB.	**None.**
2. Health Inequality Support Unit – Severe Mental Illness	**AMBER**	The committee considered the progress made by the Health Inequality Support Unit (HISU) with a specific focus on the analysis of health inequalities faced by patients with Severe Mental Illness (SMI) in LLR. The Committee suggested areas for further consideration and exploration including cancer screening rates for patients with SMI.	**None.**
3. LLR Delivery Partnership Report	**AMBER**	The committee received the LLR Delivery Partnership Report demonstrating progress being made and noted that health equity continues to be integral to the work of the partnerships.	**None.**
4. Annual Report on Health Inequalities and Equality Objectives	**GREEN**	The report was received for information following approval by the ICB Board.	**None.**
5. Equality Delivery System (EDS) 2022 Report and Action Plan	**GREEN**	The Committee were assured with the progress made against the Domains 2 (Workforce health and wellbeing) and Domain 3 (Inclusive Leadership) within the Equality Delivery System (EDS).	**None.**
6. Updates from UHL and LPT	**GREEN**	The regular updates and briefings from partner organisations were received.	**None**
7. The LLR Research Engagement Network (REN) project update	**GREEN**	The Committee received an update on the REN project which is an integral part of the LLR research partnership. The aim of the project is to develop a template for community engagement / empowerment that can be seamlessly integrated into future research delivery. This will be informed by the evaluation of the project and other national REN projects.	**None**

Key for level of assurance:

Green	**Assured:** there are no gaps and there are robust plans / controls in place.
Amber	**Partially assured:** there are some gaps in assurance, although assured that appropriate plans / controls are being developed to address the gaps.
Red	**Not assured:** there are significant gaps in assurance and not assured as to the adequacy of the plans / controls.

Recommendations

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.

N

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board** (public)		
Date:	11 April 2024	**Paper:**	**N**
Report title:	**Delegation of Specialised Acute Services to the Leicester, Leicestershire and Rutland Integrated Care Board**		
Presented by:	Sarah Prema, Chief Strategy Officer		
Report author:	Jo Grizzell, Senior Planning Manager		
Executive Sponsor:	Sarah Prema, Chief Strategy Officer		

To approve ☐	**For assurance** ☐	**To receive and note** ☐	**For information** ☒
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Recommendations:

The Leicester, Leicestershire and Rutland Integrated Care Board is asked to:

- **NOTE** the Acute Specialised Services Delegation Agreement (Appendix 1)
- **NOTE** the Memorandum of Understanding and Collaboration Agreement for the delegation of acute specialised services 2024/25 (Appendix 2)
- **NOTE** the Commissioning Team Agreement and Standard Operating Framework 2024/25 (Appendix 3)
- **NOTE** the Leicester, Leicestershire and Rutland Integrated Care Board Service Profile Pack (Appendix 4)

Purpose and summary of the report:

Following approval by the LLR ICB Board at its meeting on 14th March 2024 the ICB has taken on delegated responsibility for 59 specialised acute and pharmacy services.

On 6th December 2023, following submission of the pre-delegation assessment framework, the NHS England Board approved the eleven Midlands ICBs application for the delegation of an initial 59 specialised acute services. These services are currently subject to statutory joint working through the East (and West) Midlands Joint Committees.

It is important to note that the East Midlands CEOs requested that further due diligence be undertaken on areas of risk and in particular resources. That being staff capacity and capability over the transition year (in advance of transfer to ICB hosting in 2024/25) and the ability to meet requirements for delegation as ICBs take on the commissioning role. This will be closely monitored by the Joint Committees. Further details in relation to the due diligence exercise are included within paragraphs 12 – 14 in the main body of this report.

This paper is for information and formal noting.

Appendices:	Appendix 1	Acute Specialised Services Delegation Agreement 2024/25
	Appendix 2	Memorandum of Understanding and Collaboration Agreement for the

	Appendix 3	delegation of acute specialised services 2024/25 Commissioning Team Agreement and Standard Operating Framework 2024/25
	Appendix 4	Service Profile Pack
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• Not applicable	

The report is helping to deliver the following strategic objective(s) – *please tick all that apply***:**		
1. Improve outcomes	Improve outcomes in population health and healthcare.	☒
2. Health inequalities	Tackle inequalities in outcomes, experience and access.	☒
3. Value for money	Enhance productivity and value for money.	☒
4. Social and economic development	Help the NHS support broader social and economic development.	☒
5. NHS Constitution	Deliver NHS Constitutional and legal requirements.	☒

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	

Implications:	
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	NHS England have an overarching risk register in place that is monitored by the Midlands Acute Specialised Commissioning Group (MASCG). Any risks that directly impact the LLR ICB will be captured within a risk register that will be monitored by the LLR PODs, Specialised Acute and Pharmacy Steering Group.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	Not in the context of this report.

c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	Not in the context of this report.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	Not in the context of this report.
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	Not in the context of this report.

Delegation of Specialised Acute Services to the Leicester, Leicestershire and Rutland Integrated Care Board

11 April 2024

Introduction

1. Since April 2023, the Midlands ICBs and NHS England have operated under statutory joint working arrangements to commission specified specialised services. This has included 59 acute specialised services identified in the Specialised Commissioning Roadmap (May 2022) as suitable and ready for delegation.

2. Following an agreed due diligence process the 11 Midlands ICBs have approved formal delegation arrangements of the 59 services from 1st April 2024. This is in line with the ICB readiness submission to NHS England though the pre-delegation assessment framework and the subsequent NHS England Board approval in December 2023.

3. National policy requires ICBs to work in formal collaboration regarding specialised services. This responsibility will be enacted through the East and West Midlands Joint Committees.

4. All ICBs are expected to receive the delegation of all agreed specialised services (acute, mental health and learning disabilities, and vaccinations) by no later than April 2025 and this will include a further 23 services. The proposed phasing of delegation, with 59 services proceeding in April 2024, provides the Midlands ICBs with the opportunity to build experience in commissioning these services with a developmental safety net of a transitional year. NHS England will provide significant support to ICBs from 2024 to 2025 as they take on these delegated functions.

5. The formal Delegation Agreement requires ICBs to collaborate in a multi-ICB partnership. The Delegation Agreement is therefore supported by a Collaboration Agreement and Commissioning Standard Operating Framework, which includes NHSE as a partner in their continued role in commissioning retained services. The approach supports the requirement to consider the cross-system population needs that support safe and sustainable care in specialised provision.

6. The Midlands also have in place a joint Memorandum of Understanding as a part of the suite of delegation documents, setting out our collaborative commitment to working together to maximise the benefits of delegation for patients, populations and across complex pathways.

Responsibilities and Accountabilities

7. The delegation of specialised commissioning does not change the accountability for these services as this remains with NHS England.

8. Upon delegation the services became the responsibility of the 11 Midlands ICBs. As noted, the ICBs are required to commit to working together to commission these services. NHS England remains a partner in this process and is responsible for the commissioning of retained specialised services.

Benefits of delegation

9. The primary purpose of delegation is to benefit the care provided to patients across their care pathways, improve access and reduce inequalities for whole populations. There is a significant opportunity to ensure that the disconnect between the commissioning of specialised services through NHS England and the local commissioning bodies is removed.

10. The clinical leaders across ICBs and NHS England have identified the delegation benefits as follows:
    - **Equity of access for all patients:** There is strong evidence that this varies across geographies with those further from specialised provision less likely to have access. Delegation provides the opportunity to understand access and consider outcomes and value across pathways.
    - **Whole pathway approach:** Joining up the whole pathway is likely to encourage focus on upstream prevention improving overall patient outcomes and reducing pressure on specialised services. In addition, this ensures that any proposed changes in specialised services are planned with interdependent local services. This could include diagnostic services, services that have a key pathway linkage or support services in health care or local authority provision.
    - **Facilitation of whole pathway transformation** across ICS footprints as new services are introduced. It will allow implementation of clinical advances as close to home as possible for patients whilst maintaining speciality capacity for when needed most.

11. An example of the benefits of delegation is set out below:

Renal Services

The need for **renal dialysis** can be reduced by ICBs focusing on identifying those at risk of developing kidney disease and its progression. New treatments are now available to delay progression which if systematically implemented should reduce population dialysis and transplantation needs.

Currently planning and delivery are separate between primary and tertiary care and more local solutions could be developed. More integrated commissioning of specialised renal services would make innovations easier by:

- The same people and organisation being responsible for commissioning both the specialised (e.g. dialysis) and non- specialised (GP led) parts of the patient pathway ensuring complete clinical joined up pathway.
- Budgets could be pooled which creates more of an incentive to prevent renal progression, promotion of home therapies to reduce transportation costs and prompt referral for renal transplantation.
- Wider service provision could be included more easily e.g. psychological and welfare support.
- Services can be tailored around the needs of local populations helping to address health inequalities.
- Those who do need specialist services will still be able to access them in line with national standards and policies.

Summary of the due diligence process

12. The 11 ICBs and NHS England worked together throughout 2023/24 through formal joint working arrangements. This has enabled ICB specialised services leads to understand and work alongside NHS England teams, making informed decisions on finance, quality, commissioning and contracting.

13. The approach to the transition process for delegation has been led through joint working groups covering finance, governance, clinical quality, strategic commissioning, and planning. This approach was informed by the design principles and operating model set by ICB CEOs.

14. The comprehensive national safe delegation checklist, which all regions utilise to provide joint ICB and NHS England assurance on deliverables for safe delegation, has guided the approach to due diligence. In addition, learning from the POD delegation, an additional process was agreed and led in the Midlands including ICB and NHS England leads. The summary due diligence reports have focussed on four key domains and have been received by the East Midlands and West Midlands Joint Committees. The due diligence domains are set out below:

    - **Quality** – understanding of the quality issues as the receiving organisations and the agreed framework for how ICBs will operate in 2024/25.
    - **Finance** – Clarity on the absolute risks and issues required for transition. Agreed position on the ICB allocations and methodology and risk share to mitigate the risks for ICBs.
    - **Resources** – staff capacity and capability over the transition year (in advance of transfer to ICB hosting in 2024/25) and the ability to meet requirements for delegation as ICBs take on the commissioning role.
    - **Benefits and opportunities** – Clarity on the benefits of proceeding with delegation in 2024 /25. This assessment must also consider the missed opportunity that may accrue through any delays to delegation.

    There has been a level assurance met against each of these domains.

15. The joint working groups have co-produced several key documents that support the delegation of these services, these include:

    - **Delegation Agreement:** Nationally mandated document setting out the formal legal requirements of delegation.

    - **Memorandum of Understanding (MoU) and Collaboration Agreement 2024/25** The MoU sets out the key principles and commitments to supporting the collaborative working model for the 11 ICBs in the Midlands and NHS England Midlands. The MOU should be read in conjunction with the formal Collaboration Agreement which is a mandated requirement of the delegation process. The Collaboration Agreement, which is between the 11 ICBs and NHS England sets out how ICBs will make joint decisions through delegation of responsibility to the existing Joint Committees in the East and West Midlands, how they will commission the services and the financial framework in which they operate including the operation of a pooled fund between the 11 ICBs to manage financial risks across the Midlands. The agreement also sets out how NHS England will work with the ICBs on services that have been identified as

suitable for future delegation but are not yet being delegated. The initial agreement is for one year in which it will be reviewed prior to further service delegation.

- **Commissioning Team Agreement and Operating Framework:** This document describes the multi-disciplinary team (finance, clinical and quality, commissioning, and support teams) who will work on behalf of the 11 ICBs and NHS England. These staff will continue to be employed by NHS England for 2024/25. The document describes who the teams are, what they do and how they work.

- **Service Portfolio Reports:** **T**hese documents have been developed regionally to ensure an appropriate baseline position related to specialised service lines including:
  - A clear understanding of the services provided within each individual ICB.
  - Organisational memory on quality issues captured, written down and communicated formally to receiving bodies.
  - Identification of the top issues/risks along with mitigating actions captured for handover.

16. The service portfolio reports will continue to be developed and subsequently form the detailed functional document to enable commissioning for ICB populations and across multi-ICBs.

Future arrangements

Decision-Making

17. Decisions relating to the 59 specialised services will be made through the Joint Committees, established through the Joint Working Agreement in operation in the East and West Midlands. Terms of Reference have been amended from the Joint Working Agreement arrangements to reflect this change. The committees have authority to establish appropriate subsidiary arrangements to support the efficient operation of those services, which will include establishing appropriate delegations to enable day-to-day decision making through sub-groups. Details of these subsidiary arrangements are summarised in the Collaboration Agreement and will be formally ratified by the Joint Committees at their first meeting after 1 April 2024 (schedule 2 – governance arrangements). The governance structure is outlined below:

18. In addition, an Operating Model Group (OMG) was established with representation from the 11 ICBs that was instrumental in informing and developing the arrangements for the delegation of specialised services. It will continue to meet on a monthly basis to ensure that systems and processes are robustly embedded.

19. **Finance Sub-group -** A Joint Finance and Contracting Sub-group reporting to the Committees that will oversee the financial framework.

20. The ICBs have agreed to establish and maintain a mutually agreed pooled fund arrangement for in-year financial management, with a defined contribution based on the allocation received for the 59 delegated specialised services which will be transferred to the host ICB, (Birmingham and Solihull ICB) on behalf of the Midlands. The details of the management of this are articulated within the Collaboration Agreement (schedule 4 – financial arrangements).

21. NHS England will commit to continue to regularly review the overall financial position and risks with ICBs and ensure the retained services and 59 acute delegated services are reviewed together.

22. **Quality Sub-group -** Quality will be overseen by the Specialised Commissioning Quality Group. The group will provide a forum for routinely and systematically bringing together partners from across ICSs and the region to share insight and intelligence in relation to quality concerns, identify opportunities for improvement and develop regional responses as required. The focus of the discussions will be on intelligence, learning, issues and risks that are recurrent and/ or have an impact wider than individual ICSs.

23. **Midlands Specialised Services Commissioning Sub-group** – A multi-disciplinary group that oversees the design, development, planning, transformation, improvement, and reduction of inequalities for the effective delivery of services.

24. During 2024/25 the ICBs and NHS England will continue to develop and share expertise through a clearly defined joint workplan to include quality, finance, commissioning and planning.

25. In line the agreed governance framework ICBs should add the following to their SFI's 'Delegated Specialised Commissioning - Decisions will be made in line with the arrangements agreed by the East/West Midlands Joint Commissioning Committee which has delegated authority to set approval limits in line with those arrangements.' It has also been suggested that the financial thresholds are included.

Conclusion

26. In summary ICBs have been jointly working with NHS England throughout 2023/24 to commission acute specialised services and gain an understanding of the risks and issues.

27. The delegation arrangements were approved by the LLR ICB Board at its meeting on 14th March 2024.

28. The Midlands ICBs will work together and receive an initial delegation of 59 Acute Specialised in 2024/25 enabling ICBs to have the benefit of learning and developing their approach in a phased manner before the full delegation of further specialised services (including mental health and learning disabilities) and immunisation and vaccination services in 2025/26.

Recommendations

The Leicester, Leicestershire and Rutland Integrated Care Board is asked to:

- **NOTE** the Acute Specialised Services Delegation Agreement (Appendix 1)
- **NOTE** the Memorandum of Understanding and Collaboration Agreement for the delegation of acute specialised services 2024/25 (Appendix 2)
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- **NOTE** the Leicester, Leicestershire and Rutland Integrated Care Board Service Profile Pack (Appendix 4)

Appendix 1

Dated 2024

(1) **NHS ENGLAND**

- and -

(2) **NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB INTEGRATED CARE BOARD**

Delegation Agreement between NHS England and NHS Leicester, Leicestershire and Rutland ICB in relation to Specialised Commissioning Functions

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DELEGATION AGREEMENT FOR SPECIFIED FUNCTIONS

1. PARTICULARS

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

Integrated Care Board	NHS Leicester, Leicestershire and Rutland ICB
Area	Leicester, Leicestershire and Rutland
Date of Agreement	[Date]
ICB Representative	[Insert details of name of manager of this Agreement for the ICB]
ICB Email Address for Notices	[Insert Address]
NHS England Representative	Dale Bywater, Regional Director (Midlands)
NHS England Email Address for Notices	england.midlandscorporate@nhs.net

1.2 This Agreement comprises:

1.2.1 the Particulars (Clause 1);

1.2.2 the Terms and Conditions (Clauses 2 to 31);

1.2.3 the Schedules; and

1.2.4 the Mandated Guidance

Signed by **NHS England**

DALE BYWATER

REGIONAL DIRECTOR - MIDLANDS

(for and on behalf of NHS England)

Signed by **NHS Leicester, Leicestershire and Rutland Integrated Care Board**

[Insert name of Authorised Signatory]

[Insert title of Authorised Signatory]

[for and on behalf of] NHS Leicester, Leicestershire and Rutland Integrated Care Board

TERMS AND CONDITIONS

2. INTERPRETATION

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

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

2.2.1 the Developmental Arrangements;

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

2.2.3 Mandated Guidance;

2.2.4 all Schedules excluding Developmental Arrangements and Local Terms; and

2.2.5 Local Terms.

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

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

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

3. BACKGROUND

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

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

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

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

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

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

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

4. TERM

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

5. PRINCIPLES

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

5.1.1 at all times have regard to the Triple Aim;

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

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

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

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

5.1.6 act in a timely manner;

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

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

6. DELEGATION

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

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

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

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

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

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

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

7. EXERCISE OF DELEGATED FUNCTIONS

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

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

7.2.1 the terms of this Agreement;

7.2.2 Mandated Guidance;

7.2.3 any Contractual Notices;

7.2.4 the Local Terms;

7.2.5 any Developmental Arrangements;

7.2.6 all applicable Law and Guidance;

7.2.7 the ICB's constitution;

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

7.2.9 Good Practice.

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

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

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

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

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

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

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

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

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

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

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

8. REQUIREMENT FOR ICB COLLABORATION ARRANGEMENT

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

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

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

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

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

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

8.4.3 provisions for independent scrutiny of decision making;

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

8.4.5 the Delegated Services which are subject to the arrangements;

8.4.6 financial arrangements and any pooled fund arrangements;

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

8.4.8 terms of reference for decision making; and

8.4.9 limits on onward delegation.

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

9. PERFORMANCE OF THE RESERVED FUNCTIONS AND COMMISSIONING SUPPORT ARRANGEMENTS

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

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

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

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

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

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

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

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

10. FINANCE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10.8 NHS England may in respect of the Delegated Funds:

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

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

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

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

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

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

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

10.12.2 any NHS payment scheme published by NHS England;

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

10.12.4 any Capital Investment Guidance;

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

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

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

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

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

Pooled Funds

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

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

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

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

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

10.15.1 the agreed aims and outcomes of the arrangements;

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

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

10.15.4 the Delegated Services which are subject to the arrangements;

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

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

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

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

11. INFORMATION, PLANNING AND REPORTING

11.1 The ICB must provide to NHS England:

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

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

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

Forward Plan and Annual Report

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

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

Risk Register

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

12. FURTHER ARRANGEMENTS

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

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

12.3 The approval of any Further Arrangements may:

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

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

12.4 All Further Arrangements must be made in writing.

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

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

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

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

13. STAFFING, WORKFORCE AND COMMISSIONING TEAMS

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

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

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

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

14. BREACH

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

14.1.1 exercise its rights under this Agreement; and

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

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

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

14.2.2 ratify any decision in accordance with Clause 6.5;

14.2.3 substitute a decision in accordance with Clause 6.6;

14.2.4 amend Developmental Arrangements or impose new Developmental Arrangements;

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

14.2.6 exercise the Escalation Rights in accordance with Clause 15 *(Escalation Rights)*; and/or

14.2.7 exercise its rights under common law.

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

14.4 If:

14.4.1 the ICB does not comply with this Agreement;

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

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

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

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

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

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

15. ESCALATION RIGHTS

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

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

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

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

15.3 Nothing in Clause 15 *(Escalation Rights)* will affect NHS England's right to substitute a decision in accordance with Clause 6.6, revoke the Delegation or terminate this Agreement in accordance with Clause 27 *(Termination)* below.

16. LIABILITY AND INDEMNITY

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

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

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

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

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

17. CLAIMS AND LITIGATION

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

17.2 Except in the circumstances set out in Clause 17.5 and subject always to compliance with this Clause 17 *(Claims and Litigation)*, the ICB shall be responsible for and shall retain the conduct of any Claim.

17.3 The ICB must:

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

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

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

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

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

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

NHS England Stepping into Claims

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

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

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

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

Claim Losses

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

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

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

18. DATA PROTECTION, FREEDOM OF INFORMATION AND TRANSPARENCY

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

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

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

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

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

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

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

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

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

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

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

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

19. IT INTER-OPERABILITY

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

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

20. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY

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

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

21. PROHIBITED ACTS AND COUNTER-FRAUD

21.1 The ICB must not commit any Prohibited Act.

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

21.2.1 to revoke the Delegation;

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

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

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

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

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

21.6 The ICB must, on becoming aware of:

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

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

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

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

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

21.7.2 all Staff who may have information to provide.

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

22. CONFIDENTIAL INFORMATION OF THE PARTIES

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

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

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

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

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

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

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

22.3.2 in connection with any litigation between the Parties;

22.3.3 to comply with the Law;

22.3.4 to any appropriate Regulatory or Supervisory Body;

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

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

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

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

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

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

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

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

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

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

22.7 This Clause 22 will survive the termination of this Agreement for any reason for a period of five (5) years.

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

23. INTELLECTUAL PROPERTY

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

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

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

24. NOTICES

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

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

25. DISPUTES

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

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

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

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

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

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

26. VARIATIONS

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

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

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

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

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

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

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

26.3 Where NHS England wishes to vary the Agreement in accordance with Clause 26.2 it must notice in writing to the ICB of the wording of the proposed variation and the date on which that variation is to take effect which must, unless it is not reasonably

practicable, be a date which falls at least thirty (30) Operational Days after the date on which the notice under that clause is given to the ICB.

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

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

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

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

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

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

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

26.7.1 that it accepts the Variation Proposal; or

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

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

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

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

27. TERMINATION

27.1 The ICB may:

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

27.1.2 terminate this Agreement;

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

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

27.1.4 the ICB meets with NHS England within ten (10) Operational Days of NHS England receiving the notice set out at Clause 27.1.3 above to discuss arrangements for termination and transition of the Delegated Functions to a successor commissioner in accordance with Clause 28.2; and

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

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

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

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

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

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

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

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

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

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

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

27.3.8 the ICB merges with another ICB or other body.

27.4 This Agreement will terminate upon revocation or termination of the full Delegation (including revocation and termination in accordance with this Clause 27 *(Termination)*) except that the provisions referred to in Clause 29 (*Provisions Surviving Termination*) will continue in full force and effect.

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

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

28. CONSEQUENCE OF TERMINATION

28.1 Termination of this Agreement, or termination of the ICB's exercise of any of the Delegated Functions, will not affect any rights or liabilities of the Parties that have accrued before the date of that termination or which later accrue in respect of the term of this Agreement. For the avoidance of doubt, the ICB shall be responsible for any Claims or other costs or liabilities incurred in the exercise of the Delegated Functions during the period of this Agreement unless expressly agreed otherwise by NHS England.

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

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

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

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

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

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

28.3.2 at the reasonable request of NHS England:

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

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

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

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

29. PROVISIONS SURVIVING TERMINATION

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

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

29.2.1 Clause 10 (*Finance*);

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

29.2.3 Clause 16 *(Liability and Indemnity*);

29.2.4 Clause 17 (*Claims and Litigation*);

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

29.2.6 Clause 25 (*Disputes*);

29.2.7 Clause 27 (*Termination*);

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

30. COSTS

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

31. SEVERABILITY

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

32. GENERAL

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

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

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

SCHEDULE 1: Definitions and Interpretation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"IPR"	means intellectual property rights and includes inventions, copyright, patents, database right, trademarks, designs and confidential know-how and any similar rights anywhere in the world whether registered or not, including applications and the right to apply for any such rights;
"Law"	means any applicable law, statute, rule, bye-law, regulation, direction, order, regulatory policy, guidance or code, rule of court or directives or requirements of any regulatory body, delegated or subordinate legislation or notice of any regulatory body (including any Regulatory or Supervisory Body);
"Local Terms"	means the terms set out in Schedule 8 *(Local Terms)* and/or such other Schedule or part thereof as designated as Local Terms;
"Losses"	means all damages, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services) proceedings, demands and charges whether arising under statute, contract or common law;
"Managing Conflicts of Interest in the NHS"	the NHS publication by that name available at: https://www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-guidance-for-staff-and-organisations/ ;
"Mandated Guidance"	means any protocol, policy, guidance, guidelines, framework or manual relating to the exercise of the Delegated Functions and issued by NHS England to the ICB as Mandated Guidance from time to time, in accordance with Clause 7.5 which at the Effective Date of Delegation shall include the Mandated Guidance set out in Schedule 7;
"National Commissioning Group (NCG)"	means the advisory forum in respect of the Retained Services currently known as the National Commissioning Group for Specialised, Health and Justice and Armed Forces Services;
"National Standards"	means the service standards for each Specialised Service, as set by NHS England and included in Clinical Commissioning Policies or National Specifications;
"National Specifications"	the service specifications published by NHS England in respect of Specialised Services;
"Need to Know"	has the meaning set out in paragraph 1.2 of Schedule 6 (*Further Information Governance and Sharing Provisions)*;
"NICE Regulations"	means the National Institute for Health and Care Excellence (Constitution and Functions) and the Health and Social Care Information Centre (Functions) Regulations 2013 as amended or replaced;
"NHS Act"	means the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022 and other legislation from time to time);

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

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

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

"Specified Purpose"	means the purpose for which the Relevant Information is shared and processed, being to facilitate the exercise of the ICB's Delegated Functions and NHS England's Reserved Functions as specified in paragraph 2.1 of Schedule 6 *(Further Information Governance and Sharing Provisions)* to this Agreement;
"Staff or Staffing"	means the Parties' employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of either Party (whether or not the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors' and their sub-contractors' personnel;
"Sub-Delegate"	shall have the meaning in Clause 12.2;
"System Quality Group"	means a group set up to identify and manage concerns across the local system. The system quality group shall act as a strategic forum at which partners from across the local health and social care footprint can share issues and risk information to inform response and management, identify and mitigate quality risks and concerns as well as share learning and best practice;
"Triple Aim"	means the duty to have regard to wider effect of decisions, which is placed on each of the Parties under section 13NA (as regards NHS England) and section 14Z43 (as regards the ICB) of the NHS Act;
"UK GDPR"	means Regulation (EU) 2016/679 of the European Parliament and of the Council of 27th April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018;
"Variation Proposal"	means a written proposal for a variation to the Agreement, which complies with the requirements of Clause 26.5.

SCHEDULE 2: Delegated Services

Delegated Services

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

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

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

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

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

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

SCHEDULE 3: Delegated Functions

1 Introduction

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

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

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

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

1.1.4 supporting the management of the Specialised Commissioning Budget;

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

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

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

2 General Obligations

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

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

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

Specific Obligations

3 Assurance and Oversight

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

3.1.1 the Oversight Framework published by NHS England;

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

3.1.3 any other relevant NHS oversight and assurance guidance;

collectively known as the “Assurance Processes”.

3.2 The ICB must:

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

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

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

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

4 Attendance at governance meetings

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

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

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

5 Clinical Leadership and Clinical Reference Groups

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

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

6 Clinical Networks

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

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

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

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

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

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

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

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

7 Complaints

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

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

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

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

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

7.3.2.1 acknowledgements provided within three (3) Operational Days;

7.3.2.2 responses provided within forty (40) Operational Days;

7.3.2.3 response not provided within six (6) months;

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

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

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

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

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

8 Commissioning and optimisation of High Cost Drugs

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

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

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

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

8.5 The ICB must ensure:

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

8.5.2 effective introduction of new medicines;

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

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

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

8.5.6 consistency of prescribing and unwarranted prescribing variation are addressed.

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

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

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

9 Contracting

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

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

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

9.1.3 management of Specialised Services Contracts.

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

10 Data Management and Analytics

10.1 The ICB shall:

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

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

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

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

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

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

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

11 Finance

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

12 Freedom of Information and Parliamentary Requests

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

13 Incident Response and Management

13.1 The ICB shall:

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

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

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

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

14 Individual Funding Requests

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

15 Innovation and New Treatments

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

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

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

17 Provider Selection and Procurement

17.1 The ICB shall:

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

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

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

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

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

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

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

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

17.3.3 made transparently; and

17.3.4 compliant with relevant Guidance and legislation.

18 Quality

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

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

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

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

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

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

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

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

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

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

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

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

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

19 Service Planning and Strategic Priorities

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

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

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

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

20 National Standards, National Specifications and Clinical Commissioning Policies

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

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

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

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

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

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

21 Transformation

21.1 The ICB shall:

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

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

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

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

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

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

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

SCHEDULE 4: Reserved Functions

Introduction

1. Reserved Functions in Relation to the Delegated Services

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

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

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

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

2. Retained Services

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

3. Reserved Specialised Service Functions

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

Reserved Functions

4. Assurance and Oversight

4.1. NHS England shall:

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

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

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

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

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

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

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

5. Attendance at governance meetings

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

5.2. NHS England shall:

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

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

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

6. Clinical Leadership and Clinical Reference Groups

6.1. NHS England shall be responsible for the following:

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

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

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

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

6.2.1. Clinical Commissioning Policies;

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

7. Clinical Networks

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

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

7.3. NHS England shall be responsible for:

7.3.1. developing national policy for the Relevant Clinical Networks;

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

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

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

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

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

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

8. Complaints

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

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

9. Commissioning and optimisation of High Cost Drugs

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

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

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

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

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

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

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

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

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

10. Contracting

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

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

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

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

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

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

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

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

11. Data Management and Analytics

11.1. NHS England shall:

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

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

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

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

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

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

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

12. Finance

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

13. Freedom of Information and Parliamentary Requests

13.1. NHS England shall:

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

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

14. Incident Response and Management

14.1. NHS England shall:

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

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

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

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

15. Individual Funding Requests

15.1. NHS England shall be responsible for:

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

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

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

16. Innovation and New Treatments

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

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

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

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

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

18. Provider Selection and Procurement

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

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

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

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

19. Quality

19.1. In respect of quality, NHS England shall:

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

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

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

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

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

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

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

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

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

20. National Standards, National Specifications and Clinical Commissioning Policies

20.1. NHS England shall carry out:

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

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

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

20.1.4. determination of content for national clinical registries.

21. Transformation

21.1. NHS England shall be responsible for:

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

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

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

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

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

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

SCHEDULE 5: Retained Services

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

SCHEDULE 6: Further Information Governance And Sharing Provisions

PART 1

1. Introduction

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

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

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

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

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

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

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

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

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

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

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

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

2. Purpose

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

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

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

3. Benefits of information sharing

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

4. Lawful basis for sharing

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

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

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

5. Restrictions on use of the Shared Information

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

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

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

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

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

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

6. Ensuring fairness to the Data Subject

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

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

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

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

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

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

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

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

7. Governance: Staff

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

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

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

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

7.5. The Parties shall ensure that:

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

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

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

8. Governance: Protection of Personal Data

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

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

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

8.4. If any Party becomes aware of:

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

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

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

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

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

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

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

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

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

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

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

8.7. In particular, each Party shall:

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

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

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

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

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

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

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

8.10. The Parties' Single Points of Contact set out in paragraph 13 will be the persons who, in the first instance, will have oversight of third party security measures.

9. Governance: Transmission of Information between the Parties

9.1. This paragraph supplements paragraph 8 of this Schedule.

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

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

accordance with good information governance and clinical safety practice, so as to ensure that the correct patient record and/or data is identified.

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

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

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

10. Governance: Quality of Information

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

11. Governance: Retention and Disposal of Shared Information

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

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

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

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

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

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

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

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

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

12. Governance: Complaints and Access to Personal Data

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

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

12.3. The Parties shall use all reasonable endeavours to work together to resolve any dispute or complaint arising under this Schedule or any data processing carried out further to it.

12.4. Basic details of the Agreement shall be included in the appropriate log under each Party's publication scheme.

13. Governance: Single Points of Contact

13.1. The Parties each shall appoint a Single Point of Contact to whom all queries relating to the particular information sharing should be directed in the first instance.

14. Monitoring and review

14.1. The Parties shall monitor and review on an ongoing basis the sharing of Relevant Information to ensure compliance with Data Protection Legislation and best practice. Specific monitoring requirements must be set out in the relevant Data Sharing Agreement.

SCHEDULE 7: Mandated Guidance

Generally applicable Mandated Guidance

- National Guidance on System Quality Groups.
- Managing Conflicts of Interest in the NHS.
- Arrangements for Delegation and Joint Exercise of Statutory Functions.
- Guidance relating to procurement and provider selection.
- Information Governance Guidance relating to serious incidents.
- All other applicable IG and Data Protection Guidance.
- Any applicable Freedom of Information protocols.
- Any applicable Guidance on Counter Fraud, including from The NHS Counter Fraud Authority.
- Any applicable Guidance relating to the use of data and data sets for reporting.
- Guidance relating to the processes for making and handling individual funding requests, including:
    - Commissioning policy: Individual funding requests;
    - Standard operating procedures: Individual funding requests.

Workforce

- Guidance on the Employment Commitment.

Finance

- Guidance on NHS System Capital Envelopes.
- Managing Public Money (HM Treasury).

Specialised Services Mandated Guidance

- Commissioning Change Management Business Rules.
- Cashflow Standard Operating Procedure.
- Finance and Accounting Standard Operating Procedure.
- Provider Collaborative Guidance.
- Clinical Commissioning Policies.
- National Specifications.
- National Standards.
- The Prescribed Specialised Services Manual

SCHEDULE 8: Local Terms

None – local terms are described as part of the Collaboration Agreement and Operating Framework which includes a pooled budget established by the ICBs

General

Where there is a Dispute as to the content of this Schedule, the Parties should follow the Disputes procedure set out at Clause 25.

Following signature of the Agreement, this Schedule can be amended by the Parties using the Variations procedure at Clause 26.

NHS England can amend this Schedule without the ICB's consent by using the variation procedure set out in Clause 26.2 but the expectation is that variations should be by consent.

SCHEDULE 9: Developmental Arrangements

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

The Developmental Arrangements

The following Developmental Arrangements apply to this Agreement:

Finance
Ringfencing – Delegated specialised commissioning allocations will be ringfenced to be spent only on specialised commissioning services. This includes reserves and discretionary growth funding as well as existing contractual spend, both block and variable elements. This does not determine which specialised services those allocations are spent on. Any variation of this condition would need to be to be approved by the regional Director of Commissioning or Director of Finance.

Review
Review and removal of the delegation arrangement is the responsibility of the Regional Director of Finance and Regional Director of Commissioning Integration. This will be carried out based on the regional and individual ICB financial position and following and agreed assurance process.

SCHEDULE 10: Administrative and Management Services

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Appendix 2

Memorandum of Understanding
&
Collaboration Agreement
For the Delegation of Acute Specialised Services
2024-2025

Memorandum of Understanding (MoU)
Delegation of Acute Specialised Services
2024-2025

1.0 Introduction

This Memorandum of Understanding (MoU) sets out the key principles and commitments to supporting the collaborative working model for the 11 ICBs in the Midlands and NHSE Midlands.

The MOU covers the year 2024-25 and is referred to as the transitional year. In this year 59 Acute Specialised Service Lines will be formally delegated (Subject to Board Approval). The MOU should be read in conjunction with the formal Collaboration Agreement which is a mandated requirement of the delegation process.

The Midlands are committed to working together to achieve best outcomes promoting pathway integration and parity of access to drive improvements in population health.

Our aim in this transitional year is to set out the practical ways in which we will work together to mitigate any potential risks and issues and to develop a strong operating model for the future.

2.0 Principles

This MOU is a statement based on principles of co-operation between all organisations including:

- To build strong relationships and an environment based on trust and collaboration.
- To seek to continually improve whole pathways of care and to design and implement effective and efficient integration.
- To share information and best practice and work together to identify solutions, eliminate duplication of effort, mitigate risks, and promote value.
- To have regard to each other's needs and views
- To work within the intentions set out within the Delegation Agreement.
- To commit to continue to work together during 2024/25 to build on the foundation from statutory joint working and learn lessons from previous delegation.

3.0 Responsibilities and Accountabilities

The delegation of specialised commissioning does not change the accountability of the services lines and functions remaining with NHS England.

Upon delegation the services become the responsibility of the 11 Midlands ICBs who are required to commit to working together to commission these services. NHSE remains a partner in this process and is also responsible for the commissioning of retained specialised services.

ICB responsibilities for the delegated services are as follows:

- All delivery is conducted in the name of the ICB, and legal liabilities are the ICBs.
- Decisions in relation to the commissioning and management of the delegated services
- Planning delegated services for the population, including carrying out needs assessments
- Undertaking reviews of delegated services in respect of the population
- Supporting the management of the specialised commissioning budget for delegated services

- Co-ordinating a common approach to the commissioning and delivery of delegated services with other health and social care bodies in respect of the population where appropriate

NHSE accountabilities and responsibilities for the delegated services are as follows:

- Remains politically accountable to the Secretary of State and parliament, although not directly legally responsible for any shortcomings or delivery failures.
- Has continued responsibilities to support the ICBs in their delegated responsibilities providing guidance and expertise.
- NHSE could be subject to judicial review and challenge.

Joint consideration will be given to the development of a future concordat to underpin future joint working arrangements from 2025/26.

4.0 Pre delegation assurance requirements

A robust programme of work has been underway (jointly managed between NHSE and the ICBs) throughout the year to oversee the delegation of services from April 2024.
Over and above, this work it was agreed that additional due diligence requirements would be enacted to ensure ICBs have all the necessary assurance to allow them to sign off at ICB Boards in March 2024. These include the following:

- **Sender /Receiver Summary report -** One of the key documents to be produced will be a summary of the safe delegation checklist report completed by NHSE (as the sender organisation) approved by the joint working groups summarising the following:
    - Performance – activity /waiting lists against trajectory /improvement plans.
    - Contracts – outstanding issues/disputes
    - Procurements
    - Operational work programme
    - Risk register and mitigations
    - Corporate – complaints /litigations/FoIs
    - Finance – investment /cases
    - Responsibilities around high-cost drugs and devices

- **Service Profiles** – including assessment of quality and fragile services by ICB. This report will be available prior to Board sign off and updated for April 2024.
- **Finance** – Risk managed through a Pooled Fund approach between ICBs in 2024/25, working closely with NHSE to manage the overall financial position of specialised services recognising differential growth between retained and delegated services.
- **Quality Assurance Framework** – outlines the transitional arrangements for quality assurance responsibilities.
- **Benefits of delegation** – set out the practical examples of the benefits of delegation for patients.

Note: current ICB performance analysis already includes specialised activity data

5.0 Working arrangements of the teams /functions in 2024/25

The Specialised Services Standard Operating Framework sets out who the Midlands Specialised Commissioning team are and how they will operate.
This team is committed to the following:

- Agreeing individual joint priorities recognising the breadth of commissioning responsibility for delegated and retained functions. The Director posts will have a single set of priorities on behalf of the 11 ICBs and NHSE.

- Delivering an agreed work plan for the actions agreed for delegated services and retained services.
- Improving specialised services health inequalities through delivering recommendations in the health inequalities strategy.

The team will progress:

- New approaches to working with ICB colleagues to ensure a shared leadership model and learning to enable expertise in specialised services, and system expertise to be combined to improve outcomes.
- Full engagement in joint development opportunities to ensure that the experience across Programmes of Care is maximised and opportunities to drive value are realised.
- Explore ways to further support the staff through the transitional year to maintain the workforce.
- Develop new ways of working during the transition year to reflect the changing environment.

In the transitional year, executive and operational leadership for the Operating Framework will be through:

- A Specialised Services Executive Group (including the East and West ICB CEO Strategic Leads for Specialised Commissioning and the NHSE Regional Director of Commissioning Integration
- A multi-professional Specialised Services Senior Leadership Team function including input from Midlands Specialised Commissioning and East and West ICB professional executive leads.

Recognising 2024/25 as a transitional year prior to delegation of further services, the Operating Model Working Group (OMG) will be responsible for the joint planning for this next phase of delegation, with assurance and escalation through the joint Delegation and Transfer Programme Board and direction from the ICB CEOs/NHSE development sessions.

Decision making will be through ICB Boards and the NHSE Regional Support Group. Connectivity between the current and future agendas will be ensured through the Specialised Executive Group and reports to the Joint Committees.

6.0 Finance and Governance

Formal governance will be through the East and West Midlands Joint Committees who will formally stand-up a sub-group of the committees, these being:

- Midlands Acute Specialised Services Group – Commissioning including Planning Development, Transformation, and Reducing Inequalities
- Finance and Contracting Group – Financial Management and Financial Planning
- Specialised Commissioning Quality Group – Quality Oversight and Assurance

In addition, advisory groups including, the Collaborative Clinical Executive Group will provide clinically lead transformation and improvement advice guidance and recommendations for pathway re-design.

To ensure the integrated planning and decision making around the needs of the Midlands populations, these forums will consider NHSE Midlands retained functions as well as delegated functions; however, decision making for retained functions will be through the Midlands Commissioning Group and / or National Commissioning Group, as appropriate.
The Director of Specialised Commissioning will represent the perspectives of the East and West Midlands Joint Committees at the national NHSE Delegated Commissioning Group.

Finance
During the transitional year it is recognised that the management of financial risks across all ICBs will be mitigated through working with NHSE through several routes:

- Pooled fund arrangements

The ICBs will establish and maintain a mutually agreed pooled fund arrangement for in-year financial management, with a defined contribution based on the allocation received for the 59 delegated specialised services being transferred to the Host ICB, (Birmingham & Solihull ICB) on behalf of the Midlands. The detail of the management of this will be articulated in detail within the Collaboration Agreement.

- Joint contractual meetings

There will be close working relationships across NHSE/ICBs with the aim to have a single contractual meeting with providers to understand the whole position.

The specialised services contracts are operated on a block basis – for the elements of the contracts covered by the block, commissioners will have no financial exposure to activity variance. In 24/25 Elective activity is managed through the Elective Recovery Fund which will be managed on the same basis as 2023/24 with contract values and allocations being adjusted for activity variances. There will be no financial risk to commissioners associated with the application of ERF.

There are a small number of variable services (linked to Best Practice Tariffs) within the contract, these being:

- Chemotherapy
- Diagnostic Imaging
- Nuclear Medicine
- PRT-CT
- Molecular Radiotherapy
- Renal Transplant

These services are paid on a cost per case basis. Opening baselines for variable services will be based on 2023/24 outturn with growth applied based on historic activity.

There remains a potential risk at an ICB and regional level of variance against contract and budget for these services. A contingency of 0.5% will be held in the Pooled budget to manage in year financial risk to mitigate the impact of variable service financial risks.
NHSE will commit to continue to regularly review in partnership with ICBs the overall financial position and risks and ensure the retained /59 acute services are reviewed together.

Data protection – to support and enable the appropriate sharing of information and data to facilitate joint working a DPIA will be approved and signed by each ICB in March 2024 which will be supported by and included in a dedicated schedule within the Collaboration Agreement

Complaints and FoI – All complaints received (on average circa 5-7 per annum across the whole Specialised portfolio including retained services) are managed by the Head of Services with input from subject matter experts with clinical and quality review. Complaints will continue to be managed in this way for ICB and NHSE during 2024/25, with reports to the Tier 2 subgroups. Both the FoI and complaints process will be detailed in the Commissioning Team Agreement and Operating Framework for 2024/25.

The Midlands Specialised Commissioning Team will operate on behalf of all the 11 ICBs and NHSE. It is recognised that relationships and new ways of working will take time to develop but there is a commitment to increasing focus towards and with systems, ensuring increasing shared ownership, access to subject matter expertise and, wherever possible. reducing points of contact for systems and providers. Any changes and/or recruitment will be jointly agreed and coordinated through the joint leadership team.

The Specialised Services Networks are a Midlands resource, whose work plans, reflecting operational and strategic priorities, will be agreed through the Collaborative Clinical Executive and MASCG on behalf of the Joint Committees. The funding/resources for these networks remains with NHSE and will not be delegated to ICBs in 2024/25.
The Specialised Clinical Services Strategy will inform the 2025/26 specialised services operational plan and the priorities for transformational activity. It is currently being jointly developed and is scheduled for completion by the end of Qtr. 2. The Clinical Services Strategy will be agreed through formal governance and subject to final approval by the Joint Committees.

7.0 Development plan

It is recognised that over and above the due diligence requirements put in place to support the delegation process we will commit to putting in place a development plan for 2024/25.

This will clearly set out the key deliverables agreed between ICBs and NHSE to further develop a robust operating model.
The development plan will be initiated and developed through executive and operational working sessions planned from April 2024.

This will be developed further.

Priority Objectives	Commitments to date	Joint SROs
Culture / OD – team development	Develop joint OD plans Collaborative recruitment	Karen Helliwell, Sarah Prema, Alison Kemp
Clinical Strategy	Clinical Networks Agreed clinical strategy and action plan Clinical benefits and outcomes	Clara Day. Nilesh Sanganee, Colette Marshall
Contracting	Integrated performance reporting Integrated commissioning intentions for 2025/26 Integrated contracting a	Ali Kemp, East and West rep leads to be confirmed
Finance	Analysis of impact of differential local pricing in spec com contracts. Reconciliation of Trust cost base between core and specialised services. Impact of needs-based allocations and convergence from 2025/26.	Madi Parmer, Jon Cooke, East CFO To be confirmed

8.0 Assurance

A national assurance framework has been developed and published that provides an approach to assurance that will minimise significant additional contacts and maximise existing NHSE assurance arrangements. ICBs will be requested to self-assess aspects of delivery of specialised provision. The collaborative agreement however sets out how integrated working will be delivered in 2024/25 and ensure that risk is jointly understood, and mitigation is managed through agreed governance.

9.0 Review process during 2024/25

This MoU and Collaboration Agreement will be subject to quarterly review within the ICB CEO Time Out Sessions and reported to Joint Committees.
A formal review will be coproduced and progressed in Q3/402024/25 in preparation for revised agreements, including further delegations, in advance of 2025/26.
There is a commitment to a formal post transactions review in 2026/27

END

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THIS AGREEMENT is made on the first day of April 2024

BETWEEN:

(1) **NHS Lincolnshire Integrated Care Board** of Bridge House, The Point, Lions Way, Sleaford, NG34 8GG ("Lincolnshire ICB"); and

(2) **NHS Nottingham & Nottinghamshire Integrated Care Board** of Sir John Robinson House, Sir John Robinson Way, Arnold, Nottingham, NG5 6DA ("Nottingham & Nottinghamshire ICB"); and

(3) **NHS Leicester, Leicestershire & Rutland Integrated Care** Board of Room G30, Pen Lloyd Building, County Hall, Glenfield, Leicester, LE3 8TB ("Leicester, Leicestershire & Rutland ICB"); and

(4) **NHS Northamptonshire Integrated Care Board** of Francis Crick House, 6 Summerhouse Road, Northampton, Northamptonshire, NN3 6BF ("Northamptonshire ICB"); and

(5) **NHS Derby & Derbyshire Integrated Care Board** of Cardinal Square, 10 Nottingham Road, Derby, Derbyshire, DE1 3QT ("Derby & Derbyshire ICB"). **NHS Lincolnshire Integrated Care Board** of Bridge House, The Point, Lions Way, Sleaford, NG34 8GG ("Lincolnshire ICB"); and

(6) **NHS Birmingham & Solihull Integrated Care Board** of First Floor, Wesleyan, Colmore Circus, Birmingham, B4 6AR ("Birmingham & Solihull ICB"); and

(7) **NHS Black Country Integrated Care Board** of Civic Centre, St Peters Square, Wolverhampton WV1 1SD ("Black Country ICB"); and

(8) **NHS Herefordshire & Worcestershire Integrated Care Board** of Kirkham House, John Comyn Drive, Perdiswell, Worcester, WR3 7NS ("Herefordshire & Worcestershire ICB"); and

(9) **NHS Coventry & Warwickshire Integrated Care Board** of Westgate House, Market St, Warwick CV34 4DE ("Coventry & Warwickshire ICB"); and

(10) **NHS Shropshire, Telford & Wrekin Integrated Care Board** of Halesfield 6, Halesfield, Telford, TF7 4BF ("Shropshire, Telford & Wrekin ICB"); and

(11) **NHS Staffordshire & Stoke-on-Trent Integrated Care Board** of Winton House, Stoke Road, Stoke-on-Trent ST4 2RW ("Staffordshire & Stoke-on-Trent ICB"); and

(12) **NHS England** of Quarry House, Quarry Hill, Leeds, LS2 7UE (acting under the name NHS England) (**"NHS England"**).

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

Lincolnshire ICB, Nottingham & Nottinghamshire ICB, Leicester, Leicestershire & Rutland ICB, Northamptonshire ICB, Derby & Derbyshire ICB, Birmingham & Solihull ICB, Black Country ICB, Herefordshire & Worcestershire ICB, Coventry & Warwickshire ICB, Shropshire, Telford & Wrekin ICB and Staffordshire & Stoke-on-Trent ICB are together referred to in this Agreement as the "ICBs", and "ICB" shall mean any of them.

BACKGROUND

(A) NHS England has statutory functions to make arrangements for the provision of prescribed services for the purposes of the NHS.

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

(C) Pursuant to section 65Z5 of the NHS Act, NHS England and the ICBs can establish and maintain joint arrangements in respect of the discharge of their Commissioning Functions.

(D) Under the Delegation Agreement made pursuant to section 65Z5, NHS England has delegated the Delegated Functions to each of the ICBs. NHS England has retained responsibility for the NHS England Reserved Functions and commissioning of the Retained Services.

(E) It is agreed that to exercise the Delegated Functions in the most efficient and effective manner, some of the Delegated Services are best commissioned collaboratively between multiple ICBs.

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

NOW IT IS HEREBY AGREED as follows:

1. COMMENCEMENT AND DURATION

1.1 This Agreement has effect from the date of this Agreement and will remain in force unless terminated in accordance with Clause 23 (*Termination & Default)* below.

2. PRINCIPLES AND AIMS

2.1 The Partners acknowledge that, in exercising their obligations under this Agreement, each Partner must comply with the statutory duties set out in the NHS Act and must:

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

2.1.2 consider how, in performing its obligations, it can address health inequalities;

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

2.1.4 act always in good faith towards each other.

2.2 The Partners agree:

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

2.2.2 to seek to continually improve whole pathways of care including Specialised Services and to design and implement effective and efficient integration;

2.2.3 to act in a timely manner;

2.2.4 to share information and best practice, and work collaboratively to identify solutions, eliminate duplication of effort, mitigate risks, and reduce cost;

2.2.5 to act at all times, ensure the Partners comply with the requirements of the Delegation Agreements including Mandated Guidance;

2.2.6 to act at all times in accordance with the scope of their statutory powers; and

2.2.7 to have regard to each other's needs and views, irrespective of the relative contributions of the Partners to the commissioning of any Services and, as far as is reasonably practicable, take such needs and views into account.

2.3 The Partners' aims are:

2.3.1 to maximise the benefits to patients of integrating the Delegated Functions with the ICBs' Commissioning Functions through

designing and commissioning the Specialised Services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim;

3. SCOPE OF THE ARRANGEMENTS

3.1 This Agreement sets out the Joint Working Arrangements through which the Partners will work together to commission Services. This may include one or more of the following commissioning mechanisms (the "Flexibilities") although this list is not exhaustive:

3.1.1 Lead Commissioning Arrangements: where agreed Commissioning Functions are delegated to a lead Partner (Lead Partner);

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

3.1.3 Joint Commissioning Arrangements: where the Partners exercise agreed Commissioning Functions jointly;

3.1.4 the establishment of one or more Joint Committees;

3.1.5 the establishment of one or more Commissioning Teams;

3.1.6 the establishment of one or more Pooled Funds;

3.1.7 the use of one or more Non-Pooled Fund.

3.2 At the Commencement Date the Partners agree that the following Joint Working Arrangements shall be in place:

3.2.1 Delegation by NHS England of the Delegated Functions to each individual ICB in accordance with the relevant Delegation Agreement.

3.2.2 Establishment of the following Joint Working Arrangements:

- Establishment of a Commissioning Team in accordance with Clause 5.1 through which agreed Delegated Services may be commissioned [as set out in the Commissioning Team Agreement and Standard Operating Framework];
- Delegation of responsibilities by the ICBs to the two Joint Committees for the East and West Midlands established under existing multi-ICB Joint Working Agreements;
- Approval of the three schemes for the commissioning of delegated specialised services for the East and West Midlands multi-ICBs and for the collaborative commissioning of retained services as set out in Schedule 3;
- Establishment of financial risk share and pooled budget arrangement as set out in Schedule 4.

4. FUNCTIONS

4.1 The purpose of this Agreement is to establish a framework through which the Partners can secure the commissioning of health services in accordance with the terms of this Agreement.

4.2 This Agreement shall include such Commissioning Functions as shall be agreed from time to time by the Partners and set out in the relevant Scheme Specifications.

4.3 The Scheme Specifications for the Individual Schemes included as part of this Agreement at the Commencement Date are set out in Schedule 3.

4.4 Where the Partners add a new Individual Scheme to this Agreement, a Scheme Specification for each Individual Scheme shall be completed and approved by each Partner in accordance with the variation procedure set out in Clause 13 (*Variations*).

4.5 The Partners shall work in co-operation and shall endeavour to ensure that all Services are commissioned with all due skill, care and attention irrespective of the Joint Working Arrangements utilised.

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

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

4.6.2 endeavour to ensure that all Commissioning Functions included in the relevant Individual Scheme are funded as agreed by each Partner in respect of each Financial Year;

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

4.6.4 perform all commissioning obligations with all due skill, care and attention;

4.6.5 undertake performance management and contract monitoring of all service contracts including (without limitation) the use of contract notices where Services fail to deliver contracted requirements;

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

4.6.7 keep the other Partner(s) regularly informed of the effectiveness of the Joint Working Arrangements including any forecasted Overspend or Underspend where there is a Pooled Fund or Non-Pooled Fund.

5. COMMISSIONING TEAM

5.1 The Partners agree to establish a Commissioning Team(s) as set out in Schedule 6 (*Commissioning Team Arrangements*).

6. STAFFING

6.1 The staffing arrangements in respect of each Individual Scheme shall be as set out in the relevant Scheme Specification and/or the Commissioning Team Agreement and Standard Operating Framework.

7. JOINT COMMITTEE

7.1 Where Partners intend to form a Joint Committee then the arrangements for the Joint Committee shall be as set out in Schedule 2 (*Governance Arrangements*); and the relevant Joint Committee Terms of Reference.

8. GOVERNANCE

8.1 Overall strategic oversight of partnership working between the Partners shall be as set out in Schedule 2 (*Governance Arrangements*).

8.2 Each Partner has internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

8.3 The Governance Arrangements shall set out how the Partners shall provide overall oversight and approval of Individual Schemes and variations to those Individual Schemes.

8.4 Each Scheme Specification shall confirm the Governance Arrangements in respect of the Individual Scheme and how that Individual Scheme is reported to each partner.

9. POOLED FUNDS, NON-POOLED FUNDS AND RISK SHARING

9.1 The Partners may establish Pooled Funds, Non-Pooled Funds and agree Risk Sharing in accordance with Schedule 4 (*Financial Arrangements*).

10. REVIEW

10.1 Save where the Partners agree alternative arrangements (including alternative frequencies) the Partners shall undertake an Annual Review of the operation of this Agreement, any Pooled Fund and Non-Pooled Fund and the provision of the Services within three (3) months of the end of each Financial Year.

10.2 Annual Reviews shall be conducted in good faith.

11. COMPLAINTS

11.1 Complaints will be managed by the specialised commissioning team hosted by NHSE England in line with the agreed complaints process.

11.2 A report summarising complaints, actions and lessons learnt will be provided to the East and West Board annually.

12. FINANCES

12.1 The financial arrangements shall be as agreed between the Partners in the relevant Scheme Specification and Schedule 4 (*Financial Arrangements*).

12.2 Unless expressly provided otherwise in this Agreement or otherwise agreed in advance in writing by the Partners, each Partner shall bear its own costs as they are incurred.

13. VARIATION

13.1 The Partners acknowledge that the scope of the Collaboration Arrangements may be reviewed and amended from time to time.

13.2 This Agreement may be varied by the agreement of the Partners at any time in writing in accordance with the Partners' internal decision-making processes.

13.3 No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Partners.

13.4 Where the Partners agree that there will be:

13.4.1 a new Pooled Fund;

13.4.2 a new Individual Scheme; or

13.4.3 an amendment to a current Individual Scheme,

the Partners shall agree the new or amended Individual Scheme in accordance with the Governance Arrangements and, in respect of amendments, the Scheme Specification. Each new or amended Individual Scheme must be signed by each of the Partners. A request to vary an Individual Scheme, which may include (without limitation) a change in the level of Financial Contributions or other matters set out in the relevant Scheme Specification, may be made by any Partner but will require agreement from all the Partners. The notice period for any variation unless otherwise agreed by the Partners shall be three (3) months or in line with the notice period for variations within the associated Service Contract(s), whichever is the shortest.

13.5 Partners may propose additional schemes to be added to this agreement via the Joint Committees.

13.6 The following approach shall, unless otherwise agreed, be followed by the Partners:

13.6.1 on receipt of a request from one Partner to vary the Agreement including (without limitation) the introduction of a new Individual Scheme or amendments to an existing Individual Scheme, the Partners will first undertake an impact assessment and identify the likely impact of the variation including those Individual Schemes and Service Contracts likely to be affected;

13.6.2 the Partners will agree any action to be taken because of the proposed variation. This shall include consideration of:

13.5.2.1 governance and decision-making arrangements;

13.5.2.2 oversight and assurance arrangements;

13.5.2.3 contracting arrangements; and/or

13.5.2.4 whether the proposed variation could have an impact on a Commissioning Team and/or any Staff;

13.6.3 wherever possible agreement will be reached to reduce the level of funding in the Service Contract(s) in line with any reduction in budget; and

13.6.4 should this not be possible, and one Partner is left financially disadvantaged because of the proposed variation, then the financial risk will, unless otherwise agreed, be apportioned according to the financial risk share arrangement detailed in Schedule 4.

14. DATA PROTECTION

14.1 The Partners must ensure that all Personal Data processed by or on behalf of them while carrying out the Joint Working Arrangements is processed in accordance with the relevant Partner's obligations under Data Protection Legislation and Data Guidance, and the Partners must assist each other as necessary to enable each other to comply with these obligations.

14.2 Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a need-to-know basis. If any Partner:

14.2.1 becomes aware of any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted, or unusable; or

14.2.2 becomes aware of any security breach,

in respect of the Relevant Information, it shall promptly notify the relevant Partners and NHS England. The Partners shall fully cooperate with one another to remedy the issue as soon as reasonably practicable.

14.3 In processing any Relevant Information further to this Agreement, each Partner shall at all times comply with their own policies and any NHS England policies and guidance on the handling of data.

14.4 Any information governance breach must be responded to in accordance with the Information Governance Guidance for Serious Incidents. If any Partner is required under Data Protection Legislation to notify the Information Commissioner's Office or a Data Subject of an information governance breach, then, as soon as reasonably practical and in any event on or before the first such notification is made, the relevant Partner must fully inform the other Partners of the information governance breach. This clause does not require the relevant Partner to provide information which identifies any individual affected by the information governance breach were doing so would breach Data Protection Legislation.

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

14.6 The Partners will share information to enable joint service planning, commissioning, and financial management subject to the requirements of

Law, including the Data Protection Legislation in respect of any Personal Data.

14.7 Other than in compliance with judicial, administrative, governmental, or regulatory process in connection with any action, suit, proceedings or claim or otherwise required by any Law, no information will be shared with any third parties save as agreed by the Partners in writing.

14.8 Schedule 5 *(Further Information Governance and Sharing Provisions)* makes further provision about information sharing and information governance.

15. IT INTER-OPERABILITY

15.1 The Partners will work together to ensure that all relevant IT systems operated by the Partners in respect of the Joint Working Arrangements are inter-operable and that data may be transferred between systems securely, easily and efficiently.

15.2 The Partners will each use reasonable endeavours to help develop initiatives to further this aim.

16. FURTHER ARRANGEMENTS

16.1 The Partners must give due consideration to whether any of the Commissioning Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under section 65Z5 and section 75 of the NHS Act. The Partners must comply with any Guidance around the commissioning of Specialised Services by means of arrangements under section 65Z5 or 75 of the NHS Act.

17. FREEDOM OF INFORMATION

17.1 Each Partner acknowledges that the others are a public authority for the purposes of the Freedom of Information Act 2000 ("FOIA") and the Environmental Information Regulations 2004 ("EIR").

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

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

17.2.2 each Partner shall consult the other Partners as relevant regarding the possible application of exemptions in relation to the FOIA or EIA Information requested; and

17.2.3 each Partner acknowledges that the final decision as to the form or content of the response to any request is a matter for the Partner to whom the request is addressed.

17.3 The commissioning team will respond to all FOIA requests on behalf of Partners as part of the administrative responsibility set out in Schedule 6 (Commissioning Team Agreement and Standard Operating Framework).

18. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY

18.1 The Partners must ensure that, in delivering the Joint Working Arrangements, all Staff comply with Law, with Managing Conflicts of Interest in the NHS and other Guidance, and with Good Practice, in relation to gifts, hospitality and other inducements and actual or potential conflicts of interest.

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

19. CONFIDENTIALITY

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

19.2 Subject to Clause 19.3, the receiving Partner agrees:

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

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

19.2.3 to maintain the confidentiality of the disclosing Partner's Confidential Information.

19.3 The receiving Partner may disclose the disclosing Partner's Confidential Information:

19.3.1 in connection with any Dispute Resolution Procedure;

19.3.2 to comply with the Law;

19.3.3 to any appropriate Regulatory or Supervisory Body;

19.3.4 to its Staff, who in respect of that Confidential Information will be under a duty no less onerous than the Receiving Partner's duty under Clause 19.2;

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

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

19.4 The obligations in Clause 19 will not apply to any Confidential Information which:

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

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

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

19.5 This Clause 19 does not prevent NHS England making use of or disclosing any Confidential Information disclosed by an ICB where necessary for the purposes of exercising its functions in relation to that ICB.

19.6 This Clause 19 will survive the termination of this Agreement for any reason for a period of five (5) years.

19.7 This Clause 19 will not limit the application of the Public Interest Disclosure Act 1998 in any way whatsoever.

20. LIABILITIES

20.1 Subject to Clause 20.2, and 20.3, if a Partner ("First Partner") incurs a Loss arising out of or in connection with this Agreement (including a Loss arising under an Individual Scheme) as a consequence of any act or omission of another Partner ("Other Partner") which constitutes negligence, fraud or a breach of contract in relation to this Agreement then the Other Partner shall be liable to the First Partner for that Loss.

20.2 Clause 20.1 shall only apply to the extent that the acts or omissions of the Other Partner contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Partner acting in accordance with the instructions or requests of the First Partner. Clause 20.1 shall not apply in respect of Loss where an alternative arrangement has been agreed by the Partners and set out in the relevant Scheme Specification.

20.3 If any third party makes a Claim or intimates an intention to make a Claim against any Partner, which may reasonably be considered as likely to give rise to liability under this Clause 20, the Partner that may have a Claim against the Other Partner will:

20.3.1 as soon as reasonably practicable give written notice of that matter to the Other Partner specifying in reasonable detail the nature of the relevant Claim;

20.3.2 not make any admission of liability, agreement, or compromise in relation to the relevant Claim without the prior written consent of the Other Partner (such consent not to be unreasonably conditioned, withheld or delayed); and

20.3.3 give the Other Partner and its professional advisers reasonable access to its premises and Staff and to any relevant assets, accounts, documents and records within its power or control so as to enable the Other Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant Claim.

20.4 Each Partner shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a Claim against the other pursuant to this Agreement.

20.5 Unless expressly agreed otherwise, nothing in this Agreement shall affect:

20.5.1 the liability of NHS England to any person in respect of NHS England's Commissioning Functions; or

20.5.2 the liability of any of the ICBs to any person in respect of that ICB's Commissioning Functions.

20.6 Each ICB must:

20.6.1 comply with any requirements set out in the Delegation Agreement in respect of Claims and any policy issued by NHS England from time to time in relation to the conduct of or avoidance of Claims or the pro-active management of Claims;

20.6.2 if it receives any correspondence, issue of proceedings, claim document or other document concerning any Claim or potential Claim, immediately notify the other Partners and send each relevant Partner all copies of such correspondence; and

20.6.3 co-operate fully with each relevant Partner in relation to such Claim and the conduct of such Claim.

21. DISPUTE RESOLUTION

21.1 Where any dispute arises between the ICBs in connection with this Agreement, the Partners must use their best endeavours to resolve that dispute.

21.2 Where any dispute is not resolved under Clause 21.1 on an informal basis, any Authorised Officer may convene a special meeting of the Partners to attempt to resolve the dispute.

22. BREACHES OF THE AGREEMENT

22.1 If any Partner ("Relevant Partner") fails to meet any of its obligations under this Agreement, the other Partners (acting jointly) may by notice require the Relevant Partner to take such reasonable action within a reasonable timescale as the other Partners may specify to rectify such failure. Should the Relevant Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 21 (*Dispute Resolution*).

22.2 Without prejudice to Clause 22.1, if any Partner does not comply with the terms of this Agreement (including if any Partner exceeds its authority under this Agreement), the other Partners may at their discretion agree to:

22.2.1 waive their rights in relation to such non-compliance;

22.2.2 ratify any decision;

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

22.2.4 exercise the Dispute Resolution Procedure in accordance with Clause 21 *(Dispute Resolution).*

23. TERMINATION AND DEFAULT

23.1 If an ICB wishes to end its participation in this Agreement, the relevant ICB must provide at least six (6) months' notice to the other Partners of its intention to end its participation in this Agreement and must have given prior notification to NHS England. Such notification shall only take effect from the end of 31 March in any calendar year and shall only take effect where alternative arrangements for the provision of the Delegated Services and effective exercise of the Delegated Functions are in place for the period immediately following termination.

23.2 Each Individual Scheme may be terminated in accordance with the terms set out in the relevant Scheme Specification provided that each Partner is assured that the relevant Services will continue to be appropriately commissioned.

23.3 The ICBs will work together to ensure that there are suitable alternative arrangements in place in relation to the Services.

24. CONSEQUENCES OF TERMINATION

24.1 Upon termination of this Agreement (in whole or in part), for any reason whatsoever, the following shall apply:

24.1.1 the Partners agree that they will work together and co-operate to ensure that the winding down of these arrangements is carried out smoothly and with as little disruption as possible to patients, employees, the Partners and third parties, to minimise costs and liabilities of each Partner in doing so;

24.1.2 where there are Commissioning Team arrangements in place the Partners shall discuss and agree arrangements for the Staff and any financial arrangements;

24.1.3 where a Partner has entered a Service Contract in exercise of the Functions of any other Partner which continues after the termination of this Agreement, all Partners shall continue to provide necessary funding in accordance with the agreed contribution for that Service prior to termination and will enter all appropriate legal documentation required in respect of this;

24.1.4 where there are Lead Commissioning Arrangements in place, the Lead Partner shall make reasonable endeavours to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place the Lead Partner in breach of the Service Contract) where the other Partner requests the same in writing provided that the Lead Partner shall not be required to make any payments to a Service provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment;

24.1.5 where there are Joint Commissioning Arrangements in place, the Partners shall co-operate with each other as reasonably necessary to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place any Partner in breach of the Service Contract) where a Partner requests the same in writing provided that no Partner shall be

required to make any payments to a Service provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment;

24.1.6 where a Service Contract held by a Lead Partner relates all or partially to services which relate to the other Partner's Functions and provided that the Service Contract allows, the other Partner may request that the Lead Partner assigns the Service Contract in whole or part upon the same terms as the original contract; and

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

24.2 The provisions of Clauses 14 (*Data Protection*), 17 (*Freedom of Information*), 19 (*Confidentiality*), 20 (*Liabilities*) and 24 (*Consequences of Termination*) shall survive termination or expiry of this Agreement.

25. PUBLICITY

25.1 The Partners shall use reasonable endeavours to consult one another before making any public announcements concerning the subject matter of this Agreement, the Joint Working Arrangements or any Services provided under the Joint Working Arrangements.

26. EXCLUSION OF PARTNERSHIP OR AGENCY

26.1 Nothing in this Agreement shall create or be deemed to create a legal partnership under the Partnership Act 1890 or the relationship of employer and employee between the Partners.

26.2 Save as specifically authorised under the terms of this Agreement, no Partner shall hold itself out as the agent of any other Partner.

27. THIRD PARTY RIGHTS

27.1 The Contracts (Rights of Third Parties) Act 1999 shall not apply to this Agreement and accordingly the Partners to this Agreement do not intend that any third party should have any rights in respect of this Agreement by virtue of that Act.

28. NOTICES

28.1 Any notices given under this Agreement must be sent by e-mail to the relevant Authorised Officers or their nominated deputies.

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

29. ASSIGNMENT AND SUBCONTRACTING

29.1 This Agreement, and any rights and conditions contained in it, may not be assigned or transferred by a Partner, without the prior written consent of the other Partners, except to any statutory successor to the relevant Commissioning Function.

30. SEVERABILITY

30.1 If any term, condition, or provision contained in this Agreement shall be held to be invalid, unlawful or unenforceable to any extent, such term, condition or provision shall not affect the validity, legality or enforceability of the remaining parts of this Agreement.

31. WAIVER

31.1 No failure or delay by a Partner to exercise any right or remedy provided under this Agreement or by Law shall constitute a waiver of that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy. No single or partial exercise of such right or remedy shall prevent or restrict the further exercise of that or any other right or remedy.

32. STATUS

32.1 The Partners acknowledge that they are health service bodies for the purposes of section 9 of the NHS Act. Accordingly, this Agreement shall be treated as an NHS contract and shall not be legally enforceable.

33. ENTIRE AGREEMENT

33.1 This Agreement constitutes the entire agreement and understanding of the Partners and supersedes any previous agreement between the Partners relating to the subject matter of this Agreement.

34. GOVERNING LAW AND JURISDICTION

34.1 Subject to the provisions of Clause 21 (*Dispute Resolution*) and Clause 32 (*Status*), this Agreement shall be governed by and construed in accordance with English Law, and the Partners irrevocably agree that the courts of England shall have exclusive jurisdiction to settle any dispute or claim that arises out of or in connection with this Agreement.

35. FAIR DEALINGS

35.1 The Partners recognise that it is impracticable to make provision for every contingency which may arise during the life of this Agreement and they declare it to be their intention that this Agreement shall operate between them with fairness and without detriment to the interests of any Partner and that, if in the course of the performance of this Agreement, unfairness to any Partner does or may result, then the Relevant Partner(s) shall use reasonable endeavours to agree upon such action as may be necessary to remove the cause or causes of such unfairness.

36. COUNTERPARTS

36.1 This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

This Agreement has been entered into on the Commencement Date

SIGNED by John Turner .....

for and on behalf of NHS Lincolnshire Integrated Care Board (Signature)

.....

(Date)

SIGNED by Amanda Sullivan .....

for and on behalf of NHS Nottingham & Nottinghamshire Integrated Care Board (Signature)

.....

(Date)

SIGNED by Dr Caroline Trevithick .....

for and on behalf of NHS Leicester, Leicestershire & Rutland Integrated Care Board (Signature)

.....

(Date)

SIGNED by Toby Sanders .....

for and on behalf of NHS Northamptonshire Integrated Care Board

(Signature)

.....

(Date)

SIGNED by Chris Clayton .....

for and on behalf of NHS Derby & Derbyshire Integrated Care Board

(Signature)

.....

(Date)

SIGNED by Philip Johns .....

for and on behalf of NHS Coventry & Warwickshire Integrated Care Board

(Signature)

.....

(Date)

SIGNED by Mark Axcell .....

for and on behalf of NHS Black Country Integrated Care Board

(Signature)

.....

(Date)

SIGNED by Simon Trickett .....

for and on behalf of NHS Herefordshire & Worcestershire Integrated Care Board

(Signature)

.....

(Date)

SIGNED by David Melbourne .....

for and on behalf of NHS Birmingham & Solihull Integrated Care Board

(Signature)

.....

(Date)

SIGNED by Peter Axon .....

for and on behalf of NHS Staffordshire & Stoke-on-Trent Integrated Care Board

(Signature)

.....

(Date)

SIGNED by Simon Whitehouse .....

for and on behalf of NHS Shropshire, Telford & Wrekin Integrated Care Board (Signature)

.....

(Date)

SIGNED by Roz Lindridge .....

For and on behalf of NHS England (Signature)

.....

(Date

SCHEDULE 1: DEFINITIONS AND INTERPRETATIONS

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

“Agreement"	means this agreement between the Partners comprising these terms and conditions together with all schedules attached to it;
“Aligned Commissioning Arrangements”	means the arrangements by which the Partners agree to commission a Service in a co-ordinated and collaborative manner. For the avoidance of doubt, an aligned commissioning arrangement does not involve the delegation of any functions between ICBs;
“Annual Review”	means the annual review of the arrangements under this Agreement by the Partners;
“Area”	means the geographical area covered by the ICBs;
"Authorised Officer"	the individual(s) appointed as Authorised Officer in accordance with the agreed Terms of Reference;
“Claim”	means for or in relation to the Commissioning Functions (a) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal, or the Secretary of State, any governmental, regulatory, or similar body, or any department, board or agency or (b) any dispute with, or any investigation, inquiry or enforcement proceedings by any governmental, regulatory or similar body or agency;
“Clinical Commissioning Policies”	a nationally determined clinical policy sets out the commissioning position on a particular clinical treatment issue and defines accessibility (including a not for routine commissioning position) of a medicine, medical device, diagnostic technique, surgical procedure, or intervention for patients with a condition requiring a specialised service;
“Clinical Reference Groups”	means a group consisting of clinicians, commissioners, public health experts, patient and public voice representatives and professional associations, which offers specific knowledge and expertise on the best ways that Specialised Services should be provided;
“Collaborative Commissioning Agreement”	means an agreement under which NHS Commissioners set out collaboration arrangements in respect of commissioning Specialised Services Contracts;
"Commencement Date"	[means 1 April 2024];
"Commissioning Functions"	the respective statutory functions of the Partners in arranging for the provision of services as part of the health service;
“Commissioning Team”	means a staffing arrangement for commissioning agreed Services through an integrated team structure. This can be either set up using: . Lead Commissioning (one Partner hosts the Unit as Lead and all functions are delegated to that Partner); or . Joint Commissioning or Aligned Commissioning (one Partner may host but no functions are delegated). The Partners will need to agree whether decisions are taken via a Joint Commissioning

arrangement such as a Joint Committee or whether each Partner is required to take decisions;

"Confidential Information"	means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement or Joint Working Arrangements made pursuant to it and: i. which comprises Personal Data or which relates to any patient or his treatment or medical history; ii. the release of which is likely to prejudice the commercial interests of a Partner; or iii. which is a trade secret;
"Contracting Standard Operating Procedure"	means any contracting standard operating procedure produced by NHS England in respect of the Delegated Specialised Services;
"Data Controller"	shall have the same meaning as set out in the Data Protection Legislation;
"Data Processor"	shall have the same meaning as set out in the Data Protection Legislation;
"Data Sharing Agreement"	means any data sharing agreement entered in accordance with Schedule 5 (*Further Information Governance and Sharing Provisions*);
"Data Guidance"	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement regarding information governance, confidentiality, privacy, or compliance with Data Protection Legislation to the extent published and publicly available or their existence or contents have been notified to the ICB by NHS England and/or any relevant Regulatory or Supervisory Body. This includes but is not limited to guidance issued by NHS Digital, the National Data Guardian for Health & Care, the Department of Health and Social Care, NHS England, the Health Research Authority, the UK Health Security Agency, and the Information Commissioner;
"Data Protection Legislation"	means the UK General Data Protection Regulation, the Data Protection Act 2018, the Regulation of Investigatory Powers Act 2000, the Telecommunications (Lawful Business Practice) (Interception of Communications) Regulations 2000 (SI 2000/2699), the Privacy and Electronic Communications (EC Directive) Regulations 2003 (SI 2426/2003), the common law duty of confidentiality and all applicable laws and regulations relating to the processing of Personal Data and privacy, including where applicable the guidance and codes of practice issued by the Information Commissioner;
"Data Protection Officer"	shall have the same meaning as set out in the Data Protection Legislation;
"Data Security and Protection Toolkit"	means the toolkit at: https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/data-security-and-protection-toolkit or as amended or replaced from time to time
"**Delegated Commissioning Group**" **"DCG"**	means the advisory forum in respect of Delegated Services set up by NHS England currently known as the Delegated Commissioning Group for Specialised Services;

“Delegation Agreement(s)”	means the Delegation Agreements under which NHS England delegate specific NHS England Specialised Services Commissioning Functions to each ICB;
“Delegated Functions”	means the Specialised Services Commissioning Functions of NHS England delegated to each ICB under a Delegation Agreement;
“Delegated Services”	means those Specialised Services commissioned in exercise of the Delegated Functions;
"Dispute Resolution Procedure"	the procedure set out in Clause 21 (*Dispute Resolution*);
“EIR”	means the Environmental Information Regulations 2004;
“Finance Guidance”	guidance, rules and operating procedures produced by NHS England that relate to these Joint Working Arrangements, including but not limited to the following: • Commissioning Change Management Business Rules; • Contracting Standard Operating Procedure; • Cashflow Standard Operating Procedure; • Finance and Accounting Standard Operating Procedure; • Service Level Framework Guidance;
“Flexibilities”	Mean the flexibilities that the Partners may use to work in a co-ordinated manner as set out at Clause 3 (*Scope of the Arrangements*);
“Financial Contribution”	means the financial contributions agreed by each Partner in respect of an Individual Scheme in any Financial Year;
“Financial Year”	means each financial year running from 1 April in any year to 31 March in the following calendar year;
"FOIA"	the Freedom of Information Act 2000 and any subordinate legislation made under it from time to time, together with any guidance or codes of practice issued by the Information Commissioner or relevant government department concerning this legislation;
"FOIA or EIR Information"	has the meaning given under section 84 of FOIA or the meaning given for “environmental information” under the EIR as applicable;
“Good Practice”	means using standards, practices, methods and procedures conforming to the law, reflecting up-to-date published evidence and exercising that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced commissioner;
“Governance Arrangements”	means the governance arrangements in respect of the Arrangements agreed by the Partners and as set out in Schedule 2 (*Governance Arrangements*);
“Guidance”	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the Partners have a duty to have regard (and whether specifically mentioned in this Agreement or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified by any relevant Regulatory or Supervisory Body;
“High-Cost Drugs”	means medicines not reimbursed though national prices and identified on the NHS England high-cost drugs list;

"ICB Reserved Functions"	Where there is any delegation of an ICB's Commissioning Functions or further delegation of Delegated Functions, those functions that remain reserved to each ICB;
"Indemnity Arrangement"	means either: (i) a policy of insurance; (ii) an arrangement made for the purposes of indemnifying a person or organisation; or (iii) a combination of (i) and (ii);
"Individual Scheme"	means an arrangement in relation to how the ICBs will work together using one or more of the Flexibilities which has been agreed by the Partners to be included within this Agreement as part of the Joint Working Arrangements;
"Joint Committee"	means the joint committee(s) established by the partners that perform functions under this Agreement on the terms set out in their Terms of Reference;
"Joint Functions"	any Functions that are delegated to a Joint Committee;
"Joint Commissioning"	means Partners agreeing to jointly exercise agreed Commissioning Functions on behalf of each other in exercise of the functions of each Partner part of that Individual Scheme. This may, for example, be through agreeing to enter into the same contract or by use of a Joint Committee;
"Joint Working Arrangements"	means the Flexibilities that the Partners have agreed to use to work in a co-ordinated manner which, at the Commencement Date, are as set out in Clause 3;
"Law"	means: i. any statute or proclamation or any delegated or subordinate legislation; i. any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and i. any judgment of a relevant court of law which is a binding precedent in England;
"Lead Commissioning Arrangements"	means the arrangements by which one Partner commissions Services in relation to an Individual Scheme on behalf of another Partner or Partners in exercise of the Commissioning Functions of the ICB Partners;
"Lead Partner"	means the Partner responsible for commissioning under a Lead Commissioning Arrangement;
"Loss"	means all damages, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services) proceedings, demands and charges whether arising under statute, contract or common law;
"Managing Conflicts of Interest in the NHS"	means the NHS publication by that name available at: https://www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-guidance-for-staff-and-organisations/ or such publication that amends or replaces that publication;

"Mandated Guidance"	means any protocol, policy, guidance, guidelines, framework or manual relating to the exercise of Delegated Functions and issued by NHS England from time to time as mandatory;
"National Standards"	means the service standards for each Specialised Service, as set by NHS England and included in Clinical Commissioning Policies or National Specifications;
"National Specifications"	the service specifications published by NHS England in respect of Specialised Services;
"Need to Know"	has the meaning set out in Schedule 5 *(Further Information Governance and Sharing Provisions)*;
"NHS Act"	the National Health Service Act 2006;
"NHS England Functions"	NHS England's Commissioning Functions exercisable under or by virtue of the NHS Act;
"NHS England Reserved Functions"	those aspects of the Specialised Commissioning Functions for which NHS England retains commissioning responsibility;
"Non-Personal Data"	means data which is not Personal Data;
"Non-Pooled Funds"	means the budget detailing the financial contributions of the Partners which are not included in a Pooled Fund in respect of a particular Service as set out in the relevant Scheme Specification;
"Operational Days"	means a day other than a Saturday, Sunday, Christmas Day, Good Friday or a bank holiday in England;
"Partners"	means the parties to this Agreement;
"Personal Data"	has the meaning set out in the Data Protection Legislation;
"Pooled Funds"	means any pooled fund established and maintained by the Partners as a pooled fund;
"Population"	means the population for which an ICB or all the ICBs have the responsibility for commissioning health services;
"Provider Collaborative"	means a group of Providers who have agreed to work together to improve the care pathway for one or more Services;
"Provider Collaborative Arrangements"	means the arrangements entered in respect of a Provider Collaborative;
"Provider Collaborative Guidance"	means any guidance published by NHS England in respect of Provider Collaboratives;
"Regional Quality Group"	means a group set up to act as a strategic forum at which regional partners from across health and social care can share, identify, and mitigate wider regional quality risks and concerns as well as share learning so that quality improvement and best practice can be replicated;
"Regulatory or Supervisory Body"	means any statutory or other body having authority to issue guidance, standards, or recommendations with which the relevant Party and/or Staff must comply or to which it or they must have regard, including: i. CQC;

ii. NHS England;

iii. the Department of Health and Social Care;

iv. NICE;

v. Healthwatch England and Local Healthwatch;

vi. the General Medical Council;

vii. the General Dental Council;

viii. the General Optical Council;

ix. the General Pharmaceutical Council;

x. the Healthcare Safety Investigation Branch; and

xi. the Information Commissioner;

"Relevant Information"	means the Personal Data and Non-Personal Data processed under this Agreement, and includes, where appropriate, "confidential patient information" (as defined under section 251 of the NHS Act), and "patient confidential information" as defined in the 2013 Report, The Information Governance Review – "*To Share or Not to Share?"*);
"Reserved Functions"	means NHS England Reserved Functions or ICB Reserved Functions;
"**Relevant Clinical Networks"**	means those clinical networks identified by NHS England as required to support the commissioning of Specialised Services for the Population;
"Retained Services"	means those Specialised Services for which NHS England shall retain commissioning responsibility, as set out the Delegation Agreement;
"Risk Sharing"	means an agreed arrangement for risk and benefit sharing between the Partners;
"Scheme Specification"	means a specification setting out the Joint Working Arrangements in respect of an Individual Scheme agreed by the Partners to be commissioned under this Agreement;
"Services"	means such health services as agreed from time to time by the Partners as commissioned under the Joint Working Arrangements and more specifically defined in each Scheme Specification;
"Service Contract"	means an agreement entered into by one or more of the Partners in exercise of its obligations under this Agreement to secure the provision of Services in accordance with the relevant Individual Scheme
"Single Point of Contact"	the member of Staff appointed by each relevant Partner in accordance with Paragraph 13 of Schedule 5 *(Further Information Governance and Sharing Provisions)*
"Special Category Personal Data"	has the meaning set out in the Data Protection Legislation;
"Specialised Commissioning Budget"	means the budget identified by NHS England in respect of each ICB for the purpose of exercising the Delegated Functions;

"Specialised Commissioning Functions"	means the statutory functions conferred on NHS England under Section 3B of the NHS Act 2006 and Regulation 11 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996 (as amended or replaced);
"Specified Purpose"	means the purpose for which the Relevant Information is shared and processed to facilitate the exercise of the Joint Working Arrangements as specified in Schedule 5 *(Further Information Governance and Sharing Provisions)* to this Agreement;
"Specialised Services"	means the services commissioned in exercise of the Specialised Commissioning Functions;
"Specialised Services Contract"	means a contract for the provision of Specialised Services entered in the exercise of the Specialised Commissioning Functions;
"Specialised Services Provider"	means a provider party to a Specialised Services Contract;
"Staff"	means the Partners' employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of any Partner (whether the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors' and their sub-contractors' personnel;
"Standard Operating Framework"	means the agreement(s) that sets out the arrangements for a Commissioning Team;
"Terms of Reference"	means the Terms of Reference for the Joint Committee agreed between the Partners at the first meeting of the Joint Committee;
"Triple Aim"	means the duty on each of the Partners in making decisions about the exercise of their functions, to have regard to all likely effects of the decision in relation to: i. the health and well-being of the people of England; ii. the quality of services provided to individuals by the NHS; iii. efficiency and sustainability in relation to the use of resources by the NHS;
"Underspend"	means any expenditure from a Pooled Fund or Non-Pooled Fund in a Financial Year which is less than the value of the agreed contributions by the Partners for that Financial Year;
"UK GDPR"	means Regulation (EU) 2016/679 of the European Parliament and of the Council of 27th April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018.

2. References to statutory provisions shall be construed as references to those provisions as respectively amended or re-enacted (whether before or after the Commencement Date) from time to time.

3. The headings of the Clauses in this Agreement are for reference purposes only and shall not be construed as part of this Agreement or deemed to indicate the meaning of the relevant Clauses to which they relate. Reference to Clauses are Clauses in this Agreement.

4. References to Schedules are references to the schedules to this Agreement and a reference to a Paragraph is a reference to the paragraph in the Schedule containing such reference.

5. References to a person or body shall not be restricted to natural persons and shall include a company, corporation, or organisation.

6. Words importing the singular number only shall include the plural.

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

8. Where anything in this Agreement requires the mutual agreement of the Partners, then unless the context otherwise provides, such agreement must be in writing.

9. Any reference to the Partners shall include their respective statutory successors, employees and agents.

10. In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

11. Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

SCHEDULE 2: GOVERNANCE ARRANGEMENTS

1. Joint Committees

1.1. The overall oversight and governance arrangements for these collaborative working arrangements will be discharged through the Joint Committees established by the ICBs through Joint Working Agreements between NHS Lincolnshire Integrated Care Board, NHS Nottingham and Nottinghamshire Integrated Care Board, NHS Leicester, Leicestershire and Rutland Integrated Care Board, NHS Northamptonshire Integrated Care Board and NHS Derby and Derbyshire Integrated Care Board (the "East Midlands ICBs") and NHS Birmingham and Solihull Integrated Care Board, NHS Black Country Integrated Care Board, NHS Coventry and Warwickshire Integrated Care Board, NHS Herefordshire and Worcestershire Integrated Care Board, NHS Shropshire, Telford and Wrekin Integrated Care Board and NHS Staffordshire and Stoke-on-Trent Integrated Care Board (the "West Midlands ICBs")

1.2. The Terms of Reference and other detailed arrangements that support the operation of the Joint Committees are detailed in the Joint Working Agreements between the East and West ICBs. They set out that the two Joint Committees will have delegated authority on behalf of the East and West ICBs respectively to discharge the functions delegated to the ICBs by NHS England in respect of Specialised Services, including establishing appropriate subsidiary arrangements to enable effective decision-making and detailed oversight of performance, finance, and quality.

1.3. In recognition that effective collaboration may require aligned decisions from all the partners, the Joint Committees may consider meeting 'in common' where this is appropriate and will ensure that decisions by either the East or West Joint Committee that impact on the other are made having taken relevant views from the other committee into account.

1.4. The NHS England regional team will continue to work jointly with the Joint Committees on the commissioning of retained specialised services. This will include, where appropriate, discharging its authority (through accountable directors) in consultation with the Joint Committees.

1.5. The subsidiary arrangements established by the Joint Committees will include appropriate schemes of reservation and delegation in place to enable Sub-Groups of the Joint Committees and/or members of staff employed by Joint Commissioning Team to have the authority to make decisions. These arrangements will be developed in collaboration with NHS England to support effective working on both the delegated and retained services.

2. Joint Subgroups

2.1. There will be three joint subgroups established by the partners to support these arrangements, these being:

- **Midlands Acute Specialised Commissioning Group (MASCG)**
- **Specialised Commissioning Quality Group**
- **Finance and Contracting Group**

2.2. Subsidiary arrangements established by the Joint Committees will include providing delegated authority to **Midlands Acute Specialised Commissioning Group (MASCG)** a Joint Sub-Group established by all the partners to make decisions on both the delegated and retained services.

2.3. The role of MASCG will be to support the partners and the Joint Committees in ensuring that the delivery of the delegated and retained services is effective, efficient, and economical and in line with each partner's statutory responsibilities.

2.4. MASCG will report and make recommendations to the Joint Committees in respect of delegated services and to Midlands Commissioning Group in respect of the retained services and will always operate in accordance with its agreed terms of reference (which are set out in Appendix 1 of this schedule) and the relevant schemes of reservation and delegation and standing financial instructions for delegated and retained services.

2.5. Each of the partners will appoint a member of MASCG who is authorised to act as part of the group and participate in collective decision making on behalf of their organisation. MASCG will also ensure that its decisions are taken with the advice of suitable subject matter experts.

2.6. **Specialised Commissioning Quality Group –** This group, chaired by the Regional Medical Director for Commissioning (RMDC) will provide a forum to share and discuss potential and known issues which impact on the quality and safety of Acute Specialised Commissioned services in the Midlands region and agree any remedial action.

2.7. The purpose of the Specialised Commissioning Quality Group is to provide a forum for routinely and systematically bringing together partners from across ICSs and the region to share insight and intelligence in relation to quality concerns, to identify opportunities for improvement and to develop regional responses as required. The focus of the discussions will be on intelligence, learning, issues and risks that are recurrent and/ or have an impact wider than individual ICSs.

2.9 **Finance and Contracting Subgroup** – will have responsibility to oversee the management of the pooled fund on behalf of the Joint Committees.

2.10 The purpose of the Finance and Contracting Subgroup is to provide robust joint financial management of the pooled fund on behalf of the ICBs in line with the terms set out in schedule 4 of this agreement.

Subgroups reporting to East and West Joint Committees

3. Clinical Governance

3.1. The ICBs will access the clinical, pharmaceutical, and quality governance functions provided by the Midlands Commissioning Multidisciplinary Team via the

Commissioning Team Arrangements and Standard Operating Framework.

3.2. Clinical engagement and leadership will be secured at multiple tiers across the Midlands region and will draw upon established clinical networks including those formally commissioned plus the informal networks that have been recognised over time.

3.3. The Specialised Services Operational Delivery Networks (ODNs) will continue to be formally commissioned by NHS England. NHS England will retain the financial responsibility for the ODNs and will continue to play a key role in supporting understanding of clinical quality for the relevant services.

3.4. At a senior clinical level, the Collaborative Clinical Executive Forum (CCEF), a regional forum of Acute Provider and ICB Chief Medical Officers (CMOs), will continue to meet regularly and engage with the Midlands Commissioning Team. Advice offered via that forum will feed into the decision -making process via the Midlands Acute Specialised Commissioning Group (MASCG) and into the Joint Committees.

3.5. The Commissiong Team will retain Medical Director, Pharmacy and Nursing roles which will provide a vital conduit to local systems and the national clinical leadership architecture.

3.6. Governance and decision-making for high-cost drugs assurance will be via Joint Committees and their sub-groups, with links to the Regional Pharmacy Leadership Board. The pharmacy team for High Costs Drugs will work across ICBs and NHS England informed by other senior pharmacists across the region e.g., HCD pharmacists, regional cancer pharmacists,

3.7. High-cost tariff excluded drugs will continue to be reimbursed through a national process by NHS England irrespective of whether they are used for delegated services, meaning that ICBs will not bear the financial risk of new specialised drugs growth.

4. Quality Governance

4.1. Key quality concerns requiring escalation relating to the Joint Services will be reported monthly to the Joint Committees by the Specialised Commissioning Quality Group. Furthermore, key quality concerns for specialised services will continue to be reported to and discussed at the NHSE led Regional Quality Group, of which all ICBs are members. These groups will ensure key quality concerns are fed back into systems to inform conversations at a local level.

4.2. Key quality concerns involving specialised services will also be reported into Midlands Acute Specialised Commissioning Group (MASCG) of which all 11 Midlands ICBs are members and have representation. Specialised Commissioning Quality Group will provide a forum for delegated decision making, including on quality matters.

4.3. To be proactive on identification of areas for quality improvement, a Quality Surveillance and Improvement Programme (QSIP) has been established to support implementation of the NHSE Midlands Acute Specialised Commissioning Quality Surveillance & Improvement Framework (QSIF). The QSIP aims to provide strategic direction and support implementation of the Quality Surveillance and Improvement Framework QSIF and will agree priorities for the Programme in addition to evaluating risks related to the Programme and to devise and implement mitigations and remedial action. The QSIF involves triangulating intelligence and data from several sources (e.g., CQC reports, specialised services dashboards, national audit etc) to monitor the

quality of each service. This work is overseen by the QSIP Programme Board, has ICB representation, is chaired by the RMDC and reports to MASCG.

4.4. The Joint Committees will also agree a comprehensive Quality Assurance Framework which will provide a high-level description of the proposed overarching governance arrangements including for quality assurance in the Midlands region in terms of how decisions are made; outline reporting flows; where assurances will be sought, and the structures put in place to ensure that NHSE and ICB's act within their powers and discharge their responsibilities correctly and appropriately.

5. Financial Governance

5.1 The Financial governance arrangements in Schedule 4 shall apply to the Collaborative Arrangements.

5.7 **Risk Management Arrangements** - In line with their overall role to provide strategic decision-making, leadership, and oversight for the joint services the Joint Committee will establish a monitoring and management in relation to risk and issue management and escalation, and co-ordinating the approach to intervention with providers where there are quality or contractual issues. This will include feeding back to individual ICBs for consideration of any impact on their own risk management arrangements.

5.8 A formal risk register will be maintained by the Midlands Commissioning Team and reported monthly through the Midlands Acute Specialised Commissioning Group to ensure ICBs are aware of any risks they may impact their systems.

6. Assurance arrangements

6.1. The Joint Committees will be responsible for ensuring that the ICBs are able to meet their obligations under the NHSE Oversight and Assurance Framework in relation to the delegation of specialised services which, requires that the ICBs must at all times operate in accordance with:

(a) the Oversight and Assurance Framework published by NHS England;

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

(c) any other relevant NHS oversight and assurance guidance;

collectively known as the "Assurance Processes".

And that the ICBs must:

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

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

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

(d) Provide any information and comply with specific actions in relation to the Delegated Specialised Services, as required by NHS England,

including metrics and detailed reporting in accordance with the Terms of Reference.

Appendix 1 – MASCG Terms of Reference

Document name:		Midlands Acute Specialised Commissioning (MASC) Group/ Terms of Reference	
Senior Responsible Owner (SRO):		Alison Kemp	
Lead:		Jon Currington	
Author:		Mel Harris, Peter McKenzie	
Version	1.5	**Date:**	[Publish Date]

Document management

Revision history

Version	Date	Summary of changes
0.1	28/02/23	Initial template
0.2	08/03/23	Incorporating JC/MD edits
1.0	02/08/23	Updated by JC to include financial limits as requested by Joint Committees and non-material amendments for clarity and consistency.
1.1	30/01/24	Amendments to align with ICB Collaboration Agreement for 2024/25
1.2	02/02/24	JM review and update
1.3	05/02/24	JM review and Update
1.4	06/02/24	PMcK review and update including JC Feedback
1.5	21/02/24	Version for approval in Collaboration Agreement

Approved by

This document must be approved by the following people:

Name	Signature	Title	Date	Version
Matt Day		Regional Director Specialised Commissioning and Health and Justice		0.2
Formal Midlands Acute Specialised Commissioning Group	Approved		17/03/23	0.2
Delegation Governance Working Group				0.2
East Midlands Joint Committee	Approved		20/06/23	0.3
West Midlands Joint Committee	Approved		14/07/23	0.3
Midlands Commissioning Group				0.3

Related documents

Title	Owner	Location
ICB Collaboration Agreement for Specialised Services	NHSE & 11 Midlands ICBs	
East Midlands Joint Committee Terms of Reference	NHSE & 5 EM ICBs	
West Midlands Joint Committee Terms of Reference	NHSE & 6 WM ICBs	

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Midlands Acute Specialised Commissioning Group (MASCG) Terms of Reference 2024/25	
Introduction and purpose	From April 2024, NHS England delegated responsibility to the eleven Integrated Care Boards ("the ICBs") in the Midlands region for commissioning 59 Prescribed Specialised Services (the "delegated services"). To discharge these duties the ICBs and NHS England have developed a collaboration agreement that sets out that the individual ICBs will delegate responsibilities to the existing East and West Joint Committees (JC) established under the Joint Working Agreements between the ICBs. The two JCs are defined as Tier I Bodies and their responsibilities for the delegated services are set out in their Terms of Reference. NHS England will continue to be responsible for other Prescribed Specialised services, including 29 services designated as suitable but not yet ready for delegation to the ICBs (the "retained services") and will seek input from the ICBs into the commissioning of Retained Specialised Services. NHS England will continue to have budgetary responsibility and holds accountability and responsibility for high-cost drugs within specialised services. NHSE and ICBs will collaborate in the commissioning of high-cost drugs via joint working arrangements. The Collaboration Agreement sets out that the ICBs and NHSE will establish the Midlands Acute Specialised Commissioning Group (MASCG) as a Joint Sub-group to support the JCs and NHSE in the effective and efficient commissioning of both the delegated and retained services. MASCG will have delegated decision-making authority from both JCs and NHS England and will provide joint oversight for the commissioning of all Prescribed Acute Specialised Services for the population of the Midlands.
The Terms of Reference	These Terms of Reference are intended to support effective collaboration between NHS England and ICBs acting through MASCG. They set out the roles, responsibilities, membership, decision-making powers, and reporting arrangements of the MASCG in accordance with the Collaboration Agreement. The MASCG will operate under the limitations of the delegated authority given to it by the East and West Joint Committees (for the delegated services) and NHS England Standing Financial Instructions (SFI) (for the retained service) . This will include authority to make decisions of a value up to £2.5 Million for contract variations and extensions for directly commissioned healthcare services and up to £2.5 million for clinical

	and non-clinical business cases. Values above this will be referred upwards to the JCs and/or authorised decision makers in NHS England as appropriate.
Role of the Group	The role of the MASCG is to support the JCs and NHS England in discharging their duties with respect to prescribed specialised services safely, effectively, efficiently and economically. The MASCG will achieve this through: • Determining the appropriate structure of the MASCG; ▪ Making decisions in relation to the planning and commissioning of delegated and retained specialised services and working collaboratively on any associated commissioning or statutory functions, for the population within the scope of the agreed authority for the group; ▪ Making recommendations to the Joint Committees and NHS England as appropriate in relation to decisions required for delegated and retained specialised services that fall outside the scope of the agreed authority for the group; ▪ Making recommendations on the population-based financial allocation and financial plans for delegated and retained Specialised Services to the Joint Committees and NHS England as appropriate; ▪ Oversight and assurance of all specialised services, either directly or through Tier 3 sub-groups, in relation to quality, operational and financial performance, including co-ordinating risk and issue management and escalation, and developing the approach to intervention with specialised services providers where there are quality or contractual issues and escalating these issues to the Joint Committees and NHS England when required; ▪ Identifying and setting strategic priorities and undertaking ongoing assessment and review of joint specialised services within the remit of the Group and consistent with national, regional and ICS plans, including tackling unequal outcomes and access; ▪ Supporting the development of partnership and integration arrangements with other health and care bodies in relation to all specilaised services including Provider Collaboratives and the Cancer Alliances, and working closely across regional footprints, where there are cross-border patient flows to providers; ▪ Engaging effectively with stakeholders, including patients and the public, and involving them in decision-making; ▪ Obtaining appropriate clinical advice and leadership, including through Clinical Reference Groups and relevant Clinical Networks;

	▪ Linking in with the NHS England National team in order to implement policies, initiatives and service specifications; ▪ Supporting longer-term planning for both delegated and retained services; and ▪ Discussing any matter which any member of the Group believes to be of such importance that it should be brought to the attention of the Group. The Group must adhere to these Terms of Reference but may otherwise regulate its own procedures.
Accountability and reporting	The MASCG is a joint sub-group, established in line with the Collaboration Agreement between the eleven Midlands ICBs and NHS England and is formally accountable to the JCs for delegated services and to the NHS England Midlands Commissioning Group (MCG) for retained services. It will report to the Joint Committees and the MCG after each meeting and make recommendations and escalate issues when required.
Membership	The core membership of the MASCG will comprise one representative of each of the eleven ICBs, nominated by the respective Chief Executive Officer with authority to participate in the collective decision-making of the Group on behalf of their organisation and the Regional Director of Specialised Commissioning, NHS England Midlands. A named substitute may be nominated to attend if a core member of the MASCG is unavailable or unable to attend or because they are conflicted. Core members must ensure that their substitute is fully authorised to act on their behalf. The MASCG will be supported by the NHS England Midlands Acute Specialised Commissioning (MASC) Team including: • Chief Medical Officer for Commissioning • Head of Acute Specialised Commissioning • Deputy Director of Nursing and Quality • Heads of Finance • Regional Pharmacy Lead • Consultants in Public Health • Head of Business Intelligence • Head of Planning • Acute Commissioning Leads Subject matter experts will also support the MASCG from core ICB functions including the offices of the Chief Medical Officers, Chief Nursing Officers and Chief Finance Officers. During 2024/25 (until transfer of staff) this will include nominated ICB Quality and Finance leads on behalf of all the ICBs of the West (6) and the East (5) whose role will be to provide a liaison between MASCG and the Finance and

	Quality sub-groups established to support Joint Commissioning arrangements. The ICBs will agree who will attend the Group, which Include members of the Clinical Collaboration Forum from these functions, and they will be invited on a standing basis. Individuals or representatives of other organisations that may be invited to observe proceedings and contribute to the MASC Group's work at the discretion of the Chair. A list of the members will be made available.
Chair	MASCG will be co-chaired by the Regional Director, Specialised Commissioning, NHS England Midlands and an ICB representative elected from the core membership. The co-chairs will arrange cover in their absence.
Meetings	MASCG shall meet monthly with arrangements to meet face-to-face and virtually. At its first meeting (and at the first meeting following each subsequent anniversary of that meeting) the MASCG shall prepare a of meetings and work programme for the forthcoming year.
Quorum	The MASCG shall be quorate if the Chair, or their nominated deputy is present together with representation from the ICBs from the Joint Committee that any decisions on the agenda relate to. In urgent circumstances, consideration will be given by the Chair to make decisions which significantly impact an ICB or ICBs not present subject to confirmation of support of the relevant ICB or ICBs outside of the meeting. These situations, together with the outcome will be formally recorded in the minutes.
Decisions and voting arrangements	The decision-making arrangements for the Group will be in line with the delegated authority provided to it by the Joint Committees and NHS England. Items for decision will clearly indicate the source of the authority for the decision which will determine which members will be eligible to participate in the decision-making for that item: - • For items on behalf of the East Midlands Joint Committee this will be the core representatives from Derby and Derbyshire, Leicester, Leicestershire and Rutland, Lincolnshire, Nottingham and Nottinghamshire and Northamptonshire ICBs; • For items on behalf of the West Midlands Joint Committee this will be the Core representatives from Birmingham and Solihull, Black Country, Coventry and Warwickshire, Herefordshire and Worcestershire, Shropshire Telford and Wrekin and Staffordshire and Stoke-on-Trent ICBs;

	• For items on behalf of NHS England this will be the Regional Director Specialised Commissioning and Health and Justice in consultation with the other core members. Items for decision that impact more than one group of eligible members will be decided by all those eligible members. MASCG shall aim to make decisions by consensus of the eligible core membership wherever possible. Where this is not possible the Chair will check whether all the information is available to make a decision or if there are alternative options that may offer an acceptable solution. The core members must ensure that matters requiring a decision are anticipated, and that sufficient time is allowed prior to Group meetings for discussions and negotiations internally and between ICBs and other partners to take place. Where possible papers will be co-developed and jointly sponsored by NHS England and the ICBs. At the discretion of the Chair, where it is not possible to make a decision at the meeting decisions may be deferred to the next meeting or, with appropriate consultation with eligible core members, to take a decision outside of the meeting. Where it has not been possible, despite the best efforts of the core membership, to come to a consensus decision the Chair may decide that a decision may be escalated to the relevant Joint Committee or MCG as appropriate, supported by detail of the issues raised and further steps taken.
Conduct and conflicts of interest	Members of the MASCG will be expected to act consistently with existing statutory guidance, NHS Standards of Business Conduct, Nolan Principles and relevant organisational policies. Where any core member of the MASCG or the MASC Team or observer has an actual or potential conflict of interest in relation to any matter under consideration by the MASC Group, that individual must declare that interest and take appropriate action to manage the conflict, which could include not participating in the discussion or voting at meetings (or parts of meetings) in which the relevant matter is discussed. The Chair will be responsible for making final decisions on the appropriate management of conflicts of interest.
Confidentiality of proceedings	All members in attendance at a MASCG are required to give due consideration to the possibility that the material presented to the meeting, and the content of any discussions, may be confidential or commercially sensitive, and to not disclose information or the content of deliberations outside of the meeting's membership, without the prior agreement of the MASCG.
Publication of notices, minutes and papers	The MASC Multi-Disciplinary Team of NHS England shall provide sufficient resources, administration and secretarial support for the proper organisation and functioning of the Group.

	The co-chair(s) (or in the absence of the co-chairs, the person covering for them) shall see that notice of meetings of the MASCG, together with an agenda listing the business to be conducted and supporting documentation, is issued one week, (seven calendar days), prior to the date of the meeting. The proceedings and decisions taken by the MASCG shall be recorded in minutes, and those minutes circulated in draft form having been reviewed by the person who presided at the meeting within two weeks of the date of the meeting. The MASCG shall approve those minutes at its next meeting.
Review of the Terms of Reference	These Terms of Reference will be in place for the 2024/25 transitional year only. Updated Terms of Reference will be in place to reflect post April 2025 arrangements.

SCHEDULE 3: INDIVIDUAL SCHEMES

Part 1– East Midlands scheme

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1 OVERVIEW OF THE EAST MIDLANDS SCHEME FOR DELEGATED SPECIALISED SERVICES IN 2024/25

1.1 This scheme sets out the arrangements through which the Partners will work together to commission the 59 specialised services delegated to the East Midlands Integrated Care Boards (ICBs) by NHS England on 1st April 2024.

1.2 The Partners' aims are:

(a) to maximise the benefits to patients of integrating the Delegated Functions with the ICBs' Commissioning Functions through designing and commissioning the Specialised Services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim.

2 SERVICES AND FUNCTIONS

2.1 NHS England has delegated the statutory function for the commissioning of the 59 delegated specialised services to the ICBs. The key powers and duties that the ICBs will be required to carry out in exercise of the delegated functions being, in summary:

(a) decisions in relation to the commissioning and management of the delegated services;

(b) planning delegated services for the population, including carrying out needs assessments;

(c) undertaking reviews of delegated services in respect of the population;

(d) supporting the management of the specialised commissioning budget for delegated services;

(e) co-ordinating a common approach to the commissioning and delivery of delegated services with other health and social care bodies in respect of the population where appropriate; and

(f) such other ancillary activities that are necessary to exercise the specialised commissioning functions.

2.2 A list of the delegated services included within the scheme are detailed within schedule 2 of the Delegation Agreement

2.3 The services are being provided to the populations within the East Midlands ICBs geographical footprints.

3 PARTNERS

3.1 The partners of this scheme are NHS England, Lincolnshire ICB, Nottingham & Nottinghamshire ICB, Leicester, Leicestershire & Rutland ICB, Northamptonshire ICB, Derby & Derbyshire ICB.

4 THE ARRANGEMENTS

4.1 The Scheme will be overseen by the East Midlands Joint Committee established via a Joint Working Agreement between the ICBs whose role shall be to carry out the strategic decision-making, leadership and oversight functions relating to the commissioning of specified delegated specialised services as agreed by the partners and outlined in Schedule 2 of the ICB Collaboration Agreement.

4.2 Administrative and management functions will be provided to the multi-ICB by the Multidisciplinary Team, hosted in 2024-2025 by NHS England. Details of which are set out in an Commissioning Team Agreement and Standard Operating Framework between all parties.

4.3 Details of the financial arrangements relating to this scheme are contained with Schedule 4 of the ICB Collaboration Agreement.

5 GOVERNANCE ARRANGEMENTS

5.1 The scheme shall be governed by the East Midlands Joint Committee, as set out in Schedule 2 of the ICB Collaboration Agreement.

5.2 The terms of reference of the Joint Committee are set out in the Joint Working Agreement between the ICBs.

6 COMMISSIONING, CONTRACTING, ACCESS

6.1 Commissioning Arrangements

Delegated services will be commissioned from providers on behalf of the ICBs by the Commissioning Team in line with legislative requirements and the NHS planning guidance 2024/25.

6.2 Contracting Arrangements

The list of contracts which are in place across the Midlands in 2023/24 for services due to be delegated in April 24 are contained in Appendix 1. These include;

- 26 x Main NHS Provider contracts
- 2 x Section 75 contracts (in collaboration with Northants & Lincs Local Authorities for HIV)

The scheme will be administered by the Commissioning Team, where;

- Each Midlands provider will have a contract for specialised services where NHSE is the co-ordinating commissioner and a separate contract for core ICB services where the ICB is the co-ordinating commissioner.
- On the specialised services contracts the ICBs will either be associate commissioners or receive service responsibilities via GC12.

6.2.1 The contracting arrangement for the scheme will be as follows:

- The scheme will encompass all existing contracts.
- The contracts will be agreed in line with the National Contracting SOP and the ICB Collaboration Agreement.

- The contracts will be funded in line with the pooled budget arrangements detailed in Schedule 4 of the ICB Collaboration Agreement.

- The contracts will be managed on behalf of the Midlands multi-ICB, by the Commissioning Team.

6.3 **Access**
The scheme will apply to all delegated specialised services provided via contracts with providers.

7. HIGH-COST DRUGS

7.1 All identified service lines that are delegated include any activities within these areas including High-Cost drugs and support through the networks. Financial responsibility for HCD and networks remains within NHSE, and responsibility will be managed through collaboration and appropriate decision making.

8. FINANCIAL GOVERNANCE ARRANGEMENTS

8.1. The financial governance arrangements are set out in Schedule 4 of the ICB Collaboration Agreement.

9. NON FINANCIAL RESOURCES

9.1. The non-financial resources required to deliver scheme will be provided by NHSE in accordance with Schedule 6 of the ICB Collaboration Agreement.

10. STAFF

10.1. The commissioning team responsible for the operational delivery of specialised commissioning for delegated services will be hosted by NHS England in 2024/25.

10.2. The arrangement through which the commissioning team will provide this support to the ICBs is set out Schedule 6 of the ICB Collaboration Agreement.

11. ASSURANCE AND MONITORING

11.1. The arrangements in relation to assurance and monitoring in relation to this scheme are contained Schedule 4 of the ICB Collaboration Agreement.

12. AUTHORISED OFFICERS

12.1. The authorised officers for this scheme are as follows:

Partner	**Name of Authorised Officer – Tier 1**
Lincolnshire ICB	John Turner
Nottingham & Nottinghamshire ICB	Amanda Sullivan
Leicester, Leicestershire & Rutland ICB	Dr Caroline Trevithick
Northamptonshire ICB	Toby Sanders
Derby & Derbyshire ICB	Dr Chris Clayton

Partner	Name of Authorised Officer – Tier 1
NHS England	Roz Lindridge

13. INTERNAL APPROVALS

13.1. The levels of authority relating to this scheme are described within Schedule 4 of the ICB Collaboration Agreement.

14. REGULATORY REQUIREMENTS

14.1. Details in relation to regulatory requirements in relation to this scheme are contained within the delegation agreement and will be fulfilled on behalf of the ICBs by the Commissioning Team.

15. COMPLAINTS

15.1. Complaints will be managed by the specialised commissioning team hosted by NHSE England in line with the agreed complaints process.

15.2. A report summarising complaints, actions and lessons learnt will be provided to the East and West Board annually.

Part 2 – West Midlands scheme

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1 OVERVIEW OF THE WEST MIDLANDS SCHEME FOR DELEGATED SPECIALISED SERVICES IN 2024/25

1.1 This scheme sets out the arrangements through which the Partners will work together to commission the 59 specialised services delegated to the West Midlands Integrated Care Boards (ICBs) by NHS England on 1st April 2024.

1.2 The Partners' aims are:

(a) to maximise the benefits to patients of integrating the Delegated Functions with the ICBs' Commissioning Functions through designing and commissioning the Specialised Services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim.

2 SERVICES AND FUNCTIONS

2.1 NHS England delegates to the ICBs the statutory function for the commissioning of the 59 delegated specialised services. The key powers and duties that the ICBs will be required to carry out in exercise of the delegated functions being, in summary:

(a) decisions in relation to the commissioning and management of the delegated services;

(b) planning delegated services for the population, including carrying out needs assessments;

(c) undertaking reviews of delegated services in respect of the population;

(d) supporting the management of the specialised commissioning budget for delegated services;

(e) co-ordinating a common approach to the commissioning and delivery of delegated services with other health and social care bodies in respect of the population where appropriate; and

(f) such other ancillary activities that are necessary to exercise the specialised commissioning functions.

2.2 A list of the delegated services included within the scheme are detailed within schedule 2 of the Delegation Agreement

2.3 The services are being provided to the populations within the West Midlands ICBs geographical footprints.

2.4 There are currently no planned changes to the services in 2024/25.

3 PARTNERS

3.1 The partners to this scheme are as recorded in the main Collaboration Agreement.

3.2 The partners of this scheme are NHS England, The Black Country ICB, Staffordshire & Stoke ICB, Shropshire Telford & Wrekin ICB, Coventry and Warwickshire ICB, Herefordshire & Worcestershire ICB and Birmingham & Solihull ICB.

4 THE ARRANGEMENTS

4.1 The Scheme will be overseen by the West Midlands Joint Committee established via a Joint Working Agreement between the ICBs whose role shall be to carry out the strategic decision-making, leadership and oversight functions relating to the commissioning of specified delegated specialised services as agreed by the partners and outlined in Schedule 2 of the ICB Collaboration Agreement.

4.2 Administrative and management functions will be provided to the multi-ICB by the Multidisciplinary Team, hosted in 2024-2025 by NHS England. Details of which are set out in a Commissioning Team Agreement and Standard Operating Framework between all parties.

4.3 Details of the financial arrangements relating to this scheme are contained with Schedule 4 of the ICB Collaboration Agreement.

5 GOVERNANCE ARRANGEMENTS

5.1 The scheme shall be governed by the West Midlands Joint Committee as set out in Schedule 2 of the ICB Collaboration Agreement.

5.2 The terms of reference of the Joint Committee are contained within the Joint Working Agreement between the ICBs.

6 COMMISSIONING, CONTRACTING, ACCESS

6.1 Commissioning Arrangements

Delegated services will be commissioned from providers on behalf of the ICBs by the Commissioning Team in line with legislative requirements and the NHS planning guidance 2024/25.

6.2 Contracting Arrangements

The list of contracts which are in place across the Midlands in 2023/24 for services due to be delegated in April 24 are contained in Appendix 1. These include;

- 26 x Main NHS Provider contracts

The scheme will be administered by the Commissioning Team, where;

- Each Midlands provider will have a contract for specialised services where NHSE is the co-ordinating commissioner and a separate contract for core ICB services where the ICB is the co-ordinating commissioner.
- On the specialised services contracts the ICBs will either be associate commissioners or receive service responsibilities via GC12.

The contracting arrangement for the scheme will be as follows:

- The scheme will encompass all existing contracts.

- The contracts will be agreed in line with the National Contracting SOP and the ICB Collaboration Agreement.

- The contracts will be funded in line with the pooled budget arrangements detailed in Schedule 4 of the ICB Collaboration Agreement.

- The contracts will be managed on behalf of the Midlands multi-ICB, by the Commissioning Team.

6.3 **Access**
The scheme will apply to all delegated specialised services provided via contracts with providers.

7 HIGH-COST DRUGS

7.1 All identified service lines that are delegated include any activities within these areas including High-Cost drugs and support through the networks. Financial responsibility for HCD and networks remains within NHSE, and responsibility will be managed through collaboration and appropriate decision making.

8 FINANCIAL GOVERNANCE ARRANGEMENTS

8.1 The financial governance arrangements are set out in Schedule 4 of the ICB Collaboration Agreement.

9 NON FINANCIAL RESOURCES

9.1 The non-financial resources required to deliver scheme will be provided by NHSE in accordance with Schedule 6 of the ICB Collaboration Agreement.

10 STAFF

10.1 The commissioning team responsible for the operational delivery of specialised commissioning for delegated services will be hosted by NHS England in 2024/25.

10.2 The arrangement through which the commissioning team will provide this support to the ICBs is set out in Schedule 6 of the ICB Collaboration Agreement.

11 ASSURANCE AND MONITORING

11.1 The arrangements in relation to assurance and monitoring in relation to this scheme are contained Schedule 4 of the ICB Collaboration Agreement.

12 AUTHORISED OFFICERS

12.1 The authorised officers for this scheme are as follows:

Partner	**Name of Authorised Officer – Tier 1**
Coventry & Warwickshire ICB	Philip Johns
The Black Country ICB	Mark Axcell
Herefordshire & Worcestershire ICB	Simon Trickett
Birmingham & Solihull ICB	David Melbourne

Partner	Name of Authorised Officer – Tier 1
Staffordshire and Stoke on Trent ICB	Peter Axon
Shropshire Telford and Wrekin ICB	Simon Whitehouse
NHS England	Roz Lindridge

13 INTERNAL APPROVALS

13.1 The levels of authority relating to this scheme are described within Schedule 4 of the ICB Collaboration Agreement.

14 REGULATORY REQUIREMENTS

14.1 Details in relation to regulatory requirements in relation to this scheme are contained within the delegation agreement and will be fulfilled on behalf of the ICBs by the Commissioning Team.

15 COMPLAINTS

15.1 Complaints will be managed by the specialised commissioning team hosted by NHSE England in line with the agreed complaints process.

15.2 A report summarising complaints, actions and lessons learnt will be provided to the East and West Board annually.

Part 3– Retained Services Scheme

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1 OVERVIEW OF THE SCHEME FOR RETAINED SPECIALISED SERVICES IN 2024/25

1.1 This scheme sets out the arrangements through which the Partners will work together to commission the specialised services for which responsibility is being retained by NHS England in 2024/25 but identified as suitable for future delegation to Integrated Care Boards (ICBs) in the future.

1.2 The Partners' aims are:

(a) to maximise the benefits to patients by working collaboratively on the Retained Functions in preparation for future delegation and integration with the ICBs' Commissioning Functions through designing and commissioning the Specialised Services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim.

2 SERVICES AND FUNCTIONS

2.1 NHS England has identified that the statutory function for the commissioning of the specialised services is suitable for future delegation to the ICBs. Whilst this responsibility is being retained by NHS England for 2024/25 it will involve the ICBs in the of these functions being, in summary:

(a) decisions in relation to the commissioning and management of the services;

(b) planning for the services for the population, including carrying out needs assessments;

(c) undertaking reviews of services in respect of the population;

(d) supporting the management of the specialised commissioning budget for the services;

(e) co-ordinating a common approach to the commissioning and delivery of the services with other health and social care bodies in respect of the population where appropriate; and

2.2 A list of the services included within the scheme are detailed within Appendix 2 of this Schedule.

2.3 The services are being provided to the populations within the Midlands ICBs geographical footprints.

3 PARTNERS

3.1 The partners for joint working within this scheme are NHS England, Birmingham and Solihull ICB, Black Country ICB, Coventry and Warwickshire ICB, Herefordshire and Worcestershire ICB, Shropshire, Telford and Wrekin ICB, Staffordshire and Stoke-on-Trent ICB, Lincolnshire ICB, Nottingham & Nottinghamshire ICB, Leicester, Leicestershire & Rutland ICB, Northamptonshire ICB, Derby & Derbyshire ICB

4 THE ARRANGEMENTS

4.1 NHS England will retain responsibility for the delivery of the functions covered by this scheme, working with the ICBs through appropriate consultation with and reporting to the East Midlands Joint Committee and the West Midlands Joint Committee established via a Joint Working Agreements between the ICBs.

4.2 Administrative and management functions will be provided to deliver the scheme by the multi-disciplinary commissioning team, hosted in 2024-2025 by NHS England. Details of which are set out in a commissioning team agreement between all parties.

4.3 Financial arrangements for this scheme will follow NHS England's budgetary and financial arrangements.

5 GOVERNANCE ARRANGEMENTS

5.1 NHS England will continue to hold responsibility for the delivery of the functions covered by the scheme.

5.2 Decision making will be in line with NHS England's Scheme of Reservation and Delegation subject to decisions being taken in consultation with the ICBs and the Joint Committees where appropriate.

5.3 The exercise of NHS England functions in consultation with the Joint Committees will be achieved by NHS England Officers with appropriate delegated authority attending meetings of the East Midlands Joint Committee and West Midlands Joint Committee when exercising that authority.

5.4 NHS England will report on the delivery of the functions under this scheme to the East Midlands and West Midlands Joint Committees.

6 COMMISSIONING, CONTRACTING, ACCESS

6.1 Commissioning Arrangements

6.1.1 Services will be commissioned from providers by the Commissioning Team in line with legislative requirements and the NHS planning guidance 2024/25.

6.2 Contracting Arrangements

6.2.1 The scheme will be administered by the Commissioning Team.

6.2.2 The contracting arrangement for the scheme will be as follows:

- The scheme will encompass all existing contracts.
- The contracts will be agreed in line with the National Contracting SOP and the ICB Collaboration Agreement.
- The contracts will be funded by NHS England.
- The contracts will be managed by the Commissioning Team.

6.3 Access

The scheme will apply to all delegated specialised services provided via contracts with providers.

7 HIGH-COST DRUGS

7.1 All identified service lines that are delegated include any activities within these areas including High-Cost drugs and support through the networks. Financial responsibility for HCD and networks remains within NHSE, and responsibility will be managed through collaboration and appropriate decision making.

8 FINANCIAL GOVERNANCE ARRANGEMENTS

8.1 The financial governance arrangements will be in line with NHS England's Scheme of Reservation and Delegation and Standing Financial Instructions.

9 NON-FINANCIAL RESOURCES

9.1 The non-financial resources required to deliver scheme will be provided by NHSE in accordance with Schedule 6 of the ICB Collaboration Agreement.

10 STAFF

10.1 The commissioning team responsible for the operational delivery of specialised commissioning for the services will be retained by NHS England.

11 ASSURANCE AND MONITORING

11.1 NHS England's requirements in relation to Assurance and Monitoring will apply to this scheme.

12 INTERNAL APPROVALS

12.1 The levels of authority relating to this scheme will follow NHS England's Scheme of Reservation and Delegation and Standing Financial Instructions

13 REGULATORY REQUIREMENTS

13.1 NHS England will retain responsibility for fulfilling the regulatory requirements in relation to this scheme.

14 COMPLAINTS

14.1 Complaints will be managed by the specialised commissioning team within NHSE England in line with the agreed complaints process.

APPENDIX 1 – LIST OF CONTRACTS HELD WITH PROVIDERS IN 2023/24

Standard Contracts

BIRMINGHAM COMMUNITY HEALTHCARE NHS FOUNDATION TRUST
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST
DERBYSHIRE COMMUNITY HEALTH SERVICES FOUNDATION TRUST
CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST
GEORGE ELIOT HOSPITAL NHS TRUST
KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST
MIDLANDS PARTNERSHIP NHS FOUNDATION TRUST
NORTHAMPTON GENERAL HOSPITAL NHS TRUST
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST
SHREWSBURY AND TELFORD HOSPITAL NHS TRUST
THE DUDLEY GROUP NHS FOUNDATION TRUST
THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST
THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST
THE ROYAL WOLVERHAMPTON NHS TRUST
THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST
UNITED LINCOLNSHIRE HOSPITALS NHS TRUST
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST
UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST
WALSALL HEALTHCARE NHS TRUST
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST
WYE VALLEY NHS TRUST

Section 75 Contracts

LINCOLNSHIRE COMMUNITY HEALTH SERVICES NHS TRUST
NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST

APPENDIX 2 RELEVANT SERVICES

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
4	Adult specialist respiratory services	29E	Management of central airway obstruction
		29V	Complex home ventilation
15	Adult specialist renal services	11T	Renal transplantation
29	Haematopoietic stem cell transplantation services (adults and children)	02Z	Blood and marrow transplantation services
		ECP	Extracorporeal photopheresis service
45	Cystic fibrosis services (adults and children)	10Z	Cystic fibrosis services
55	Gender dysphoria services (children and adolescents)	22A	Gender identity development service for children and adolescents
56	Gender dysphoria services (adults)	22Z	Gender identity services
		42A	Gender dysphoria: genital surgery (trans feminine)
		42B	Gender dysphoria - genital surgery (trans masculine)
		42C	Gender dysphoria: chest surgery (trans masculine)
		42D	Gender dysphoria - non-surgical services
		42E	Gender dysphoria: other surgical services
58	Specialist adult gynaecological surgery and urinary surgery services for females	04K	Specialised services for women with complications of mesh inserted for urinary incontinence and vaginal prolapse (16 years and above)
		04L	Reconstructive surgery and congenital anomalies of the female genital tract
65	Specialist services for adults with infectious diseases	18T	Tropical Disease
82	Paediatric and perinatal post mortem services	F23	Paediatric and perinatal post mortem services
87	Positron emission tomography-computed tomography services (adults and children)	01P	Positron emission tomography- computed tomography services (PETCT)
89	Primary malignant bone tumours service (adults and adolescents)	01O	Primary malignant bone tumours service (adults and adolescents)
101	Severe intestinal failure service (adults)	12Z	Severe intestinal failure service
103A	Specialist adult haematology services	03C	Castleman disease
105	Specialist cancer services (adults)	01L	Soft tissue sarcoma
		01X	Penile cancer
111	Clinical genomic services (adults and children)	20G	Genomic laboratory testing services
		20H	Pre-Implantation genetic diagnosis and associated in-vitro fertilisation services
		20Z	Specialist clinical genomics services
		MOL	Molecular diagnostic service
114	Specialist haemoglobinopathy services (adults and children)	38S (DPC)	Sickle cell anaemia -direct patient care
		38T (DPC)	Thalassemia - direct patient care
		38X (HCC)	Haemoglobinopathies coordinating centres (HCCs)
		38X (SHT)	Specialist Haemoglobinopathies Teams (SHTs)
115	Specialist immunology services for adults with deficient immune systems	16X	Specialist immunology services for adults with deficient immune systems
115A	Specialist immunology services for children with deficient immune systems	16Y	Specialist immunology services for children with deficient immune systems
134	Specialist services to support patients	05C	Specialist augmentative and alternative

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
	with complex physical disabilities (excluding wheelchair services) (adults and children)		communication aids
		05E	Specialist environmental controls
137	Spinal cord injury services (adults and children)	06A	Spinal cord injury services (adults and children)
6	Adult secure mental health services	22S(a)	Secure and specialised mental health services (adult) (Medium and low) - including LD / ASD / WEMS / ABI / DEAF
		22S(b)	Secure and specialised mental health services (adult) (Medium and low) - Excluding LD / ASD / WEMS / ABI / DEAF
		22S(c)	Secure and specialised mental health services (adult) (Medium and low) - ASD
		22S(d)	Secure and specialised mental health services (adult) (Medium and low) – LD
		22S(e)	Secure and specialised mental health services (adult) Medium Secure Female WEMS
		22S(f)	Secure and specialised mental health services (adult) (Medium and low) – ABI
		22S(g)	Secure and specialised mental health services (adult) (Medium and low) - DEAF
		YYY	Specialised mental health services exceptional packages of care
8	Adult specialist eating disorder services	22E	Adult specialist eating disorder services
32	Children and young people's inpatient mental health service	22C	Tier 4 CAMHS (MSU)
		24E	Tier 4 CAMHS (children's service)
		23K	Tier 4 CAMHS (general adolescent inc eating disorders)
		23L	Tier 4 CAMHS (low secure)
		23O	Tier 4 CAMHS (PICU)
		23U	Tier 4 CAMHS (LD)
		23V	Tier 4 CAMHS (ASD)
98	Specialist secure forensic mental health services for young people	24C	FCAMHS
102	Severe obsessive compulsive disorder and body dysmorphic disorder service (adults and adolescents)	22F	Severe obsessive compulsive disorder and body dysmorphic disorder service
116	Specialist mental health services for Deaf adults	22D	Specialist mental health services for Deaf adults
124	Specialist perinatal mental health services (adults and adolescents)	22P	Specialist perinatal mental health services
133	Specialist services for severe personality disorder in adults	22T	Specialist services for severe personality disorder in adults

SCHEDULE 4: FINANCIAL ARRANGEMENTS

PART A: POOLED FUND MANAGEMENT

1 ESTABLISHMENT OF A POOLED FUND

1.1 The ICBs have agreed to establish and maintain a mutual agreement pooled fund arrangement for in-year financial management of Schemes 1 and 2 of Schedule 3 of this agreement, with a defined contribution based on the allocation received will be transferred to the Host ICB, (Birmingham & Solihull ICB) on behalf of the Midlands.

The monies held in a Pooled Fund may only be expended on the following:

- the Contract Price;
- Third Party Costs where these are set out in the relevant Scheme Specification or as otherwise agreed in advance in writing in accordance with the relevant Scheme Specification;
- Approved expenditure as set out in the relevant Scheme Specification or as otherwise agreed in advance in accordance with the relevant Scheme Specification.
(collectively known as "Permitted Expenditure")

1.2 The Pooled Fund is explicitly for the management of in year expenditure against specialised services contractual commitments. This includes all contractual commitments for the population of Midlands ICBs including any out of Region contractual arrangements.

1.3 The Pooled Fund is not intended to be the route for recurrent commissioning decisions for specialised services. Such decisions would be made through the governance structure established in East and West Midlands.

1.4 The Partners may only depart from the definition of Permitted Expenditure or exceed Pooled Fund budget with the express written agreement of each relevant Partner and in line with approved delegations.

1.5 Birmingham & Solihull ICB on behalf of the Midlands shall be the Partner responsible for:

- Holding all monies contributed to the Pooled Fund on behalf of itself and the other Partners;
- Providing the financial administrative systems for the Pooled Fund; and
- The manager of the Pooled Fund (“Pooled Fund Manager”) will be the Director Specialised Commissioning of Finance
- Ensuring that the Pooled Fund Manager complies with its obligations under this Agreement.

2. RISK EXPOSURE

2.1. ICB population-based allocations have been developed on the basis of current contractual commitments as demonstrated in the document “ICB Baseline Development”.

2.2. All ICB 2024/25 opening baselines have been updated for 2023/24 variable activity levels and precommitments.

2.3. All ICB 2024/25 opening baselines are in recurrent financial balance and there is no risk exposure from opening contract baselines for 2024/25.

2.4. The specialised services contract is operated on a block basis and there is no financial exposure to activity variance through the block contract.

2.5. Elective activity is managed through the Elective Recovery Fund which will be managed on the same basis as 2023/24 with contract values and allocations being adjusted for activity variances. There will be no financial risk associated with the application of ERF. There are a small number of variable services (linked to Best Practice Tariffs) within the contract, these being:

- Chemotherapy
- Diagnostic Imaging
- Nuclear Medicine
- PRT-CT
- Molecular Radiotherapy
- Renal Transplant

2.6. These services are paid on a cost per case basis. Opening baselines for variable services will be based on 2023/24 outturn with growth applied based on historic activity.

2.7. There remains risk at an ICB and regional level of variance against contract and budget for these services.

2.8. ICBs hold contracts with providers outside the geographical boundary of the Midlands. It is expected that there will be consistency between planning assumptions and contractual growth across regions, but there is a risk that differential application of growth by other NHS England regions will impact on partners to this agreement.

2.9. A contingency of 0.5% will be held to manage in year financial risk to mitigate the impact of variable service financial risks and consequences of cross regional contractual commitments.

2.10. The use of a Pooled Fund will mitigate in year fluctuation at ICB level for variable services within delegated specialised services.

3. POOLED FUND MANAGEMENT

3.1. The Pooled Fund Manager for Pooled Fund shall have the following duties and responsibilities:

- The day-to-day operation and management of the Pooled Fund,
- Ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this Agreement and the relevant Scheme Specification,
- Maintaining an overview of all joint financial issues affecting the Partners in relation to the Services and the Pooled Fund,
- Ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund,
- Reporting to the relevant governance group as required by this Agreement,
- ensuring action is taken to manage any projected under or overspends relating to the Pooled Fund in accordance with this Agreement, and
- preparing and submitting reports as required by the relevant Scheme Specification.

3.2. The Partners may agree to the virement of funds between Pooled Funds or amending the allocation of the Pooled Fund between Individual Schemes.

4. FINANCIAL CONTRIBUTIONS

4.1. The pooled fund shall initially operate for the financial year 2024/25. Should the scheme be continued into future years, the Financial Contribution to any Pooled Fund for each subsequent Financial Year of operation shall be subject to review by the Partners.

4.2. Unless otherwise agreed, no provision of this Agreement shall preclude the Partners from making additional contributions to a Pooled Fund from time to time by mutual agreement. Any such additional contributions of Non-Recurrent Payments shall be explicitly recorded in the budget statement as a separate item.

4.3. ICBs will pay contributions to the Pooled Fund for Specialised Services to the identified Host ICB.

4.4. Contributions will be the equivalent of the allocation for delegated specialised services or an amount specified by the payments schedule calculated by the specialised commissioning team.

Table of contributions to be added once final 2024/25 allocations have been confirmed.

Partner	**Name of CFO**	**Contribution to the Fund**
Coventry & Warwickshire ICB		
The Black Country ICB		
Herefordshire & Worcestershire ICB		
Birmingham & Solihull ICB		
Staffordshire and Stoke on Trent ICB		
Shropshire Telford and Wrekin ICB		
Lincolnshire ICB		
Nottingham & Nottinghamshire ICB		
Leicester, Leicestershire & Rutland ICB		
Northamptonshire ICB		
Derby & Derbyshire ICB		

5. RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPEND

5.1. The Host Partner for the relevant Pooled Fund shall, through the Specialised Commissioning Team Fund Manager, manage expenditure from a Pooled Fund within the Financial Contributions and shall use reasonable endeavours to ensure that the expenditure is limited to Permitted Expenditure.

5.2. The Host Partner shall not be in breach of its obligations under this Agreement if an Overspend occurs provided that it has used reasonable endeavours to ensure that the only expenditure from a Pooled Fund has been incurred and it has informed the Partners of any variance.

5.3. In the event that the Pooled Fund Manager identifies an actual or projected Overspend the Pooled Fund Manager must ensure that the Partners are informed as soon as reasonably possible.

5.4. If expenditure from the Pooled Fund in any Financial Year is less than the aggregate value of the Financial Contributions made for that Financial Year, financial resources will be returned to the Partners proportionate to the contributions to the Pooled Fund. Arrangements shall be subject to the Law and the Standing Orders and Standing Financial Instructions of the Partners.

5.5. Any unmitigated net variance will need to be recognised in the Agreement of Balances exercise completed as part of the month 09 financial reporting process.

5.6. Residual variances (under or overspend), after mitigations and application of contingency, will be allocated to ICBs proportionately to contributions to the Pooled Fund.

6. CAPITAL EXPENDITURE

6.1. Pooled Funds shall not be applied towards any one-off expenditure on goods or services, which will provide continuing benefit and would historically have been funded from the capital budgets of one of the Partners. If a need for capital expenditure is identified this must be agreed by the Partners.

7. POOLED FUND FINANCIAL GOVERNANCE

7.1. The partners in the Pooled Fund shall make monthly payments of one twelfth of the Pooled Fund contributions by the 5th of the month.

7.2. The Specialised Commissioning Team will manage specialised services through the host ledger managing financial risk across all Partner ICBs.

7.3. All contractual payments including variable adjustments will be managed by the Specialised Commissioning Team through the single joint Specialised Commissioning contract in line with the Contracting Standard Operating Procedure.

7.4. In year financial management will be undertaken at a multi ICB level across eleven ICBs in the Midlands region, mitigating the risk of variation between systems.

7.5. Regional financial variances (under or overspend) would be mitigated through the application of local financial management and the use of the contingency held by the Host, as agreed by partners, to minimise exposure to financial fluctuation.

7.6. Residual variances (under or overspend), after mitigations and application of contingency, will be allocated to ICBs proportionately to contributions to the Pooled Fund.

8. POOLED FUND FINANCIAL REPORTING AND ASSURANCE

8.1. The Joint finance subgroup will have responsibility to oversee the management of the pooled fund on behalf of the Joint Committees.

8.2. ICB level in year financial reporting will show contributions to the pool in the ICB position thereby demonstrating a break-even position for specialised commissioning on monthly financial reports.

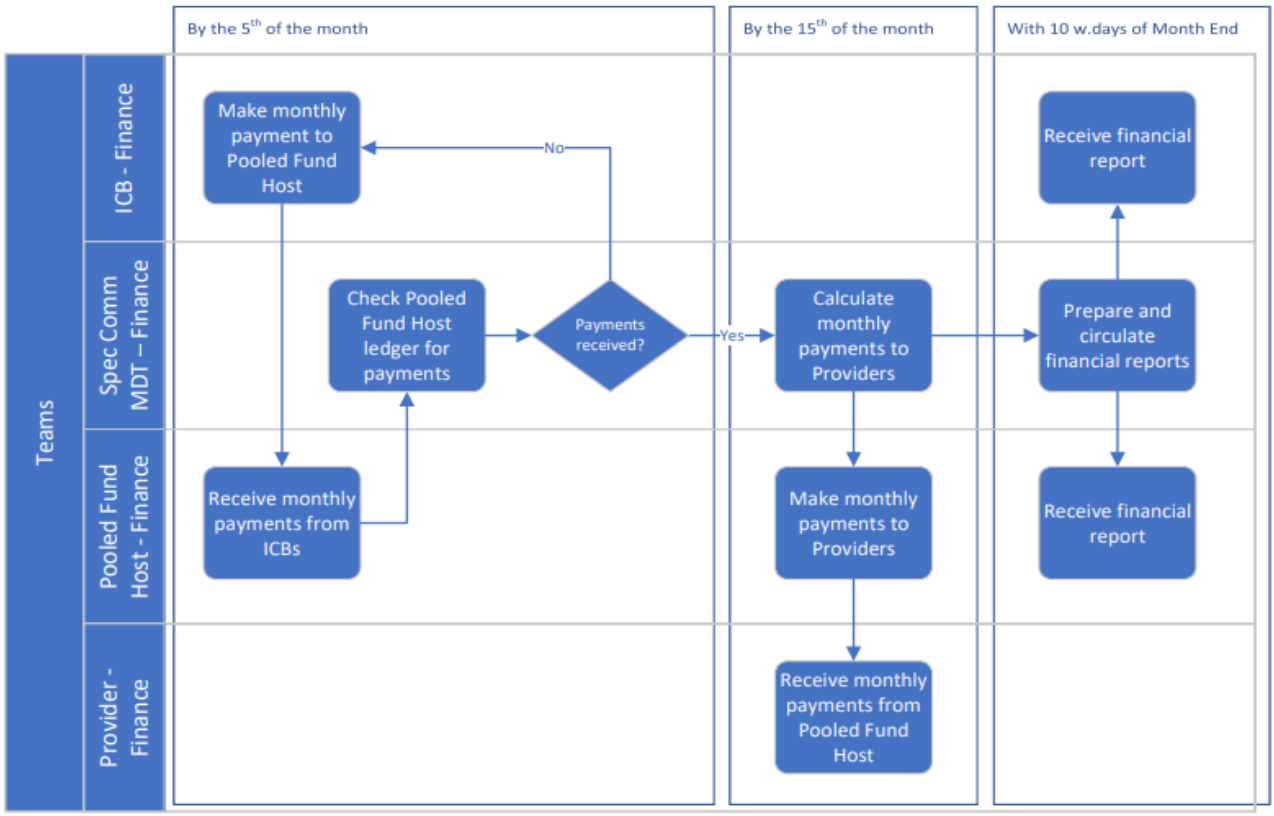
8.3. Performance reporting will be developed at an ICB and multi ICB level to enable local intelligence on performance in delegated specialised services.

8.4. The Specialised Commissioning Team on behalf of the Host will prepare quarterly memorandum finance reports at individual ICB level to ensure all ICBs have full sight of the overall actual performance of specialised commissioning and indicative ICB level performance.

8.5. Year-end reporting will be prepared in line with nationally produced annual accounts timetables recognising any locally agreed requirements.

8.6. As part of the year end process the Specialised Commissioning Team will prepare reconciliation journals to update individual ICB ledgers with detailed Provider level expenditure in line with Pooled Fund contributions.

8.7. Financial Flow arrangements are illustrated below



PART B: OTHER FINANCIAL ARRANGEMENTS

9. BUDGETARY DELEGATION

9.1. Commissioning decisions will be made in line with the Arrangements agreed by the East/West Midlands Joint Commissioning Committee which has Delegated Authority to set approval limits in line with those arrangements. Initial approval limits, subject to the agreement of the Joint Committees are set out in Annex 1 to this schedule.

9.2. ICBs have agreed to delegate budgetary responsibility to the specialised commissioning team for the processing and delivery of specialised services transactions. These delegations are to facilitate the delivery of contract signature, purchase orders and non-purchase order invoices and budgetary virement and are set out in Annex 2 to this schedule.

9.3. For 2024/25, the specialised commissioning team will be employed by NHS England on behalf of the partner ICBs. From 2025/26 the specialised commissioning team will be employed by the Host ICB.

10. AUDIT ARRANGEMENTS

10.1. Transactions through ICB ledgers will be subject to audit through existing internal audit arrangements. It will be the responsibility of ICBs to ensure that this appropriately referenced in the 2024/25 audit plan.

10.2. In 2024/25 Specialised Commissioning Team responsible for the management of specialised commissioning resources will continue to be employed by NHS England but will access the ledger of the Host ICB to process transactions for specialised services.

10.3. In 2024/25 the Host ICB will commission a specific review of the financial control, governance and assurance of the Specialised Commissioning Team delivered service to provide assurance to ICBs that the controls in place for specialised services are robust.

11. FINANCIAL MANAGEMENT

11.1. Financial transactions for the 59 delegated specialised services will be processed through the Oracle ISFE ledger system of the Host ICB. Specialised Commissioning team will have appropriate access to ICB ledgers enabled.

11.2. Financial monitoring reports will be produced by the NHSE hosted Specialised Commissioning Team on behalf of the ICBs. The team, for 2024/25, will provide financial support to ICBs for delegated services and NHSE for retained and highly specialised services.

11.3. Financial reports will be prepared monthly within ten working days of the end of the month. Forecast outturn positions will be included in the monitoring reports from quarter 2.

11.4. Monthly budget reporting with variance analysis and forecasting will be provided the Joint Finance Subgroup, Host ICB, and Partner ICBs including:

- ICB reporting based on pool contribution,
- Overall pool financial performance report to be shared with all ICBs,
- Management and review of reserves and investments.

Annex 1 to Schedule 4

Commissioning Decisions Budgetary Delegation Schedule

Description of Delegation (All Delegations are Annual Values)	**Delegated Limits**		
	Director of Specialised Commissioning	**MASCG**	**Joint Committees**
Approval of extensions to contracts and contract variations	N/a	Up to £2.5m	Above £2.5m
Approval of business cases for investment for **existing services** within **existing budget envelope**	Unlimited		
Approval of business cases for investment for **existing services** with **additional investment**	Up to £1m	Up to £2.5m	Above £2.5m
Approval of business cases for investment for **existing services** with **new investment**	Up to £1m	Up to £2.5m	Above £2.5m

Annex 2 to Schedule 4

Operational Budgetary Delegation Schedule

Contract award, signature and variation		
Description of delegation: Approval of contract award reports, providing requirements for competitive tendering have been met. Signature of contracts and contract variations, within the approved budget.		
Delegated Limit Limits are annual values	Up to £2m	Unlimited
Approvers and/or restrictions No variation can be granted to a contract awarded under the PCR threshold where the value of the variation results in the contract value exceeding the PCR threshold.	Commissioning Lead – Acute Specialised Commissioning (Contracting)	Director of Specialised Commissioning Director of Commissioning Finance (specialised commissioning).

Purchase Requisitions, invoices and non POs			
Description of delegation: Approval of purchase requisitions, purchase credit notes, invoices and non-purchase order invoices. Approval of contract payments to NHS providers.			
Delegated Limit	Up to £50k	Up to £2m or 1/12 of contract value for NHS Providers	Over £2m
Approvers and/or restrictions Expenditure must be covered by a relevant budget. Purchase orders should be raised for all nonhealthcare goods and services and the non-purchase order route should only be used in exceptional circumstances.	Specialised commissioning: Contract Managers or Budget Holders	Director of Specialised Commissioning Director of Commissioning Finance (specialised)	Director of Specialised Commissioning **or** Director of Commissioning Finance (Specialised) **And** Pooled Fund Host CFO

Budget Virements			
Description of delegation: Approval of budget virements/movements within approved revenue and capital budgets.			
Delegated Limit	Up to £50k	Up to £2m	Over £2m
Approvers and/or restrictions Expenditure must be covered by a relevant budget.	Specialised commissioning Contract Managers or Budget Holders	Director of Specialised Commissioning	MASCG

Purchase orders should be raised for all nonhealthcare goods and services and the non-purchase order route should only be used in exceptional circumstances.		Director of Commissioning Finance (specialised)	

SCHEDULE 5: FURTHER INFORMATION GOVERNANCE AND SHARING PROVISIONS

PART 1

1. Introduction

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

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

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

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

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

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

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

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

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

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

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

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

2. Purpose

2.1. The Specified Purpose of the data sharing is to facilitate the exercise of the Joint Working Arrangements.

2.2. Each Partner must ensure that they have in place appropriate Data Sharing Agreements to enable data to be received from any third party organisations from which the Partners must obtain data in order to achieve the Specified Purpose. Where necessary specific and detailed purposes must be set out in a Data Sharing Agreement that complies with all relevant legislation and Guidance.

3. Benefits of information sharing

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

4. Lawful basis for sharing

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

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

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

5. Restrictions on use of the Shared Information

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

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

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

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

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

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

6. Ensuring fairness to the Data Subject

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

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

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

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

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

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

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

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

7. Governance: Staff

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

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

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

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

7.5. The Partners shall ensure that:

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

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

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

8. Governance: Protection of Personal Data

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

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

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

8.4. If any Partner becomes aware of:

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

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

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

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

8.5.1. in accordance with the terms of this Agreement and otherwise (to the extent that it acts as a Data Processor for the purposes of Article 27-28 GDPR) only

in accordance with written instructions from the originating Data Controller in respect of its Relevant Information;

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

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

8.6. The Partners shall act generally in accordance with Data Protection Legislation requirements. This includes implementing, maintaining, and keeping under review appropriate technical and organisational measures to ensure and demonstrate that the processing of Personal Data is undertaken in accordance with Data Protection Legislation, and in particular to protect the Personal Data (and Special Category Personal Data) against unauthorised or unlawful processing, and against accidental loss, destruction, damage, alteration or disclosure. These measures shall:

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

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

8.7. Each Partner shall:

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

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

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

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

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

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

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

8.9. The Partners' Single Points of Contact set out in paragraph 13 will be the persons who, in the first instance, will have oversight of third-party security measures.

9. Governance: Transmission of Information between the Partners

9.1. This paragraph supplements paragraph 8 of this Schedule.

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

9.3. Wherever possible, Personal Data should be transmitted and held in pseudonymised form, with only reference to the NHS number in 'clear' transmissions. Where there are significant consequences for the care of the patient, then additional data items, such as the postcode, date of birth and/or other identifiers should also be transmitted, in accordance with good information governance and clinical safety practice, to ensure that the correct patient record and/or data is identified.

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

9.5. Each Partner shall keep an audit log of Relevant Information transmitted and received during this Agreement.

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

10. Governance: Quality of Information

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

11. Governance: Retention and Disposal of Shared Information

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

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

11.3. If a Partner is required by any Law, regulation, or government or regulatory body to retain any documents or materials that it would otherwise be required to return or destroy

in accordance with this Schedule, it shall notify the other Partners in writing of that retention, giving details of the documents or materials that it must retain.

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

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

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

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

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

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

12. Governance: Complaints and Access to Personal Data

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

12.2. Complaints about information sharing shall be reported to each Partner. Complaints about information sharing shall be routed through each Partner's own complaints procedure unless otherwise provided for in the Joint Working.

12.3. The Partners shall use all reasonable endeavours to work together to resolve any dispute or complaint arising under this Schedule or any data processing carried out further to it.

12.4. Basic details of the Agreement shall be included in the appropriate log under each Partner's publication scheme.

13. Governance: Single Points of Contact

13.1. The Partners each shall appoint a Single Point of Contact to whom all queries relating to the particular information sharing should be directed in the first instance.

14. Monitoring and review

14.1. The Partners shall monitor and review on an ongoing basis the sharing of Relevant Information to ensure compliance with Data Protection Legislation and best practice.

Specific monitoring requirements must be set out in the relevant Data Sharing Agreement.

SCHEDULE 6: COMMISSIONING TEAM AGREEMENT and STANDARD OPERATING FRAMEWORK

COVERED UNDER A SEPARATE AGREEMENT - COMMISIONING TEAM AGREEMENT AND OPERATING FRAMEWORK

Appendix 3

Midlands Acute Specialised Commissioning (MASC)

Commissioning Team Agreement and Standard Operating Framework for 2024/25

Contents:

1. Introduction

This agreement sets out the purpose and role of the Midlands Acute Specialised Commissioning (MASC) Multidisciplinary Team, how it will operate and how it will be governed from 1st April 2024 to 31st March 2025.

This Commissioning Team Agreement and Standard Operating Framework should be read in conjunction with:

- Overarching governance documents
  - Delegation Agreement
  - Memorandum of Understanding and Collaboration Agreement
- Key documents produced as part of the above Agreements including,
  - Cash Flow SOP
  - Contracting SOP
  - Financial Risk Share and Pooling Arrangement
  - Quality Assurance Framework
    and other key operating instructions
- National guidance relating to the roles and responsibilities of NHS England in relation to specialised services.

This agreement will commence on 1st April 2024 for one year only. The year will operate as a transition for some defined functions with NHSE remaining the employing organisation.

The Multidisciplinary Team will support the following organisations in the commissioning of delegated services:

- NHS Lincolnshire ICB
- NHS Derbyshire ICB
- NHS Nottingham and Nottinghamshire ICB
- NHS Leicester, Leicestershire, and Rutland ICB
- NHS Northamptonshire ICB

Known as the East Midlands Multi-ICB.

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

Known as the West Midlands Multi-ICB.

And the following organisation in the commissioning of retained specialised services and financial and governance responsibility High Cost Drugs and clinical networks:

- NHS England

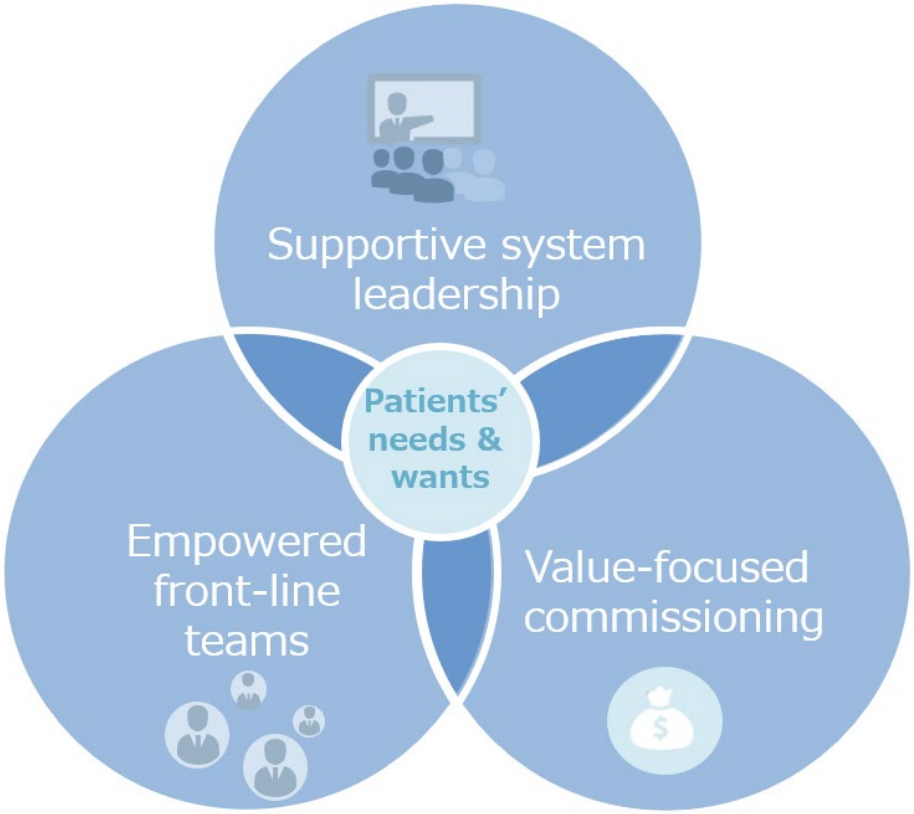
The team will be responsible for commissioning, financial and clinical and quality management of the 59 delegated specialised services on behalf of the East and West Midlands Joint Committees and the retained services on behalf of NHSE in collaboration with the ICBs.

2. Values and Principles

The Multidisciplinary Team will work to support the following:

- **Programmes of Care**:
  Specialist services – which are low volume and high cost – that must be in place and able to meet the needs of patients and families at the right time and in the right way, aligned to national specifications.
- **Patient Pathways**:
  Delegation enables improved working between commissioners and across networks to ensure the best value for patients moving through services.
- **Providers and Partners**:
  That fewer, better relationships create improvements in delivery and new models support this (provider collaboratives)
- **Population Outcomes**:
  That systems can articulate the benefit to their patients of working across all services from prevention through to highly specialist intervention.

The principles of a successful model are set out below:



The Multidisciplinary Team will work coherently and consistently and will champion specialised care on behalf of the 12 commissioning partners. They will work as a part of a network of partners, enabling staff to deliver across complex geographies and as part of multi-layered systems and local collaboration.

3. Key Terms

The following are key terms and abbreviations to support navigation through specialised commissioning and specialised services:

MASC	Midlands Acute Specialised Commissioning
MDT	Multi-Disciplinary Team: The collaboration between specialist components of the MASC that provide the single support offer – Commissioning (inc. Contracting), Pharmacy, Finance, Nursing & Quality, Business Intelligence & Analytics and Regional Communications and Engagement. Complaints will be dealt with by the relevant functional teams.
MASCG	Midlands Acute Specialised Commissioning Group, the Tier 2 sub-group of the East and West Midlands Joint Committees, representing all 12 partners
EMJC/WMJC	East Midlands/West Midlands Joint Committee, the Tier 1 governance structure for the East/West Midlands multi-ICB.
DELEGATED SERVICES	The 59 Specialised Services being delegated from NHSE to Midlands ICB on 1st April 2024
RETAINED SERVICES	The remaining Specialised Services not being delegated on 1st April 2024 which will be retained by NHSE.
POC	Programmes of Care which operate on a Pan-Midlands footprint and to individual contracts (27 NHS and 3 IS) at a system level including; • Blood and Infection • Cancer • Internal Medicine • Trauma; and • Women and Children
DCG	Delegated Commissioning Group for national decisions applied to delegated services including updates to specification. The Regional Director of Specialised Commissioning will represent the ICBs on the Group
NCG	National Commissioning Group for Non-Delegated Services. The Regional Director of Specialised Commissioning will represent NHSE Midlands on the Group
ODN(s)	Operational Delivery Network(s) for Specialised Services
HCDs	High-Cost Drugs

4. Key elements

The following are key elements relating to the operation of the Multidisciplinary Team in 2024/25:

- The Multidisciplinary Team will support the delivery of delegated and retained services. The team will not be split, in terms of time aligned to these, but will be driven by needs as agreed through the MASCG. The 59 delegated services are the predominant areas of focus for the team based on the work plan.

- Corporate support will be provided by NHSE as the host organisation including estates, IT, legal support, HR and business administration.

- The Multidisciplinary Team will link with NHSE Regional and National directorates regarding risk management where this is appropriate.

- Although the responsibility for commissioning of the 59 specialised services is delegated to the Midlands ICBs on 1st April 2024, accountability remains with NHSE. This will be managed by the NHSE Midlands regional team through an Oversight and Assurance Framework informed by subject matter expertise provided by the Multidisciplinary Team and wider regional commissioning integration team.

- The team will work to ensure consistency of communication through the established governance model, recognising the different populations and system issues in the East and West Midlands. The team will remain pan-Midlands in structure.

5. Administrative & Management Services

5.1 Purpose, Roles, Responsibilities and Functions

The Multidisciplinary Team recognises the robust governance required to operate on behalf of 12 organisations and to ensure that conflicts of interest are well managed.

The Multidisciplinary Team represents specialist knowledge in relation to Acute Specialised Services. However, the team will also be working with expert commissioning partners across 11 ICBs to deliver pathway improvements and maximise value in systems and with provider partners.

The Multidisciplinary Team will ensure the day-to-day management and monitoring of Specialised Acute and Pharmacy services provided across the Midlands. This requires ongoing integrated working through the links with the Acute Providers either directly with corporate and clinical teams or via Operational Delivery Networks (ODNs).

The Multidisciplinary Team will report on performance, progress on transformation priorities, and make recommendations for improvement through the Tier 1 and 2 governance groups and through NHSE governance frameworks, aligned to an agreed work programme. The Multidisciplinary Team will manage operational, financial, and quality risks in line with agreed escalation routes in line with this collaborative approach.

The Multidisciplinary team will carry out all duties in relation to the commissioning of delegated services liaising through the East and West Boards and their subgroups. The team details are below but in summary are made up of

Supporting Retained NHSE Functions and Delegated ICB Functions	
Function	Number (includes those who have a wider portfolio beyond specialised services)
Finance	17 WTE
Commissioning & Pharmacy	41 WTE
Quality	8 WTE
Commissioning Support	5 WTE

A list of key contacts is provided below

Core Functions	Lead Officer	Contact details
Commissioning & contracting	Alison Kemp Jon Currington	Alison.kemp1@nhs.net Jon.currington@nhs.net
Pharmacy	Susanna Allen	susanna.allen@nhs.net
Finance	Jon Cooke/ Pete Davies	Jon.cooke1@nhs.net Peter.davies4@nhs.net
Clinical & Quality	Dr Colette Marshall Dr Mel McFeeters	colette.marshall6@nhs.net melanie.mcfeeters@nhs.net
Business Intelligence & Analytics	Simon Collings	Simon.collings@nhs.net
Regional Comms Team	Claire Deeley	claire.deeley@nhs.net
Specialised Networks (ODMs)	Kieren Caldwell	Kieren.caldwell@nhs.net

5.2 Specialised Commissioning & Contracting Team

The Commissioning & Contracting Team is responsible for commissioning prescribed acute specialised services as described in the Manual of Prescribed Services, in line with national service specifications and policies, on behalf of ICBs for delegated services and NHSE for retained services.
The team discharges its responsibilities through a structure of five Clinical Programmes of Care (PoC) which operate on a pan-Midlands footprint and to individual contracts (27 NHS and three Independent Sector (IS) providers) at a system level.

The five PoC are:

- Blood and Infection;
- Cancer;
- Internal Medicine;
- Trauma; and
- Women and Children.

Each PoC is headed by a Commissioning Lead from a clinical, finance or management background with specific expertise in their PoC area. Each of the PoC Leads has a lead responsibility for named ICBs, although at present the role is largely nominal based on the individual contracts their team is responsible for (Appendix 1). The Commissioning Lead for Blood and Infection also has lead responsibility for Contracting across the Midlands.

The Head of Acute Specialised Services oversees all these functions and reports directly to the Director of Specialised Commissioning.

The core functions the team deliver on behalf of ICB partners include:

- Co-ordinating commissioner for the 59 delegated services;
- Contract negotiation and Contract Relationship Management with Midlands Acute Providers;
- Oversight of transformation portfolio focused on improving health outcomes & reducing inequalities.
- Single point of contact for all acute specialised services for Specialised Networks, provider clinicians and management teams and ICB teams; and
- Oversight and assurance of all acute specialised services.

Working with:

- ICB teams;
- Other regional NHS England functions as part of a single Multi-Disciplinary Team (MDT) (e.g. pharmacy, medical, nursing, finance, business intelligence, communications etc.);
- Regional and National NHS England Teams including clinical reference groups;
- Clinical and corporate teams at NHS trusts and other service providers; and
- Cancer Alliances and Specialised Networks

Complaints

All complaints received (on average circa 5-7 per annum across all Specialised services inc retained services) are managed by the Head of Services with input from subject matter experts with clinical and quality review. Complaints will continue to be managed in this way for ICB and NHSE during 24/25.

The team carries out similar functions on behalf of NHS England for the 90 retained services.

The team consists of

Supporting Retained NHSE Functions and Delegated ICB Functions		
Role	**Grade**	**WTE**
Director of Specialised and Collaborative Commissioning	ESM1	*
Senior Programme Director – Specialised Clinical Networks	Band 9	*
Head of Acute Specialised Commissioning	Band 8D	1.00
Commissioning Lead – Acute Services	Band 8C	5.00
Senior Commissioning Manager	Band 8B	6.00
Programme Manager – specialised commissioning	Band 8B	1.00
Senior Neurorehabilitation Case Manager	Band 8B	1.00
Commissioning Manager	Band 8A	3.00
Neurorehabilitation Case Manager	Band 8A	3.00
Contract Manager	Band 7	2.00
Commissioning Officer	Band 6	2.00
Project co-ordinator	Band 6	1.00
Commissioning Support Officer	Band 5	2.00
Business Support Assistant	Band 4	1.00
	Total	**30.00**

*Denotes these posts have wider portfolio responsibilities than for acute specialised services alone.

5.3 Specialised Pharmacy Team

The role of the Specialised Commissioning Pharmacy team is to support clinical and pharmacy colleagues in Trusts, across regions and nationally in optimising the use of medicines, ensuring that high-cost drugs are introduced efficiently and used consistently in line with national clinical commissioning policy. The team work to improve uptake and access to new High-Cost Drugs (HCDs), ensuring that high-cost medicines are prescribed and delivered in the safest, most cost-effective manner. A contact list for the Pharmacy team including which Trusts they support can be found in Appendix 2.

Responsibilities are discharged in line with national service specifications and clinical commissioning policies with responsibility and accountability for the high-cost drugs budget being with NHS England in 2024/25. The team will collaborate with ICBs via the joint working arrangements to optimise the commissioning of high cost drugs.
The core functions of the Pharmacy team to deliver on behalf of the ICBs for delegated service and NHSE retained services are as follows:

- Medicines prescribed/ dispensed in a manner that provides value for money.
- Consistency of application of prescribing policies for HCDs.
- Optimised value for money re medicines and procurement and use.
- Specialised care provided closer to home with improved quality of life for patients with longer term conditions.
- Strategic view of medicines related issues.
- Efficient use of resources

Working with:

- Acute Trusts and Providers
- Regional ICB and Trust Pharmacy Leads
- Colleagues within Commissioning Team MDT
- NHSE National and Regional teams

The team consists of

Supporting Retained NHSE Functions and Delegated ICB Functions		
Role	**Grade**	**WTE**
Director of Specialised & Collaborative Commissioning	ESM1	*
Head of Pharmacy Commissioning (Midlands)	Band 8D	1.00
Senior Pharmacy Lead – Midlands	Band 8C	1.00
Pharmacy Programme Manager	Band 8B	3.00
Pharmacy Analyst (Midlands)	Band 7	2.00
	Total	**7.00**

*Denotes these posts have wider portfolio responsibilities than for acute specialised services alone.

5.4 Specialised Finance Team

The Commissioning Finance Team is responsible for working in partnership with all elements of the commissioning directorate to support ICB delegated acute services and NHSE retained services.

The team has wider responsibilities across Acute Specialised Commissioning, Specialised Mental Health and Learning Disabilities, Offender Personality Disorder Service and Health and Justice commissioning portfolios.

The core finance functions are as follows:

- Financial Planning
    - Lead on national allocations processes for all commissioned services – both delegated and non-delegated for 2024/25, ensuring all adjustments are validated and attributed to system population level.
    - Ensure planning methodologies (eg ERF, Needs Based Proposals) are checked and challenged through national finance forums nationally and communicated locally.
    - Support local planning arrangements and engagement both internally and with ICBs to support contract management (in compliance with SOP), negotiation and risk provision.
- Payments
    - Lead all payments to NHS and non-NHS providers in compliance with Standard Financial Instructions/Standing Orders and the agreed Scheme of Delegation. This includes the submission of the monthly payment file and working with Corporate Finance functions to deliver compliance.
- Payment System Engagement
    - Engage at a national level of payment system reform and application. It is the local expertise on the application of Payment Systems and will provide expert advice to Provider business cases and service development proposals.
- Cash Management
    - Co-ordination of all cash requirements for Delegated and Retained Specialised Services
- Budget Management
    - Ensure budgets fully reflect planning assumptions and are phased appropriately in accordance with Best Financial Management Practice for all services including delegated.
- Financial Reporting
    - Maintain robust ledger accounting in accordance with agreed timetables to comply with local and national guidelines to ensure assurance over the accuracy of ledger reporting and finance information for both reporting groups both nationally, regionally and at ICB level.
    - Ensure internal controls for processes are resilient and audit compliant and in accordance with SFIs.
- Investments
    - Provision of expert technical advice to ensure all service proposals are reviewed and approved in accordance with due processes.
- Provision of support to internal and external meetings across MDT Commissioning, Nationally and regionally across all commissioned services.
- Support of ongoing development to Delegation process and workstreams nationally on behalf of Midlands region.

The core functions the team deliver on behalf of partners is as follows:

Financial Management, Financial Planning, Financial Reporting, Audit Compliance, National, System and Provider level engagement

Working with:

- ICB Specialist Networks
- NHS trusts and other service providers
- National and Regional NHS England directorates

The Midlands Specialised Commissioning portfolio consists of Acute and Mental Health services along with management of the associated high-cost drugs and devices allocations and Operational Deliver Networks (ODN) budgets.

The population-based split of allocations relating to service budgets has been adopted in 2023/24 reporting. This will be expanded further in 2024/25 to cover the total allocations including any reserves and contingency.

The Finance team for Specialised Services consists of:

Supporting Retained NHSE Functions and Delegated ICB Functions		
Role	Grade	WTE
Director of Commissioning Finance	ESM 1	*
Deputy Director of Finance Specialised Commissioning	Band 9	1.0
Assistant Director of Finance	Band 8D	2.0
Assistant head of Finance	Band 8C	2.0
Senior Finance Manager	Band 8B	2.0
Finance Manager	Band 8A	3.0
Finance Officer	Band 7	1.0
Finance Support	Band 5	2.0
Finance Support	Band 4	1.0
Finance Assistant	Band 2	2.0
	Total	**16.0**

* Denotes these posts have wider portfolio responsibilities than for acute specialised services alone.

The finance team is responsible for all Specialised Commissioning finance including non-acute and retained services.

5.5 Specialised Services Clinical and Quality Team

The Clinical and Quality team are responsible for managing quality in relation to all specialised services in line with the national Quality Framework for Specialised Services 2024/25, on behalf of ICBs for delegated services and NHSE for retained services.
They operate in accordance with the Midlands Quality Assurance Framework, the National Quality Board's (NQB) National Guidance on Quality Risk Response and Escalation in Integrated Care Systems (NQB 2022) and 'A Shared Commitment to Quality' (NQB 2020) and align to the following agreed principles:

- Integration with NHSE/ICB regional governance
- Clear lines of accountability and escalation for each stage of the quality assurance process
- Share intelligence in an open, timely way.
- Proactively monitor and follow up on early warning signs.
- Agree responsibilities, accountabilities, and governance routes, taking a system-led approach where possible, at all stages of the process.
- Monitor and mitigate future risks.
- Commitment to drive quality improvement through ongoing learning and development.

The core functions the quality team deliver to support delivery of the statutory quality duties are as follows:

- Reviewing the data on the quality of acute specialised services e.g. Specialised Services Dashboards, and triangulation with wider data sources and metrics.
- Identification & management of quality risks using agreed governance and escalation mechanisms.
- SME input into the incident oversight process in line with PSIRF and the management of complaints.
- Provision of clinical and professional advice and support for commissioning managers and clinical and quality teams.
- Support quality improvement & transformation, reduce unwarranted variation, including national & regional programmes, Midlands Quality Surveillance & Improvement Framework.

Working with:

- Formal Operational Delivery Networks (ODNs) & Informal Clinical Networks
- Regional and national teams - Commissioners, national quality group for specialised services, Clinical Reference Groups (CRGs), System Teams, Subject Matter Experts (SMEs), ASC pharmacy team
- ICB Quality Teams, Provider Trusts

The Specialised Services Clinical and Quality team consists of

Supporting Retained NHSE Functions and Delegated ICB Functions		
Role	**Grade**	**WTE**
Regional Medical Director - Commissioning	ESM1	*
Deputy Director of Nursing & Quality	Band 9	*
Assistant Director of Nursing & Quality: Acute SC	Band 8D	1.00
Head of Clinical Quality Reviews: Specialised Commissioning	Band 8C	1.00
Head of Quality: Acute Specialised Commissioning	Band 8C	1.00
Senior Quality Officer	Band 7	1.00
Quality Officer	Band 6	2.00
	Total	**6.00**

*Denotes these posts have wider portfolio responsibilities than for acute specialised services alone.

5.6 Business Intelligence & Analytics Team

The Commissioning Business Intelligence & Analytics functions provide analytical support across the commissioning portfolio. The team is led by NHSE employed BI and Analytics staff with most of the team's analytical capacity and capability being supplied by Arden and GEM CSU through a nationally held and agreed contract. This contract will remain in place for 2024/25 and will be reviewed during that time in collaboration with NHSE regional commissioning team and the ICBs. The core functions are as follows:

- Act in with accordance and the delivery of the NHS Long Term Plan specifically pertaining to Specialised and Direct Commissioning within NHSE Midlands Region;
- Support commissioning through the development of insight-based analytics including planning, performance, assurance, and oversight of regional delivery against annual Operational Planning.

- Provide population health-based analysis to deliver improved outcomes for patients and ensure wider management of pathways of care.
- Deliver a high-quality integrated commissioning BI function which is reflective of, and responsive to the needs of delegated and retained commissioning teams within the Midlands.
- Support the NHSE national team in identifying and delivering data and analytics strategic priorities in preparation for delegation of specialised services, reflective of regional priorities in the Midlands.
- Collaborate effectively in creating an efficient workforce model to deliver a BI service that is responsive to changing needs.

The core functions the team deliver on behalf of partners is as follows:

- Performance and assurance for commissioning programmes
- Data Quality
- AIVs and Challenges
- Planning and Priority Setting
- Demand and Capacity

Working with:

- ICBs
- Specialist Networks
- External Data Providers i.e. Academic Health Science Provision
- NHS trusts and other service providers
- Department of Health and Social Care
- National NHS England directorates

The team consists of

Supporting Retained NHSE Functions and Delegated ICB Functions		
Role	**Grade**	**WTE**
Head of Planning and Decision Support	Band 9	*
Head of Data and Information	Band 8D	*
Senior Planning Manager	Band 8B	*
	Total	*

*Denotes these posts have wider portfolio responsibilities than for acute specialised services alone.

5.7 Specialised Networks

The core functions include:

- Lead major programmes (i.e. currently paediatric sustainability and neonatal cot configuration) which include specialised networks.
- Oversight of programme delivery across 24 networks
- Risk management and operational delivery/transactional change success via network work programmes
- Engagement with key stakeholders is effective, timely and useful.
- Improving network board functionality.

The team consists of

Supporting Retained NHSE Functions and Delegated ICB Functions

Role	Grade	WTE
Senior Programme Manager – Integrated Commissioning	Band 9	*

*Denotes these posts have wider portfolio responsibilities than for acute specialised services alone.

The role of the Programme Director is to:

- Develop and deliver the strategy for acute specialised networks.
- Provide subject matter leadership to network leadership teams which are imbedded in provider organisations.
- Oversee the collaborative development of network work programmes.
- Lead the Collaborative Clinical Executive Forum, securing regional clinical engagement into the key strategic decisions made by the Acute Specialised Commissioning Team.
- Support the development of Acute Provider Collaboratives including, but not limited to EMAP and WMAP.
- Develop systems for clinical quality assurance and responsiveness when it involves specialised clinical networks.

5.8 Regional Communications and Engagement Team

The role of the Regional Communications and Engagement team is to:

- Develop communications strategies and plans around individual services – new services, changes to services or closures of services – working together with specialised operating teams, relevant ICB and provider/s.
- Engage with stakeholders and patient groups around these services.
- Brief relevant ICB and NHS colleagues
- Hold regular meetings with ICBs and providers as well as having mechanisms for cascading news and materials from national teams.
- Promote the work of specialised services within ICBs and NHS England through internal mechanisms.
- Manage any media queries, liaising with specialised team and provider and gaining approval from ICB communications.
- Develop any proactive activity such as media releases, social media, or stakeholder materials with approval from ICB communications teams.
- Share newsletters and regional updates with system ICB communications leads.
- Update and maintain regional NHSE web pages for any information relevant to specialised services.
- ICB & NHSE responsibilities in relation to the duty to consult with patients and the public under section 13Q can be found in Appendix 3

The core functions the team deliver on behalf of partners is as follows:

- Handling of Media queries
- Development of materials such as press releases, social media, and stakeholder briefings.
- Development of internal news stories
- Advice on stakeholder and patient engagement
- Managing stakeholder and patient consultations

Working with:

- ICBs
- Specialised Networks
- NHS trusts and other service providers
- NHS England national and regional directorates

The team consists of

Supporting Retained NHSE Functions and Delegated ICB Functions		
Role	**Grade**	**WTE**
Regional Communications and Engagement Lead	Band 8C	1.0*
Communications Manager	Band 7	0.8*
	Total	**2.00***

*Denotes these posts have wider portfolio responsibilities than for acute specialised services alone.

6. Costs and Liabilities

6.1 Costs

During the 2024/25 transitional year where NHS England will continue to employ all staff and functions that support the 59 delegated services.
The costs associated with the provision of the Administrative and Management Services set out in section 5 by the Specialised Services Multi-disciplinary team shall not be included within the Delegated Funds allocated or transferred to the ICBs for 1st April 2024 to 31st March 2025 and that NHS England shall meet those costs.

6.2 Liabilities

NHS England shall be liable for any losses arising out of negligent acts or omissions in respect of the provision of Administrative and Management Services except where such losses arise as a result of action taken in accordance with instruction from any ICB or a failure of an ICB to provide on request appropriate instruction.

NHS England will meet the liabilities as a result of:

- Death or personal injury caused by its negligence.
- Fraud
- Fraudulent misrepresentation

7. Learning and Development

7.1 MaST training and professional development

The costs associated with the provision of agreed ongoing learning and development including mandatory (MaST) training for the Specialised Services Multidisciplinary team will be met by NHSE.

100% compliance is required by all staff for the MaST training detailed below:

Equality, Diversity and Inclusion

As part of the system leadership arrangements for the NHS, we recognise the importance of becoming a role model for the rest of the NHS in respect of issues relating to equality, diversity, and inclusion in the workplace.

Fraud Awareness
This course focuses on providing you with awareness of the key aspects of fraud and corruption in the NHS and help you know your responsibilities to combat it.

Data Security Awareness
This course focuses on the importance of data security in health and social care. It will help you understand how to comply with the law, define potential threats and how to identify and avoid breaches.

Health and Safety
This course focuses on health and safety in the workplace. You will gain an understanding for responsibilities under Health and Safety Law, different types of safety signage, basic fire safety principle, basic moving, and handling techniques and why incident reporting is so important.

Safeguarding Children & Adults at Risk of Harm or Abuse
This course introduces safeguarding children and adults at risk of harm or abuse. It focuses on safeguarding in the NHS, data sharing, domestic abuse, and associated legislation as well as what you can do when raising a concern.

Records Management
This course introduces you on the importance of records management, legal and contractual requirements, and guidance on how to keep information secure.

Patient Safety
This course introduces patient safety for all NHS staff. It focuses on the essentials for creating patient safety and helps recognise that the NHS is a system of essential and interconnected parts; a team with a common goal.

7.2 Dynamic Conversations

NHSE will meet all costs and requirements of ensuing all members of the Specialised Services Multi-disciplinary team have regular performance and development through regular Dynamic Conversations.

Dynamic Conversations are an opportunity for both line managers and team members to have meaningful, fluid, and organic 1:1s. Dynamic Conversations put wellbeing at the forefront of initial conversations and will help to support colleagues through change.

NHSE will ensure that monthly 1:1s with line managers are regularly scheduled.

8. Escalations, FoI & Incident Management

8.1 Freedom of Information and Parliamentary Requests

All Freedom of Information and Parliamentary Requests relating to Delegated Services should be forwarded to the Multi-Disciplinary Team will ensure the appropriate handling, management, and response, ensuring where appropriate that ICBs are informed and engaged. The team will also ensure they provide reasonable support to ICBs in responding to freedom of information and parliamentary correspondence as required.

8.2 Incident Response and Management

The Multi-Disciplinary Team shall provide such reasonable support as required by an ICB in relation to local incident management for Delegated Specialised Services.

8.3 Provider Selection and Procurement

The Multi-Disciplinary Team shall act on instructions from the ICBs in relation to provider selection and procurement processes for the Delegated Specialised Services.

8.4 Escalations

If an ICB has cause to raise concerns regarding the performance, actions or conduct of a member of the Multi-Disciplinary Team the ICB will in the first instance contact by email the Director of Specialised & Collaborative Commissioning, who will where possible provide an acknowledgement within 7 days of receipt.

The Director of Specialised & Collaborative Commissioning will provide the ICB with feedback and action taken with 30 days.

If for any reason the ICB is unhappy with the response the concerns can be escalated to the NHS England Regional Director of Commissioning

9 Confidential information

The ICBs and NHSE shall always use its best endeavours to keep confidential and ensure that its employees and agents keep confidential any information in relation to the business and affairs of another Partner.

If the information referred to herein is subject to a freedom of information (FOI) or other request to share the data, then NHS England will be responsible for the fulfilment of the request, but will seek views from the ICBs before undertaking this in accordance with the Freedom of Information Code of Practice issued by the Cabinet Office under section 45 of the Freedom of Information Act 2000.

The ICBs and NHSE will not make any press announcements about this Agreement or publicise this Agreement or any of the terms in any way. The ICBs and NHSE shall ensure that any such information disclosed is solely for the purpose of performing its obligations under this Agreement.

10 Finance

10.1 Scope

Schedule 4 of the ICB Collaboration Agreement provides detail of the approach to risk sharing and other financial arrangements, this section specifies how the Specialised Commissioning Finance Team within the Multidisciplinary Team will operate on behalf on the ICBs during 2024-25.

10.2 Multidisciplinary Team – Specialised Commissioning Finance Team

The role, functions and staffing model of the Specialised Commissioning Finance Team within the Multidisciplinary Teams is described in section 5.4 above. The team will aim to work on behalf of and in partnership with ICBs on financial planning and allocations, contract finance, financial management including risk management, financial reporting, financial control and cash management.

The team will also support NHSE Midlands on retained services and work with the National Finance Team to support future delegations. The team will continue to work across Midlands ICBs to ensure the maintenance of an efficient and effective service across both delegated and retained specialised services.

The Specialised Commissioning Finance Team will support other functions within the Multidisciplinary Team covering planning, service reviews and provider performance issues. For 2024/25, work with ICB and providers will be enhanced to extend existing arrangements covering contract arrangements, financial reporting, and risk management, building on the current finance, contracts and operational steering groups.

10.3 Multidisciplinary Team – Discretion relating to finances.

The issues of scope and limitations to decision making are addressed specifically in schedule 4 of the Collaboration Agreement

Historic investment decisions have been reviewed to ensure that the suggested limits would be operationally appropriate in respect of:

- The approval limits across systems and by MASCG
- Contract Awards
- Purchase Requisitions, Invoices and Non-Purchase Orders
- Budget virements

10.4 Multidisciplinary Team – Making payments in accordance with contracts.

The arrangements for making payments in accordance with contracts has been outlined as part of the delegation arrangements in the Cashflow SOP. NHS England will engage with ICBs to share contract payment schedules for NHS and Non-NHS providers linked to Contracting SOP.

The team will also be responsible for:

- Engagement to ensure supplier payment information is current and inclusive.
- Production of timetable for monthly activities shared and aligned with ICB officers.
- Operation of Financial Limits agreed in line with SFI's by ICB CFOs.
- Specific arrangements for monthly sign reporting sign offs and contract adjustments.
- Detail of ERF adjustments.

10.5 Multidisciplinary Team – Expectation in relation to financial reporting

The development and engagement between Specialised Commissioning Finance Team and ICBs in respect of Financial Reporting will be conducted through the East and West Midlands Joint Committees' formal Finance Sub-Group. This will include;

- Allocations for 59 delegated specialised services would be made to the eleven ICBs in the Midlands.
- ICBs would transfer allocations for the commissioning of these specialised services to the identified host ICB.
- The Specialised Commissioning Finance Team would manage specialised services through the host ledger managing financial risk across all eleven ICBs.
- All contractual payments would be managed by the Multidisciplinary Team through the single joint Specialised Commissioning contract (see Contracting SOP).
- In-year financial management would be undertaken at a multi-ICB level, mitigating the risk of variation between systems.

- Regional financial variances (under or overspend) would be mitigated through a contingency held by the host to minimise exposure to financial fluctuation as part of the risk sharing agreement.
- ICB level in-year financial reporting would show contributions to the pool in the ICB position thereby demonstrating a break-even position for specialised commissioning on monthly financial reports.
- Performance reporting would be developed at an ICB and multi ICB level to enable local intelligence on performance in these services.
- The Specialised Commissioning Finance Team would prepare finance reports at organisational level to ensure all ICBs have full sight of the overall actual performance of specialised commissioning and indicative ICB level performance.
- Residual variances after mitigations would be allocated to ICBs based on contributions to the pool.
- Adjustments will be made to timescales agreed through the Finance sub-group.

10.6 Multidisciplinary Team – Dispute process in relation to activities undertaken.

In the event of a dispute relating to finance or the activities undertaken by the Specialised Commissioning Finance Team, the following escalation routes will apply;

- Address with NHS England Senior Finance Leads through to Director of Commissioning Finance
- Escalation to Finance Subgroup
- Further escalation to Joint Committees

10.7 Multidisciplinary Team – Access to ledgers

ICB CFOs will be required to approve access to ICB ledger to assure internal controls and processes. In addition, validation of ledger codes for specialised services, together with confirmation of supplier codes prior to the commencement of 2024/25 on each of the ICB ledgers will be required.

Appendix 1 – Contract Leads for NHSE Specialised Contracts

Area	ICB	Provider	Provider Acronym	Provider Code	Contract Lead	Escalation lead
East	Derby and Derbyshire	University Hospitals of Derby and Burton	UHDB	RTG	Nick Hey	Nick Hey
East	Derby and Derbyshire	Chesterfield Royal Hospital NHS Trust	CRH	RFS	Nick Hey	Nick Hey
East	Leicester, Leicestershire and Rutland	University Hospitals of Leicester NHS Trust	UHL	RWE	Steph deCelis	Dom Tolley
East	Lincolnshire	United Lincolnshire Hospitals NHS Trust	ULHT	RWD	Nick Hey	Nick Hey
East	Lincolnshire	Lincolnshire Community Health Service NHS Trust	LCHS	RP7	Dawn Newman	Nick Hey
East	Northamptonshire	Kettering General Hospital NHS Trust	KGH	RNQ	Steph deCelis	Dom Tolley
East	Northamptonshire	Northamptonshire General Hospital Trust	NGH	RNS	Steph deCelis	Dom Tolley
East	Nottingham and Nottinghamshire	Nottingham University Hospitals NHS Trust	NUH	RX1	Nick Hey	Nick Hey
East	Nottingham and Nottinghamshire	Sherwood Forest Hospitals NHS Trust	SFHT	RK5	Dawn Newman	Nick Hey
West	Birmingham and Solihull	Birmingham Community Healthcare NHS Trust	BCHC	RYW	Nikita Panesar	Leila Marchant
West	Birmingham and Solihull	Birmingham Women's and Childrens Hospital NHS Foundation Trust	BWCH	RQ3	Sarah Simkins	Sumana Bassinder
West	Birmingham and Solihull	Royal Orthopaedic Hospital NHS Foundation Trust	ROH	RRJ	Leila Marchant	Sumana Bassinder
West	Birmingham and Solihull	Sandwell and West Birmingham Hospitals NHS Trust	SWBH	RXK	Leila Marchant	Sumana Bassinder
West	Birmingham and Solihull	University Hospital Birmingham NHS Foundation Trust	UHB	RRK	Leila Marchant	Sumana Bassinder
West	Coventry and Warwickshire	University Hospitals Coventry and Warwick NHS Trust	UHCW	RKB	Emma Partridge	Laura Morris
West	Coventry and Warwickshire	South Warwickshire Foundation Trust	SWFT	RJC	Jasmeet Najran	Emma Partridge
West	Coventry and Warwickshire	George Eliot Hospital NHS Trust	GEH	RLT	Jasmeet Najran	Emma Partridge
West	Coventry and Warwickshire	Coventry and Warwickshire Partnership Trust	CWPT	RYG	Maria Muro	Emma Partridge
West	Herefordshire and Worcestershire	Worcestershire Acute Hospitals NHS Trust	WAHT	RWP	Nick Hey	Nick Hey
West	Herefordshire and Worcestershire	Wye Valley NHS Trust	WVT	RLQ	Maria Muro	Emma Partridge
West	Shropshire, Telford and Wrekin	Shrewsbury and Telford Hospitals NHS Trust	SATH	RXW	Jasmeet Najran	Emma Partridge
West	Shropshire, Telford and Wrekin	Robert Jones Agnes Hunt Foundation Trust	RJAH	RL1	Jasmeet Najran	Emma Partridge
West	Staffordshire and Stoke on Trent	University Hospital of North Midlands NHS Trust	UHNM	RJE	Emma Partridge	Laura Morris
West	Staffordshire and Stoke on Trent	Midland Partnership	MPFT	RRE	Maria Muro	Emma Partridge
West	The Black Country	The Dudley Group of Hospitals NHS Foundation Trust	DGOH	RNA	Nikita Panesar	Leila Marchant
West	The Black Country	The Royal Wolverhampton NHS Trust	RWHT	RL4	Leila Marchant	Sumana Bassinder
West	The Black Country	Walsall Healthcare NHS Trust	WHT	RBK	Leila Marchant	Sumana Bassinder

Appendix 2 – Specialised Pharmacy Contacts

ICB	Provider	Pharmacist Lead	Pharmacy Analyst Lead
Birmingham and Solihull	University Hospitals Birmingham NHS Foundation Trust	Susanna Allen	Jeetender Dhap
Birmingham and Solihull	Birmingham Women's and Children's Hospital NHS Foundation Trust	Susanna Allen	Emma Shannon
Birmingham and Solihull	Royal Orthopaedic Hospital NHS Foundation Trust	Anand Mistry	Jeetender Dhap
The Black Country	Royal Wolverhampton Hospitals NHS Trust	Anand Mistry	Jeetender Dhap
The Black Country	The Dudley Group of Hospitals NHS Foundation Trust	Dhiren Bharkhada	Emma Shannon
The Black Country	Walsall Healthcare NHS Trust	Anand Mistry	Jeetender Dhap
The Black Country	Sandwell and West Birmingham Hospitals NHS Trust	Anand Mistry	Jeetender Dhap
Coventry and Warwickshire	University Hospitals Coventry and Warwickshire NHS Trust	Anand Mistry	Jeetender Dhap
Coventry and Warwickshire	South Warwickshire NHS Foundation Trust	Dhiren Bharkhada	Jeetender Dhap
Coventry and Warwickshire	George Eliot Hospital NHS Trust	Dhiren Bharkhada	Jeetender Dhap
Coventry and Warwickshire	Coventry and Warwickshire NHS Partnership Trust	Anand Mistry	Emma Shannon
Herefordshire and Worcestershire	Worcestershire Acute Hospital NHS Trust	Anand Mistry	Emma Shannon
Herefordshire and Worcestershire	Wye Valley NHS Trust	Anand Mistry	Jeetender Dhap
Shropshire, Telford and Wrekin	Shrewsbury and Telford Hospitals NHS Trust	Dhiren Bharkhada	Emma Shannon
Shropshire, Telford and Wrekin	Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Trust	Anand Mistry	Emma Shannon
Staffordshire and Stoke-on-Trent	University Hospitals North Midlands NHS Trust	Dhiren Bharkhada	Jeetender Dhap
Staffordshire and Stoke-on-Trent	Midlands Partnership Foundation Trust	Anand Mistry	Emma Shannon
Derbyshire	Chesterfield Royal Hospital NHS Foundation Trust	Anand Mistry	Emma Shannon
Derbyshire	University Hospitals Derby and Burton	Dhiren Bharkhada	Jeetender Dhap
Nottinghamshire	Nottingham University Hospitals NHS Trust	Susanna Allen	Emma Shannon
Nottinghamshire	Nottingham Treatment Centre	Dhiren Bharkhada	Jeetender Dhap
Nottinghamshire	Sherwood Forest Hospitals NHS Foundation Trust	Dhiren Bharkhada	Jeetender Dhap
Lincolnshire	Lincolnshire Community Health Services NHS Trust	Anand Mistry	Emma Shannon
Lincolnshire	United Lincolnshire Hospitals NHS Trust	Anand Mistry	Emma Shannon
Leicester, Leicestershire and Rutland	University Hospitals Leicester	Dhiren Bharkhada	Jeetender Dhap
Northamptonshire	Kettering General Hospital NHS Foundation Trust	Dhiren Bharkhada	Jeetender Dhap
Northamptonshire	Northampton General Hospital NHS Trust	Dhiren Bharkhada	Emma Shannon
Northamptonshire	Northamptonshire Healthcare NHS Foundation Trust	Anand Mistry	Jeetender Dhap

Appendix 3: Fulfilling statutory duties (13Q) & Communications & Engagement

Introduction

The delegation of 59 specialised services to ICBs will mean some changes in the way communications and engagement are handled. This document aims to clarify the roles and responsibilities after delegation of this initial groups of 59 services in April and before planned transfer of staff in April 2025.

General principles

Each ICB will be responsible for communications and engagement for the 59 delegated specialised services within its own system.

In this transitional year, the existing commissioning communications team of Communications and Engagement Lead and Communications Manager will continue to manage activity for the 59 delegated services, working with the existing operating teams, and reporting to the relevant ICB or ICBs.

The regional NHS Midlands media team will retain responsibility for matters where there is a risk to NHS reputation – for instance if the impact is significant or wider than one joint committee (East and West).

Full details of specialised services contacts in comms and engagement and in the operational teams will be shared.

Reactive media enquiries

Media enquiries will be flagged to communications team and with ICB and specialised operating team. Providers may be liaised with, and ICB communications will be kept informed by NHSE communications team. The ICB/s will approve the final planned response (they may choose to deliver the response if they wish).

Proactive activity

National activity will be cascaded via the NHS Midlands communications team to all ICBs individually – for instance new treatments.

Individual activity around services will be undertaken by the NHSE communications team working with the operational team and provider and reporting into ICB communications teams.

Healthwatch and engagement

Responsibility for engagement with Healthwatch groups and other system-wide stakeholders will be treated as follows:

- Individual services at trusts will be carried out by providers with approvals from ICBs – for instance location changes; changes in service levels
- Region-wide services (e.g. renal services; paediatric reviews) will be carried out by NHSE communications with prior approval from ICBs

NHS England in the Midlands will include region-wide news regarding access to services, investment, healthcare trends etc in updates to MPs, DsPH etc but ICBs will be informed and involved in each instance.

Patient and stakeholder engagement to fulfil statutory duties (13Q)

NHS England will be responsible for ensuring statutory duties are met.

NHSE communications team will liaise with specialised operating team and providers to ensure that engagement and consultation activity is being undertaken whenever necessary.

NHSE communications team will report to ICB communications and to the NHS England national team as part of the six monthly reporting duties.

HOSC

Specialised operating teams are sometimes required to liaise with HOSCs.

If this arises in the period to April 2025, ICB communications teams will be informed and involved.

Appendix 4

Service Profile Pack Leicester, Leicestershire, & Rutland ICB

Midlands Specialised Delegation Programme

Date of issue: MAR 2024

Introduction

This service profile pack contains essential high-level information regarding the 59 specialised services being delegated to your ICB on the 1st April 2024. It has been co-designed by ICB and NHSE representatives from the Clinical & Quality workstream of the Midlands Specialised Delegation Programme and provides some examples of the clinical case for change and how delegation will better support better services for patients. It includes information about the services that are being delegated, where they are being provided, the volume of current activity and the planning priorities for 2024/25.

A suite of service profiles containing details of clinical outcomes, patient safety concerns and workforce challenges will be available at the time of delegation. The service profile for Vascular Services is included as an example.

Dr Colette Marshall
Regional Medical Director of Commissioning, NHS England

Dr Clara Day
Chief Medical Officer, BSOL ICB

Sally Roberts
Chief Nursing Officer, Black Country ICB

Dr Nil Sanganee
Chief Medical Officer, LLR ICB

Kay Darby
Chief Nursing Officer, LLR ICB

Contents

1. Case for Change

Why delegate specialised services?

What should this mean for our patients, populations and their communities?

ICBs and providers to have **freedom to design services and to innovate** in meeting the national standards where they take on delegated or joint commissioning responsibility

ICBs and providers able to **pool specialised budget and non-specialised budgets** to best meet the needs of their population, tackle health inequalities and to join up care pathways for their patients

ICBs and providers able to use world class assets of specialised services to **better support their communities closer to home** (e.g. designing local public health initiatives, greater diagnostics and screening)

Quality of patient care

Patients will receive more **joined up care** – better communication and sharing of information between professionals and services.

More of a **holistic, multi-disciplinary approach** to care. A range of professionals can be involved in planning a patient's care.

Increase focus and investment on **prevention**.

Patients will receive the **right care at the right time in the right place**.

Better **step-down care** to support patients who are ready to leave specialised care.

Equity of access

Population based budgets means decisions on spend are based on the **needs of a local population** – the demographics, health behaviours etc rather than on activity in hospitals.

Specialised clinical expertise will have a role in managing population health and to **challenge underlying drivers of health inequalities**.

Providers and professionals working collaboratively, free from organisational constraints and commissioning boundaries, will help improve **quality of care and tackle unwarranted variation**.

Opportunity to **level up access across the country**

Value

Investment in preventative care could **reduce demand** for specialised services.

Providers and professionals can **better manage patient demand**, even when one part of the system becomes stretched. Patients can be re-directed or transferred so they have faster and better access to treatment

A whole system approach creates opportunities **to protect and build 'workforce resilience'**, as shown during the pandemic.

Pooled/delegated budgets allow **underspends to be shared or reinvested** and avoids commissioning pressures on any one organisation.

- Accessible care
- Tailored care
- Seamless care
- Effective care
- Preventative care

Case study examples of benefits are included in Appendix A.

2.Contracted Delegated Services by Provider

Contracts Overview

- The contract portfolio for Specialised Services in the Midlands in 2023/24 includes
  - 27 Main NHS Provider Contracts
  - 2 NHS Standalone Service Contracts
  - 4 Standalone Independent sector Contracts
- These contracts are currently managed for NHS England by the Midlands Acute Specialised Commissioning (MASC) Team
- Following the delegation of the 59 Specialised Services in April 2024, the MASC Team will continue to manage these contracts on behalf of the 11 ICBs for delegated services and on behalf on NHSE for retained services.

- **The next slide contains a list of which delegated specialised services are provided by Trusts within the Leicester, Leicestershire & Rutland system.**

- **Further details including the following contact details is available in Appendix 1.1;**
  - Commissioning Lead
  - Contract Manager
  - Quality Lead
  - Finance Lead

Specialised Services provided by Trust in Leicester, Leicestershire & Rutland ICS

University Hospitals of Leicester
Adult congenital heart disease services
Adult specialist respiratory services
Adult specialist rheumatology services
Adult specialist cardiac services
Adult specialist endocrinology services
Adult specialist ophthalmology services
Adult specialist orthopaedic services
Adult specialist renal services
Adult specialist services for people living with HIV
Adult specialist vascular services
Adult thoracic surgery services
Bone conduction hearing implant services (adults and children)
Complex spinal surgery services (adults and children)
Fetal medicine services (adults and children)
Specialist adult gynaecological surgery and urinary services for females
Specialist adult urological services for men
Specialist allergy services (adults and children)
Specialist dermatology services (adults and children)
Specialist metabolic disorder services (adults and children)
Specialist services for adults with infectious diseases
Paediatric cardiac services
Radiotherapy services (adults and children)
Specialist cancer services (adults)
Specialist cancer services for children and young adults
Specialist colorectal surgery services (adults)
Specialist dentistry services for children
Specialist ear, nose and throat services for children
Specialist endocrinology services for children
Specialist gastroenterology, hepatology and nutritional support services for children
Specialist gynaecology services for children
Specialist gynaecology services for children
Specialist haematology services for children
Specialist maternity care for adults diagnosed with abnormally invasive placenta
Neonatal critical care services
Specialist neuroscience services for children
Specialist ophthalmology services for children
Specialist orthopaedic services for children
Paediatric critical care services
Specialist plastic surgery services for children
Specialist rehabilitation services for patients with highly complex needs (adults and children)
Specialist respiratory services for children
Specialist services for complex liver, biliary and pancreatic diseases in adults
Specialist paediatric urology services

Opcare Ltd
Specialist services to support patients with complex physical disabilities (excluding wheelchair services) (adults and children)

3. Activity Data by ICB

Activity Overview

- Specialised Services are delivered to Midlands' patients at Trusts across the Midlands. In addition, some Midlands patients access Specialised Services in Trust outside of the Midlands region.

- Midlands' providers treat patients from the Midlands but also patients from other regions.

- The following slide (Slide 11) gives an overview of these activity flows for patients and providers in the Leicester, Leicestershire & Rutland system for Month 1 to 9 of 2023

- Slide 12 aggregates the same information at a regional level and gives an overview of activity flows for patients and providers in the Midlands region for comparison.

Example

NPoC (National Programme of Care (NPoC) Category and Clinical Reference Group (CRG)	Intra Activity	Imported Activity	Exported Activity	Total Activity by Providers in Mid ICB	Total Activity for Patients from Mid ICB	Grand Total
A06 - RENAL SERVICES	61,165	100,885	5,479	162,050	66,644	**167,529**

- **Further detail, including a drill-down to individual provider. is available in Appendix 2.1.**

Total Activities for QK1: NHS Leicester, Leicestershire & Rutland ICB

Activity Period: M01-M09 2023/24 (Apr 2023 – Dec 2023)

	A	B	C	A+B	A+C	A+B+C
NPoC (National Programme of Care (NPoC) Category and Clinical Reference Group (CRG)	Intra ICB	Imports	Exports	Total Activity by Providers in Mid ICB	Total Activity for Patients from Mid ICB	Grand Total
A06 - RENAL SERVICES	61,165	21,471	137	82,636	61,302	**82,773**
B03 - SPECIALISED CANCER SURGERY	45,171	576	2,370	45,747	47,541	**48,117**
B01 - RADIOTHERAPY	27,153	77	625	27,230	27,778	**27,855**
E02 - SPECIALISED SURGERY IN CHILDREN	19,233	317	493	19,550	19,726	**20,043**
D06 - SPECIALISED EAR AND OPHTHALMOLOGY SERVICES	18,281	49	309	18,330	18,590	**18,639**
E08 - NEONATAL CRITICAL CARE	12,033	258	448	12,291	12,481	**12,739**
E03 - PAEDIATRIC MEDICINE	11,226	124	281	11,350	11,507	**11,631**
A05 - CARDIOTHORACIC SERVICES	9,955	362	759	10,317	10,714	**11,076**
D01 - REHABILITATION AND DISABILITY	5,793	-	131	-	5,924	**5,924**
E05 - CONGENITAL HEART SERVICES	4,469	245	152	4,714	4,621	**4,866**
F03 - HIV	4,173	92	91	4,265	4,264	**4,356**
A09 - SPECIALISED RHEUMATOLOGY	3,868	17	135	3,885	4,003	**4,020**
B05 - CHILDREN AND YOUNG ADULT CANCER SERVICES	3,253	20	121	3,273	3,374	**3,394**
E07 - PAEDIATRIC INTENSIVE CARE	3,093	125	157	3,218	3,250	**3,375**
A04 - VASCULAR DISEASE	2,954	36	40	2,990	2,994	**3,030**
E04 - PAEDIATRIC NEUROSCIENCES	2,587	19	156	2,606	2,743	**2,762**
A02 - HEPATOBILIARY AND PANCREAS	2,232	122	65	2,354	2,297	**2,419**
A01 - SPECIALISED RESPIRATORY	2,093	3	152	2,096	2,245	**2,248**
D04 - NEUROSCIENCES	3	-	1,267	-	1,270	**1,270**
A03 - SPECIALISED ENDOCRINOLOGY	1,067	15	63	1,082	1,130	**1,145**
F06 - SPECIALISED IMMUNOLOGY AND ALLERGY SERVICES / E03 - PAEDIATRIC MEDICINE	1,037	16	11	1,053	1,048	**1,064**
A08 - SPECIALISED DERMATOLOGY	634	-	104	-	738	**738**
B02 - CHEMOTHERAPY	-	-	679	-	679	**679**
D03 - SPINAL SERVICES	232	-	34	-	266	**266**
A07 - SPECIALISED COLORECTAL SERVICES	193	-	-	-	193	**193**
E06 - METABOLIC DISORDERS	90	-	15	-	105	**105**
D07 - SPECIALISED PAIN	-	-	58	-	-	**58**
E09 - SPECIALISED WOMENS SERVICES	28	-	6	-	34	**34**
D10 - SPECIALISED ORTHOPAEDIC SERVICES	18	-	3	-	21	**21**
F04 - INFECTIOUS DISEASES	3	-	11	-	14	**14**
D02 - MAJOR TRAUMA	-	-	13	-	-	**13**
Unknown	2,725	82	23	2,807	2,748	**2,830**
Grand Total	**244,762**	**24,026**	**8,910**	**268,788**	**253,672**	**277,698**

Total Activities for Midlands Region

Activity Period: M01-M09 2023/24 (Apr 2023 – Dec 2023)

	A	B	C	A+B	A+C	A+B+C
NPoC (National Programme of Care (NPoC) Category and Clinical Reference Group (CRG)	Intra Activity	Imported Activity	Exported Activity	Total Activity by Providers in Mid ICB	Total Activity for Patients from Mid ICB	Grand Total
A06 - RENAL SERVICES	761,379	38,806	37,405	800,185	798,783	**837,589**
B03 - SPECIALISED CANCER SURGERY	723,206	8,546	74,570	731,752	797,776	**806,322**
B05 - CHILDREN AND YOUNG ADULT CANCER SERVICES	332,751	343	2,546	333,094	335,297	**335,640**
A05 - CARDIOTHORACIC SERVICES	225,064	8,465	18,289	233,529	243,353	**251,818**
B02 - CHEMOTHERAPY	190,405	17,030	27,686	207,435	218,091	**235,121**
B01 - RADIOTHERAPY	173,641	3,242	31,152	176,883	204,793	**208,035**
E03 - PAEDIATRIC MEDICINE	156,469	7,358	9,089	163,827	165,558	**172,916**
E06 - METABOLIC DISORDERS	154,286	3,165	401	157,451	154,687	**157,852**
D04 - NEUROSCIENCES	99,651	4,807	26,781	104,458	126,432	**131,239**
E02 - SPECIALISED SURGERY IN CHILDREN	103,670	2,598	11,090	106,268	114,760	**117,358**
E08 - NEONATAL CRITICAL CARE	105,630	1,225	9,172	106,855	114,802	**116,027**
D06 - SPECIALISED EAR AND OPHTHALMOLOGY SERVICES	92,348	1,555	5,811	93,903	98,159	**99,714**
D01 - REHABILITATION AND DISABILITY	45,596	1,068	2,513	46,664	48,109	**49,177**
A02 - HEPATOBILIARY AND PANCREAS	31,850	3,463	4,058	35,313	35,908	**39,371**
E05 - CONGENITAL HEART SERVICES	31,235	917	3,217	32,152	34,452	**35,369**
E04 - PAEDIATRIC NEUROSCIENCES	25,760	425	4,088	26,185	29,848	**30,273**
F03 - HIV	25,665	488	1,529	26,153	27,194	**27,683**
A09 - SPECIALISED RHEUMATOLOGY	23,300	79	2,256	23,379	25,556	**25,635**
A04 - VASCULAR DISEASE	20,593	516	2,420	21,109	23,013	**23,529**
A01 - SPECIALISED RESPIRATORY	15,767	90	4,701	15,857	20,468	**20,558**
A03 - SPECIALISED ENDOCRINOLOGY	17,142	563	2,381	17,705	19,523	**20,086**
E07 - PAEDIATRIC INTENSIVE CARE	13,978	221	2,659	14,199	16,637	**16,858**
D02 - MAJOR TRAUMA	5,499	516	201	6,015	5,700	**6,216**
D03 - SPINAL SERVICES	4,113	296	549	4,409	4,662	**4,958**
A08 - SPECIALISED DERMATOLOGY	3,594	14	1,074	3,608	4,668	**4,682**
F06 - SPECIALISED IMMUNOLOGY AND ALLERGY SERVICES / E03 - PAEDIATRIC MEDICINE	2,640	74	804	2,714	3,444	**3,518**
E09 - SPECIALISED WOMENS SERVICES	2,661	10	117	2,671	2,778	**2,788**
D10 - SPECIALISED ORTHOPAEDIC SERVICES	2,081	460	66	2,541	2,147	**2,607**
F04 - INFECTIOUS DISEASES	120	-	2,202	120	2,322	**2,322**
D07 - SPECIALISED PAIN	812	3	901	815	1,713	**1,716**
A07 - SPECIALISED COLORECTAL SERVICES	970	7	135	977	1,105	**1,112**
Unknown	3,956	93	1,035	4,049	4,991	**5,084**
Grand Total	**3,395,830**	**106,444**	**290,897**	**3,502,273**	**3,686,727**	**3,793,170**

4. Quality Dashboard Overview

Quality Dashboard Overview

The following slides provide the following information on delegated specialised services

- How many units in the Midlands are delivering the service?
- Is the service required to submit data to the Specialised Services Quality Dashboard? (see next slide for definition on an SSQD)
- Is the service supported by an Operational Delivery Network (ODN) or other Clinical Network?
- Is the team aware of any Serious Incidents (Sis) relating to the service?
- Is the team aware of any complaints relating to the service?
- Is the team aware of any CQC reports relating to the service?
- Is the team aware of any other intelligence relating to the service?

Example

Priority	Service	Units	Has SSQD Y/N	Has Network Y/N	Any SIs reported April 2022-present Y/N	Any complaints reported 2021-present Y/N	CQC Reports Y/N	Any other intelligence available on quality of care e.g. Peer Review Visits, national audits, GIRFT reports
1	ACC	61	Y	Y	Y	N	1 UHB	Network Peer Reviews, GIRFT
		There are 61 sites in the Midlands delivering ACC (Adult Critical Care)	There are SSQDs relating to ACC	There is a Network for ACC	There are SIs relating to ACC	There are no complaints relating to ACC	There is a CQC report relating to ACC at UHB	There network peer reviews and a GIRFT report relating to ACC

Specialised Services Quality Dashboard (SSQD)

- SSQDs are designed to provide assurance on the quality of care by collecting information about outcomes from healthcare providers. SSQDs are a key tool in monitoring the quality of services, enabling comparison between service providers and supporting improvements over time in the outcomes of services commissioned by NHS England.

- For each SSQD, there is a list of agreed measures for which data is to be collected. Healthcare providers, including NHS Trusts, NHS Foundation Trusts and independent providers, submit data for each of the agreed measures.

- Each SSQD is ‘refreshed’ with up-to-date outcomes submitted from national data sources, and where necessary healthcare providers, on a quarterly basis. The information provided by the SSQDs is used by NHS England specialised services commissioners to understand the quality and outcomes of services and reasons for excellent performance. Healthcare providers can use the information to provide an overview of service quality compared with other providers of the same service.

Quality Overview Dashboard (1 of 4)

Priority	Service	Total No. of Units in Midlands	Has SSQD Y/N	Has Network Y/N	Any SIs reported April 2022-present Y/N	Any complaints reported 2021-present Y/N	CQC Reports Y/N	Any other intelligence available on quality of care e.g. Peer Review Visits, national audits, GIRFT reports
1	ACC	61	Y	Y	Y	N	1 UHB	Network Peer Reviews, GIRFT
2	Cancer- Chemotherapy	43	Y	Y	Y	N	N	GIRFT
3	Cirrhosis of the liver	36	Y	Y	N	N	N	N
4	Neonatal Care	25	Y	Y	Y	N	N	Network Peer Reviews
5	Cardiology: implantable cardioverter defibrillator (ICD)	17	Y	Y	Y	N	N	National Audit
6	Cardiology: primary percutaneous coronary intervention (PPCI) (Adult)	11	Y	Y	N	N	N	National audit, GIRFT
7	Cardiac MRI	11	Y	Y	N	N	N	National audit, GIRFT
8	In centre haemodialysis: main & satellite units	11	Y	Y	Y	N	N	N
9	Cardiac surgery (Adults)	10	Y	Y	Y	N	N	National Audit, GIRFT
10	Haemophilia (All ages)	10	Y	Y	N	N	N	National Audits
11	Fetal medicine – (West Mids has AIP & Fetal Med)	9	Y	Y	N	N	N	National Audits
12	Cancer: anal	8	Y	Y	N	N	N	National Audits, GIRFT
13	Specialised kidney, bladder, & prostate cancer services	8	Y	Y	Y	N	N	GIRFT
14	Cardiac: electrophysiology & ablation services	7	Y	Y	N	N	N	National Audits, GIRFT
15	Thoracic surgery (adults)	6	Y	Y		N	N	N
16	Hepatobiliary & pancreas (Adult)	6	Y	Y	N	N	N	N
17	Cancer: pancreatic (Adult)	5	Y	Y	N	N	N	N
18	Cancer: malignant mesothelioma (Adult)	4	Y	Y	N	N	N	N
19	Level 3 - Paediatric Critical Care	4	Y	Y	N	N	Y	GIRFT
20	Adult congenital heart disease (ACHD)	2	Y	Y	N	N	N	National Audits, GIRFT(Cardiology)
21	Stereotactic radiosurgery & stereotactic radiotherapy (Intracranial) (All ages)	2	Y	Y	N	N	N	N
22	Testicular cancer	2	Y	Y	N	N	N	GIRFT

Quality Overview Dashboard (2 of 4)

Priority	Service	Total No. of Units in Midlands	Has SSQD Y/N	Has Network Y/N	Any SIs reported April 2022-present Y/N	Any complaints reported 2021-present Y/N	CQC Reports Y/N	Any other intelligence available on quality of care e.g. Peer Review Visits, national audits, GIRFT reports
23	Cancer: Clinical chemotherapy	28	N	Y	N	N	N	N
24	Cancer: chemotherapy ITC	18	N	Y	N	N	N	N
25	Cancer chemotherapy Higher Intensity	14	N	Y	N	N	N	N
26	Renal – assessment & prep for renal replacement therapy	10	N	Y	N	N	N	N
27	Haemodialysis to treat established renal failure	10	N	Y	N	N	N	N
28	Peritoneal dialysis to treat established renal failure	10	N	Y	N	N	N	N
29	Renal dialysis – intermittent haemodialysis & plasma exchange to treat acute kidney injury	10	N	Y	N	N	N	N
30	Level 2 - Paediatric Critical Care	8	N	Y	N	N	I KGH	N
31	Complex spinal surgery (All ages)	8	N	Y	N	N	N	N
32	Paed surgery: surgery (and surgical pathology, anaesthesia & pain)	7	N	Y	N	N	N	N
33	Colorectal: transanal endoscopic microsurgery (TEMS)	7	N	Y	N	N	N	N
34	Specialised HIV services (Adults)	7	N	Y	N	N	N	N
35	Specialised cancer surgery: non-surgical	6	N	Y	N	N	N	N
36	Paed medicine: respiratory	5	N	Y	Y	N	N	N
37	Neurosciences: specialised neurology (Adults)	5	N	Y	N	N	N	N
38	Cardiology: inherited cardiac services (All ages)	5	N	Y	N	N	N	N
39	Neurosurgery: Adults	4	N	Y	Y	N	N	N
40	Brain & other rare CNS tumours	4	N	Y	N	N	N	N
41	Major trauma (Adult)	4	N	Y	Y	N		Network Peer Reviews
42	Specialised services for haemoglobinopathy (All ages): haemoglobinopathies coordinating care centres	3	N	Y	N	N	N	N
43	Major trauma (children)	2	N	Y	Y	N	N	Network Peer Reviews
44	Paed surgery: chronic pain	2	N	Y	N	N	N	

Quality Overview Dashboard (3 of 4)

Priority	Service	Total No. of Units in Midlands	Has SSQD Y/N	Has Network Y/N	Any SIs reported April 2022-present Y/N	Any complaints reported 2021-present Y/N	CQC Reports Y/N	Any other intelligence available on quality of care e.g. Peer Review Visits, national audits, GIRFT reports
45	Specialised immunology (All ages)	13	Y	N	N	N	N	National Audits, GIRFT
46	Vascular disease: arterial	11	Y	N	Y	N	N	National Audits, GIRFT
47	Specialised rheumatology services (Adult)	10	Y	N	N	N	N	Y GIRFT
48	Haemophilia (All ages)	10	Y	N	N	N	N	Y National Audits
49	Implantable hearing aids for microtia, bone anchored hearing aids….	7	Y	N	N	N	N	N
50	Paed medicine: rheumatology	7	Y	N	N	N	N	N
51	Specialised complex surgery for urinary incontinence and vaginal prolapse (16yrs & above)	7	N	N	N	N	N	N
52	Colorectal: faecal incontinence (Adult)	6	Y	N	N	N	N	N
53	Interstitial lung disease	6	Y	N	N	N	N	QSIP self-assessment pilot
54	Intestinal failure (Adult)	6	Y	N	N	N	N	N
55	Specialised endocrinology services (Adult)	6	Y	N	N	N	N	N
56	Cystic fibrosis (children)	5	Y	N	N	N	N	N
57	Cystic fibrosis (Adult)	4	Y	N	N	N	N	N
58	Complex disability equipment: prosthetic specialised services (all ages) with limb loss	3	Y	N	N	N	N	N
59	Positron emission tomography – computed tomography (PET CT) (All ages)	3	Y	N	N	N	N	N
60	Cleft lip and/or palate	3	Y	N	N	N	N	N
61	Complex gynae: congenital gynae anomalies (Children 13yrs & above and adults)	4	Y	N	N	N	N	N
62	Fetal medicine (East Midlands don't have network)	3	Y	N	N	N	N	N
63	Specialised resp services (Adult): severe asthma	3	Y	N	N	N	N	N
64	Metabolic disorders (Children)	3	Y	N	N	N	N	N
65	Metabolic disorders (Adult)	1	Y	N	N	N	N	N
66	Adult highly specialist pain management services	1	Y	N	N	N	N	N
67	Spinal cord injuries	1	Y	N	N	N	N	N
68	Complex gynae/female urology: genito-urinary tract fistulae (Girls & women aged 16yrs & above)	1	Y	N	N	N	N	N

Quality Overview Dashboard (4 of 4)

Priority	Service	Total No. of Units in Midlands	Has SSQD Y/N	Has Network Y/N	Any SIs reported April 2022-present Y/N	Any complaints reported 2021-present Y/N	CQC Reports Y/N	Any other intelligence available on quality of care e.g. Peer Review Visits, national audits, GIRFT reports
69	Specialised HIV (Adults)	19	N	N	N	N	N	N
70	Specialised ophthalmology (Paeds)	10	N	N	N	N	N	N
71	Colorectal: transanal endoscopic microsurgery (TEMS) (Adult)	7	N	N	N	N	N	N
72	Paed medicine: gastro, hepatology & nutrition	7	N	N	N	N	N	N
73	Paed medicine: endocrinology & diabetes	6	N	N	N	N	N	N
74	Colorectal: complex IBD (Adults)	6	N	N	N	N	N	N
75	Specialised rehabilitation services for patients with highly complex needs (All ages)	6	N	N	N	N	N	N
76	Specialised allergy services (All ages)	6	N	N	N	N	N	N
77	Specialised dermatology services (All ages)	6	N	N	N	N	N	N
78	Neurosciences: specialised neurology (Adults)	5	N	N	N	N	N	N
79	Paed medicine: respiratory	5	N	N	N	N	N	N
80	Specialised ophthalmology (Adult)	5	N	N	N	N	N	N
81	Specialised orthopaedics (Adult)	5	N	N	N	N	N	N
82	Colorectal: distal sacrectomy (Adult)	4	N	N	N	N	N	N
83	Complex gynae – severe endometriosis	4	N	N	N	N	N	N
84	Paed medicine: haematology	4	N	N	N	N	N	N
85	Specialised ear surgery: cochlear implants	3	N	N	N	N	N	N
86	Complex disability equipment: communication aids	2	N	N	N	N	N	N
87	Metabolic disorders (lab services)	2	N	N	N	N	N	N
88	Environmental control equipment for patients with complex disability (All ages)	2	N	N	N	N	N	N
89	Paed medicine: renal	2	N	N	N	N	N	N
90	Paed medicine: specialised allergy services	2	N	N	N	N	N	N
91	Paed neuroscience: neurology	2	N	N	N	N	N	N
92	Paed medicine: immunology & infectious diseases	1	N	N	N	N	N	N

5. Quality Service Profile
Specialised Vascular (Arterial) Services

(Included as an example of profiles to follow)

Overview of the Quality Service Profiles

The following slides provide an example of the level of information held for each delegated specialised service. This Quality Service Profile for Vascular Services is provided as an example. The full suite of Quality Service Profiles is being prepared to be handed over at the point of delegation.

The following information is included in the Quality Service Profiles

- Which Midlands providers are delivering the service?
- What are the contact values and activity levels used for contract monitoring?
- What site are delivering the service?
- What local intelligence does the commissioning team hold about the service?
- What patient safety information does the quality team hold about the service?
- What information on clinical outcomes does the quality team hold about the service?
- What information on workforce and sustainability does the quality team hold about the service?

Further information in relation to Vascular Services is included in appendices 5.1-5.3.

Specialised Vascular (Arterial) Services - Overview

Eleven (5 East & 6 West) Midlands Providers (Based on 2022/23 and all Points Of Delivery). Values based on SLAM.

			Contract Monitoring Actual Price	Contract Monitoring Actual Activity
Grand Total			£19,530,304	27,310
RJE : UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£2,236,112	4,243
RKB : UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£1,470,165	942
RNA : THE DUDLEY GROUP NHS FOUNDATION TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£89,878	657
RNS : NORTHAMPTON GENERAL HOSPITAL NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£883,025	2,045
RR1 : HEART OF ENGLAND NHS FOUNDATION TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£5,956,526	2,033
RRK : UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£510,404	819
RTG : UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£1,339,425	1,324
RWD : UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£1,271,398	3,552
RWE : UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£1,526,080	4,834
RWP : WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£860,810	827
RX1 : NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£2,681,339	4,047
RXW : THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£705,142	1,987

The 11 Arterial Centres in the Midlands have no, one or more spokes as listed below
(information based on Trust returns to the National Vascular Registry (NVR)):

	Arterial centre (Hub)	Associated Centre (Spoke)
East Midlands	Nottingham University Hospital (Nottingham City Hospital)	Kings Mill (Mansfield)
	University Hospitals Leicester (Glenfield)	
	University Hospitals of Derby and Burton (Royal Derby Hospital)	Chesterfield Royal Hospital
	Northampton General Hospital	Kettering General Hospital
	United Lincolnshire Hospitals (Pilgrim Hospital Boston)	ULHT Lincoln County Hospital
West Midlands	University Hospitals North Midlands (Royal Stoke)	County Hospital Stafford, Leighton Hospital Crewe;
	Shrewsbury & Telford Hospitals (Royal Shrewsbury Hospital)	Princess Royal Telford;
	Dudley Group Hospitals (Russell's Hall)	New Cross Wolverhampton, Manor Hospital Walsall;
	University Hospitals Birmingham (Birmingham Heartlands Hospital)	QE Birmingham, Good Hope Sutton Coldfield, Solihull Hospital, City Hospital Birmingham, Sandwell Hospital
	Worcester Acute Hospitals (Worcester Royal Infirmary);	
	University Hospitals Coventry & Warwickshire (Walsgrave)	George Eliot, Warwick Hospital

Specialised Vascular (Arterial) Services - Overview

The Action on Vascular (AoV) Project Closure Report (2023) using **National Vascular Registry (NVR) data** included a summary of outstanding issues for the Midlands region.

- In 2018, there were 12 vascular Arterial Centres in the Midlands. Following a merger in the **West Midlands**, one centre ceased providing inpatient vascular care – **Queen Elizabeth, Birmingham.** This did not result in a compliant service at **UHB (Heartlands),** with IR staffing and activity levels being low.
- Of the remaining hospitals in West Midlands none is fully compliant. Activity and staffing are low in **SaTH**, activity is low at **Dudley** and **UHCW**, with **Carotid Endartectomy (CEA)** activity low at **UHNM** and finally, **IR** staffing is low at **WAH**.
- There have been no changes in the provider landscape in **East Midlands**. Three hospitals have **acceptable staffing but low activity** - **UHDB (CEA), NUH Abdominal Aortic Aneurysm (AAA)** and **UHL (AAA).** The challenges in **NGH** and **ULHT** have been partially mitigated by the link with **UHL**, but activity and staffing remain low.
- Based on current activity the region could support nine or ten arterial centres (if activity levels in the index procedures fall no further), but current patient flows result in all of the current centres failing to meet minimum activity requirements with the exception of **WAH.**
- Complex aneurysm procedures are currently undertaken at ten centres. Based on current activity the region is unlikely to be able to support more than three centres undertaking this work. Currently only one centre does more than 12 complex procedures per year **(UHB).**

Specialised Vascular (Arterial) Services

The below information is validated data as of 09/01/2024

Patient Safety

Serious Incidents (consider PSIRF/LFPSE when available)	**Appendix 5.1** Details of two incidents reported between the period of April 2022 – present
Never Events	None identified
CQC Reports	None identified

Workforce & Sustainability

Workforce/ Recruitment & retention	GIRFT and Vascular Society recommend a minimum of 6 vascular surgeons and 6 Interventional Radiologists providing 24/7 cover in an arterial centre. Recruitment and retention of IR consultants is a challenge nationally and particularly for smaller centres. This can lead to service fragility and challenges in terms of sustainability (see below).
GMC national training survey/ NETS – national education trainees survey	GMC NTS 2023 – no red flags, green flag for regional training in East Midlands (rated significantly better than expected)
Summary of known risks of service/provider organisation	Census data collected in January 2023 as part of the national Action on Vascular Programme highlighted the following: Worcester – low IR staffing (4 consultants) SaTH – 5 surgeons and low IR staffing (3 consultants) UHB – low IR staffing (4 consultants) ULHT – 5 surgeons and low IR staffing (3 consultants) NGH – low IR staffing (3 consultants)
Other Information	None identified

Clinical Outcomes

Notable examples of high performance / innovation	None identified
Specialised Services Quality Dashboard (SSQD):	**Appendix 5.2** Providers are required to submit; • Quarterly:13 quality indicators • Annually: 3 quality indicators Indicators include activity data for elective and emergency aneurysms, endarterectomy and amputation; as well as morbidity and mortality metrics
Mortality data	Most recent National Vascular Registry report reveals no mortality outliers for the index procedures (aortic aneurysm surgery, carotid endarterectomy, amputation, lower limb revascularisation).
GIRFT	• National rollout of NCIP portal to consultant vascular surgeons is now under way - Getting It Right First Time - GIRFT Published 08 Jan 24 • arterial - Getting It Right First Time - GIRFT
National Audits	• National Vascular Registry State of the Nation report 2023 – HQIP Published: 09 Nov 2023 • Impact of the COVID-19 pandemic on vascular surgery in the UK (NVR) – HQIP Published: 08 Jun 2023
Other information sources (if Applicable)	**Appendix 5.3** Update from NHSE Trauma POC Lead Aug 23, CQUIN - critical limb ischaemia continues. CQUIN08 Revascularisation within 5 Days Objective: Revascularise patients with chronic limb-threatening ischaemia within 5 days, in line with the national standard, to reduce to length of stay, in-hospital mortality rates, readmissions and amputation rates. Target: 45% to 65% Q1 Scores - Specialised Commissioning Incentives Workspace - FutureNHS Collaboration Platform

6. Services currently classified as Enhanced Monitoring or Intensive Support

Overview of the ASC Quality Highlight report

There is an agreed Quality Assurance framework in place to manage risk across the 12 organisations for 2024/25. Clinical and Quality risks are reported when they are at an Intensive Level or an Enhances level surveillance in line with the NQB guidance. During 2023/24 these have been reported to the East and West Joint Committees, which will continue in 2024/25.

There are no services currently at an Intensive Level of surveillance

There are current 3 services that are being delegated that are at an Enhanced level of surveillance. The following slides contain a copy of January's ASC Quality Highlight report. This report is presented to the Midlands Acute Specialised Commissioning Group (MASC) and the East & West Midlands Joint Committees monthly.

The Quality Highlight report details

- Which services which are subject to enhanced monitoring or intensive support
- Any information relating to the issue/concern and its impact
- Any mitigating actions which are being carried out to address the issue/concern
- Any other intelligence received by the quality team that month
- Any learning or best practice to be shared

Acute Specialised Commissioning Highlight Report – East Midlands

Date:	18/01/2024

Key messages

No new quality concerns raised at an enhanced or intensive surveillance level for the Acute Specialised Services in the East Midlands Systems for January 2024
Quality concerns and issues arising in Specialised Services are assessed utilising the NHSE Midlands Quality Assurance Framework and are identified as on Routine, Enhanced or Intensive Surveillance in line with NQB Guidance.

Key Messages

#	**Concern/Issue** *New or Ongoing and Escalation Level*	**Programme of care /Speciality**	**Organisation & Integrated Care System (ICS)**	**Concern/Issue identified, Description/Impact** *Please include whether this requires **formal escalation** to RQG following discussion at commissioning meetings*	**Proposed mitigation/Action being taken/Key Learning Points**
1	Ongoing – Enhanced Surveillance	Neonatal Services	Kettering General Hospital (KGH) Northants ICB	• 01/09/23 Emerging theme identified by EM ODN in relation to resuscitation, stabilisation and escalation of deteriorating neonates. This has been based on triangulation of information from serious incident reports and mortality reviews undertaken over the last 2 years, as well as HSIB reports and patient and staff feedback. • 18/9/23 further concerns raised by the EMNODN regarding clinical practice on the unit. Decision taken by NHS England (Midlands) to immediately pause KGH's designation as a Local Neonatal Unit (LNU) and to close the unit to new admissions for babies who meet LNU criteria as a precautionary step.	• Formal letter to trust from ODN outlining concerns 08/09/23. • 13/09/23 exec call (NHSE, ICB and Trust) to review the actions in place, their sustainability, and medium/long term actions or strategic work need to collectively undertake. Immediate actions taken include doubling up of rota to ensure quality and safety and provided assurance to NHSE whilst further consideration of options for action, including the impact, is undertaken. • 18/09/23 NHSE review of available information in relation to concerns raised by EM ODN. Decision taken to immediately pause KGH designation as a Local Neonatal Unit (LNU) and to close the unit to new admissions for babies who meet the criteria normally treated at an LNU on patient safety grounds, whilst further inquiry is undertaken and to allow the required action and assurance work to be completed. • Silver & Gold IMT calls put in place to monitor progress with completing the actions as well as to manage patient flow in order to mitigate the impact for affected patients on the maternity pathway that have been identified in the QIA/EQIA that has been completed. • External Peer Review Visit undertaken 28/11/23 to evaluate the progress, including the additional skills training. Good progress noted in a number of areas, and a decision taken to stand down the Silver and Gold Calls and move to monthly monitoring of completion of the remaining actions. • These monthly meetings are now established, and the Peer Review Report is being finalised and will be sent to the trust by 22/01/24.

Acute Specialised Commissioning Highlight Report – East Midlands

INTELLIGENCE SHARING - horizon scanning, trends etc
Neonatal Unit Care Neonatal care has been agreed as one of the joint NHSE/ICB priority areas and a paper outlining the intentions was previously presented to MASCG and the E & W Joint Commissioning Committees. Linked to the national focus on maternity and the Ockenden review at NUH, as well as in the wake of the Lucy Letby trial, there is significant media attention on neonatal care. Key challenges in neonatal care also include significant staffing challenges in a number of units, plus regional work continues in relation to high neonatal mortality rates. A number of reports have been produced over the last 6 months by N&Q, PH & Commissioning teams based on MBRRACE and local unit data, and action is in progress through the ODNs as well as through each LMNS. Oversight will continue through MASCG, the E & W JCCs as well as through the Regional Perinatal Quality Group which the ICB's also attend. Work has also begun to develop a combined maternity and neonatal daily Sitrep across the region which will collate the operational position in each unit and system, and also then enable reports to be produced showing trends. The second phase of this work is to agree the key quality outcome metrics for neonatal care that can then be added to the Maternity Heatmap that already exists. An NHSE internal Perinatal Improvement Programme Group has also been established to coordinate actions across all involved directorates which includes specialised commissioners. **Fetal Medicine Services** There are a number of services in the region that have reported capacity issues in the Consultant workforce Mutual aid conversations are urgently being progressed and the issue has also been flagged to the regional Fragile Services Working Group.
LEARNING AND SHARING - best practice, outcomes
Please share below any examples of positive assurance, good news stories, innovation, lessons learned, best practice, thematic work and intelligence that would be helpful to other regions N/A

7. Fragile Services

Overview of Fragile Services database

The Fragile Services database is a list of services that the quality or commissioning team is monitoring due to information being received which suggests the service may be subject to some fragility.

This could be as a number of any of the following causes

- Capacity pressures
- Demand pressures
- Workforce issues
- Recruitment and retention issues
- Training and education issues
- Potential lack of provider

The Fragile Service Programme reviews the level of risk and takes appropriate mitigating actions. Whilst some fragile services can be attributed to a specific ICB, some affect whole pathways and have an impact at a regional level.

Fragile Services

The table below contains a count of the number of services across the region that have been bought to the attention of the Fragile Services Programme. These services are across ICB and Specialised Commissioned services as fragile services have the potential to affect the whole pathway.

	ICB specific						Generic	Total
Midlands Region							34	34
East Midlands	LLR	Notts	N'hants	Lincs	Derby		3	92
	21	35	8	15	10			
West Midlands	BSOL	BC	C&W	H&W	SSOT	STW	2	63
	16	8	6	15	4	12		
								189

Fragile Services in delegated Spec Comm services: Leicester, Leicestershire & Rutland ICB

Specialty	Site	Reason for fragility	Detail and actions
Adult critical care	UHL	Recruitment and retention of staff; estates	Action plan in place
Head and neck cancer	UHL	Lack of consultant workforce	Leicester now working closely with neighbouring trusts for mutual aid with joint appointments, weekly East Mids operational meeting to structure mutual aid between units.
Cardiac physiology	UHL	Recruitment and retention of staff	Action plan in place
Neonatal	UHL	Recruitment and retention of staff	Recruitment ongoing
Oncology	UHL	Lack of nursing workforce	Low numbers of nursing in oncology and chemotherapy suite. Active recruitment ongoing.

Other services in UHL/LLR on the fragility register which may impact on pathways for delegated services are:

- UHL estates technical staff,
- Theatre staff,
- General internal medicine nursing,
- Midwives,
- ENT,
- Dermatology
- Paediatrics: immunology,
- CAMHs,
- Haematology,
- Palliative care,
- Pharmacy,
- Safeguarding,
- Tone management,
- Dietetics
- CAMHs,
- Eating disorders,
- Perinatal pathology,
- Community mental health

8. Deep Dives

Completed Deep Dives

As part of Joint Working on Specialised Services in 2023-24, the Midlands Acute Specialised Commissioning Team conducted a series of deep dives into priority services which were present to the East & West Midlands Joint Committees and the Clinical Collaborative Executive Forum (CCEF).

The following deep dives have been included in the appendices for information.

- **Appendix 8.1**
  Adult Critical Care

- **Appendix 8.2**
  Vascular Services

- **Appendix 8.3**
  Haemoglobinopathy

- **Appendix 8.4**
  Neonatal Services

9. 2024-25 Priorities

Overview of 2024-25 Priorities

As part of the 2024-25 planning round the Specialised Commissioning MDT have engaged with ICB to agree the 2024-25 priority pathways for specialised services in the Midlands.

The 9 priorities approved by ICBs and NHSE at the Midlands Acute Specialised Commissioning Group were as follows

- Neonatal Intensive Care,
- Adult Critical Care,
- Haemoglobinopathy,
- Severe Asthma,
- Oncology Review,
- Acute Aortic Dissection,
- Paediatric Critical Care,
- Multiple Sclerosis,
- Spinal Cord Injury.

Further details of each priority are included in Appendix B.

10. Links

Links

- NHS commissioning » Specialised services (england.nhs.uk)
- NHS England » Prescribed specialised services manual
- NHS commissioning » National Programmes of Care and Clinical Reference Groups (england.nhs.uk)
- NHS England » Service specifications
- NHS England » Commissioner assignment method 2024/25
- Prescribed Specialised Services Tools - NHS Digital
- NHS England » Directly commissioned services reporting requirements
- Integrating specialised services within Integrated Care Systems - FutureNHS Collaboration Platform

Appendix A.
Case for change examples

Example of how ICSs are already making a difference -Virtual e-clinics for kidney disease

- Patients with renal failure in Tower Hamlets now get more time with a specialist consultant thanks to the local ICS redesigning services around the sickest patients.
- Kidney doctors at Barts Health NHS Trust and GPs in the area set up a virtual e-clinic for GPs so they can send questions on kidney patients direct to consultants for a quick reply. The system also flags up patients that might need specialist treatment
- Since it began, waiting times for outpatients have dropped from as much as 15 weeks to just five days for advice, increasing face to face time for consultants and patients for those who most need it.
- The demand for outpatient appointments has reduced to a fifth of previous levels freeing up to time and money for reinvestment in NHS services.
- More integrated commissioning of specialised renal services would make these sorts of innovations easier as –
  - The same people and organisation would be responsible for commissioning both the specialised (eg dialysis) and non specialised (GP led) parts of the patient pathway reducing complexity and bureaucracy
  - Budgets will be pooled which creates more of an incentive to keep patients out of hospital and treat them closer to home
  - Services can be tailored around the needs of local populations helping to address health inequalities
  - Those who do need specialist services such as dialysis will still be able to access them in line with national standards and policies

"We were seeing a lot of patients who gained little from seeing a consultant, and instead are supporting GPs to help these patients. If we think a patient does need extra care then they can get in to see us far more easily, and into the right specialist clinic. Our team can now focus on those on dialysis, or with more severe kidney disease, where specialists can make the biggest difference."

Dr Neil Ashman, who developed the system with local GP Dr Sally Hull

Case for change examples

Current Commissioning Arrangements	Consequences of Current Arrangements
HIV Services Commissioned nationally but Patient care delivered through HIV services via Local Authorities	Service and workforce fragmentation in some areas across England
Mental Health and LDA Services Most Commissioned by CCGs. Only CYP, adult low and medium secure and adult eating disorder services are nationally commissioned.	Specialised MH services are at the end of the pathway focused on inpatient and interventionalist care leaving little incentive for upstream investment by CCGs
Neurology Spec com funds neurology patients only at certain designated centres / in outpatients where the patient has been referred by a consultant. Neurological needs of patients not seen at a centre are met by hospitals funded by CCGs	Discourages development of local provision by CCGs at sites other than neuroscience centres – patients have to travel further. Discourages service evolution, patients not seen in the right places.
Renal Costs of Kidney disease, dialysis and transplantation is funded via Spec com but surgery and most outpatient care is funded by CCGs. Transport is supported by CCGs and makes up 30% of elective transport in the NHS	Funding for renal medicine is complex and discourages upstream investment in prevention and earlier stages of the pathway.

Introduction of ICSs will…

- Enable NHSE and Local Government to collaborate on the commissioning of HIV and sexual health services strengthening pathways with domestic abuse, Sexual Assault Referral Centres and mental health services.
- Help enable a joint approach to support and deliver recommendations from HIV action plan.
- Help to ensure greater integration in the design of services informed by data and insight on the needs of local communities – helping to reduce inequalities.
- Enable local providers of services for mental health and learning disabilities and /or autism to take control of budgets to improve outcomes by managing whole pathways of care.
- Seek to avoid inpatient admissions and provide high quality alternatives to admission.
- Provide an opportunity to improve quality and access to services by moving decisions closer to communities
- Enhance collaboration between partners including across larger geographical footprints
- Make it easier to deliver upstream interventions in primary care around diagnosis and early treatment, to potentially prevent or delay the need for transplants further down the pathway
- Potentially lead to greater investment in home dialysis with financial benefits (from reduction in travel costs) being reinvested elsewhere.
- Support greater focus on prevention and provision of care closer to home.

What do we want to be different in the new model?

	Planning and Governance	Collaborative Delivery	Funding
PRESENT	Prevention, diagnosis, acute treatment, chronic management and specialised services are planned and commissioned by different organisations with plans based on different historic views resulting in misaligned priorities	Some patients have multiple touchpoints across multiple organisations for the same condition which results in limited opportunities to join up care and support innovation and technological advances	Current funding approach provides limited incentives to reduce cost through innovation which can result in specialised budgets outstripping funding available
FUTURE	All organisations across whole patient pathway working under a single planning structure with aligned incentives and plans based on a single forward view of population needs.	Fewer touchpoints which are built around the needs of the patient enabling greater innovation and collaboration and more joined up services across the patient pathway	Care funded on a population basis and with local organisations working together to set and manage budgets incentivised to innovate and save costs, leading to sustainable systems and more focus on the needs of local populations.
EXAMPLE	 Mr Wu, 68yrs Type II Diabetes End stage renal failure Needing dialysis. Can delay the need for dialysis through identification and intervention of his CKD by his GP, thereby improving his quality of life and care experience	 Mrs. Jagathesan, 74yrs Complex cardiac history awaiting a heart procedure, lives far from Cardiac centre. Can attend local hospital for pre-assessment ahead of her surgery, receive follow up care close to home in local or virtual clinics.	 Miss Jones, 19yrs Rare neurological disorder Waiting for multiple diagnostics. Gets co-ordinated diagnostics through a single point of access, reducing outpatient appointments and enabling faster diagnosis and treatment – meaning better patient experience and cost-effective care

Case for change – examples and themes

Current Arrangements	Consequences	Integration Opportunities
Sickle Cell Spec comm funds haematology services. ICBs funds the upstream pathway – from genetic screening, pre-conception care, newborn screening, primary care, urgent and emergency care.	Lack of joined up care meant that significant service quality issues went unchecked for years. Opportunities to support patients through core ICB offerings (e.g. community nursing) were missed – haematology didn't have sight of the offering and ICBs didn't have sight of the service.	Single commissioner will have a view of the entire end-to-end pathway and will have the mechanism to identify and address issues. One accountable group for ensuring quality services. Integrating specialised haematology services in and end-to-end pathway can improve connectivity with ICB core services (maternity, primary care, community support, urgent and emergency care access) for people with Sickle Cell disease.
Fragmented funding and pathways	**Disincentives to improve outcomes and £**	**"steps to the left" and end-to-end pathways**
Neurology Only funded at certain Neurosciences centres – even if the specialist consultant works at multiple hospitals. Neurological needs of patients not seen at a centre are met by hospitals funded by ICBs.	Discourages development of local services outside the neuroscience centre (investment from ICBs) – patients have to travel further. Inconsistent provision leading to inequities. Discourages service evolution, with no common approach to pathway development.	Introduce a consistent approach to commissioning neurology services – enabling improved quality and access, and services closer to home. Enhance collaboration between partners including across larger geographical footprints. Create streamlined pathways leading to faster diagnosis and more cost effective care.

HIV Pilot - Ensuring Comprehensive HIV Screening in Emergency Departments (EDs) Across South London

Almost all hospitals in South London in high or extremely high prevalence areas offer opt-out HIV ED testing.

Cases identified in South London EDs:

- At KCH, the oldest patient identified through ED testing was 95.
- At GSTT, a significant number of patients testing positive in ED have primary infection (20%) with very high viral loads.
- At SGUH, an HIV diagnosis was suspected in only 11 (22%) of the subsequently 50 positive cases.
- At Croydon, newly diagnosed HIV-positive patients now need shorter hospital stays, from an average of 34.9 days down to only 2.4.

2. Opt-out HIV tests are offered to those who need blood tests (c.300,000 people).

5. If a test is reactive, the patient is invited for further tests by the sexual health service.

7. On appropriate treatment, patients with HIV can expect to live as long as someone without HIV. Those with undetectable viral loads cannot pass HIV onto anyone else, even in unprotected sex. Clinicians try to re-engage patients lost to follow-up.

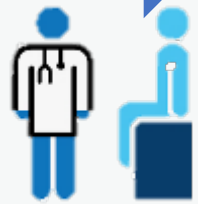
The process of HIV screening in EDs → What happens next → Uptake

1. Over 1 million people attend Emergency Departments* in South London every year.

3. The level of uptake of HIV tests varies across South London, from 34% - 98%.

4. One sample and blood bottle can be used for both the blood tests and the HIV test, meaning the additional costs are largely lab-associated.

6. Newly diagnosed patients are brought into care and put on treatment. Early detection is vital to reduce HIV/AIDS related complications.



This variation across South London means that not all patients who have HIV are being identified. This is due to key factors such as the age of those tested, the length of time before re-testing repeat ED attendees, and general operationalisation of the screening strategy.

This pilot aims to address this through 'levelling up' across south London, supported by a minimum service specification.

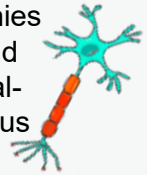
There is variation in lab costs across South London, with costs ranging from £2.50 to £5.55 per test. Some trusts use 2 blood bottles.

~150 patients are newly diagnosed with HIV in EDs in South London every year. Each person living with HIV newly linked to care could avoid NHS costs of over £200,000.

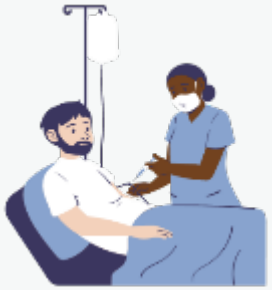
"Making a diagnosis of HIV today does mean spending money on the treatment tomorrow; missing a diagnosis today means greater treatment costs in years to come (and not just for one patient, but for anyone else before or after them in the chain of transmission)."

Home based immunoglobulin therapy (IVIg) in Neurology in South London

1. Home based Immunoglobulin therapy for people with autoimmune neuropathies is safe and effective and less costly than hospital-administered intravenous immunoglobulin (IVIg)



2. Some patients are required to come into hospital (day case units) for recurrent infusions every 3-6 weeks, which may takes place over two to five successive days. Each episode of treatment costs £4k.



3. This is highly disruptive to quality of life. Patients frequently require time off work which makes maintaining employment challenging and costs them greatly through loss of income and travel.

4. Alternatively, many patients are suitable for home therapies – including a subcutaneous injection they can deliver themselves. This can transform the patient experience, and patients report high levels of satisfaction with this option.

5. In addition to being more convenient, this method offers clinical benefits as lower drug doses can be used more frequently. This is better tolerated by patients (reduces adverse reactions), avoids fluctuations in condition between treatment and reduces risk of stroke and other blood related issues related to large doses.

6. This contributes to improved use of hospital estates (freeing capacity in day case units for other activity), reduces drug costs through VAT savings and is cheaper for patients (reduced travel and lost income). Additionally, it offers greater environmental sustainability (reduced travel).

7. The model has been in place at Kings College Hospital for several years. We are proposing to support the Neurosciences centre to establish a service, using learnings from Kings as well as learnings in home care from the OPAT pilot.

8. Funding is available to recruit a CNS to support patients on this pathway. Project management support is available from SLOSS for implementation. **Trust and system support is required to manage and plan for day case activity and income changes.**

Appendix B. 2024-25 priorities – detailed slides

Midlands Oncology Service Review: Fragile		**Lead:** Laura Morris	**Ref:** C1
Delegation Status: Green (HCD retained)	**ICB:** All	**National Priorities: Recovery:** Cancer, Use of Resources. **LTP:** Workforce, Inequalities. **DCG**	
What is the problem in summary? Oncology is identified as a fragile service across the Midlands. Performance challenged, with 8/11 systems in tiered support. Inequity of timely access at Trust and tumour site level. Oncologist vacancy rate is 15% , expected to rise to 25% in 2027 with 20% forecast to retire over 5 years. Midlands has the lowest WTE per population in England. There are also workforce challenges in chemo nurses; therapeutic radiographers and medical physics. Across the Midlands, we spend £522 million on SACT per year (activity, drugs and support costs), plus Radiotherapy spending.		**What are we looking to achieve?** Reduce variation in waiting times; increase productivity and share best practice through the development of new models of care, workforce strategies and shared resource. **Scope:** Workforce; capacity; service models **Specific Partners:** Cancer Alliance (EAG/ECAG); EMAP (priority area); ICB cancer leads	
Planned Deliverables: - Mutual aid framework (Q1). - Develop plans for managing agency/locum costs (Q1). - Review and appraise variety of current financial spends and service models for oncology services (Q2). - Produce Virtual Ward criteria (Q2). - Confirm transformation plans in place at system for virtual or community clinics (Q4)		**How will we know if things have improved (KPI)?** - Reduced and consistent waiting times across systems. - Reduced vacancy rates. - Unit cost reduction. - Consistent approach to managing mutual aid.	

Acute Aortic Dissection		**Lead:** Jon Gulliver	**Ref:** IM1
Delegation Status: Green	**ICB:** All	**National Priorities: Recovery:** UEC, Use of Resources. **LTP:** Workforce, Health Inequalities. **DCG**	
What is the problem in summary? Acute aortic dissection (AAD) is rare and immediately fatal for 48%. For Type A making it to cardiac surgery, mortality is 25%. Surgery is time critical. All cardiac surgery centres have at least one AAD specialist surgeon but with no coordinated regional on-call rota presenting challenges to accessing intervention. There is consensus that coordination will improve outcomes for patients and reduce waits but there is resistance to change.		**What are we looking to achieve?** Reduce variation in access to emergency surgery and improved outcomes through the introduction of coordinated East and West on call rotas. **Scope:** Workforce; capacity; service models **Specific Partners:** Cardiac Transformation Programme, Cardiac Networks.	
Planned Deliverables: - Approved SOP(Q1). - SPOC testing and training(Q1). - Recruit MDT coordinator (Q1). - Establish regional MDT(s) (Q2). - Agree process for collecting and reporting KPI (Q1). - Service go live (Q1 WM, Q2 EM).		**How will we know if things have improved (KPI)?** - In hospital mortality with/without intervention; 1 year mortality. - LOS. - Referral numbers. - Intervention/no intervention. - Time from referral to intervention. - Deaths between diagnosis and intervention Type A. - Deaths between diagnosis and place of safety Type B. - Patient satisfaction.	

Severe Asthma		**Lead:** Jon Gulliver	**Ref:** IM2
Delegation Status: Green	**ICB:** All	**National Priorities: Recovery:** UEC, Use of Resources. **LTP:** Health Inequalities.	
What is the problem in summary? Severe asthma (SA) is a debilitating, chronic disease with an average of 4 asthma attacks and 4x more A&E visits pa, patients with SA account for ~50% of all asthma-related healthcare costs. Biologic treatment has the potential to improve lives and reduce the use of healthcare/social resource. Access is variable and ~80% of eligible patients are currently not prescribed a biologic.		**What are we looking to achieve?** Increase access to biologics for patients with SA to improve outcomes for patients and reduce the use of other healthcare resource. **Scope:** All patients with severe asthma. **Specific partners:** Respiratory Network	
Planned deliverables: - Review of current treatment and patient pathways for the management of asthma across primary and secondary care including case finding for biologics, diagnosis and treatment optimisation. - Review of the data to understand the inequalities that are present in accessing biologics treatment, based on underlying service and/or patient factors. - Share with respiratory networks and specialist asthma centres to inform options appraisal.		**How will we know if things have improved (KPI)?** - Number of new initiations per ICB - Increase in percentage bio penetration per ICB - Reduction of variation in bio penetration by ICB	

Multiple Sclerosis Service Review: Risk Register		**Lead:** Dom Tolley	**Ref:** T1
Delegation Status: Green	**ICB: BSol; H+W; Black Country**	**National Priorities: Recovery:** Elective, Use of Resources. **LTP:** Workforce, Health Inequalities.	
What is the problem in summary? A review of the MS tertiary service provided by University Hospitals Birmingham to a number of ICBs has found significant waiting times and increasing numbers of patients to be seen for initial consultations to access to Drug Modifying Therapies (DMTs) and lack of structure for the ongoing management of this patient group. There is a lack of good governance with regards to the prescribing and monitoring of these patients, which has a potential of harm.		**What are we looking to achieve?** Improve access of eligible MS patients to DMTs and ongoing care of those already on treatment outside of BSol ICB. **Scope:** All patients eligible MS patients who should fall under the care of UHB. **Specific partners:** None	
Planned deliverables: - Review of West Midlands regional MS DMT pathways and governance and current financial spend for MS DMT patients and produce options appraisal for MASG and JCs, to include the development of Neurology ODNs (Q2) - Develop and implement a revised MS DMT clinical pathway, including shared care agreements (Q4).		**How will we know if things have improved (KPI)?** - Reduction in waiting list and waiting times for MS patients on DMT clinical pathway by the end of 2024/25	

Spinal Cord Injury Services		**Lead:** Dom Tolly	**Ref:** T2
Delegation Status: Green	**ICB: All**	**National Priorities: Recovery:** UEC, Use of Resources. **LTP:** Workforce, Health Inequalities. **DCG**	
What is the problem in summary? The Midlands region only has one commissioned Spinal Cord Injury (SCI) rehabilitation unit (RJAH), which has the second longest waiting times for admission in England. The unit cannot manage high cervical spinal injuries, due to lack of ACC, resulting in out of region transfers. The East Midlands does not have a SCI rehabilitation centre. Patients are managed in Sheffield or Stoke Mandeville where there are long waits. This delay in rehabilitation treatment means poorer outcomes (increased rates of HCAI and pressure sores), potential harm and DTOC.		**What are we looking to achieve?** Improved access to SCI and outcomes. Reduction in harm and DTOC resulting into lower use of healthcare resource. **Scope:** All patients presenting with a SCI and requiring rehabilitation. **Specific partners:** None	
Planned deliverables: - Complete a demand and capacity analysis for SCI rehab, including patient acuity and complexity (Q1-Q2). -Review current financial spend for SCI patients and review potential options costs for SCI services (Q1-Q2) - Present review and options papers to MASG and JCs, including QIA and 13Q (Q3), including weaning and ventilated patient services for high c-spine injured patients.		**How will we know if things have improved (KPI)?** - Reduction in LOS SCI patients. - Reduction in DTOC both from Acute beds base and to CHC services - Reducing periods of bed rest. - Reduction in complications.	

Adult Critical Care (ACC) Rehabilitation & Digital Enablement		**Lead:** Dom Tolly	**Ref:** T3
Delegation Status: Green	**ICB: All**	**National Priorities: Recovery:** UEC, Elective, Use of Resources. **LTP:** Workforce, Health Inequalities. **DCG**	
What is the problem in summary? The Midlands ACC Strategy has continued to develop a more diverse, resilient and holistic model of ACC care across the 29 ACC units. The major quality, clinical and operational improvement drive in the next 3 years of the strategy is to develop consistent 7-day services for ACC rehabilitation in line with national guidance. In doing so this potentially will reduce in LOS for ACC patients by up to 1.5 days, improve patient outcomes, reduce costs for patient episodes.		**What are we looking to achieve?** Digital enablement will provide clinical support, improved decision making through a networked approach to care through virtual ward rounds. Digital critical care platform will reduce clinical errors in transfers of care between providers, by allowing shared care records. **Scope:** All ACC units. **Specific partners:** EM and WM ACC ODNs.	
Planned deliverables: - Complete digital services review paper (Q1). - Complete ACC rehab gap analysis by provider/ICB (Q2). - Review of current spend for ACC rehab and review potential options costs for services (Q2). - Present review and options papers to MASG and JCs, including QIA (Q3).		**How will we know if things have improved (KPI)?** - Reduction in length of stays for ACC patients. - Reduction in pharmacy and parental nutritional spends.	

Haemoglobinopathies		**Lead:** Nick Hey	**Ref:** BI1
Delegation Status: Amber	**ICB: All**	**National Priorities: Recovery:** UEC, Use of Resources. **LTP:** Workforce, Health Inequalities. **DCG**	
What is the problem in summary? The APPG on Sickle Cell and Thalassaemia conducted a review of services and experiences of patients and produced 'No one's listening.' This report revealed many years of sub-standard care, stigmatisation and lack of prioritisation and patients losing trust in the NHS system. A regional review demonstrated wide variance in the level of service on offer to patients and numerous areas for improvement, in particular in improved training and knowledge at non-specialist trusts and A&Es.		**What are we looking to achieve?** Improve outcomes for patients and reduce unnecessary admissions for patients by improving networks of care. **Scope:** All haemoglobinopathy services. **Specific partners:** EM and WM HCCs.	
Planned deliverables: • Med Tech Funding (Spectra Optia) business cases . Potential for approval of additional national funding to support red blood cell exchange services - (Q2). • Review of SCD prevalence, activity and provision (Q1). • Review position against APPG report (Q1). • Review of Specialist Haemoglobinopathy Team provision – Service provision review and re-commissioning (Q4).		**How will we know if things have improved (KPI)?** - Updated review of regional position against No one's listening recommendations demonstrating improvement, especially in non-specialist centres. - Increased access and activity for red blood cell exchange.	

Neonatal Critical Care: Risk Register		**Lead:** Sumana Bassinder	**Ref:** WC1
Delegation Status: Green	**ICB: All**	**National Priorities: Recovery:** Maternity, Use of Resources. **LTP:** Workforce, Health Inequalities. **DCG**	
What is the problem in summary? Neonatal Critical Care remains an area of significant national and regional scrutiny. The Midlands also has one of the highest neonatal mortality rates in the country. There is significant work to do to implement the requirements of the NCCR including configuration, patient pathways, increase cot capacity, workforce strategy, neonatal transport review to support the revised neonatal networks. All against a backdrop of high-profile scrutiny (Ockenden, Thirlwall, Letby, Kirkup).		**What are we looking to achieve?** Improved outcomes for babies and a reduction in mortality rates. **Scope:** All NIC services. **Specific partners:** EM and WM ODNs. Perinatal Programme. LMNS	
Planned deliverables: • Review of WM capacity and configuration (Q1). • Describing patient pathways. • Financial impact of compliance (Q1) • Production of workforce strategy. • Review of neonatal transport. • Ongoing capacity monitoring and compliance review. • Perinatal dashboard (Q1) • Review of PMRT process.		**How will we know if things have improved (KPI)?** - Reduction in mortality rates. - Reduction in babies being transferred out of region for neonatal care. - Reduction in the number of cots closed due to staffing challenges.	

Paediatric Critical Care (PCC)		**Lead:** Sumana Bassinder	**Ref:** WC2
Delegation Status: Green	**ICB: All**	**National Priorities: DCG**	
What is the problem in summary? PCC capacity is an area of concern regionally and nationally for both Level 2 (High Dependency) and Level 3 (Intensive Care). National funding was received in 23/24 to increase Level 2 capacity outside of Level 3 centres but so far only a partial implementation has been achieved. Further work required to identify, increase and progress additional capacity.		**What are we looking to achieve?** Right capacity in the right place. **Scope:** All PIC services. **Specific partners:** EM and WM ODNs.	
Planned deliverables: - Monitoring of delivery of WM plans. - Plan for increase of resilient L2 capacity in the EM in line with GIRFT (Q1) - Demand, capacity and financial review of L2 and L3 provision and production of options appraisal (Q4)		**How will we know if things have improved (KPI)?** - Reduction in OPEL status levels from 23/24 surge baseline during 24/25 surge periods. - Reduction in patients transferring out of area for paediatric critical care. - Improved cot utilisation, closer to home and outside of tertiary centres.	

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Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board** (public)		
Date:	**11 April 2024**	**Paper:**	**O**
Report title:	**LLR Delivery Partnership – April briefing**		
Presented by:	Rachna Vyas, Chief Operating Officer, NHS LLR ICB		
Report author:	Rachna Vyas, Chief Operating Officer, NHS LLR ICB		
Executive Sponsor:	Caroline Trevithick, Chief Executive, NHS LLR ICB		

To approve ☐	**For assurance** ☐	**To receive and note** ☒	**For information** ☐
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Recommendations:

The Leicester, Leicestershire and Rutland Integrated Care Board is asked to:

- **RECEIVE and NOTE** the full contents of the report

Purpose and summary of the report:

1. Presented here is the February 2024 integrated delivery report from the LLR Delivery Partnership, covering progress against the LLR Operational Plan and the LLR five-year plan made at Month 11 of 2023/24.
2. Assessments against each facet of the plan are recommended as follows:

    a. Performance - Performance against the 31 NHS Mandate indicators remain positive overall.
    b. Urgent care - There is increasing variation against all UEC metrics, with ambulance handover and Category 2 response times significantly under strain. There is now daily scrutiny of the 4-hour performance to meet 76%. Enhanced escalation process has been enacted to support clinical risk and performance concerns. Clinical risk remains high in the Emergency Department and associated services.
    c. Primary Care – LLR has delivered the highest number of appointments in the region. Although the performance against locally set stretch target shows a red RAG against this. Overall, we have continued to offer more appointments in LLR. In addition, we anticipate an impact in the continued positive implementation of Pharmacy First in LLR which we expect will impact on the total number of appointments delivered in general practice.
    d. Elective Care - Industrial action and ongoing emergency pressures continue to impact on the time to reach zero 78+ waits. There will be a residual of c. 20 patients due to patient choice, complexity and admitted cancellations in March that could not be re-booked by the end of the month. Nationally and regionally the ask has been to get to the best possible position for 65+ by the end of March.
    62+ day cancer waits remain lower than plan and the position is improving. Reporting on the delivery of the 62-day standard, FDS and combined 31 day continues to be monitored via the Tier 2 programme.

e. Mental Health - LLR ICB is ranked 1/42 nationally for Adult Community MH transformation. We are 7/42 for CYP access, reaching 112% against the LTP ambition. LLR are the highest performing in the region for SMI Physical health checks and 4/42 nationally.
f. Learning Disability - Additional dedicated LD nurse capacity in place until the end of March 2024, to focus on those people who have not had a health check for 2 or more years and support attendance/identify reasonable adjustments.

Progress continues to be made across the month; despite significant industrial action, system teams have remained focussed on delivery of both one- and five-year plans

Key focus in January has been place-led planning for delivery of equitable services in areas such as cancer, immunisations and vaccinations and urgent care access. Several programmes of work have commenced at Place or neighbourhood level, in full partnership with local authorities and providers. Further work required to agree reporting dashboards, covering adult social care, public health and NHS outcomes frameworks to drive focus in 24/25.

Appendices:	• Appendix 1 – ICB Performance Report
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• LLR Delivery Partnership 22/2/24 • LLR ICB Finance Committee March 2024 • LLR ICS System Quality Group March 2024 • LLR System Executive March 2024

The report is helping to deliver the following strategic objective(s) – *please tick all that apply*:		
1. Improve outcomes	Improve outcomes in population health and healthcare.	☒
2. Health inequalities	Tackle inequalities in outcomes, experience and access.	☒
3. Value for money	Enhance productivity and value for money.	☒
4. Social and economic development	Help the NHS support broader social and economic development.	☐
5. NHS Constitution	Deliver NHS Constitutional and legal requirements.	☒

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	

Implications:	
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	BAF 2 – Health Inequalities BAF 3 – Demand and Capacity BAF 4 – Finance BAF 5 – Quality and Safety BAF 6 – Emergency Preparedness, Resilience and Response
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	No new funding requests Delivery / non-delivery of cost-improvement programmes highlighted throughout paper
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	Yes, throughout paper
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	Yes, throughout paper
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	Any new services / service changes will be made with due regard to the Inclusive Decision-Making Framework and the PSED

LLR Delivery Partnership; Delivery of the LLR one - and five - year plan - February 2024 reporting period

Background

1. Presented here is the February integrated delivery report from the LLR Delivery Partnership, covering progress against the LLR Operational Plan and the LLR five-year plan made at Month 11 of 2023/24. The aims of this paper are to highlight areas of challenge and concern across the various partnerships /collaboratives, highlight areas of good practice, and seek specific support where required from the system executive, system finance committee, system equity committee and the system quality committee or their respective sub-groups.

Overall status against Operational Plan

2. This section provides a precis against each element of 'value' by partnership. It is intended to provide a *snapshot view* on performance against constitutional metrics outlined in the NHS Mandate, delivery of associated cost improvement programmes and assurance/escalations against equity and quality metrics. Partnerships will also take the opportunity in this section to celebrate successful transformation, moving the system closer to its ambition and vision.

3. Assessments against each facet of the plan are recommended as follows:

a. Performance

Performance against the 31 NHS Mandate indictors remain positive overall.

- **Urgent care** - There is increasing variation against all UEC metrics, with ambulance handover and Category 2 response times significantly under strain. There is now daily scrutiny of the 4 hour performance to meet 76%. Enhanced escalation process has been enacted to support clinical risk and performance concerns. Clinical risk remains high in the Emergency Department and associated services.

- **Primary Care** – LLR has delivered the highest number of appointments in the region. Although the performance against locally set stretch target shows a red RAG against this. Overall we have continued to offer more appointments in LLR. In addition we anticipate an impact in the continued positive implementation of Pharmacy First in LLR which we expect will impact on the total number of appointments delivered in general practice.

- **Elective Care** - Industrial action and ongoing emergency pressures continue to impact on the time to reach zero 78+ waits. There will be a residual of c. 20 patients due to patient choice, complexity and admitted cancellations in March that could not be re-booked by the end of the month. Nationally and regionally the ask has been to get to the best possible position for 65+ by the end of March.

  62+ day cancer waits remain lower than plan and the position is improving. Reporting on the delivery of the 62-day standard, FDS and combined 31 day continues to be monitored via the Tier 2 programme.

- **Mental Health** - LLR ICB is ranked 1/42 nationally for Adult Community MH transformation. We are 7/42 for CYP access, reaching 112% against the LTP ambition. LLR are the highest performing in the region for SMI Physical health checks and 4/42 nationally.

- **Learning Disability** - Additional dedicated LD nurse capacity in place until the end of March 2024, to focus on those people who have not had a health check for 2 or more years and support attendance/identify reasonable adjustments.

- **Hypertension** - At a Place meeting in December 2023, the CVDP data for June 23 was shared and it helped to identify the gaps and age band where more focus is required – 5 PCNs with prioritised practices are engaging with the Place Lead and ICB to meet the gaps in supporting the remaining patients needing reviews.

The full performance report is attached as Appendix A.

b. Finance
Finance remains a key challenge, despite delivery of cost improvement at a higher rate than noted in previous years. Key risk to delivery remains in urgent care, with significant cost pressure due to the increased escalation status, EPRR events such as Storm Henk and periods of industrial action.

c. Quality & transformation
Quality risks raised at each partnership level have been cross checked with the System Quality Group, with deep dives in place as required. Maternity and UEC have been focus areas for January due to CQC findings, with system- or provider-led action plans in place.

d. Equity
Key focus in January has been place-led planning for delivery of equitable services in areas such as cancer, immunisations and vaccinations and urgent care access. Several programmes of work have commenced at Place or neighborhood level, in full partnership with local authorities and providers. Further work required to agree reporting dashboards, covering adult social care, public health and NHS outcomes frameworks to drive focus in 2425.

Recommendations

System Executive is asked to:

- Receive & note the full contents of the report.
- Note the risk of variation in performance, particularly with UEC, as the impact of winter and industrial action are noted

System Quality Committee is asked to:

- Receive & note the full contents of the report, including the progress of the transformative schemes showcased.
- Note the increased risk within UEC and the CEX-led escalation process in place
- Note that the System Quality Group has cross-checked quality risks highlighted in this report with either risk registers or for discussion through quality governance.

System Finance committee is asked to:

- Receive & note the full contents of the report.

System Health Equity committee is asked to:

- Receive & note the full contents of the report.
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The ICB is asked to:

- NOTE the full contents of the report, the progress outlined against both the one- and five- year plans and the escalations made to each sub-committee.

Community Care – (delivered via our Community Care Partnership)

The integration of health and care services, delivered via a single team approach, is essential to delivery of **pledge seven** of the five-year plan; to provide more joined up, holistic and person-centred care delivered closer to home. Our community health and well-being plans continue to progress at pace, aligned with our three Health and Wellbeing Board delivery plans.

Place based approaches to delivery of care are on track, with strong performance against the national metrics below. Local metrics to evidence progress against this pledge are under development in each place.

Performance against Operational Plan

Standard	Plan	Actual	RAG	Confidence in recovery / Year-end delivery
Consistently meet or exceed the 70% 2-hour community response standard	70%	93% *February*	Met	High
Meet 80% occupancy for virtual ward by September 2023	80%	*83% February*	Met	High
Overall Assessment	**No escalations to System Executive**			

Finance

No other CIP has been attributed to this programme as efficiencies are logged and counted within the LPT CIP.

Team	Scheme Name	Rag Rating	Plan	Actual / Forecast	Var	Confidence in delivery/mitigation
Non acute	BCF, discharge funding, community SDF		600	2,320,928	2,320,328	High Slippage will support system baseline
Overall Assessment		**No escalation to Finance Committee** **Finance Committee to note that slippage from virtual and physical plans will be supporting the system deficit; however, with no specific funding for winter available, this may be required in Q4 to sustain quality, safety, performance, and flow.** **Above CIP identified within ICB finances; this is outside the reported LPT position.**				

Quality & Equity

An issue has been raised through the Community Care Partnership which may impact on quality and outcomes:

Issue	Escalation
Leicester City Council's occupational therapist waiting list has reached 1300 cases. This is owing to the volume of	ALERT- Therapies workstream (LPT and LA) to support review of actions and trajectory, with clinical support provided as needed. LPT and LA action plan developed and will be shared at the next Community Care Partnership in April including improvement

assessments needed.	trajectories. The workstream have several key actions that are being progressed to help reduce the backlog.
Overall Assessment	**System Quality Group to support action plan once presented at the next Community Care Partnership**

Transformation

Achievements (aligned to Step 4 of the NHS Impact framework)	Outcome for our patients / colleagues
Increase in Virtual Ward occupancy to from 30% in April 23 to 83% in February 24 and increased VW bed plan by 10 beds. Supporting an increase in patients admitted onto VW (step up/down). Supporting earlier discharge and avoiding acute admission.	This quality improvement programme supports our patients to be treated in the place they call home, without unnecessary ambulance and hospital conveyance. It empowers our population to manage their own condition but with an evidence-based support pathway and a safety net for crisis – all of which have been requested by our staff and our patients repeatedly through our insights work. This programme supports the delivery of multiple pledges in the 5YP – **pledge three** to support our frailest, **pledge seven** around holistic care and **pledges five and six** focussed on ambulance response times and the four-hour standard. Further work around equity of service provision, taking into account digital access and literacy. LLR EDI grading process and was graded equally as developing and achieving.
Improving variation in care homes and increasing access into our community falls response services there has been a 15% (Q2 & Q3) reduction in falls conveyances. Reduction also realised for the top 20 conditions.	Improves access as **per pledge one**, **pledge three** to support our frailest, **pledge seven** around holistic care and supports 'right patient, right time, right place'.
Charnwood Ward Community Hospital continue to take all D2A Nursing Home patients. Positive outcomes upon discharge, 26% of patients returning to their own home.	All nursing home D2A patients have the opportunity to access Recovery, Reablement and Rehabilitation as per **pledge three** of the 5-year plan to identify the frailest in our communities and wrap care and support around them. And 3a of the UEC Recovery Programme Plan.
Increase in patients discharged from UHL to Community Hospital beds and receiving Intermediate Care. October 2023 71% November 2023 74% December 2023 72% January 2024 81% February 2024 79%	Positive outcomes for patients that are receiving Intermediate Care support. Long term positive effects include reduction in deconditioning and improving hospital flow. As per the Intermediate Care Strategy, supporting more patients to receive RRR increases opportunity for patients to remain independent for longer in their own home environment. This scheme is aligned to **pledge three** to identify the frailest in our communities and wrap care and support around them, and **pledge seven** to provide more joined up, holistic and patient-centred care, delivered closest to home.
Effective planning around End-of-Life care assessments, supporting reduction in LoS and supporting patient's choices and wishes.	All patients that are requiring end of life care support in the community continue to have their fast-track assessments completed whilst in hospital with quick and timely discharge to their chosen long term care setting. This scheme is aligned to **pledge three** to identify the frailest in our communities and wrap care and support around them.

Children & Young Persons (delivered through various partnerships)

Our work to improve access, experience and outcomes for children and young people across LLR is reflected in **pledge eleven** of the five-year plan. Whilst progress has been made through 2324, capacity issues and the financial position have hampered progress. Limited mitigations are now in place, with partnerships requested to take an all-age approach to their workstreams. This is under assessment and whilst improved, capacity issues remain.

Performance against Operational Plan

There are a range metrics for CYP but no standalone metrics within the 31 standards of the NHS Operational Plan. These are local system standards.

Standard	Plan	Actual	RAG	Confidence in recovery / Year-end delivery	March Update
Improve and strengthen children and young peoples visibility by embedding children and young peoples objectives within the other Collaboratives and Partnerships.	October 23	March 23	Met	High. Continual monitoring- to ensure CYP remain visible.	Linked to MH/UEC and Elective Partnership linked with 24/25 planning
Address focused health inequalities as identified in the children and young peoples core20plus5.	March 24	March 24		Medium. Workstreams established and specific health inequality subjects chosen. Focus: Oral health commenced March 2024 involving Public Health, adults and Children Immunisations- led by vaccination team – current focus on measles	
Implement and drive change through the CYP Transformation programme against NHSE set metrics and objectives (as per Long-term plan).	Jan 24	March24		Medium. Transformation team now established although there isn't full resource within workforce, workstreams are progressing, but additional support required through all partnerships	

Overall Assessment	**System exec to be aware that there are four working portfolios within CYP but all partnerships must take an all age approach, ensuring CYP are involved in every and all conversations.**	

Finance

Team	Scheme Name	Rag Rating	Plan	Actual / Forecast	Var	Confidence in delivery/mitigation
CYP	Community Paediatric Continence		£209,000	£24,289	£184,711	Medium. Service is operational. Slippage identified for savings. Service has commenced reviews of those CYP who receive continence products, to ensure their needs are met. These reviews should occur yearly, however, there is a backlog of up to 4 years. Longest waiters have now received review.
CYP	Paediatric Outpatient parenteral antibiotic therapy		£203,000	£22,954	£180,046	Low/ Medium. Workforce has now completed recruitment, final nurse to commence within LPT in March, service to mobilise in March with 1 community nurse, second to commence in May when full 7 day service will commence. Owing to absence and maternity leave within Diana nursing team, full mobilisation cannot commence until both community nurses are appointed and onboarding complete. System led meeting with Diana Team to see if possible to increase patients on scheme

Quality & Equity

Issue	Escalation
Health Inequalities: LLR is not meeting WHO 95% standard for immunisations rate. There is a backlog of dental extractions for children and young people with was not brought rates highest in the lowest IMD.	ASSURANCE- These have been identified and proposal in creation with colleagues across the system to improve these metrics over winter 23/24 with relevant colleagues. ALERT- work with the immunisations team to establish plans to mitigate increasing amounts of measles diagnosed within the West Midlands.
There is no provision for quality continence intervention and care within Leicester City for those young people aged 11 years and above	ALERT- City council hold the contract for teen health but due to regulatory boards cannot provide nursing services that would address this need. Scoping work complete to enable understanding of service required for commissioning. 12 CYP on waiting list who require this service over the last 12 months. The local authority have identified funds to provide this service, however LPT have declined proposal. Difficulty to commission a full service for such small proportion of CYP and therefore continued high level discussion required within LPT. LPT have agreed to scope supporting these 12 CYP currently on the waiting list. Ongoing work between the system to assure needs are met. Meeting taking place March 2024
Paediatric Winter plan	ASSURANCE- Rapid access clinic has commenced, 50% utilisation of slots funded only available to end of March 2024. Commenced 5/2/24. ARI appointments continue with good proportionate utilisation between adults and pediatrics. 26% utilisation by CYP (which is good as children make up 30% of population) Scoping work to obtain funds from CDC for continuation of the asthma diagnostic pathway and addition of 48 hour review process post treatment. ALERT- Data also shows LLR has increased attendances to children's emergency department, and lower usage of urgent and emergency treatment centres, than other regions. December and January data

	shows higher utilisation than the previous year. To review as part of the Winter Washup.
CYP Community Services	ALERT- Difficulties within LPT to achieve key performance indicators due to lack of availability with business analysts. Therapy service specifications have been updated, but are not signed off as completed as LPT feel they cannot submit more than 1 KPI for each area. This is being addressed by LPT Management. Working through the planning guidance for Community Therapy waiting list and waiting time improvements. ALERT – Diana Service data has identified activity down since 23/24 against plan and previous years programme. Meeting with Diana Team in March to look at issues and plans to improve
CYP Palliative Care Services	ALERT- CYP palliative care services are complex in nature and are delivered by a multitude of services across the system. This area requires clinical leadership to ensure delivery of these services is efficient and effective. This is currently a gap in provision, we do not have resource to fund 1-2 PA per month of a consultant paediatrician to lead palliative care, looking at supporting this with SDF monies. LPT have a nursing lead in post for CYP palliative care, however UHL do not. There is a rainbows nurse hosted within UHL but this is not substantial to cover the entire system. Regional funding provided for Palliative Care Regional Network for 24/25
CYP Long Covid Hub	ALERT- The Long Covid clinic for CYP has been operational since 2021, providing assessment and rehabilitation for those CYP with any symptoms related to long covid/chronic fatigue. The service receives non recurrent funding which has made recruitment extremely difficult. The service currently does not have the staff to deliver the service. NHSE have offered ongoing funding for 24/25 for LLR to deliver a pan midlands service, however recurrent recruitment is hindering LLR ability to agree to deliver this service. Paper being produced re options and impact assessment of decommissioning to go to System.
Overall Assessment	**The children and young peoples quality and performance group is now re-established with revised targeted dashboard and appropriate membership to ensure visibility of all quality and risk. Attendance over winter has been difficult to establish- ongoing work with this.**

Transformation

Achievements **(aligned to Step 4 of the NHS Impact framework)**	**Outcome for our patients / colleagues**
Diabetes: Health inequalities workstream has delivered continuous glucose monitoring to CYP who previously suffered poor diabetic control. This work has identified many alternative	Ensuring our patients achieve their potential by preventing co-morbidities that will cause life long effects within adulthood, aligned with **pledge 2, pledge 7 and pledge 11**. Work ongoing

barriers to accessibility, and also identified that language often isn't a barrier but can cause healthcare bias and perception- causing the barrier.	
Provision of ARFI Capacity in Primary Care	Plan for time out being pulled together for April 2024
Elective Care: Primary care paediatric hubs continue operationally, providing advice and accessible care within the community, supporting primary care to ensure CYP access the correct pathway.	Ensuring CYP receive the appropriate care, in a timely manner, by accessing the correct referral pathway the first time, aligned with **pledge 8.**
Urgent and Emergency Care: Rapid access clinics to operationalise 5/2/24. Senior primary care clinicians are working within CED to provide triage and diversion at the CED front door.	Ensuring all CYP are seen in the right service, by the right clinician to improve outcomes and reduce CED waiting times, aligned with **pledge 6 and 11.**
CYP System Approach: CYP Partnership time out day complete in January, aligning system priorities to ensure a focussed approach for 24/25.	Ensuring a cohesive and collaborative approach across the system to meet the needs of CYP, aligned with **pledge 11 and 13.**

Learning Disability and Autism

High confidence in reaching trajectory on all 3 standards. Currently there are ongoing issues with incorrectly added codes by NHSE that are inflating the denominator (number of people aged 14+ on the LD Register and therefore eligible for a health check) to 5,223. NHSE has advised it is placing our denominator at 5,097 for 2024/25 and if we measure performance against that figure, we have reached 74.93% to date, however we continue to report on current data extracts.

DSP and Discharge teams will be moved to LPT by 1 April, with a new work plan in place within 2 months, in line with the overall LDA Operational Plan.

Performance against Operational Plan

Standard	Plan	Actual	RAG	Confidence in recovery / Year-end delivery
LD Annual Health Checks – 75% of all people with LD aged of 14+ people will receive a health check with a Health Action Plan. **Pledge 9**	75%	3819 (73.12%)		High confidence that we will exceed the target
Reduce reliance on inpatient care for adults	30	23		High
Reduce reliance on inpatient care for under 18's	3	3		High
Overall Assessment	**No escalations to System Executive**			

Finance

Covered in SDF – no escalations to finance committee.

Team	Scheme Name	Rag Rating	Plan	Actual / Forecast	Var	Confidence in delivery/mitigation
The programme is on track to spend allocation with no CIP attributed to this SDF						
Overall Assessment		**No escalation to Finance Committee**				

Quality & Equity

Issue	Escalation
There is inadequate community support for young people with autism. **Pledge 11**	Ongoing issue.
Long waiting times for autism assessments for both children and adults. The required level of investment needed to meet the demands is significant, particularly where people access third party assessment under Right to Choose, incurring additional cost.	This does have a significant impact on patient outcomes. The outputs of the clinical prioritisation will go to Clinical Executive. This is in support of **Pledge 11**, Improve access to, experience of, and outcomes of care for children and young people; with a special focus on driving up health equity.
Overall Assessment	**All escalations being managed through System Quality Group**

Transformation

Achievements (aligned to Step 4 of the NHS Impact framework)	Outcome for our patients / colleagues
Further discharges have reduced the number of inpatients to 23. Increased support through the Keyworker scheme is supporting more people in the community and avoiding need for hospital admission.	More care delivered in least restrictive environment, more patients living in community. **Pledge 7.**
Work is ongoing to identify and repatriate any of the remaining 6, adults placed in out of area ICB commissioned beds, where this is possible and appropriate.	More care delivered in least restrictive environment, more patients living in community. **Pledge 7**.
The co-produced online self-referral form for the Dynamic Support Pathway (DSP) went live in November 2023 – since then 3 adults have self-referred themselves to the DSP and 9 CYP have been referred to the DSP. Multi-agency meetings have taken place to support the development of a bespoke action plan that will meet the individual's needs in the community. All eligible young people have been offered a Barnardo's Keyworker and a range of support/interventions have been provided.	This work supports our delivery of **Pledge 11** Improve access to, experience of, and outcomes of care for children and young people; with a special focus on driving up health equity.
Number of projects in early stages of development focusing on commissioning and support of community care providers to improve quality and sustainability of community providers.	Greater sustainability, quality and range. My ore care delivered in least restrictive environment, more patients living in community **Pledge 7**

Maternity & Women's (Delivered through our LMNS & Women's Partnerships)

Maternity

Our Local Maternity and neonatal services Board oversees the metrics behind **pledge twelve**. Our specific pledge is to engage with, listen to, empower and co-produce services with women and girls; progress against this pledge is measured through the work plan of the MNVP, National maternity survey and Maternity 'friends and family test'. This is not a direct metric in the operational plan and therefore has not yet been reported through this partnership report. Once triangulated, it will be included.

Performance against Operational Plan

Standard	Plan	Actual	RAG	Confidence in recovery / Year-end delivery
Make progress towards national safety ambition to reduce sill birth per 1,000	Reduce 22/23 4	2023/24 (up to Nov 23) 3.8	AMBER	
Neonatal mortality rate per 1,000	Reduce 2020 1.5	2021 2.4	RED	See actions below
Maternal mortality	Reduce 21/22 * (supressed as below 5)	22/23 0	GREEN	
Serious intrapartum brain injury.	TBC			
Increase fill rates against funded establishment for maternity staff.	TBA	Current midwifery vacancies: 26.2wte (6.6%) (October 42.4wte [10.7%])	AMBER	Meeting with NHSE took place. Discrepancy in some areas of reporting due to data quality issues which will be looked into. Lower than national turnover but higher than regional average turnover rate: 10.4% Lower than national leaver rate but higher than regional leaver rate: 5.6% Workforce plan in place. NHSE have extended offer of support. A follow up meeting with NHSE planned for March 2024. Improvements in vacancy rate e seen in Nov 23- as new midwives coming on board following recruitment drive.

Increase access so at least 10% of LLR women can access specialist Perinatal Mental Health Services by 31st March 2024	1260	Oct 23 714 December 23 856	RED	Dip in activity noted for Oct 23, November and December 23. Service is trying to put steps in place to recover trajectory, however we are not confident that the 10% access target will be achieved by 31st March 2024. LMNS will continue to monitor. An extraordinary meeting with the service taking place in the Feb & March 2024. Work with network and providers to agree trajectory for 24/25
Overall Assessment	**No escalations to System Executive, escalations managed through quality and safety processes**			

Finance

Team	Scheme Name	Rag Rating	Plan	Actual / Forecast	Var	Confidence in delivery/mitigation
Overall Assessment		**No escalation to Finance Committee**				

Quality & Equity

Issue	Escalation
Actions in relation to safety issues identified as inadequate in recent CQC report for LGH and LRI maternity services	ALERT - We continue to work with the Trust, LMNS and NHSE to strengthen internal and external governance and escalation routes. The LMNS is supporting the Trust's plan in response to the findings of the CQC report and we will be working closely with them, with oversight from NHS CQC conducted a follow-up assessment of UHL maternity services on January 10th and 11th, 2024. We still await formal feedback, but initial response recognised the progress the Trust has made in terms of recruitment, training, and development. Positive feedback was also received regarding the maternity triage system. However, it was noted that Induction of Labour (IOL) requires further attention, particularly in terms of risk assessment and prioritisation. The system acknowledges the concerns regarding IOL and is presently awaiting a regional review of the IOL procedures. In addition, the system has been proactive in implementing measures. They include a IOL Patient Information Group involving our Maternity and Neonatal Voice Partnership (MNVP) to help improve the pathway and communication, employing four IOL midwives to help provide continuity of care, developing an IOL App which will help to facilitate prioritisation and ensuring a IOL huddle takes place twice daily involving the Head of Midwifery.
Meet SBLCBv3	ALERT – CNST /MIS submission has been signed off by ICB/LMNS/UHL and submitted 1st Feb 2024. Whilst we were complaint for standard pertaining to

<table>
<tr><td></td><td>Saving Babies Lives Care Bundle v3 for MIS purposes, we now work towards full compliance. Key area to note is needs to have plans in place by end of March to ensure we have a in house smoking cessation service. LMNS will monitor.</td></tr>
<tr><td>Deliver Neonatal Critical Care Review recommendations (NCCR)</td><td>ALERT - Recruitment in place to attract AHP's and some posts have been filled. However, attracting the right workforce remains a challenge –as lack of pool to draw from. Ockenden funding has helped – still waiting for 24/25 confirmation of funding for Neonates (which was supposed to go directly to Trust via ODN's notification) . NHSE have confirmed specialised commissioning devolving responsibilities down to ICB from April 2024 for neonates and work in underway to look at closer join working to aid transition.
Remains on the LMNS risk log.</td></tr>
<tr><td>Make significant improvements in perinatal mortality MBRACE report</td><td>ASSURE - MBRACCE extended mortality is more than 5% greater than expected; this is consistent with other trusts providing neonatal surgery and congenital heart surgery. All perinatal deaths are reviewed using the nationally prescribed perinatal mortality review tool. We have undertaken external peer review of our approach (with Leeds Teaching Hospitals) and our use of the tool is consistent and robust. We work hard to understand as fully as possible the reasons behind all deaths, and we know the number of cases at UHL in which care may have contributed to death is very low. We are undertaking work with public health colleagues and others to build a deeper understanding of our population.
A focused session taking place 7th November 23 took place looking at improving outcomes for LLR perinatal mortality was led by Public Health. Agreement for the LLR healthy babies strategy group will bring together workstreams looking at improving outcomes and report into the LMNS Board. Further meetings are planned for March</td></tr>
<tr><td>Workforce in relation to maternity and neonatal capacity.</td><td>Maternity workforce oversight group bi-weekly meetings commenced March 2023. Workforce plan in place. It covers Maternity, Neonatal and medical focusing on Recruitment, Retention, Skill mix, Pastoral support, Empowering voices, Personal / Leaderships development.
<table><tr><th colspan="3">Date of latest BR+ assessment which informed this report</th></tr><tr><th>Birth Rate + report data</th><th>FTE</th><th>%</th></tr><tr><td>Total clinical FTE</td><td colspan="2">430.25</td></tr><tr><td>Clinical Registered MW</td><td>430.25</td><td>100.00%</td></tr><tr><td>Clinical MSSW (meet framework)</td><td>43.03</td><td>10.00%</td></tr><tr><td>Non-clinical Registered MW</td><td>43.02</td><td>9.09%</td></tr><tr><td>Total MW FTE (clinical and non-clinical)</td><td colspan="2">473.3</td></tr><tr><td>Maternity Service uplift allowance (%)</td><td colspan="2">23.00%</td></tr></table>
Current midwifery plus midwifery support workers n post (369.7 FTE) + vacancies (26.2 FTE) = establishment of 395.9 FTE against BR+ of 473.3 FTE.

We are working with NHSE to understand discrepancies noted in relation to vacancy rates for midwifery provided via our provider workforce returns (PWR) versus the rate NHSE suggests, based on the recent birthrate+ tool. NHSE suggest that our vacancy rate for December 2023 is 8.36% rather than 6.7% as reported by our Trust. As a system we are aware of data quality issues and are working with the Trust and NHSE to address them. The Trust has recently undertaken a workforce census (using a Birthrate+ tool) to understand staff numbers required measured against births/ acuity/service delivery amongst other indicators.</td></tr>
<tr><td>EM Maternal Medicine Network</td><td>LLR hosts the EM Maternal Medicine Network EM MMN is now full up and running. All key staff appointed and MDTs fully operational. However, sustainability issues due to lack on national funding. The LLR network is working with partner LMNS to look at what funding is required for 24/25 to ensure sustainability but ideally we need a new national funding approach</td></tr>
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Overall Assessment	All escalations being managed through System Quality Group and aligned processes

Transformation

Achievements (aligned to Step 4 of the NHS Impact framework)	Outcome for our patients / colleagues
LLR Maternity and Neonatal Voice Partnership (MNVP) now in place LLR Neonatal Voice Partnership (linked to the LLR MNVP) in development Completion of MNVP annual report LMNS collaboration with public health to help address equity	Ongoing dialogue/engagement to improve services via co production leading to: Higher service user satisfaction experience and access. Improved outcomes for birthing persons and babies Reduced perinatal mortal rates Improved outcomes in relation to best start in life

Women's Partnership

Our women's partnership will support the delivery of **pledge twelve** of the five-year plan as well as meet the strategic priorities set by NHSE and DHSC national teams. Whilst this programme is in its infancy, progress has been made in the canvassing of views on the scope, depth and breadth of the partnership across local partners and the wider system.

The operational plan sets out general performance metrics for the programme and it is important to note that progress through the programme will be measured by the National Women's Health Hubs submission template and a local delivery plan.

Our plans for launching women's health hubs are also on track.

Performance against Operational Plan

There are no metrics for Women's health in the 31 standards of the NHS Operational Plan; however, the women's partnership is working toward delivery of Women's health hub's across LLR, supporting the ICB vision of better access and outcomes for this we serve.

Standard	Plan	Actual	RAG	Confidence in recovery / Year-end delivery
Establish a Women's Health Partnership.	October 23	May 2024		New 'actual' date revised to May 2024. Women's Operational Delivery Group to be re-developed as the Women's Partnership with ToR and schedule to be in place. Last WODG taking place March 2024 (keeping bi-monthly schedule)

To build relationships with women's groups ensuring that we understand their needs and they have a voice in planning services across health care.			In progress	High – ongoing discussions with the engagement team on developing a women's engagement strategy and how to link into existing projects of engagement with girls and women. Work slightly delayed due to women's hubs development taking priority within the teams capacity.
Improving access to NHS fertility treatment for all couples including female same-sex couples and assessing the use of non-clinical access criteria locally.	Sept/Jan 24	Delayed - TBC	Delayed	High – Awaiting EM policy review. Outcome is delayed and the team is awaiting further communication from the strategy and planning team on when we expect to receive this to further scope transformation opportunities.
Work with system leaders to agree local models for implementation of women's health hub across LLR, to provide social, emotional and health support including sexual health, menopause, and social prescribing.	March 24	March 24	Delayed	Further assurance to be provided to SCG in March seeking final pilot approval.
Overall Assessment	**No escalations to System Executive**			

The 'standards' listed above are not related to the deliverables set out in the 2023/24 Operational Plan. Instead, these are related to the deliverables set-out in line with the 5-year-plan.

Finance

LLR ICB has received £198,000 in M6 to deliver the women's health hub agenda. Initial finance model completed in September 2023 with plans in place to expand upon these once hub process completed.

Quality & Equity

From a general programme perspective, no key quality issues have been highlighted with the potential to impact on quality and outcomes. Further work to be undertaken with the support from the Health Inequality Support Unit to assess the metrics associated with women's health hubs through the Women's Partnership.

Further work has been completed through a level 1 EIA, QIA and both qualitative and quantitative benefits realisation reviews in each place as part of planning for the health hubs.

Issue	Escalation
Women's Hubs. Given the unprecedented financial challenges facing the Integrated Care System and ICB, there is a review underway looking at all uncommitted spend we had planned from December 2023. This means that the planned spend for the Women's Hub's will be temporarily paused until this review is complete. The timescales for delivery of the hubs will alter as a result and all decisions taken will be made following the full equity and quality impact assessment process we have in place. This initiative is NHSE mandated and if not delivered will create inequity not only regionally but also nationally with LLR not having one in situ. Girls and Women will not have access to a women's health hub model and therefore remain in the same position in a fragmented system. Though Primary Care will continue to deliver services as BAU, one PCN will deliver from a current 'one stop shop' approach currently in situ which creates further inequity and inefficiencies at scale.	1. Through Executive Management Team (EMT) 2. On LMNS risk register to the ICB Board 3. EMT provided position statement to be circulated to women's health hub leads with information whilst EIA/QIA steps to be undertaken by ICB before moving forward. Updated 16/01/2024 – review undertaken with new process agreed by Strategic Commissioning Group and Exec Management Team. New timelines agreed and in place for review back at SCG. Updated 14/02/2024 – Women's Hubs approval item included on SCG agenda for Feb 2024. The following information has been provided and will seek approval. Once approval sought, issue to be resolved. • Benefits realisation undertaken including both quantitative and qualitative impacts • Quality Impact Assessment undertaken
Fertility – Policy The current NHS fertility policy in place in LLR (and the Midlands as a whole) is not fit for purpose. The current non- clinical criteria differs across the region leaving LLR open to individual appeals against certain decisions.	LLR is awaiting the outcomes to the assisted fertility policy review being undertaken by AGEM CSU for the Midlands. LLR's strategy team is awaiting the review paper which has been delayed to work through some queries raised by Midlands ICB's. An options appraisal will be provided where all Midlands ICB's will come to a general consensus as to what should be included in the EM policy and then recommendations will then go to the ICB Board for approval/review. This will give a basis to consider how the wider national recommendations may need to considered for LLR to be able to implement and deliver an equitable/consistent approach to certificate care for all couples including same-sex couples.
Overall Assessment	**All escalations being managed through System Quality Group**

Transformation

Achievements (aligned to Step 4 of the NHS Impact framework)	Outcome for our patients / colleagues
Progress made with getting the womens agenda as a priority across the system: 1. City top 5 priorities 2. County Health Inequalities JSNA 3. Rutland armed forces task and finish group Plans in place to ensure women's is regularly represented/featured at the H&W boards across LLR	Making Women's Health a priority across LLR.
Work is underway through the development of a Women's Partnership. A new Terms of Reference has been developed alongside a new schedule for wider partnership reporting into the women's programme.	The system is joined up and the programme is supported through a matrix working approach
Work has re-convened on reviewing the information within the draft women's dashboard. The Women's Programme Team is working with MLCSU colleagues to: First stage - develop a women's hub section. Second stage - align the wider dashboard to the partnership priorities to undertake a thematic review. Third stage – align other collaborative/partnership dashboards.	The vision is that the dashboard will incorporate a life-course view with data supporting the prioritisation of the women's partnership focus areas for transformation.
Women's NHSE maturity matrix completed with *very* positive feedback from the NHSE regional team on LLR's collaboration between health and public health, as well as the progress made on governance and potential hub models.	Regional and National benchmarking against peers to understand what gaps LLR may have to further strengthen the programme of work (this includes ensuring LLR's priorities align with NHSE regional and national objectives).

Medicines Optimisation Partnership M11

Performance against Operational Plan

Use of resources: Deliver a balanced net system financial position for 2023/24
Community health services: Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals.

Quality & Equity

Issue	Escalation
1.Risk to AMR work (primary care) due to capacity. Clarification of reporting mechanisms for AMR (prescribing/ diagnostics and infection prevention) within the system. Capacity issues within Pharmacy/ medicine Op	ALERT - Paper to go to SQG recommending future reporting mechanisms for AMR.
2.Narrow NHSE focus working to targets. Resistance strains emerging at UHL.	Escalation to NHSE.
3.National shortage of ADHD medicines will affect approximately 3000 patients in LLR including children. Arrangement for LPT to supply community pharmacies with stock is working well for existing patients whilst the normal supply chain is disrupted.	Escalation to NHSE. Info to be shared with mental health and CYP Delivery Groups.
National shortage of ADHD medicines will affect approximately 3000 patients in LLR including children. Arrangement for LPT to supply community pharmacies with stock is working well for supply to existing patients whilst the normal supply chain is disrupted. LPT have decided that supplies of methylphenidate are reliable enough to initiate therapy in paediatric patients.	Escalation to NHSE. Regional contracting group reviewing the issue. Local commissioning framework being development by contracting team plus business case to increase local capacity.
4.Increase in referrals to private providers under Right to Choose legislation, especially for ADHD diagnosis and treatment. Risk if drugs supplied that would be under a shared care agreement as gap in usual patient pathway and pressure to prescribe. Potentially applies to other pathways. Potentially poor patientexperience.	Being managed through the Delivery Group
5. Enfit syringe supply for medicines administration under review as robust process not in place.	Being managed through the Delivery Group. T&F group set up including CYP and maternity collaboratives engaged.
6. Drug Safety Alert regarding Sodium Valproate use in women of child-bearing age. Further action needed to restrict use in this groups to avoid teratogenic effects.	Being managed through the Delivery Group.
7. Gap in assurance of independent health care providers with respect to implementation of Drug Safety alerts such as Dermatology clinics and cataract clinics.	ICS T&F group set up and responded to MHRA alert by the end of Jan 2024 with quality improvement action plan. Comms sent out to primary care. Being managed through the Delivery Group and CQP Directorate.
8. Progress against operational plan at risk due to pharmacy work force pressures against all sectors.	Being managed through individual organisations.

9. LLR prescribing of green inhalers is improving (17.3% based on Dec prescribing data) and hopefully will achieve NHSE target by March 24 (20%)	Being managed through the delivery group.
Overall Assessment	**All escalations being managed through System Quality Group**

Transformation

A paper has been circulated for comment to inform an LLR response to the National Medicine Optimisation opportunities 2023/24. We are currently proposing to adopt the following 5 medicines optimisation priorities:

- Using best value biologic medicines in line with NHSE commissioning recommendations
- Identifying patients with atrial fibrillation and using best value direct-acting oral anticoagulants (DOACs)
- Identifying patients with hypertension and starting antihypertensives where appropriate
- Optimising lipid management for cardiovascular disease prevention
- Improving respiratory outcomes while reducing the carbon emissions from inhalers

In addition to the agreed 5 priorities to focus on, the following priorities were already being addressed within our existing workplan:

- Addressing low priority prescribing
- Obtaining secondary care medicines in line with NHSE commercial medicines framework agreements
- Appropriate prescribing and supply of blood glucose and ketone meters and testing strips

Business cases have been submitted and awaiting outcomes for:

1. Continuation of the Community Pharmacy Clinical Lead
2. Continuation of PharmOutcomes and Band 7 Community Pharmacy Project support officer.
3. Transformation Project Lead for Stoma

System Prioritisation Group agreed that the following projects could go forward:

4. LLR Micro Guide App
5. Optum simple switch service (subject to support from PCTB)
6. Eclipse Boomerang inhaler switch program (subject to support from PCTB)

Achievements (aligned to Step 4 of the NHS Impact framework)	Outcome for our patients / colleagues
Community pharmacy service delivery continues to increase for CPCS, DMS, contraception and blood pressure each year, although there is some fluctuation on a monthly basis. LLR ICS is currently the second highest achieving system in the Midlands for CPCS. Pharmacy sign-ups for the impending Pharmacy First service are currently at 90.9%, with strong engagement in the local training events.	Our patients have told us through engagement that they want to be seen in the right place, at the right time – often this is a time which suits their lifestyle. **Pledge 4** of the 5YP refers to supporting people to access GP appointments and these pathway support both what patients have asked for and the pledge made.
NHSE support for community pharmacy independent prescribing pilot to support respiratory and CPCS in 4 community pharmacies.	
Community pharmacy service for EoL and Specialised medicines was at risk of not continuing. System-wide work undertaken to review efficacy of pathway which has resulted in commissioning of service.	This pathway is essential to those nearing the end of their lives – this will mean that our patients are more likely to receive the medication they need efficiently and effectively, without needing either an ambulance call-out or a conveyance to hospital. Integrating the service with our pathways means we are closer to delivering **pledge seven** of the 5YP, joining up our services to deliver care closer to home. A full review of the service is being undertaken for future commissioning of an EoL Medication Delivery Service. The current service provision has been rolled over to support implementation of a new model in July 2024.

External funding £250K received for AF detection. Medicines Optimisation Framework 2024-25 is in its final stages. Aiming to be finalised for April 24	This will support increasing prevalence of AF in deprived areas and reduce the incidence of strokes. A T&F group has been set up with relevant stakeholders to develop an outline plan by the end of March 24 to be implemented during 2024-25. This will support our efficiency plan, medicines safety and care and outcomes of patients with chronic pain and patients with asthma.

Mental health – *delivered via our Mental Health Shadow Collaborative*

The actions being progressed through the MH collaborative align to **pledge ten** of the five-year plan, to reduce inequity in access to mental health services. The performance section describes the impact of these local actions with each of the key metrics on track for delivery. As noted below, formal reporting is three months behind – using local data sources, the collaborative can evidence progress through the targeted interventions in place, including the neighbourhood-based development of Mental health Neighbourhood Cafes (formally known as crisis cafes).

Performance against Operational Plan

Standard	Plan	Actual	RAG	Confidence in recovery / Year-end delivery
Improve access to mental health support for children and young people aged 0-25 accessing NHS funded services (compared to 2019) (Rolling 12 months data)	14,228 Q3 Plan	16,065 *Dec 23*	G	High Plans in place, key risks understood
Increase the number of adults and older adults accessing NHS Talking Therapies (Rolling 3 months data)	8,101 Q3 Plan	5,345 Dec 23	R	High Plans in place, key risks understood
Increase in the number of adults and older adults supported by community MH services with Severe Mental Illness (SMI) Number of people who receive two or more contacts from NHS or NHS commissioned community MH service (Rolling 3 months data)	6,456 Dec 23	12,920 Aug 23	G	High Plans in place, key risks understood
Work towards eliminating out of area placements (Quarterly rolling Bed days)	0 Nov 23	0 Nov 23	G	High Plans in place, key risks understood
Recover the dementia diagnosis rate to 66.7% 23/24	66.7% Q4 Plan	65.3% Jan 23	A	High Plans in place, key risks understood
Improve access to perinatal mental health services (Number of women accessing specialist perinatal MH services (Cumulative position)	940 Q3 Plan	*760* Dec-23	R	High Action plan in place, significant risks
Overall Assessment	**No performance escalations to System Executive** **Data source (MHSDS) has c 3-month time lag for reporting. Request gone to LPT for agreement to use their current performance data. Medium term plan for business intelligence to receive data from LPT directly as it's submitted to MHSDS.**			

Finance

Team	Scheme Name	Plan	Actual / Forecast	Var	RAG	Confidence in delivery/mitigation

Non acute	Contractual changes	3,121	3,121	0		High
Non acute	23/24 MHIS funding / 23/24 SDF	18,626	18,626	0		High
Overall Assessment		**No escalations to Finance Committee**				

Quality & Equity

The MH Partnership has raised no unmitigated risks.

From the programme perspective, 3 key quality issues have been highlighted, with the potential to impact on quality and outcomes:

Issue	Escalation
The waiting time CYP and adults waiting for an ADHD or ASD diagnosis is c.2 years. This is due to a surge in referrals and a lack of qualified resource to manage this increase. This remains our top issue and has been raised both regionally and nationally with NHSE. LLR waiting times (c2yrs) are lower than many in the region, the highest is 10 years.	ALERT - EIA and QIA and clinical prioritisation undertaken. Monthly escalation to NHSE. Regional NHSE lead identified, and group established. National Task and Finish group in place. Regional Team have said that the ADHD will not be included in the MHSDS or MHSDF.
As reported last month: Venepuncture for individuals unable to have standard blood-taking after de-sensitisation and other non-invasive interventions – MH and LDA cohorts.	ALERT - EIA and QIA undertaken to evidence impact on equity and quality. Service model piloted with the Alliance and LPT with a positive outcome. SDF proposed to be used for 24/25.
Overall Assessment	**All escalations being managed through System Quality Group**

Transformation

Achievements (aligned to Step 4 of the NHS Impact framework)	Outcome for our patients / colleagues
Neighbourhood Mental Health Café's: The grant application round was completed for 6 vacant cafes (all 3 Universities, Wigston, Earl Shilton and Thurnby Lodge). The grant panels met on 8th March, with a decision to award 5/6 cafes, the applications for Wigston did not meet the spec. Mental Health Matters have served notice on all remaining cafes and demobilisation plan is in place. **Melton:** Agreed with the provider to move the location of the café to a more central location, this should increase footfall and ensure costs are within allocated budget.	Part of our work to deliver **pledge one** of five-year plan to tackle inequity and **pledge ten** to reduce inequity in access to mental health services in our neighbourhoods has been to work closer with our communities in each neighbourhood.

Charnwood: – Launch of the Mental Health and Wellbeing Hub in Sileby as an outcome of the development of the local Sileby Mental Health Network. MH & Wellbeing support provided to Afghan nationals at Garratts Hay barracks which identified a wide range of challenges and issues facing individuals. In response to this situation a donations appeal was initiated to get baby equipment (clothing, nappies etc) and general adult clothing.	Our insights data tells us that there is still much stigma around mental health across our communities. **Pledge 1, Pledge 10 and Pledge 12** of the 5YP focus us on Improve the health of our most deprived communities, prevention and inequity and taking a consistent approach supports these pledges.
Rutland: The Rutland community mental health and wellbeing team MDT meetings have been established. A Reablement worker for the 3 conservations innovator site has commenced and integrated into the local delivery team. Menopause Matters have commenced at the Oakham refill Shop.	These local improvements are supporting the delivery of **pledge1 and pledge 10** of the 5YP, reducing inequity in access to mental health services narrowing the gap between those who have the best and the worst health.
GHiN Scheme - Adhar project: Therapeutic support using arts, social and cultural activities delivered as individual support and group sessions. Provide the Learn to recover project which offers personal support to clients, including 1-2-1 sessions, training workshops and community visits. Additionally, a helpline for weekends for clients who may be in crisis when their service is not operating.	Part of our work to deliver **pledge 10** of five-year plan, to reduce inequity in access to mental health services in our neighbourhoods, has been to work closer with our communities in each neighbourhood and tackle some of the root causes of mental illness. J is a grieving widow who has very recently moved from a northern city, to be closer to her family. When she moved here she didn't know anyone, had no friends, no support structure and no one to talk to about her life and feelings. She was feeling social isolation, low self-esteem due to lack of knowing how to live independently. She came across a leaflet about Adhar at a library and came to the groups, where she engaged with people who understood her circumstances, she felt better and more hopeful. Over time her confidence has grown, she has made new friends, learned how to use her mobile phone, downloaded 'Waze' sat nav and is using this so she can maintain her independence for exploring the neighbouring areas around her.

Personalisation

Introduction

The Personalisation team have several areas of responsibility and the purpose of this report is to give an overview of these key areas to assure the group of progress within the work programmes and any risks associated with them.

The key areas discussed in this paper will include.

1. Performance against Operational Plan & NHSE Personalisation targets
2. MLCSU Continuing Healthcare Contract
3. Finance
4. Quality & Equity
5. Transformation

1. Performance against Operational Plan & NHSE Personalisation Targets

There are no Personalisation metrics within the 31 standards of the NHS Operational Plan. These are pledges and standards included within LLR's 5-year plan:

- **Develop a Personalisation Strategy**

Currently in the process of revising the governance structure to introduce a new Health and Social Care Executive to focus on personalisation at Director level across the system. In addition, to develop an LLR Integration Partnership to focus on a systemwide Personalisation Strategy. The Partnership will also be responsible for development and oversight of policies that enable effective joint commissioning, and all funding streams that require joint working, i.e. CHC, S117 aftercare, shared care, FNC, etc. Both Partnership meetings and Adult and CYP workstream meetings have now commenced and the Partnership will next meet on 14th March 2024.

- **Increase Social Prescribing Link Worker capacity and referrals**

Whilst there has been no project funding allocated by NHSE for personalisation programmes in 2023/24, funding is available via the Multi-professional Education and Training Investment Plan 2024-2029. The ICB Workforce Team have collaborated with LLR Training Hub to ensure training and development is factored into Primary Care and available to third party organisations through funding programmes and engagement via Community of Practice (CoP), peer support, alignment of the competency framework of SPLW existing and new into role. Initial stages have taken place to introduce a Buddy Framework into Primary Care and Anchor Organisations, to further support the current workforce.

- **Develop a Liberty Protection Safeguards service and deliver training across the system – LPS has been paused at a national level pending next general election**

Work is being progressed on the current Court of Protection backlog, which health are responsible for. This will ensure ICB is in the best possible position once direction of travel for LPS is known, following the next general election. In the meantime, current Deprivation of Liberty processes within ICB and Local Authority continue.

- **Embed a working culture that embraces personalisation as the default approach to supporting people**

Part of the new Personalisation Strategy will focus on how to improve awareness of personalisation across the system.

5. Implement processes to create All Age Continuing Care Model

Currently working to change the terminology within the contract specification to ensure that it reflect an all age continuing care model and we will make sure that policy reviews reflect this change.

6. Maternity: increasing personalisation and choice

UHL have committed to reviewing support planning processes and develop plans for Maternity Personalised Care & Support Plans (PCSPs) in 2023/24. The Maternity Quality Improvement Team was set up in July 2023 and oversee the delivery of all national standards. There is a QI workstream with dedicated Lead which is responsible for embedding Personalised Care and

outputs from Maternity & Neonatal Voices Partnership. Work is ongoing currently to re-launch 'My Maternity Journey', a PCSP to be used for all women receiving antenatal care at UHL.

NHSE Personalisation Targets

The team are delivering against the parameters below set out by NHSE, who have advised they are no longer actively monitoring this data. There are, however, much greater issues affecting Personalisation as the delivery model for packages of care is currently unsustainable financially.

Standard	Plan	Actual	RAG	Comments
Number of people with a personal healthcare budget (Q1 – Q3 23/24)*	3,048	988		The PHB numbers have reduced as the criteria for counting Personal Wheelchair Budgets (PWB) has changed in 2023. Previously we had been allowed to count wheelchairs which were supplied by direct issue, following a comprehensive referral, as long as the recipient was aware that they had the option of choosing a PWB if they required a wheelchair that was more individualised. On reflection by NHSE and wheelchair services, it was felt this was no longer a true experience of Personalisation and therefore the wheelchairs which are issued in this way cannot be counted, resulting in a reduced number of PHB in total. Whilst actuals are not in line with trajectory, in LLR we are at default for the right to have a PHB for those in receipt of Continuing Healthcare, Continuing Care for Children, PWB and the S117 offer is available for those who wish to access it with support from MLCSU.
Personalised Care & Support Plans (cumulative April 2019 – Nov 2023)*	18,136 (Q3 plan)	45,481		Dementia – 6,259 Maternity – 25,505 Primary Care – 13,717 There are no expected risks to being over target for PCSPs. In comparison to other ICBs in the Midlands, we are on a par for Dementia and Primary Care and slightly behind on Maternity. All other Midlands ICBs are also exceeding their targets and this may suggest that the targets have been set too low.
Shared Decision Making (cumulative April 2019 – Dec 2023)*	N/A – no target set by NHSE	58,056		
Social Prescribing Link Worker referrals (cumulative April 2019 – Nov 2023)*	16,533 (Q3 plan)	48,691		There are no expected risks to being over target for SPLWs. Again, all other Midlands ICBs are also exceeding their targets,

				suggesting that the targets have been set too low
Social Prescribing Link Worker numbers (and those employed through ARRS) (FTE) (as at M9)	83.3 (Q3 plan)	40.7**		**This report has now been updated to align with the National Workforce Reporting System (NWRS) claims submitted by PCNs. PCNs can determine their own workforce to meet their needs and therefore this is difficult to influence. There has been 23% reduction in SPLWs employed since April 2023. The ICB Workforce Team have collaborated with LLR Training Hub to ensure training and development is factored into Primary Care and available to third party organisations through funding programmes and engagement via Community of Practice (CoP), peer support, alignment of the competency framework for existing SPLWs and those new into role. Initial stages have taken place to introduce a Buddy Framework into Primary Care and Anchor Organisations, to further support the current workforce.
Overall Assessment	**No Escalation to System Executive**			

*Data source – NHSE futures platform. Last updated March 24

2. MLCSU Contract

The MLCSU contract will expire on the 31 March 2024 and the Personalisation team have had agreement to direct award the contract with MLCSU for 1 year with an option to extend for a further year. The team have been working with MLCSU to progress financial discussions and it has now been confirmed that no additional investment will be available for the contract in 2024/25. As a result, MLCSU are drafting an options paper to outline the following:

1. What services MLCSU can deliver within financial envelope available and what would need to be handed back to ICB
2. If oversight is required on all services, what adjustments would be needed to KPIs to be able to deliver at lower level and outline of the associated risks

Quality Performance of MLCSU Contract

The Personalisation team monitor the performance of MLCSU delivering the Continuing Healthcare, Continuing Care for Children and S117 service.

MLCSU are largely delivering against the KPIs within the contract, and these are reviewed on a monthly basis within the PCAG meeting chaired by the Head of Personalisation or nominated deputy.

Due to timing of reporting, M11 KPI data was not available at the time of the Delivery Partnership report submission.
9 of the 54 performance indicators are rag rated red at month 10. Any areas where performance is below the standard are supported with an exception report and are examined more closely with an improvement plan created, where necessary. In some cases, the underperformance is outside the control of MLCSU or the KPI relates to small numbers, which skews the reporting. Further information on the reasons for underperformance can be found in the table further below

Indicators rag rated red in M10	Rationale/comments for underperformance
2.3 Fast Track Applications will be processed, and a care package commenced, within 48 hours of first receiving the application (within the working week), unless for valid and unavoidable reasons (cf. National Framework)	All delays (24 packages) were beyond the control of MLCSU. Packages delayed mainly due to provider capacity, discharge delays and family requests.
3.2 All appeals will be resolved by the CSU within 6 months of receipt	3 appeals due for resolution in Jan 24. All were delayed due to issues accessing full records from care providers.
4.2 Annual reviews are scheduled, undertaken and processed as detailed in the National Framework for NHS CHC & NHS FNC April 2018.	As per narrative above. Performance has improved from 12% in M9 to 26% in M10.
7.2 Annual reviews are scheduled, undertaken and processed as detailed in the National Framework for Continuing Care 2016.	As per narrative above. Performance has improved from 31% in M9 to 50% in M10. 6 reviews for were due in Jan 24, 3 of which were completed. There has been a reduction of assessment booked due to the complexity of getting the MDT together.
11.2 Annual reviews are scheduled, undertaken and processed within timeframe (S117)	As per narrative above. Performance has improved from 0% in M9 to 6% in M10. 48 reviews were due in Jan 24, 3 of which were completed. The team did however complete a total of 47 reviews in Jan 24 – the other 44 consisted of backlog reviews and 6-week reviews which must be prioritised.
18.1 Ensuring new and reviewed CHC packages are agreed within identified Framework prices.	MLCSU have a process for sourcing packages of care however factors such as patient choice, availability of suitable providers can impact on their ability to secure Framework providers/rates. Where a non-Framework provider is used, MLCSU will negotiate a rate equivalent to the Framework price, where possible. Providers who do not accept Framework rates are required to provide a breakdown of additional costs to support the higher rate. In M10, 87 out of 126 placements were agreed within Framework prices. Of the 39 placements where Framework rates were not agreed, 32 where Nursing/Residential placements.
20.1 Summary analysis with total number of invoices paid vs number outstanding. (Inc 90 Days +)	This is generally linked to providers invoicing at a higher rate, where they have applied an uplift which has not been agreed by the ICB.
25.1 Production and management of NHS Standard Contracts to all Providers of CHC services in a timely manner	Contracts were not finalised until M6, due to ICB finalising rates and the approach to applying uplifts in 2023/24. MLCSU commenced sending these in M6 and by the end of M10, 476 of 480 contracts had been sent and 74% of these had been returned so far. The contracts team continue to chase providers for return of their signed contracts, and to work with the providers who have outstanding documentation that is required before their contracts can be sent out to them.

Children's Continuing Care Policy Review

The local authorities have identified a number of cases where they are concerned that Continuing Care funding should be contributing to the package of support for a child. There are also particular concerns around health provision in education settings.

The whole Continuing Care policy needs to be updated and work has commenced through the CYP Continuing Care Policy Review Project Group with the local authorities to ensure that decisions are being made in line with the CC framework. A review of the Policy and all associated documents is being undertaken through this group.

3. Finance

There are no formal transformation programmes aligned to Personalisation however there are a range of efficiency schemes agreed for 2023/24. At M11, an annual saving of £6.7m is being forecasted against an 23/24 plan of £4.9m.

System Investment Funding was agreed in 23/24 for Liberty Protection Safeguards scheme (LPS) to the value of £475k however as per the update on p1, LPS has been paused at a national level pending the next general election. As a result, the Personalisation Team have considered options for how this could be repurposed and have secured EMT agreement to utilise some funding to facilitate clearing the ICB's Court of Protection backlog.

Summary position of Personalisation spend at M11

	YTD (£000)			FOT (£000)		
	Plan	Actual	Variance	Annual	FOT	Variance
Area						
S117	32,206	37,059	4,853	35,133	40,428	5,295
Continuing Heathcare	102,573	105,517	2,944	112,023	115,091	3,068
Summary Position	**134,778**	**142,576**	**7,798**	**147,157**	**155,519**	**8,362**

Please provide a narrative to support your FOTs.

Mental Health:

S117 - Duplicate lines removed from FOT

AHPF: 3 new service users agreed at panel and 1 ceased

Continuing Healthcare:

CHC - Position includes an underlying financial plan issue of £1,952k (total £3.39m)

LD Pool - New service user added to database

Personal Health Budgets - updated numbers for clawbacks

Efficiency Stretch - No further adjustment has been made in the forecast for future achievement of the efficiency stretch target (£2.27m).

4. Quality & Equity

Issue	Escalation
Application of eligibility frameworks – Local authorities have raised concerns regarding the ICB's recommendations for CHC funding and application of S117 and CC framework.	This will be overseen by LLR Integrated Partnership Group. Separate workstreams have been developed to address CHC, S117 and CC concerns. CHC and CYP CC Policy review meetings have commenced. S117 review meetings are being led by County LA; these commenced in June 2023 and are ongoing.
Training for Health Delegated Tasks - There is recent evidence of social care providers being rated inadequate by CQC due to a lack of training for delegated tasks. Local Authorities have raised the financial and quality concerns to the ICB and are considering only commissioning placements/home	This is now being overseen by Integrated Personalised Care Board, who are overseeing the planning and delivery of a procurement exercise to identify a training provider who can meet need. A business case to secure additional funding to support the new training model has been considered

care packages with providers who can evidence training. This would have a negative impact on hospital discharge and flow across our UEC system, as well as disruption, instability, and escalating rates (as we saw during the pandemic) within the care market. There is also a risk to patient safety if health tasks are undertaken by inappropriately trained staff.	by the system however it is now unlikely any further investment will be available in 24/25.
Targeted support is currently being provided to several nursing homes where concerns have been identified. One of which (Dane View) was rated as inadequate by CQC in July 2023.	The team continue to work alongside the Local Authority to support the provider with the action plan and a further CQC visit took place in January 2024. As a result of this visit, CQC have now changed the rating to requires improvement. ICB will continue to undertake monthly support visits and a formal i-care visit to be arranged once the LA's performance improvement process complete.
A further nursing home (Waltham Hall) has been identified by LA and ICB quality teams as having a number of concerns, including clinical leadership and governance issues. Current CQC rating Requires Improvement and outcome of ICB quality visit in July '23 was rated as non-compliant. The home has received a significant amount of support from both the LA and ICB quality teams however improvement has been slow. This situation is of a particular concern as there is no other nursing home provision within the local area.	The ICB continues to work closely with providers and partner organisations, including Local Authorities and CQC to support joint assurance visits and triangulation of information within the system, supporting improvements against action plans and ongoing safety of residents. Feedback is still awaited from CQC regarding their next steps. ICB and LA have agreed to undertake a provider escalation meeting to progress improvements. Date TBC.
A new provider (Greenacre Park) has recently opened to support nursing & complex care individuals. Accepted spinal injury patient however discharge co-coordinator identified several concerns with staff training which would have been risk to individual.	Referral to LA safeguarding and ICB safeguarding also aware. ICB to undertake basic quality check 12th March in response to concerns.
There is a lack of good quality nursing care provision in some areas of LLR. Residents may need to be moved out of their local area if it is felt they cannot remain in a particular care home for safety reasons.	The ICB continues to work closely with providers and partner organisations, including Local Authorities and CQC to support joint assurance visits and triangulation of information within the system, supporting improvements against action plans and ongoing safety of residents.
Overall Assessment	**All the above have previously been reported to System Quality Group.**

5. Transformation

Transformation programmes aligned to Personalisation have been described in previous sections of this report.

Planned Care Partnership (*covering Elective Care, Cancer & Diagnostics)*

Our planned care Partnership delivers **pledge eight** of the five-year plan to reduce waiting times for consultant led treatment. The cancer programme also supports **pledge two**, preventing illness through cancer screening and diagnostics.

Performance against Operational Plan

Standard	Plan	Actual	RAG	Confidence in recovery / Year-end delivery
Eliminate waits of over 65 weeks for elective care by March 2024.	926 Jan 24	1,010 Jan 24	Not within 5% tolerance	78+ March forecast is <20 due to complexity, patient choice and cancellations in March. The 65+ March 24 forecast is 118. There is no real majority with 10 specialties forecasting patients remaining. Main risk to activity is any future industrial action. Monitored by NHSE Tiering.
Deliver the system specific activity target (agreed through the operational planning process). Total elective and day case spells (Ops Plan E.M.10) Tolerance 5%	11,225 Jan 24	13,212 Jan 24	Met	
Deliver the system specific activity target (agreed through the operational planning process) Follow up outpatient attendances without procedure (Ops Plan E.M.38)	49,653 Jan 24	49,932 Jan 24	Met	
Continue to reduce the number of 62 days waits for cancer.	386 Feb 24	305 Feb 24	Met	Confidence in recovery to fair shares and FDS delivery remains high- risks are OPA & surgical capacity to reduce the backlog and increase % performance. Monitored via NHSE Tiering.
Meet the faster diagnosis standard of 75%	76% Jan 24	74.7% Jan 24	Within 5% tolerance	
Increase the % of cancers diagnosed at stages 1 and 2 by 2028.	TBC	TBC		TBC
Increase % of patients receiving diagnostic tests within six weeks to 95% by March 2025 (85% by March 2024).	76% Jan 24	76% Jan 24	Met	Confidence in delivery of 15% by end of March is medium due to Endoscopy and CT position. LLR operational target set at 20%. Currently at 24%. Monitored via NHSE Tiering.
Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the waiting time ambition.	32,229 Jan 24	36,807 Jan 24	Met	Confidence in delivery is high.
Overall Assessment	**System performance against the operational plan remains relatively good despite the impact of Industrial action (IA). This is evidenced by improvement locally against the 65+ and 52+ trajectories and compared to peers. No escalations to System Executive**			

Finance

Team	Scheme Name	Rag Rating	Plan (£000)	Actual / Forecast (£000)	Var (£000)	Confidence in delivery/mitigation
PC	ERF income		11,951	26,292	14,341	Confidence in place.

PC	Cataract contract		392	0	0	Opportunity assessed and agreed as not viable for 23/24. Agreed by ODG/EMT as closed
PC	**Total**		**12,343**	**26,292**	**13,949**	
Overall Assessment		**Further opportunities continue to be assessed using GIRFT and Model hospital benchmarks. Improving productivity and outpatient provision across the system to increase activity is the biggest opportunity in H2 of 23/24. Ideas for 24/25 will include a review of contracts in place with providers to ensure good VFM – support from contracting and finance will be required.**				

Quality & Equity

The measures of quality in the Planned Care Partnership are yet to be established. There are no known immediate issues or risks to escalate.

Transformation

Achievements (aligned to Step 4 of the NHS Impact framework)	Outcome for our patients / colleagues
Performance - Industrial action and ongoing emergency pressures continue to impact on the time to reach zero 78+ waits. There will be a residual of c. 20 patients due to patient choice, complexity and admitted cancellations in March that could not be re-booked by the end of the month. Nationally and regionally the ask has been to get to the best possible position for 65+ by the end of March. The forecast is 118 (was 200 last month). There is no real majority with 10 specialties forecasting patients remaining. 62+ day cancer waits remain lower than plan and the position is improving. FDS has significantly improved and UHL are now higher than plan both in month for December and YTD. Reporting on the delivery of the 62-day standard, FDS and combined 31 day continues to be monitored via the Tier 2 programme. An update from the Diagnostic Board was included in the PCP papers. The 13+ week wait position has slowed notably in Endoscopy, CT and MRI. A deep dive into Endoscopy has commenced and will provide outputs on D&C, productivity, validation and governance on April 26th. Emergency pressure and focus on urgents has affected the ability for imaging to reduce its long waits. Support is being provided to LPT for paed audiology via the bronze cell and separately with operational leads re the options to insource / provide additional weekend sessions in UHL capacity	The numbers of patients waiting for elective care for long periods of time is reducing, meaning that patients are being seen faster despite the impact of industrial action, delivering **pledge eight** of the 5YP.
EMCA Funding Update – A breakdown of the system asks for cancer EMCA investments for 24/25 and a prioritised list for submission to EMCA was shared to the group for governance purposes. The list totalled £9.3m (£2.9m pre-committed £6.4m further requests). Project prioritisation of funding has been assessed against national and local priorities, and a balance across the EMCA funding streams comprising, early diagnosis, faster diagnosis, personalised treatment, operational performance and targeted investments. Each scheme has been assessed and prioritised based on risk level to cancer performance/outcome, priority support for challenged tumour sites and balance across CMG's/System. EMCA funding for 23/24 was circa £4.7m, and £3.8m for 24/25 has already been confirmed allowing the pre-committed investments (must do's) to continue. Any	A benefits realisation exercise was recommended to the group to allow projects to be able to clearly articulate benefits of moving to a recurrently funded position.

funding received above the £3.8m will be allocated accordingly based on the prioritisation criteria. A concern raised by the group was the sustainability of projects and the risk of continuing to support schemes with non-recurrent monies. A benefits realisation exercise was recommended to allow projects to be able to clearly articulate benefits of moving to a recurrently funded position. Funding has also been confirmed for the Targeted Lung Health Checks project.	
Cancer Board Highlight Report The LLR FIT position has increased to 81.9% for February ahead of target to achieve >80% by March 2024. PCN DES work continues, which has increased performance and business intelligence knowledge across the system. Three bundles of tests are now available on ICE to improve the completeness of cancer referrals and reduce any delays to the patient pathway. Cancer awareness projects are progressing including the CRUK CAM (Cancer Awareness Measure), a face-to-face questionnaire designed to measure public awareness of the symptoms and risk factors of cancer, and improving HPV and cervical screening uptake, via a myth busting video, working with schools and an awareness event over Easter. In terms of performance, FDS target (28 days) for UHL has been achieved for the last four consecutive months. The 62-day backlog is on track to deliver the fair shares by the end of March pre further industrial action. There are ongoing challenges with the 31-day performance, particularly for radiotherapy with waits affecting breast and prostate pathways. A mitigation plan is in place which includes weekend working, reduction of prostate fractions in line with new clinical guidance and mutual aid with NGH. Additional mitigations are awaiting TLT sign off include a use of an older 5th Linacc machine to support and a longer-term plan of a new and permanent 5th machine. The Cancer Summit will be taking place in April with a focus on faster diagnosis.	Increased FDS, FIT position, and patient awareness via multiple initiatives including CRUK CAM and myth busting screening videos.
System-wide Planned Care Capacity and Strategy Local population needs assessments have been developed for the seven community hospitals in Leicestershire and Rutland. These identify elective activity currently being undertaken, elective capacity, health and wellbeing strategy, local population healthcare needs, service gaps and planned expansion of capacity. These documents will help inform the development of the UHL Elective Services in Community Facilities strategy. A time out to progress this is scheduled for 25th March, at which CMG clinical and operational leads will review the current configuration of services, focusing on what works well and areas of challenge, with a view to inform the future use of community facilities. The outcome of this timeout will be included within the UHL Clinical Strategy, scheduled for completion in May 2024.	Outcomes of the local population needs assessment will help inform the development of the UHL elective services in Community Facilities Strategy.
AI Pilot Support OTUA is a provider with an AI led automated booking solution harnessing innovative technologies like automotive speech recognition, natural language processing and translation that increase efficiently and support improved patient experience. This system is widely used in Australia and the provider are offering funded pilots for 3-6 months maximum to three NHS Trusts in the UK, UHL being one of them. The AI solution will support the recommencement of Partial Booking to Cardiology, based at the Glenfield Hospital for a period of 3 -6 months with 'go Live' expected in	AI generated partial booking will ease pressure on admin teams, improve access for patients and patient choice, and improve heath inequalities.

April 2024. The system involves, making outbound calls, receiving inbound calls and has the ability to conduct multiple calls simultaneously meaning that the system can complete bookings 10x faster than a human operator. The aim of the pilot is to ease the pressure on admin teams, improve access for patients and patient choice, and improve health inequalities with the possibility of telecommunication in different languages. Partial booking will reduce the number of DNAs and improve the capacity of admin teams. Post pilot, the cost for a service the size of cardiology is circa £3k a month, it is hoped that the financial benefits gained from the reduction of DNAs can accommodate this. The group agreed to the pilot but raised concerns around the integration to Nerve centre, patient reactions to AI, and the funding after the pilot. The consensus of the group agreed to go with the pilot to see if it is worth exploring further after benefits are established during the trial period. System digital colleagues offered support to help evaluate the benefits of the project.	

Urgent and emergency care – (*delivered by our UEC Partnership)*

The UEC Partnership supports delivery of **pledges five and six** of the five-year plan; to reduce category two response times and to reduce waiting times in the Emergency Department. Actions taken to support both pledges have yielded sustained improvement, evidenced in the performance metrics below.

Performance against Operational Plan

Standard	Month	Plan	Actual	Status	Confidence in recovery / Year-end delivery
Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25 (UHL target based on performance data for Types 1& 2)	Jan-24	76%	57%	R	Low Variability remains high and risk of de-stabilisation through Winter.
Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25. EMAS performance for LLR ICB.	Jan-24	00:30:00	00:57:54	R	Medium Variability remains high and risk of de-stabilisation through Winter.
Reduce adult general and acute (G&A) bed occupancy - Reported at ICB level. National Target =<92%	Jan-24	94%	92.7%	G	Medium Variability remains high and risk of de-stabilisation through Winter.

ED re-direction to community UEC services continues to have a positive impact on ED activity.

ED Re-direction Summary 2023/24		Dec-23	Jan-24	Feb-24	YTD TOTAL
Oadby UTC	Appointments available for UHL or NHS111 booking	2139	2653	2639	22312
	UHL booked	252	271	232	3074
	NHS111 booked	1807	2280	2169	17533
	Total Utilisation	96.26%	96.16%	90.98%	92.36%
Merlyn Vaz UTC / OoH	Appointments available for UHL booking	520	775	620	4785
	UHL booked	205	350	316	2638
Westcotes EA Hub	Appointments available for UHL booking	450	458	434	5296
	UHL booked	248	325	289	2842

UHL LRI ED April 2023 to January 2024

2023/24 Plan (gross)	216,812
2023/24 Actual (All type 1&2 from national)	223,075
2023/24 Plan v Actual (gross)	**102.89%**
ED streamed to Oadby UTC	2,842
ED streamed to M/Vaz (OoH & UTC)	2,208
ED streamed to Westcotes EA Hub	2,553
2023/24 Net Actual ED Attends	215,472
2023/24 Plan v Actual (net)	**99.38%**

Overall Assessment	**System Executive to note the variability of performance and interlink with financial position**

Finance - CIP

Team	Scheme Name	Rag Rating	Plan	Actual / Forecast	Var	Confidence in delivery/mitigation
Acute	Contract / pathway changes	CIP at risk	11,990	11,023	(967)	Low Variance is against patient transport contract. Further work to do on plan to recover. Remains part of the ICB savings plans.
Overall Assessment		The gap against the CIP attributed to UEC remains under assessment and will be driven by the Interim UEC Director via escalation to Chief Finance Officers for support				

Quality & Equity

Issue	Escalation
The NHS England Midlands Regional dashboard shows a high number of 12-hour waits; plan and improvement trajectory required	**ALERT** – Escalated to System Quality Group to support review of actions and trajectory, with clinical support provided as needed. - A UHL Action Plan has been shared with the Acute Care Collaborative. - A trajectory plan has been signed off as a part of the Winter Plan. The trajectory ambition is to achieve 4% by March 2024 in line with the KPMG Midlands Region Review and agreed targets. - The latest weekly position at 03/03/2024 is 13.49% with a six week average of 12.46%. - The Winter challenges / UEC pathway issues have been escalated to extraordinary Clinical Executive meetings and added to the System Quality Committee Risk Log.
NHS England national daily scrutiny of the ED 4hr performance metrics	**ALERT** – All systems are receiving daily scrutiny of 4hr performance, both at an acute provider and system level. In order to support this, we continue with - Maximising use of UTCs and SDECs to support ED flow - Senior clinical decision making at the beginning of the patient's journey LLR's breach threshold is 264 breaches / day maximum in order to meet 76% 4hr performance. The latest system day position at 12/03/2024 is 70%. Week to date is 68.9% and month to date is 73.2%.
Overall Assessment	**System Quality Group to support concerns raised**

UEC meetings continue, at least twice weekly, to review System risk, identify additional interventions and assess the impact of mitigations. The ED Overcrowding risk score remains at 25. Mitigations in the form of additionality at both Oadby UTC (to support walk in demand) and Merlyn Vaz UTC (to support later day unheralded demand) continue and are being assessed daily with feedback to all appropriate meetings.

Emergency Care Data Set ("ECDS") reporting is nationally mandated from July 2024, and NHS England Midlands continues to highlight LLR as a significant outlier in UEC Type 3 reporting:
- DHU are working with ICB Contracts and MLCSU BI colleagues in the development of a data warehouse to resolve longstanding and ongoing data reporting challenges.
- NHSE Midlands have advised that LRI UTC Type 3 activity will be required via ECDS from July 2024 if it becomes a designated UTC service.

Two focused improvement projects are ongoing for a limited period to mid-May 2024:

1. A 12-week improvement cycle, with the objective of getting 98% of HTG patients to the right place, at the right time of day.
Ambition: Minimum 40% of LPT patients with transport booked by 10am to have left safely by noon / 80% of UHL patients with transport booked by 3pm to have left safely by 6pm.
2. A 12-week improvement cycle, with the objective of getting 90% of pathway discharge patients home on the day that a bed/package of care is made available to them.
Ambition: Less than 2 patients per day will remain in hospital as a result of the discharge plan being changed.

Transformation

Achievements (aligned to Step 4 NHS Impact programme)	Outcome for our patients / colleagues
SHREWD software platform mobilisation	SCC operations outcomes - Improved visibility of operational pressures - Real-time coordination of capacity and action - Improved clinical outcomes ED performance updates will include - Performance for the previous day, breaches against the threshold, and drivers for any underperformance. - In-day performance, breaches threshold set for the current day, and focused areas for improvement with corresponding actions. - Utilization of data from the National A&E Dashboard and SHREWD to inform operational discussions and drive improvement efforts. Phase One mobilisation will go live on 22nd March 2024 for a range of UHL and LPT metrics, noting that there is already established reporting for both EMAS and NHS111, and that the project is one of continual development. This level of information supports the system to deliver **pledge three** to support our frailest, **pledge seven** around holistic care and supports 'right patient, right time, right place'.
EMAS updates	Phase Two of the NHS Pathways transition has commenced and is scoping direct appointment booking into urgent treatment centres. SDEC services development at LRI and Glenfield Hospital is a key priority to remove conveyance via ED as a conduit to wider hospital, both from NHS Pathways and for paramedic crews on scene. Category 2 segmentation has been reinstated and is anticipated to reduce Cat 2 calls with a commensurate increase in Cat 3 calls. These schemes support the system to deliver **pledge three** to support our frailest, **pledge seven** around holistic care and supports 'right patient, right time, right place'.

Increase in number of patients that discharged on the same day as plans given. October 58% November 58% December 55% January 57% February 60%	Reduction in incomplete discharges resulting in an increase in discharges that occurred on the same day (i.e. plans given to UHL). Themes identified through workstreams that require further work include: - Patient choice - Patients awaiting medical reviews - TTO process delays A QI programme launched in February 2024 focusing on incomplete discharge, in particular internal process issues.
Increase P1 Plans given to UHL and LPT	As agreed at UEC Partnership on the 2nd February, City and County ASC have extended the P1 offer for patients that are delayed in UHL and LPT due to reablement teams capacity. This aligns to **pledge three** to support our frailest, **pledge seven** around holistic care and supports 'right patient, right time, right place'.

Primary Care – delivered via our Primary Care Transformation Board

Transformation of primary care continues at pace, delivering **pledge four** of the LLR five-year plan to improve access to routine general practice appointments. Year one of the five-year plan includes actions to increase the 'additional roles' recruitment across LLR, the total number of appointments and streamlining access to a wider range of primary care services, such as community pharmacy pathways. Progress against these is on track and evidenced in aligned performance metrics below.

Performance against Operational Plan

Standard	Plan	Actual	RAG	Confidence in recovery/ Year-end delivery
Everyone who needs a GP appointment gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need	85-90% ranged standard	85% Dec 23		Medium/High Overall LLR has delivered on its commitment to increase appointments and improve against 2019 levels. We are the highest in the region in the number of appts delivered. We had set a local stretch further than the national target. Furthermore, success of Pharmacy First/CPCS will have resulted in reduction in GP appts.
Continue on trajectory to deliver more appts in general practice by March 2024	603,072	543,882 Dec 23		
Continue on trajectory to recruit additional roles (ARRS) by end of March 2024	477	629 Dec 23		Two months behind due to claims process. Plan in place to utilise 100% funding. Further assurance completed
Overall Assessment	**No escalations to System Executive**			

Quality & Equity

The Primary Care Transformation Board has raised no specific unmitigated quality risks.

Transformation

Achievements (aligned to Step 4 NHS Impact programme)	Outcome for our patients / colleagues
NHSE Primary Care Regional Team approached LLR ICB to showcase the local Primary Care OPEL system at the Midlands Senior Clinical Leaders Primary Care Group. Our process was well received by others in the region, and we also took learnings from other areas to improve our system locally. Specifically, where we can support practices in declaring their OPEL level by strengthening the OPEL definitions.	As we 'come out' of winter and start planning and preparing for this, it is important that we support our practices to be resilient and remain sustainable, now, and in the future. We have processes in place to proactively identify and support practices to ensure they can continue to deliver safe and optimal quality of care for our population. This supports delivery of **Pledge 4 –** access to routine GP appts.
Capacity and Access Improvement Plan (CAIP) mid-year reviews are underway. To date, 23 PCNs have shared their progress under the three priority areas: • As of 13th March, over 29,000 responses to the local pt experience survey have been received across LLR, still awaiting hard copies. • NWL PCN have increased 'same day/urgent' capacity to meet pt needs/demand. • Aegis PCN using AI to trail attaching and coding of letters into a systematic process. • Majority of practices will have transitioned to CBT (or plans in place) by March 2024 • Appropriate mapping of appts improves month on month across all practices, although there are national technical issues with this, LLR are still performing well against this. CAIP webinars will continue with focused items to support delivery of their plans.	Improving access to General Practice is key priority for LLR. Since the pandemic, LLR are delivering more appts in General Practice than ever before, yet managing demand still remains a challenge and requires transformational change in order to continue to deliver sustainable services. This means maximising all community pathways where appropriate, including self-care to ensure that patients have easy access to the right clinician at the right time based on their needs and mitigate risk of hospital admission. The changes in service delivery in practices and PCNs will primarily support achievement of **Pledge 4 –** access to routine GP appts as well as contributing to the all the pledges too.
LLR ICB working in collaboration with general practice, LMC and clinical leads for various programme areas have reviewed and 'unpicked' the current primary care funding model and simplified the community-based services 'bundle' for 2024/25. This includes a costing review of 5 services within it, which have not been reviewed since 2015/16. The change in model has been well received as well as the extensive engagement programme that has been undertaken to ensure transparency and clear understanding of proposed contract. The review of the model also means that there will be equitable access for multiple services through a delegation process the ICB are facilitating.	LLR ICB are committed to delivering equitable and accessible services in the community. Delivery of enhanced provision in general practice/PCNs/neighbourhoods, enables patients to be detected, diagnosed and managed closer to home, reducing the need to attend acute hospitals for routine services such as phlebotomy. It can also prevent unplanned admissions as multi-morbid patients are proactively managed with robust care planning in practice. This work touches on **ALL 13** pledges within the joint 5YP, with a particular focus on **pledge 1, 2, 3, 4, 7 and 8.**
As of Dec 2023, 43,582 Enhanced Access hours have been delivered in this financial year. This is in addition to the appointments delivered at practice level. These appointments have supported delivery of LD health checks, screening services, management of LTCs and other preventative services.	One of the pledges in our joint 5YP is to ensure preventative services are upscaled across LLR. By using the enhanced access additional appointments to focus on preventative services, we can ensure general practice core capacity is available for those who need an on-the-day or planned service.
96% of practices delivering against the benchmark of 75/1000 clinical contacts against a plan of 75% (Dec 23)	Tackling variation in access is supporting our ICB ambition to have equitable access to general practice services across LLR and supports our practices to show improvement against national metrics
43% of same day appointments delivered against an England average of 55% (Dec 23)	
72% of face-to-face appointments delivered against a plan of 70% (Dec 23)	

Long Term Conditions Partnership

Our Long Term Conditions Partnership will support the delivery of **pledges one, two and three** of the five-year plan which includes 1) Improving the health of our most deprived communities and narrow the gap between those who have the best and the worst health; 2) spending more money on preventing people becoming ill in the first place; 3) identifying the frailest in our communities and wrap care and support around them. Through the earlier identification of people at risk of developing a LTC and the optimisation of people with one or more long term conditions, we will help to reduce health inequities.

Performance against Operational Plan

Standard	Plan	Actual	RAG	Confidence in recovery / Year-end delivery
Increase % of patients with hypertension treated to NICE guidance to 77% by March 24	77% 23/24	67.76%*	R	Unable to correlate national data to local data due to age breakdown of QOF indicators. Plan in place, with further focus on under-served groups
Increase percentage of patients between 25 and 84 years with a CVD score greater than 20 on lipid lowering therapies to 60%	60% 23/24	61.77% = 18 years & above*	G	High Plan in place, with further focus on under-served groups
Continue to address health inequalities and deliver on the CORE20PLUS5 approach	Part of each Partnerships plans – will be strengthen through link to Health Inequalities Support Unit			
Overall Assessment	**No escalations to System Executive**			

*New data sources used from November 2023 which has led to a change in reporting. Previously local data sources have been used. This month, data is taken from the national website 'CVD Prevent' for Q2 23/24.

From a programme perspective three key finances issues have been highlighted, that are impacting on delivery of projects and have previously been flagged to the LLR Delivery Partnership. Further, some of the quality and equality issues listed underneath also have financial impacts including cost pressures highlighted for overperformance of the **Oviva** contract, overperformance of the **Tier 3 Weight Management pilot** and year two of the **Familial Hypercholesterolaemia** service.

Issue	Action to date	Escalation
1. System Development Funding is provided on an annual basis and needs to be spent in year which makes longer term planning difficult	Support requested from LLR Delivery Partnership in September, October and November 2023. Issue raised with new ICB (Integrated Care Board) CFO (Chief Finance Officer)	ALERT - mechanism to allow SDF (System Development Fund) projects to run across financial years to allow full year effect
2. Return on investment analysis for our Cardiovascular Prevention programmes shows better health outcomes for people, as well as financial savings for the system. However, the increased prescribing spend outweighs any potential savings	LTC Steering Group have worked with Business Intelligence and Medicines Optimisation Team to unpack findings. Delivery Partnership made aware September 2023. Issue raised with new CFO. LTC Partnership and Meds Optimisation Team jointly presented strategy and challenges to Clinical Executive 1st Feb. Support for approach. Profiling included in Prescribing Horizon Scan that went to Clinical Exec. Outcome awaited	ADVISE – to note risk for future discussion

3. A business case for the continuation of the **Integrated Chronic Disease programme** has received clinical support as part of the System Clinical Prioritisation process but uncertainty on how to contract for 24/25. **NEW** - Pilot paused until outcome of funding decision	Support from Deputy CFOs (Chief Finance Officer) requested by ODG (Operational Delivery Group) on how to transact Financial impact of business case remodelled following feedback from System Clinical Prioritisation and meeting with Finance Decision awaited.	ALERT – to note risk for future discussion

Quality & Equity

From a programme perspective, six key quality issues have been highlighted, with the potential to impact on quality and outcomes including a new risk:

Issue	Action to date	Escalation
1. The provider of our **type 2 diabetes structured education and behaviour change programme**, Oviva, is overperforming on activity commissioned.	Contract Team and LTC Team have worked with the provider regarding referral activity to better understand causation for oversubscription and options. Cost pressure of £104k identified. Options paper presented to ODG 5th Feb. EQIAs/QIAs completed. Proposal being developed further to better manage activity and ensure newly diagnosed diabetics continue to benefit from the service. Meeting with Oviva and Contracts Team to agree way forward.	ALERT – to note risk for future discussion
2. Not achieved full practice sign up to the **Diabetes Enhanced Service** by 31 August 2023	Practices not enhanced are supported by the Diabetes Mentors and Diabetic Specialist Nurses. Options paper taken to ODG Nov 2023, EMT, SCG 20th Feb 24 to mitigate inequity in service provision. Agreement for a further 16 practices, who have started training, to become accredited and increase access to the service for patients across LLR. Expressions of interest to be sought to support diabetic patients in the remaining 14 core practices. 12 months credit sought for pump prime funding not utilised by the 14 core practices.	ALERT – gap in service provision for 30 practices not enhanced currently supported by Diabetes Specialist Nurses. Expression of interest to cover 14 practices who will not be enhanced.
3. Nottingham University Hospital (NUH) is no longer able to host the regional **Familial Hypercholesterolaemia** service and a further 3 ICBs (Integrated Care Boards) have confirmed they are no longer able to proceed with funding, following the NHSE Turnaround letter.	Regional Team leading, overall model being hosted by NUH. Met Regional Team 5th Jan – explored West Midlands hosting service and funding for part-time 8a, admin and clinical posts. University Hospitals of Leicester interested in developing a local service. Noted as a cost pressure. EQIA/QIAs completed for ODG 19th Feb. Met Regional Team 11th Mar – West Midlands unable to host so £100k	ADVISE – Local service will not be in place for 2023/24 Risk to long term patient outcomes being explored as well as mitigations with ICB Chief Pharmacist and Clinical Lead

Commented [B01]: this happened, but the outcome was essentially that Yasmin tasked contracts to get involved, so not sure its an alert

	awarded to Primary Integrated Community Services (PICS) to host a regional service. Regional Team to work out options with PICs for local discussion.	
4. National shortage of pharmacological element for **Tier 3 Weight Management Service**	**NEW** - Normal supply of pharmacotherapy injectables further delayed from April 2024 to December 2024 due to demand and drug unlicensed. Some elements are available through clinical trials and potential for a limited supply to become available which will be prioritised.	ADVISE – To note risk to service provision
5. The provider of our **Tier 3 Weight Management Service pilot,** Leicester Diabetes Centre has identified increased costs since business case was written which is impacting on capacity and demand for the service is much higher than predicted.	Working with provider and Contracts Team to explore options. Pilot temporarily paused for new referrals on 7th March whilst Task and Finish Group consider options. EQIA/QIAs to be completed and paper to be taken to SPG in April.	ALERT – To note pause in service provision
6. Outcome of **Prescribing Horizon Scan** will impact on scale of case finding and optimisation elements of our LTC strategy	Contributed to the Medicines Optimisation horizon scanning work to ensure prescribing costs are accurately reflected. Awaiting outcome	ALERT - To note potential risk to service provision
Overall Assessment	**Support required from System quality group to understand the risk to outcomes for these areas**	

Transformation

Achievements (aligned to Step 4 NHS Impact programme)	Outcome for our patients / colleagues
Working with UHL, a LLR delivery plan for supporting compliance to a NICE Technology Appraisal on Hybrid Closed Loops has been submitted to NHS England to access national funding.	Part of our work on equity, we plan to implement to people with greatest clinical need first and establish community HCL pump starts in areas of higher socio-economic deprivation. Supports **pledges one and two**
The **Type 2 Diabetes Remission Programme** went live on 13th September 2023. The programme has reported a total of 215 referrals to date and has received referrals from 45% of LLR practices.	The programme supports weight reduction, leading to reduced and stabilised Hba1c control in eligible patients. Supports **pledges one and two**
The **Acute Respiratory Infection Hubs** offered an additional 2,705 appointments between the 1st and 31st January, with 88% of the appointments being booked (2,382). Only 1.2% of patients were referred to ED/ hospital after assessment.	The additional GP practice appointments during December 2023-March 2024 have enabled people to be seen closer to home and avoided a hospital admission where appropriate. Supports **pledges four and six**
The multifaceted **LLR Tier 3 Weight management service pilot** went live on 8th November 2023. Delivered by Leicester Diabetes Centre it offers a range of person-centred treatment options including access to: • Physical activity schemes • Diet/behavioural change coaching • Low energy diet programme (online)	Implementing a specialist weight management service supports LLR to address health inequalities. Adults living in deprived areas of LLR are most likely to be obese and severely obese. This is particularly pronounced for women where 39% of women in the most deprived areas of the UK were obese compared to only 22% in the least deprived areas. Also, LLR has a diverse ethnic mix, where levels of obesity contribute further to existing health inequalities. Reducing levels of obesity is key to tackling inequalities in

• Pharmacotherapy (when available) • Psychological support, via a psychologist and/or counsellor • Bariatric surgery preparation • Clinical trials The service has received over 600 referrals in 15 weeks.	health across the life course. Across LLR approximately one in four adults are obese and one in ten have a Body Mass Index (BMI) of 35 KgM-2 or more. Significant (and increasing) healthcare costs are attributable to excess body weight, particularly within "high" BMI ranges. Supports **pledges one and two**

Appendix 1

LLR ICS System Executive Committee March 2024

National NHS System Objectives 23/24 Performance Metrics

NHS Leicester, Leicestershire and Rutland

Midlands and Lancashire Commissioning Support Unit

NHS Leicester, Leicestershire and Rutland is the operating name of Leicester, Leicestershire and Rutland Integrated Care Board

A proud partner in the:

Leicester, Leicestershire and Rutland Health and Wellbeing Partnership

Executive Summary

The aim of this report is to provide a high-level overview of the LLR achievement of the National NHS Objectives.
We are stable on most indicators, take into consideration:-

- **Urgent Care** - a plan to mitigate 12hr ED waits has been developed and is being led by UHL.
- The LLR GP Out of Hours Service utilisation has increased to 96.15% across January and February 2024.
- Additional clinical resources are supporting walk in demand at Oadby Urgent Treatment Centre (UTC) from 06/01/2024 – 31/03/2024 and Merlyn Vaz on Monday & Tuesday evenings.
- **Primary Care** - 11% increase in Community Pharmacist Consultation Service (CPCS) referrals in January, from December, a total of 2,657 referrals. This service enables patients to be seen by the right clinician under the CPCS scheme, enabling GPs to focus on providing continuity of care to patients including proactive care and care planning.
- LLR ICB are the second highest primary care referrer in the Midlands for CPCS.
- **Elective Care** -The overall picture for elective care is challenged, however there is continued progress in the reduction of those patients waiting longest for definitive treatment. 52+ week wait position is positive with many specialties expected to reach zero in the first six months of 24/25.
- **Diagnostics** - In October 22 UHL had the largest and longest diagnostic waiting list in the country. By the end of December 23 (when compared to October 22) there has been a 43% reduction in the overall waiting list and long waits have reduced by 71% for 6+ weeks and 80% for 13+ week waits. Overall, 4,000 more tests in January 2024 compared to January 2023.
- **Cancer** - Significant reduction in UHL's 62- day backlog position, now ahead of plan. Sustained delivery of Faster Diagnosis Standard (FDS) >75% standard for most months since September 2023 (UHL).
- **Mental Health** - LLR ICB were contacted by the senior policy advisor on behalf of the national Children's Commissioner to learn more about our children's mental health and wellbeing services. They will be including this information as a case study of good practice in their annual briefing as this year LLR ICB has been recognised as one of the highest performing ICBs across several metrics.
- **Learning Disability** - Additional dedicated LD nurse capacity in place until the end of March 2024, to focus on those people who have not had a health check for 2 or more years and support attendance/identify reasonable adjustments.
- **Hypertension** - At a Place meeting in December 2023, the data for June 23 was shared and it helped to identify the gaps and age band where more focus is required – 5 PCNs with prioritised practices are CVDP engaging with the Place Lead and ICB to meet the gaps in supporting the remaining patients needing reviews.

31 Priorities Summary

Area	NATIONAL NHS OBJECTIVES 2023/24	Month	Plan	Actual	RAG	Link to Slides
Urgent and emergency care	Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25 (UHL target based on performance data for Types 1& 2)	Jan-24	76%	56.8%		Link
	Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25. EMAS performance for LLR ICB.	Jan-24	00:30:00	00:57:54		
	Reduce adult general and acute (G&A) bed occupancy - Reported at ICB level. Local Trajectories (National =<92%)	Jan-24	94%	92.7%		
Community health services	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard *In the Ops plan template commitment to achieve on numbers*	TBC				
	Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals	TBC				
Primary care	Percentage of patients where time from booking to appointment was two weeks or less	Jan-24	Lower 85% Upper 90%	83.8%		Link
	Continue on trajectory to deliver more GP appointments in general practice by the end of March 2024	Dec-23	744,970	543,882		
	Continue to recruit 26,000 (Nationally) Additional Roles Reimbursement Scheme (ARRS) roles by the end of	TBC				
	Recover dental activity. Improving units of dental activity (UDAs) towards pre-pandemic 2020 levels	Jan-24	1,867,483	1,536,626		
Elective care	Eliminate waits of over 65 weeks for elective care by Mar 24 (except where patients choose to wait longer or in specific specialties)	Jan-24	926	1,010		Link
	Deliver the system - specific activity target (agreed through the operational planning process) Total elective and day case spells (Ops Plan E.M.10) Tolerance 5%	Jan-24	11,255	13,212		
	Follow up outpatient attendances without procedure (Ops Plan E.M.38) Tolerance 5%	Jan-24	49,653	49,932		

31 Priorities Summary

Area	NATIONAL NHS OBJECTIVES 2023/24	Month	Plan	Actual	RAG	Link to Slides
Cancer	Continue to reduce the number of patients waiting over 62 days (UHL Data Only)	Feb-24	386	305		Link
	Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days	Jan-23	76%	74.7%		
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028	UHL reviewing staging data - TBC				
Diagnostics	Patients that receive a diagnostic test over 6 weeks waiting - as per the Operational Plan 23/24	Jan-24	24%	24%		Link
	Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition	Jan-24	32,229	36,807		
Maternity	Make progress towards the national safety ambition to reduce stillbirth	2023/24 (up to Nov 23)	Reduce 22/23 4	3.8		
	Neonatal mortality	2021	Reduce 2020 1.5	2.4		
	Maternal mortality	2022/23	Reduce 21/22 * (supressed	0		
	Serious intrapartum brain injury	TBC				
	Increase fill rates against funded establishment for maternity staff	TBC				
Use of resources	Deliver a balanced net system financial position for 2023/24 - System delivery of planned surplus	M9	(23,269)	(66,594)		Link
Workforce	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise	TBC				
Mental health	Improve access to mental health support for children and young people aged 0-25 accessing NHS funded services (compared to 2019) 12 mth rolling position reported for each month	Dec-23 Q3 Plan	14,228	16,065		Link
	Increase the number of adults and older adults accessing Talking Therapies (3 months rolling position)	Dec-23 Q3 Plan	8,101	5,345		
	Increase in the number of adults and older adults supported by community MH services with Severe Mental Illness (SMI) Number of people who receive two or more contacts from NHS or NHS commissioned community MH service	Dec-23	6,456	12,920		
	Work towards eliminating inappropriate adult acute out of area placements (Quarterly Rolling Bed Days data)	Nov-23	0	0		
	Recover the dementia diagnosis rate	Jan-24 Q4 Plan	66.7%	65.3%		
	Improve access to perinatal mental health services	Dec-23 Q3 Plan	940	760		

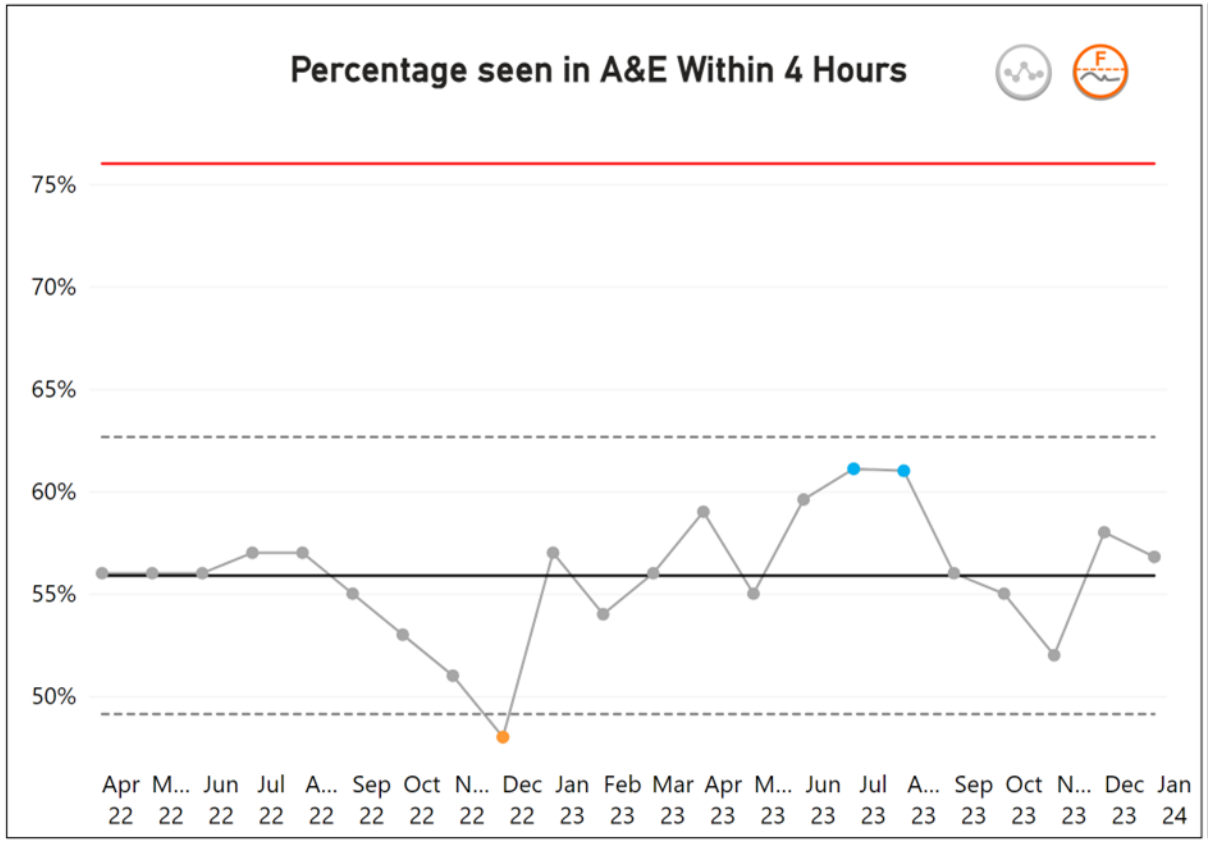
31 Priorities Summary

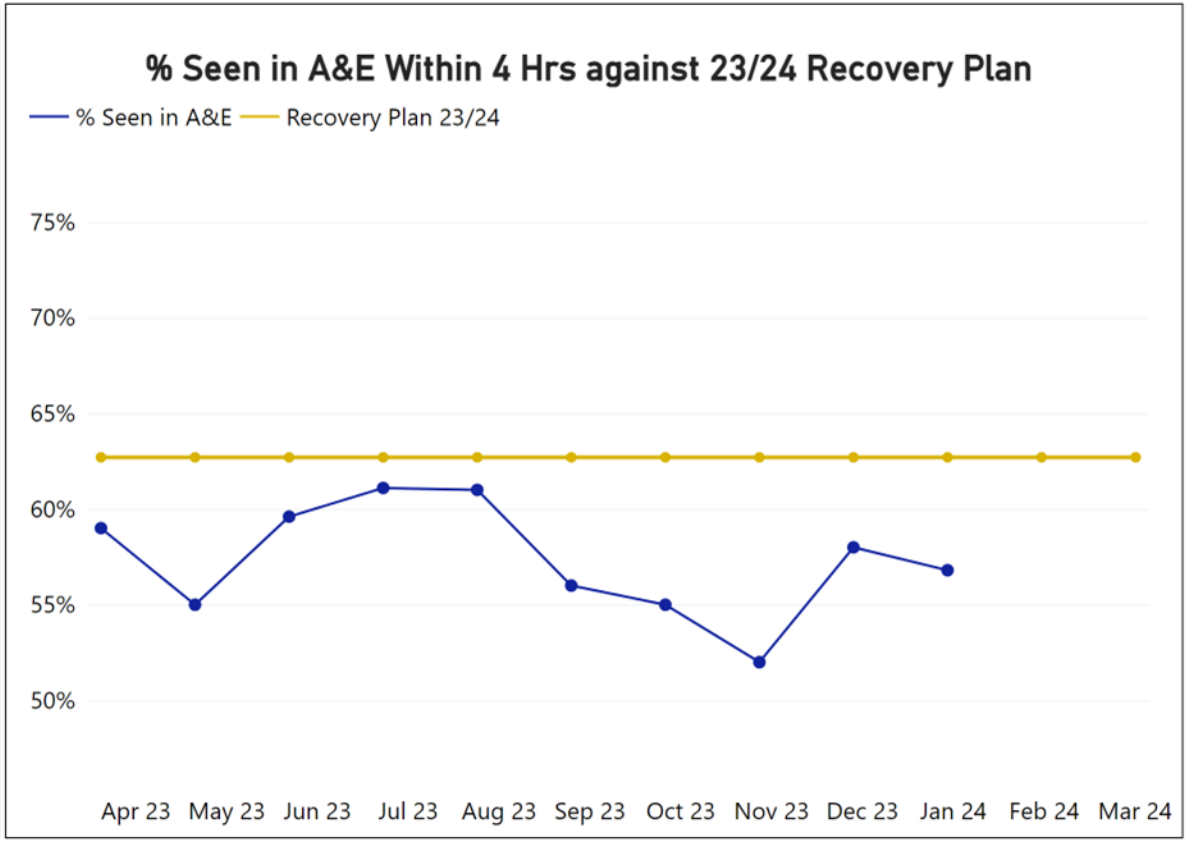
Area	NATIONAL NHS OBJECTIVES 2023/24	Month	Plan	Actual	RAG	Link to Slides
People with a learning disability and/or autism	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024 (Target 4284)	Q3 Q3 Plan	1109	1133		Link
	Number of adults with LD/Autsim in inpatient care	Feb -24 Q4 Plan	25	24		
	Number of children with LD/Autsim in inpatient care	Feb -24 Q4 Plan	3	5		
Prevention and health inequalities	CVDP002HYP: Percentage of patients aged 18 to 79 years with GP recorded hypertension, in whom the last blood pressure reading within the preceding 12 months is equal to 140/90 mmHg or less	Q2 23/24 Sept-23	77.0%	65.8%		Link
	CVDP003HYP: Percentage of patients aged 80 years or over with GP recorded hypertension, in whom the last blood pressure reading within the preceding 12 months is 150/90 mmHg or less	Q2 23/24 Sept-23	77.0%	75.8%		
	CVDP007HYP - Percentage of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age appropriate treatment threshold	Q2 23/24 Sept-23	77.0%	67.8%		
	CVDP003CHOL - Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%	Q2 23/24 Sept-23	60.0%	61.8%		
	Continue to address health inequalities and deliver on the Core20PLUS5 approach	Part of each Partnerships – strengthened through link to Health Inequalities Support Unit				

	Under achieved target
	5% Threshold
	Achieved target

Urgent and Emergency Care

Metric ID	Metric	Latest Date	Value	Target	Variation	Assurance
UEC1	Percentage seen in A&E Within 4 Hours	Jan 24	57%	76%		



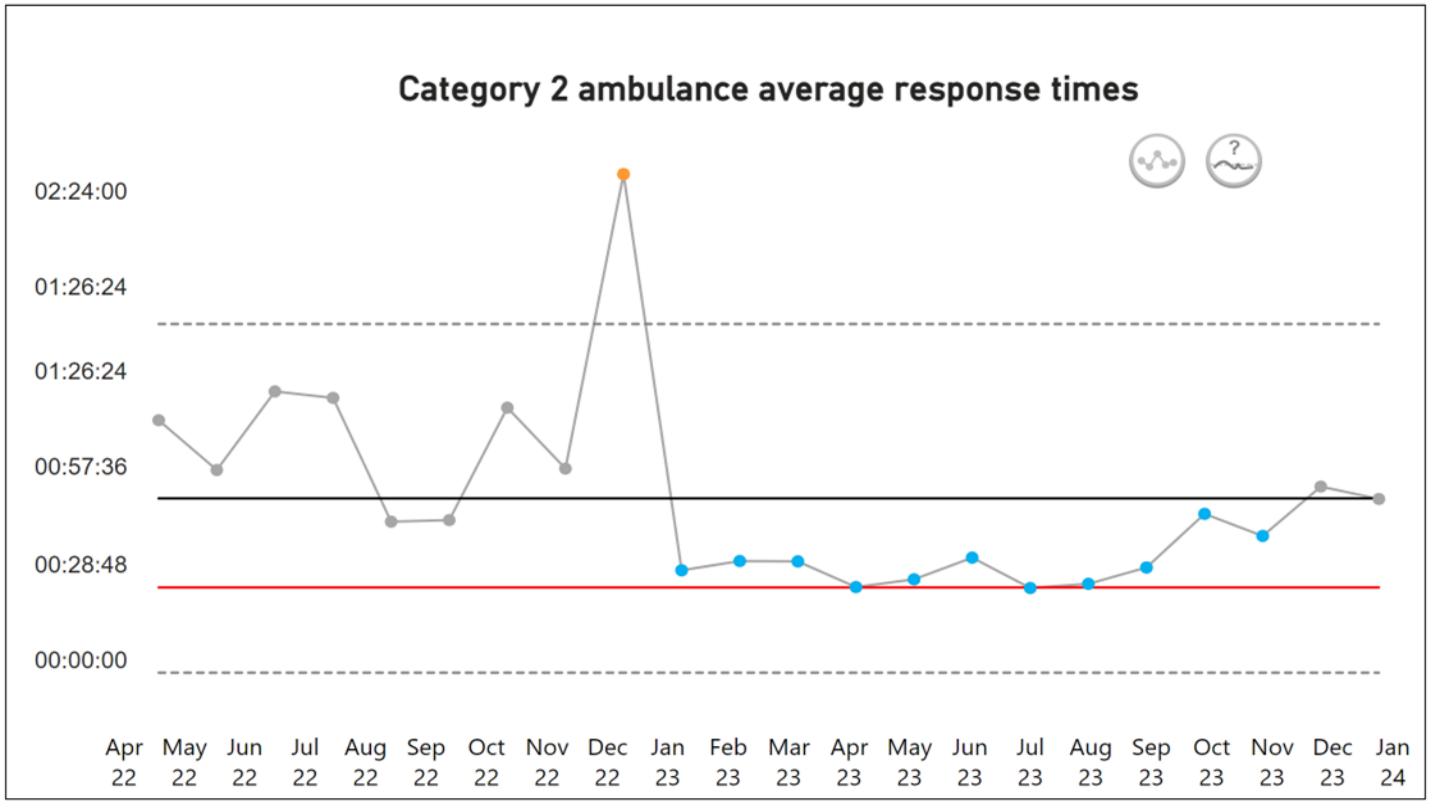


Data
Target
Median
Upper/ Lower Control Limits
No significant change (common cause variation)
special cause variation indicating improvement
special cause variation of particular concern

Link to summary table

Urgent and Emergency Care

Metric ID	Metric	Latest Date	Value	Target	Variation	Assurance
UEC2	Category 2 ambulance average response times	Jan 24	00:57:54	00:30:00		

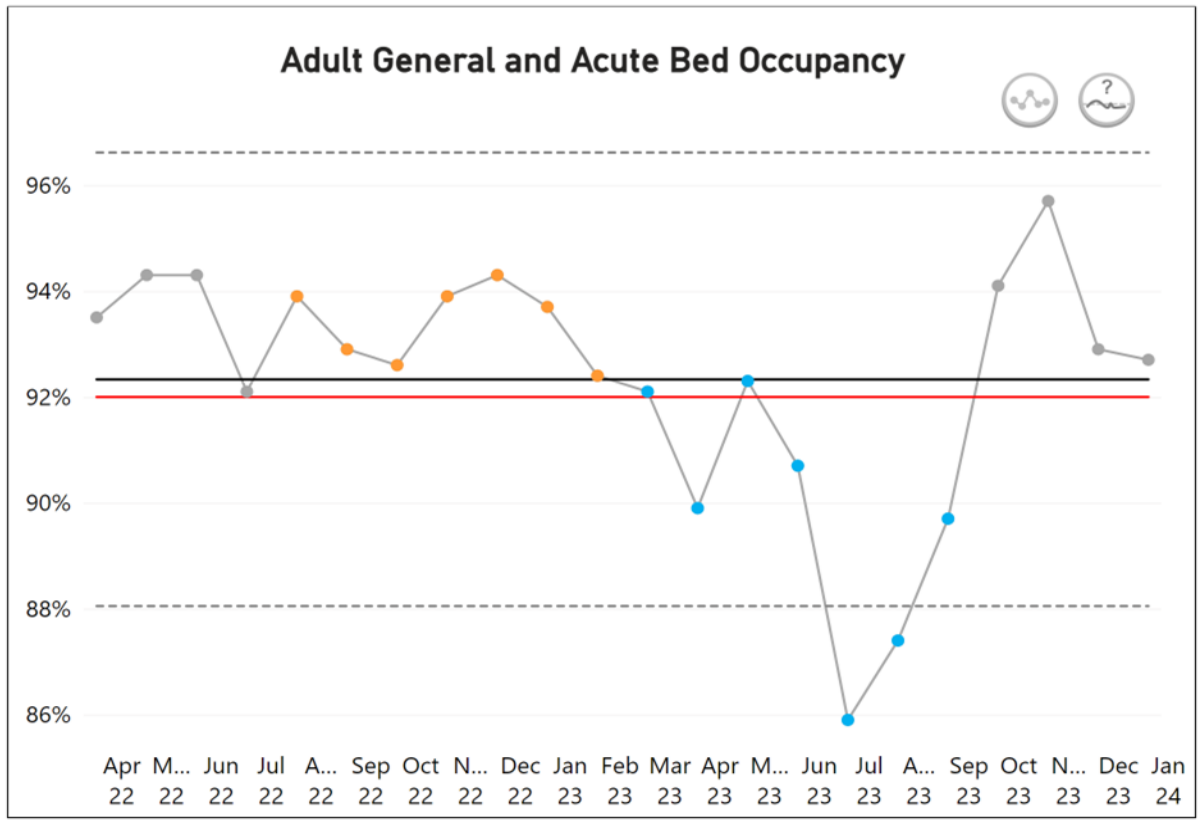


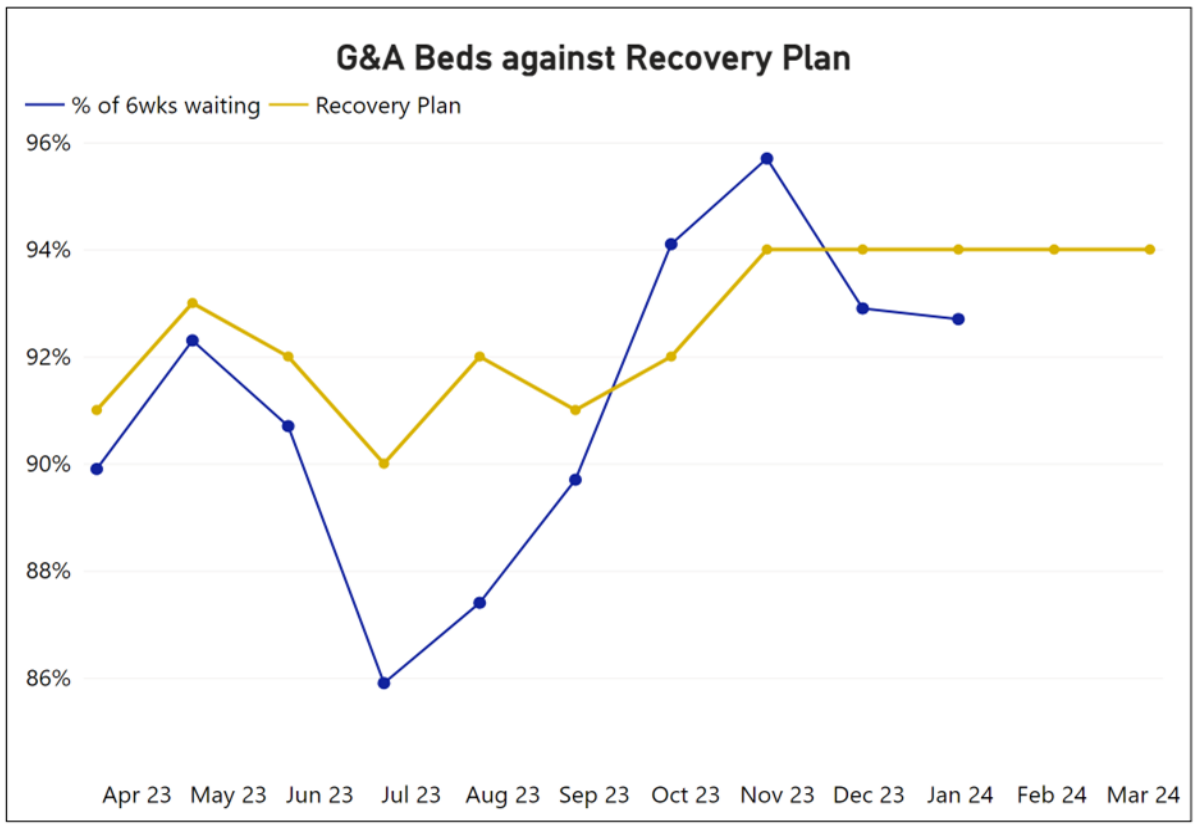
Data
Target
Median
Upper/ Lower Control Limits
No significant change (common cause variation)
special cause variation indicating improvement
special cause variation of particular concern

Link to summary table

Urgent and Emergency Care

Metric ID	Metric	Latest Date	Value	Target	Variation	Assurance
UEC3	Adult General and Acute Bed Occupancy	Jan 24	93%	92%		





Data
Target
Median
Upper/ Lower Control Limits
No significant change (common cause variation)
special cause variation indicating improvement
special cause variation of particular concern

Link to summary table

Urgent and Emergency Care

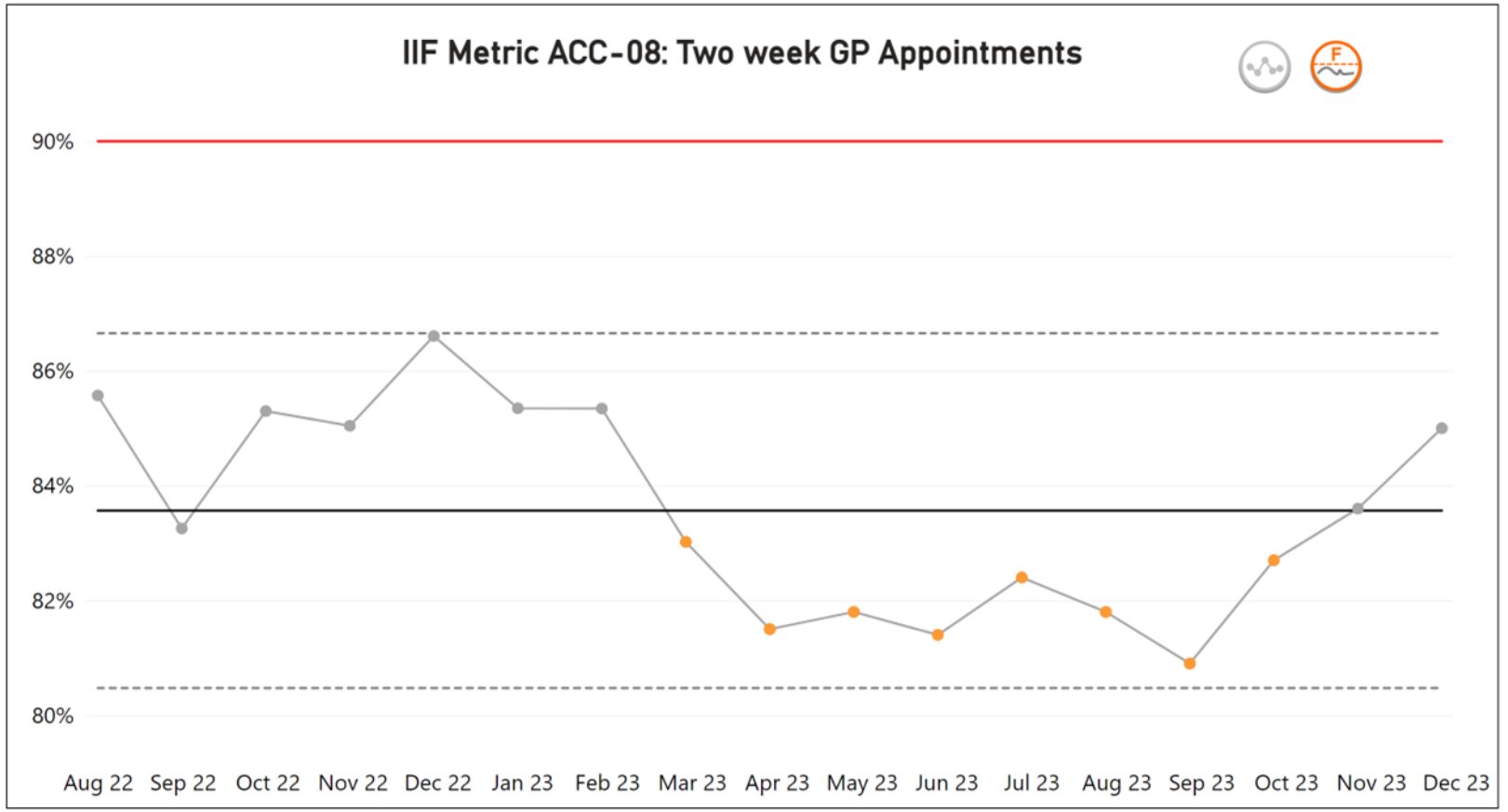
Metric	Risk	Mitigation
Improvement of A&E waiting times	• Overcrowding in the Emergency Department (ED) due to lack of flow resulting in long waits to see a doctor • Inability to create early capacity across the emergency care pathway due to lack of early discharges/using the discharge lounge overnight • High inflow of walk-in patients impacting on ambulance arrivals and poor outflow across the emergency care pathway	• UHL plan to mitigate 12hr ED waits - System Quality Group update 03/2024 • There is an increase in bed capacity in January 2024 of 33 community beds (15 @ Coalville Ward 4 and 18 @ Loughborough Grace Dieu) and March 2024 (18 beds @ Glenfield Hospital) to support performance improvement. • Further improvements to the LLR Directory of Services profiles as phase 2 of the EMAS NHS Pathways transition. • Improving Same day emergency care (SDEC) pathways to reduce ED footfall as a conduit to wider hospital services. Glenfield Chest Pain Service opened 30/10/2023.
Improve category 2 ambulance response times	• The POA Escalation Pod (“PEP”) capacity has supported ambulance handover improvements and is staffed 24/7. • LLR Ambulance C2 Mean has improved to 34m 34s for the week ended 03 March 2024. • Increase bed capacity across Q4 2023 / 2024 to support performance improvement (see above). • Improvements to the LLR Directory of Services profiles to support EMAS utilisation of NHS Pathways with review the ‘failed pathways’ for identification of further DoS enhancements during Phase 2.	
Reduce adult general and acute (G&A) bed occupancy	• Risk of discharge delays and increasing number of medically optimised for discharge patients resulting in risk of harm and deconditioning	• Working with Clinical Management Groups (CMG’s) to reduce ‘lost’ discharge outcomes. • Continue to establish Integrated Discharge Team (IDT) hub and partnership weekly face to face huddles. • Implementation of consistent Criteria led admission, Reside and Discharge planning. • Additional eight patients' capacity in the Discharge Lounge opened October 2023. • Additional HMAS patient transport crews supporting discharge supporting UEC demand in Q4 2023/24.

Good news 1: The LLR GP Out of Hours Service utilisation has increased to 96.15% across January and February 2024.
Good news 2: Additional clinical resources are supporting walk in demand at Oadby UTC from 06/01/2024 – 31/03/2024 and Merlyn Vaz on Monday & Tuesday evenings.

Patient Outcome: We will continue partnership collaboration with East Midlands Ambulance Service (EMAS) and Derbyshire Health United (DHU) to strengthen pre-hospital pathways of care. There is particular focus on conveyance to LUTC, referral to UCCH and pro-active EMAS C3 / C4 stack management with Merlyn Vaz Out of Hours service as a disposition option. We are reviewing the need for all GP OoH appointments to be available for ED streaming access.

Primary Care

Metric ID	Metric	Latest Date	Value	Target	Variation	Assurance
PC1	IIF Metric ACC-08: Two week GP Appointments	Dec 23	85%	90%		

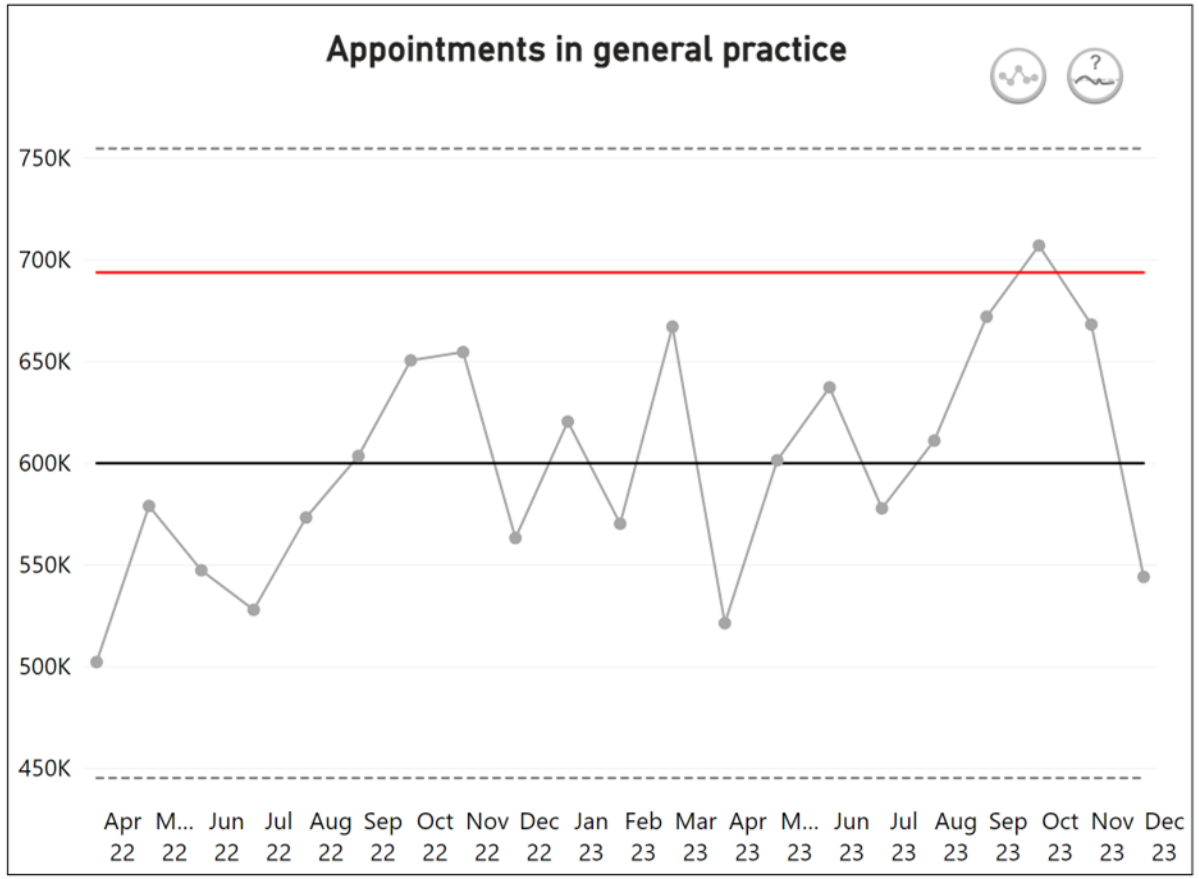


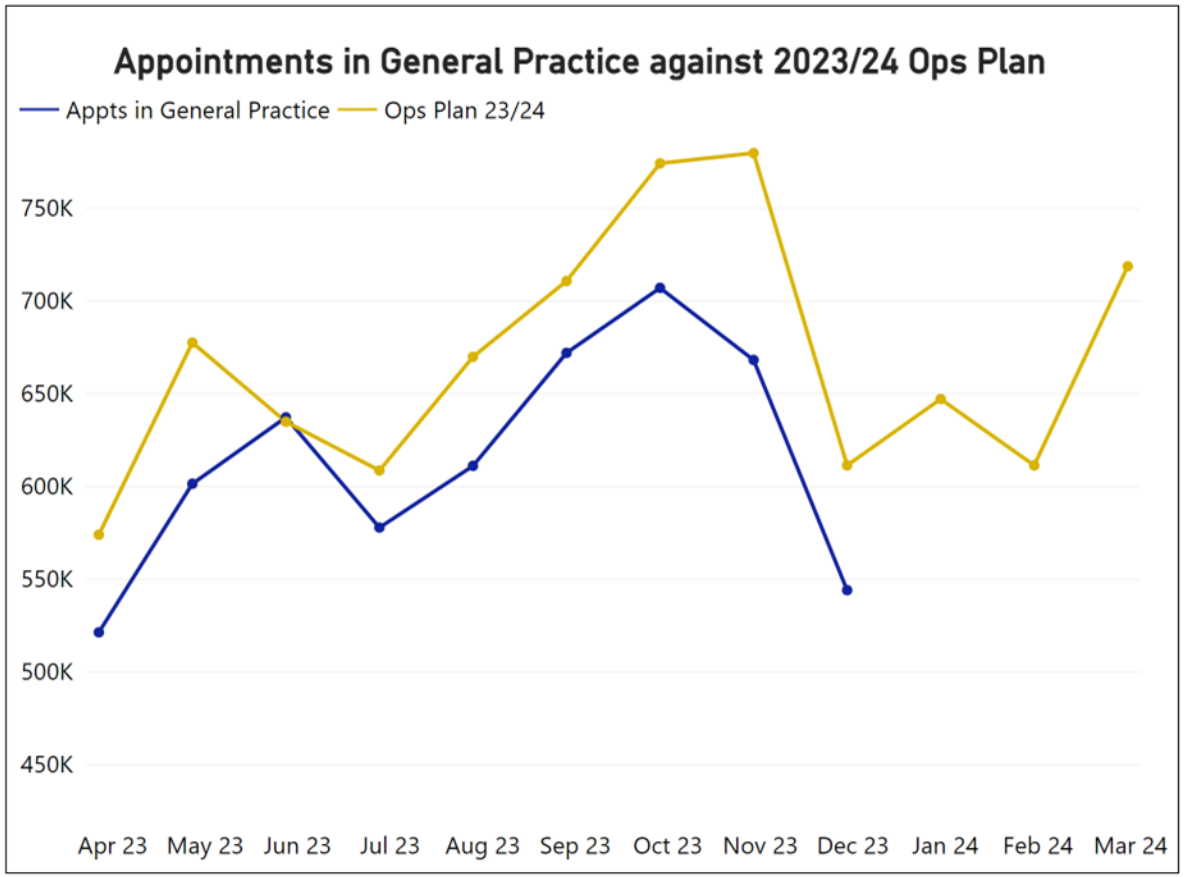
Data
Target
Median
Upper/ Lower Control Limits
No significant change (common cause variation)
special cause variation indicating improvement
special cause variation of particular concern

Link to summary table

Primary Care

Metric ID	Metric	Latest Date	Value	Target	Variation	Assurance
PC2	Appointments in general practice	Dec 23	543882	693532		



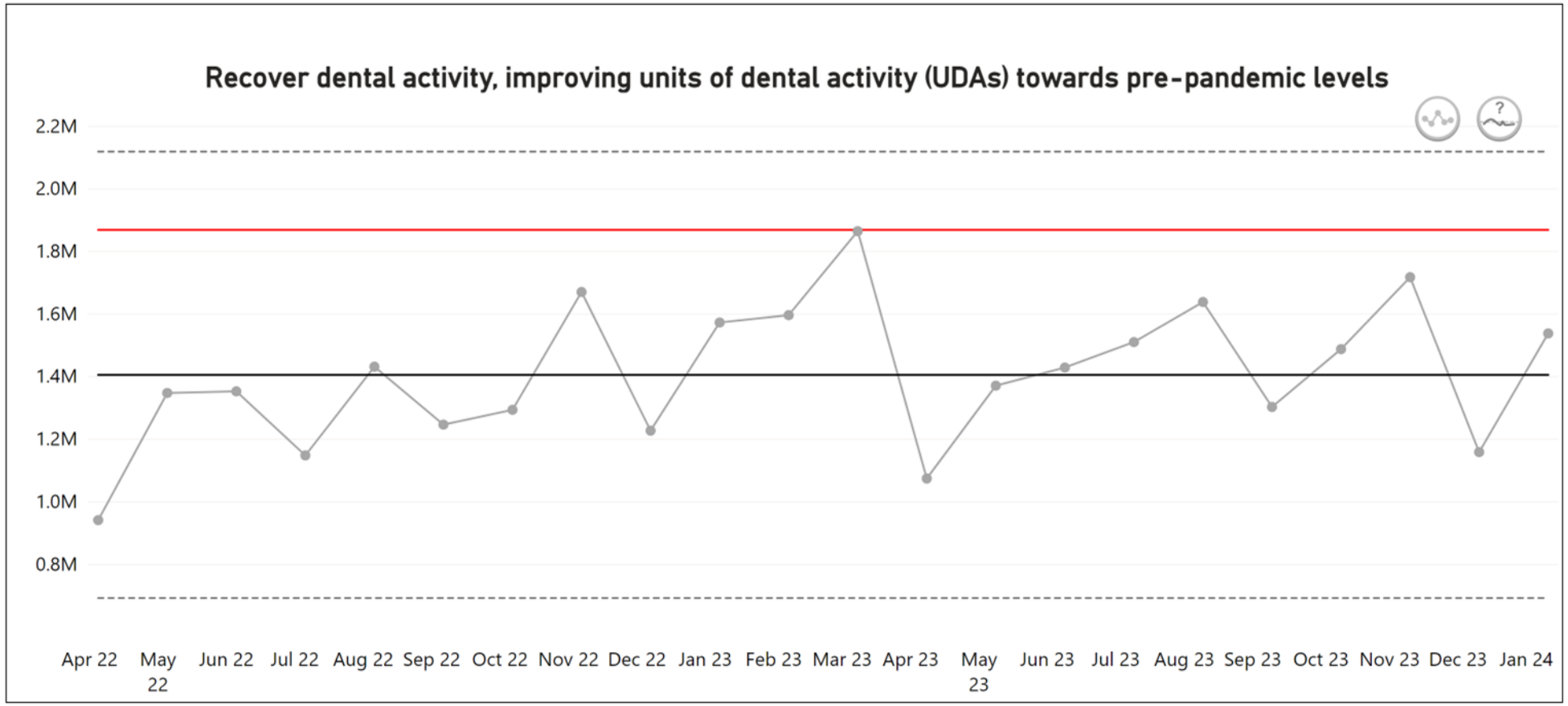


Data
Target
Median
Upper/ Lower Control Limits
No significant change (common cause variation)
special cause variation indicating improvement
special cause variation of particular concern

Link to summary table

Primary Care

Metric ID	Metric	Latest Date	Value	Target	Variation	Assurance
PC3	Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels	Jan 24	1536626	1867483		



Data
Target
Median
Upper/ Lower Control Limits
No significant change (common cause variation)
special cause variation indicating improvement
special cause variation of particular concern

Link to summary table

Primary Care

Metric	Risk	Mitigation

Everyone who needs a GP appointment gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need	• Increase in demand during winter, specifically those with respiratory conditions
	• Workforce challenges remains an issue
	• Access to other services/path ways is fragmented
		• Pharmacy First launched on 31 January 2024. As at 30th January 2024, 218 (97.8%) LLR Community Pharmacies have signed up to provide the new Pharmacy First service from 31st January 2024. The overall service consists of three core elements:
		  ○ Pharmacy First (7clinical pathways) – new element
		  ○ Pharmacy First (urgent repeat medicine supply) – previously commissioned as the CPCS.
		  ○ Pharmacy First (NHS referrals for minor illness) – previously commissioned as the CPCS.
		• CPCS referrals continue to grow in LLR with 2657 referrals in January and over 70% of practices are referring to the service.
		• The ongoing delivery of the 5 Year Workforce plan and Primary Care Strategy focuses on improving access; these are delivered via the Capacity and Access Improvement Plan; addressing the 8am rush, getting through on the phone, reviewing practice / PCN website, encouraging NHS App and online consultation usage, staff attending the Active Signposting training, promoting the Friends and Family Test (FFT) survey and publishing the findings.
		• PCNs have submitted their updated ARRS workforce plans; indicating full utilisation of their ARRS funding / Considering how these roles will address the PCN population health inequalities.
		• To support winter pressures, Acute Respiratory Infection hubs are up in place for each PCN. This is additional capacity that has been funded until 31 March 24.
		• Ongoing delivery of the Enhanced Access appts increase access and offer a range of services, MDT team focusing on Same Day, Preventive Care. Increase in Health Care Checks, Medication Reviews, Learning Disability Health Checks, Flu vaccinations.

Continue the trajectory to deliver more appointments in general practice	• Workforce challenges – recruitment and retention • Multi-morbid/complex patients – require longer appts	• GP Appointments Data Dashboard (GPAD) data indicates on average more GP Face to face appts are offered across LLR • Delivery of the 5-year workforce plan will support long term planning • Additional funding for Additional Roles Reimbursement Scheme (ARRS) funding utilised to create more capacity, offer a range of services including review and preventive care, enabling GPs to focus on complex care; the use of the Digital Transformation Leads encourage PCNs to triangulate data to address demand. • Enhanced Access can support delivery of routine care for Long Term Condition (LTC) reviews as well as same day appts / PCNS are focusing on pt cohorts to target through capacity access and improvement plans • Access to NHS App and online consultation offer improved access for patients that prefer these options

Primary Care

Metric	Risk	Mitigation
Continue to recruit ARRS roles by end of March 2024	• National and local workforce challenges	• Delivery of the 5-year workforce plan and PC Strategy will support long term planning • Training and development programmes via Training Hub target clinical and non-clinical roles • Embrace neighbourhood working with an integrated sustainable workforce and maximising Additional Roles Reimbursement Scheme • Support recruitment, retention and development of ARRS staff; networking programs facilitated via Kalu for SPWL, Training Academy offer induction and Training Prog for staff • Recruitment drive to attract workforce to LLR; benefits of working across LLR. • H&W sessions to support ARRS roles • Supervision and Training opportunity available for the ARRS through their PCNs.

Key achievements:

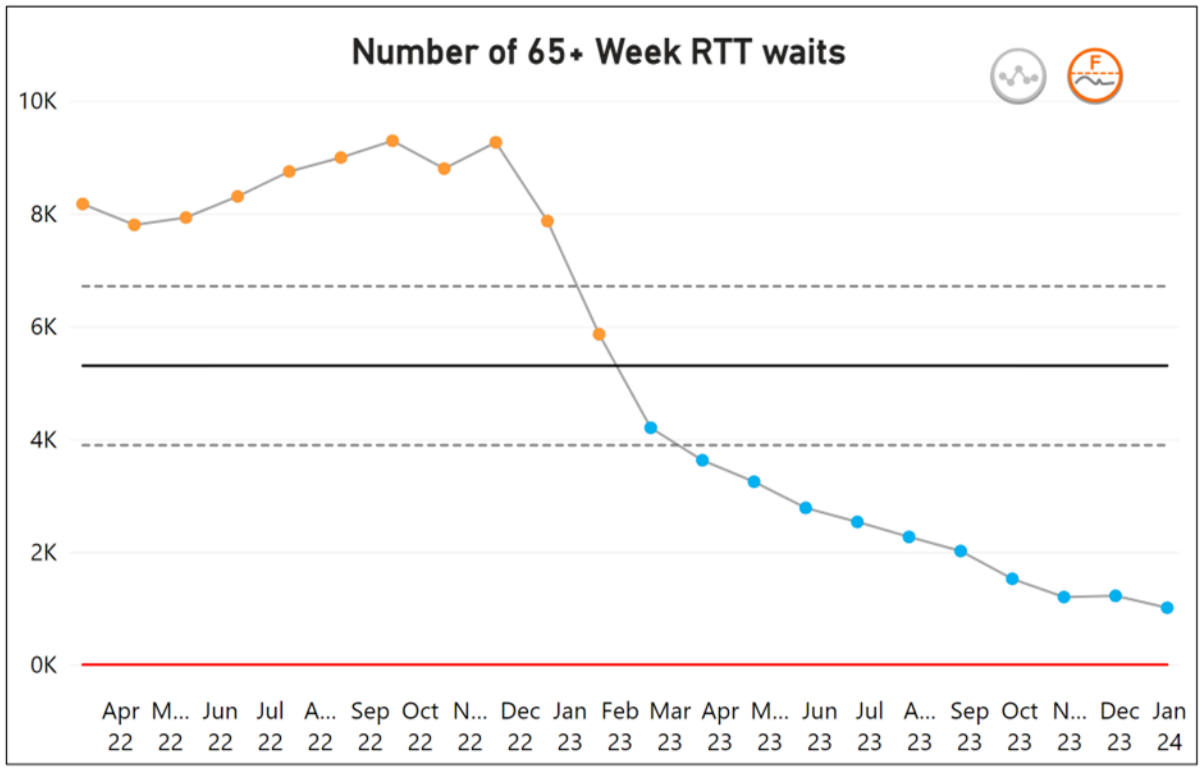
- LLR are the second highest refer in the Midlands for CPCS – 11% increase in January from the previous month.
- General Practice Funding has been approved with revised pricing for 5 services. Over 50% of practice have signed up to deliver all the services within the CBS.
- Enhanced Access appointments continue to be delivered across LLR support vaccinations, Long term conditions (LTC) reviews, screening etc.
- As part of the IIF performance, LLR are above Threshold at 86% on achieving the Cancer Fit Testing referrals.
- LLR ICB are supporting over 40 practices through a local or national improvement programme. This will support PCN Capacity and Access Improvement Plans, the primary care recovery plan by enabling practices to develop and work towards building a 'modern general practice'. In addition to this, the self-assessment that takes place with each practice will also identify actions that can improve practice/PCN resilience and sustainability. This programme will build on the local quality assessment processes in place and capture further intelligence which can support the ICB to proactively support practices and help mitigate future challenges particularly with resilience.

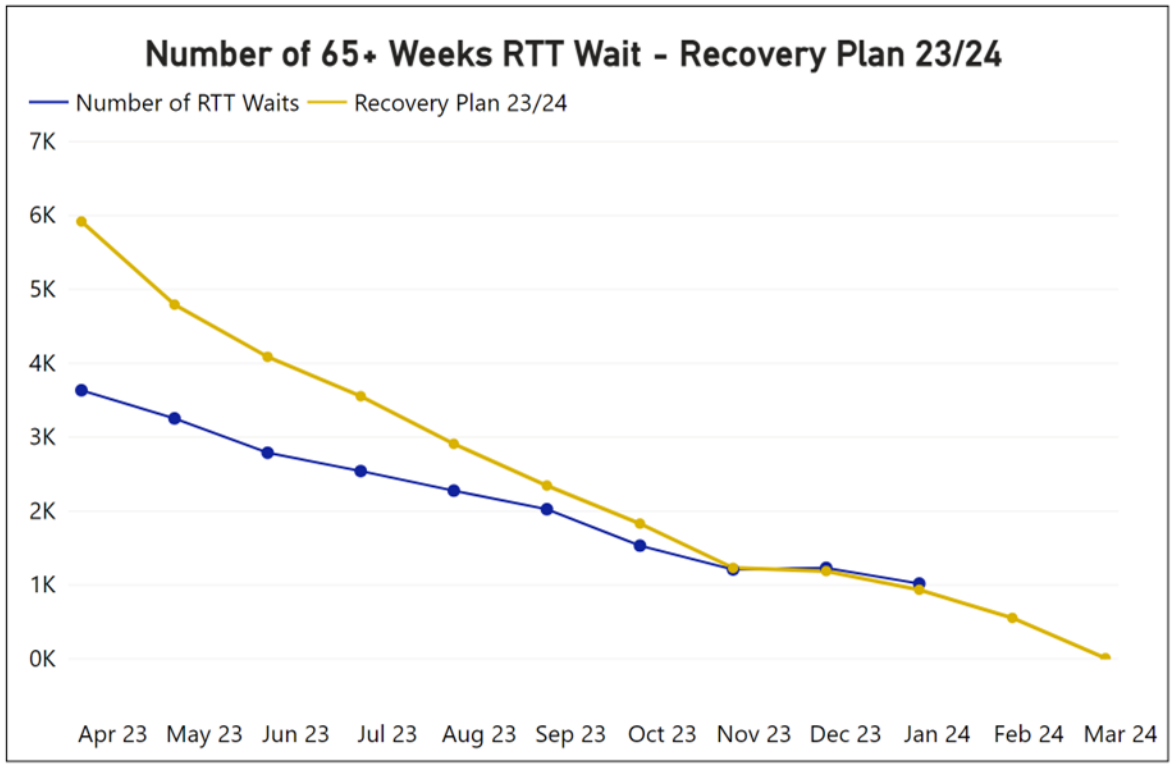
Patient Outcome:

- LLR have been fortunate to secure Free Roving Healthcare Units to support Primary Care and other services across LLR.
- These have helped deliver targeted initiatives, particularly supporting the health inequality agenda and having services within the heart of communities.
- Late last year, following the rise in measles, a local practice in Leicester City used the units to offer vaccines, including MMR and LTC health checks. The vehicle was located in Beaumont Leys Market. Patients liked the convenience of the service as no appt was needed and it enabled the practice to engage and target specific cohorts who may not be able to/or choose not to attend the practice.

Elective Care

Metric ID	Metric	Latest Date	Value	Target	Variation	Assurance
EC1	Number of 65+ Week RTT waits	Jan 24	1010	0		



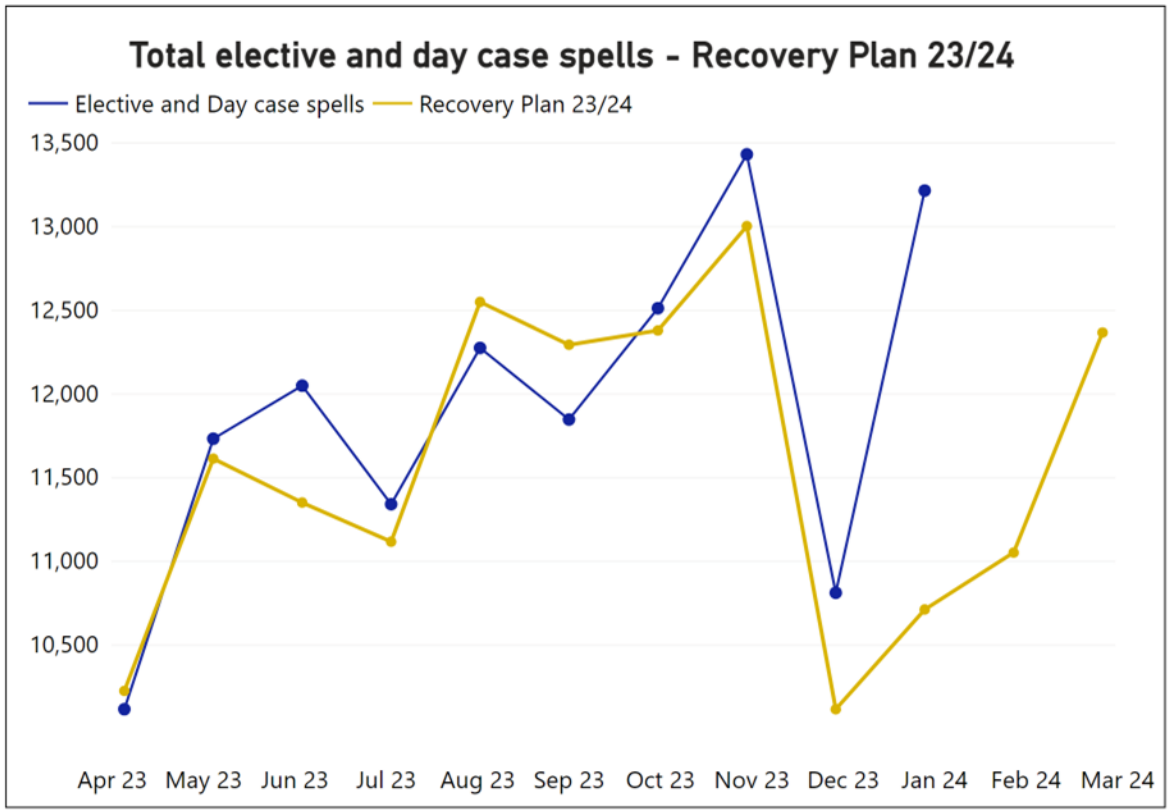


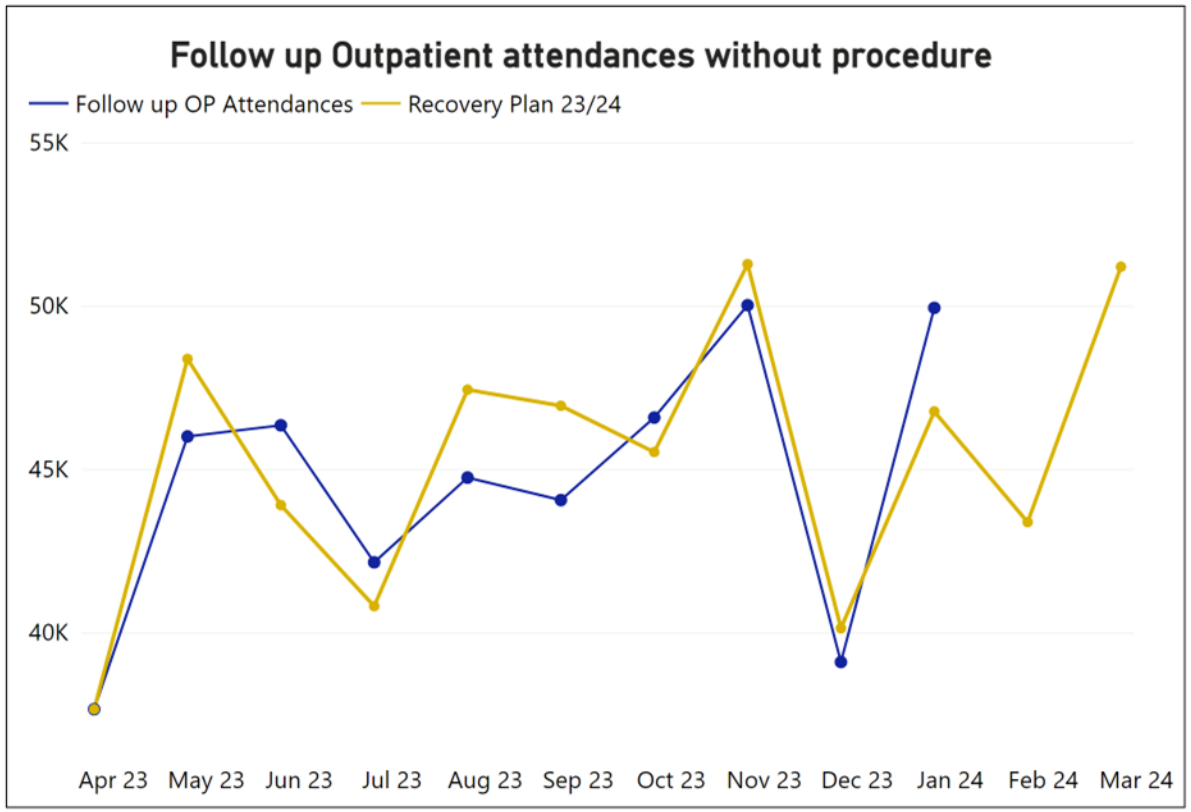
Data
Target
Median
Upper/ Lower Control Limits
No significant change (common cause variation)
special cause variation indicating improvement
special cause variation of particular concern

Link to summary table

Elective Care

Metric ID	Metric	Latest Date	Value
EC2	Total elective and day case spells	Jan 24	13212
EC3	Follow up outpatient attendances without procedure	Jan 24	49932





Data
Target
Median
Upper/ Lower Control Limits
No significant change (common cause variation)
special cause variation indicating improvement
special cause variation of particular concern

Link to summary table

Elective Care

Standard	Month	Plan	Actual	Status	Confidence in recovery / Year-end delivery
Eliminate waits of over 65 weeks for elective care by Mar 24 (except where patients choose to wait longer or in specific specialties)	Jan-24	926	1,010	R	78+ March forecast is <20 due to complexity, patient choice and cancellations in March. The 65+ March 24 forecast is 118. There is no real majority with 10 specialties forecasting patients remaining. Main risk to activity is any future industrial action. Monitored by NHSE Tiering.
Deliver the system - specific activity target (agreed through the operational planning process) Total elective and day case spells (Ops Plan E.M.10) Tolerance 5%	Jan-24	11,255	13,212	G	
Follow up outpatient attendances without procedure (Ops Plan E.M.38) Tolerance 5%	Jan-24	49,653	49,932	G	

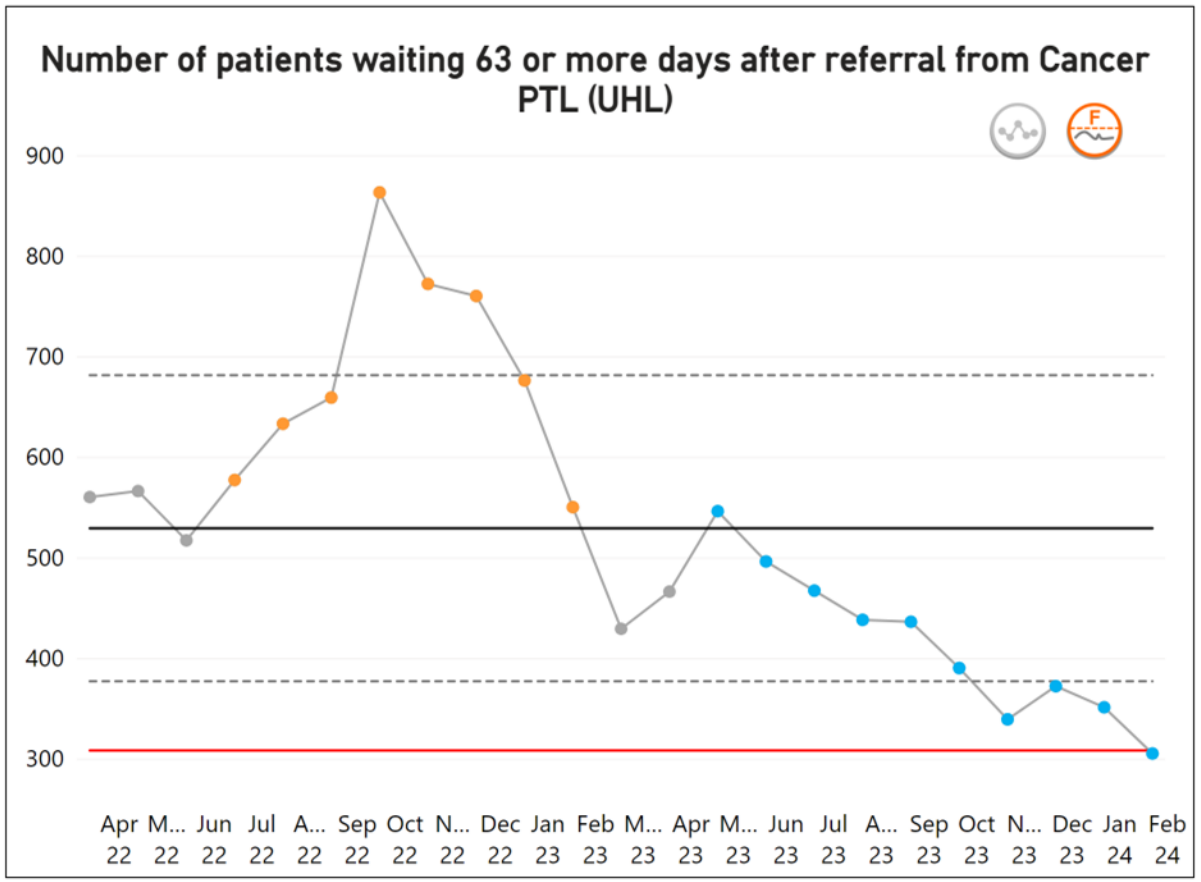
Metric	Risk	Mitigation
Eliminate waits of over 65 weeks for Elective Care Deliver the system specific activity target as agreed in the operational plan: • Elective spells YTD Plan 119,178 actual 118,613 (Jan) • Total outpatient attendances YTD Plan 914,835 actual 927,334	• Impact of any future industrial action • Pressure due to the emergency and cancer demand impacting upon elective activity • Workforce challenges in theatres and anaesthetics reducing theatre capacity and in sub-speciality workforce teams e.g. urogynaecology (Gynaecology) and balance testing (ENT)	• The overall picture for Elective Care is challenged, however there is continued progress in the reduction of those patients waiting longest for definitive treatment • The UHL long waiter position is monitored daily in addition to weekly meetings with the COO and Deputy COO for the 65 week wait March 24 cohort • Use of Independent Sector and Insourcing Providers • Use of Elective Recovery Fund (ERF) funds to support additional activity

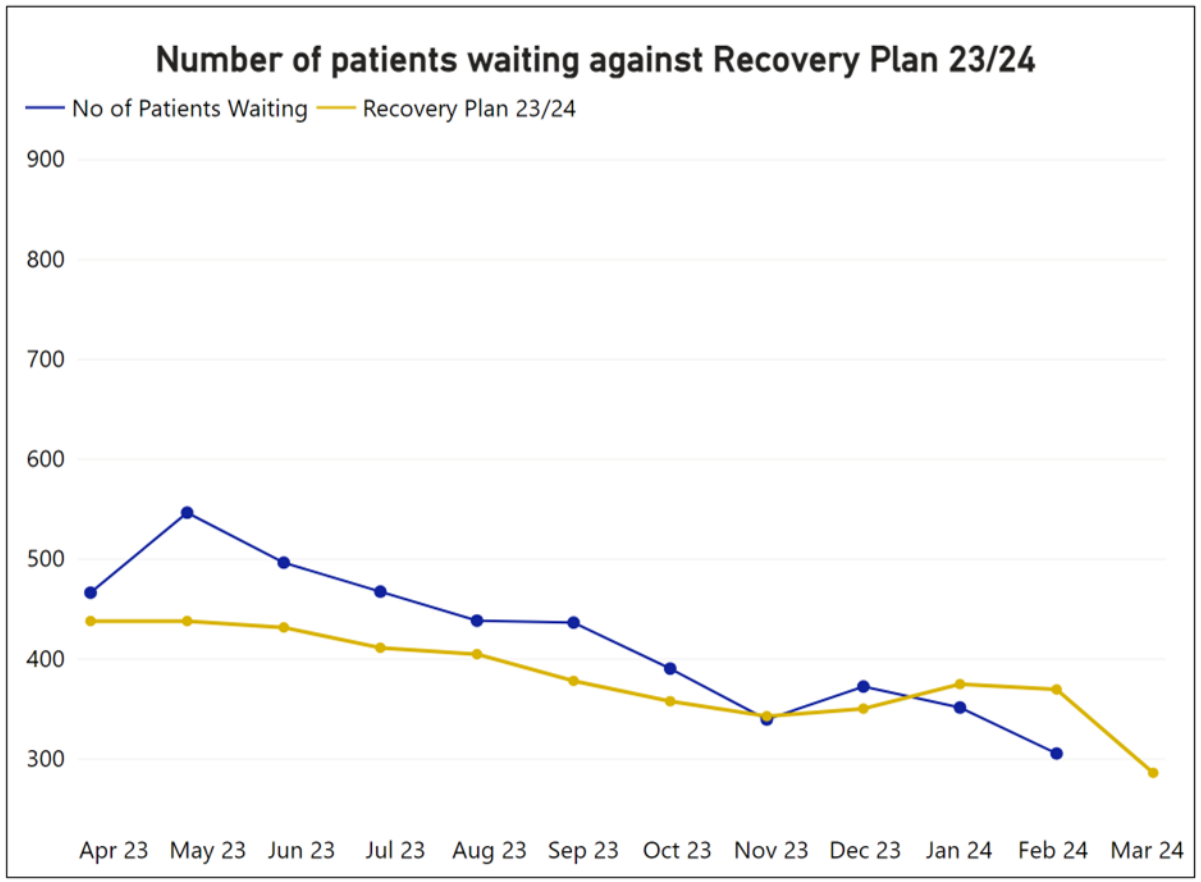
Good news:
- 65+ position ahead of national target for most specialties. Previously forecasting c.200 at end of March now 118
- 52+ week wait position is positive with many specialties expected to reach zero in the first six months of 24/25
- January total elective spells remain better than plan in month for both inpatient and day case activity
- Follow up without a procedure below plan (positive).

Patient Outcome: The time to wait for treatment or a decision that no treatment is required continues to reduce.

Cancer

Metric ID	Metric	Latest Date	Value	Target	Variation	Assurance
C1	Number of patients waiting 63 or more days after referral from Cancer PTL (UHL)	Feb 24	305	308		



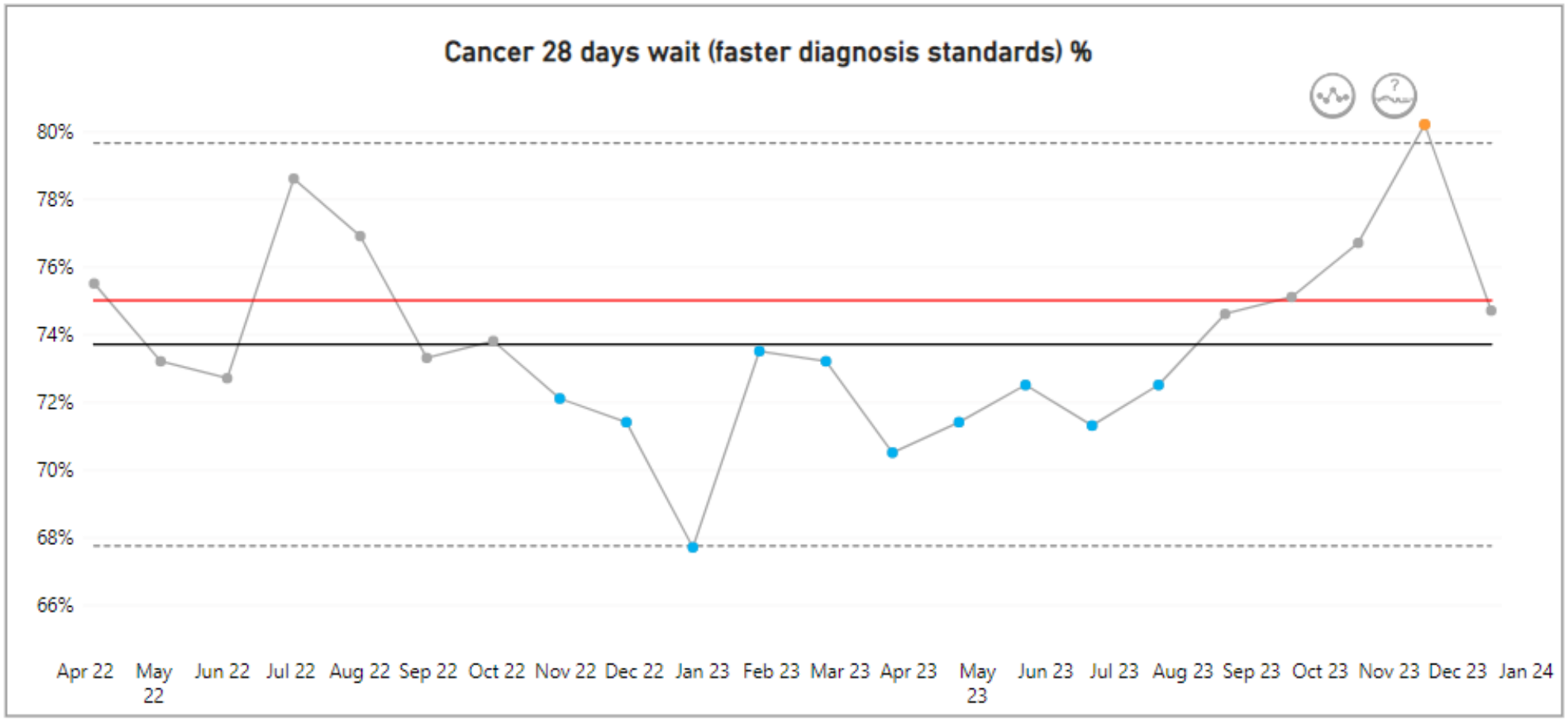


Data
Target
Median
Upper/ Lower Control Limits
No significant change (common cause variation)
special cause variation indicating improvement
special cause variation of particular concern

Link to summary table

Cancer

Metric ID	Metric	Latest Date	Value	Target	Variation	Assurance
C2	Cancer 28 days wait (faster diagnosis standards) %	Jan 24	75%	75%		



Data
Target
Median
Upper/ Lower Control Limits
No significant change (common cause variation)
special cause variation indicating improvement
special cause variation of particular concern

Link to summary table

Cancer

Standard	Month	Plan	Actual	Status	Confidence in recovery / Year-end delivery
Continue to reduce the number of patients waiting over 62 days (UHL Only)	Feb-24	386	305	G	Confidence in recovery to fair shares and FDS delivery remains high – risks are OPA & surgical capacity to reduce the backlog and increase % performance. Monitored via NHSE Tiering.
Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days	Jan-23	76%	74.7%	A	

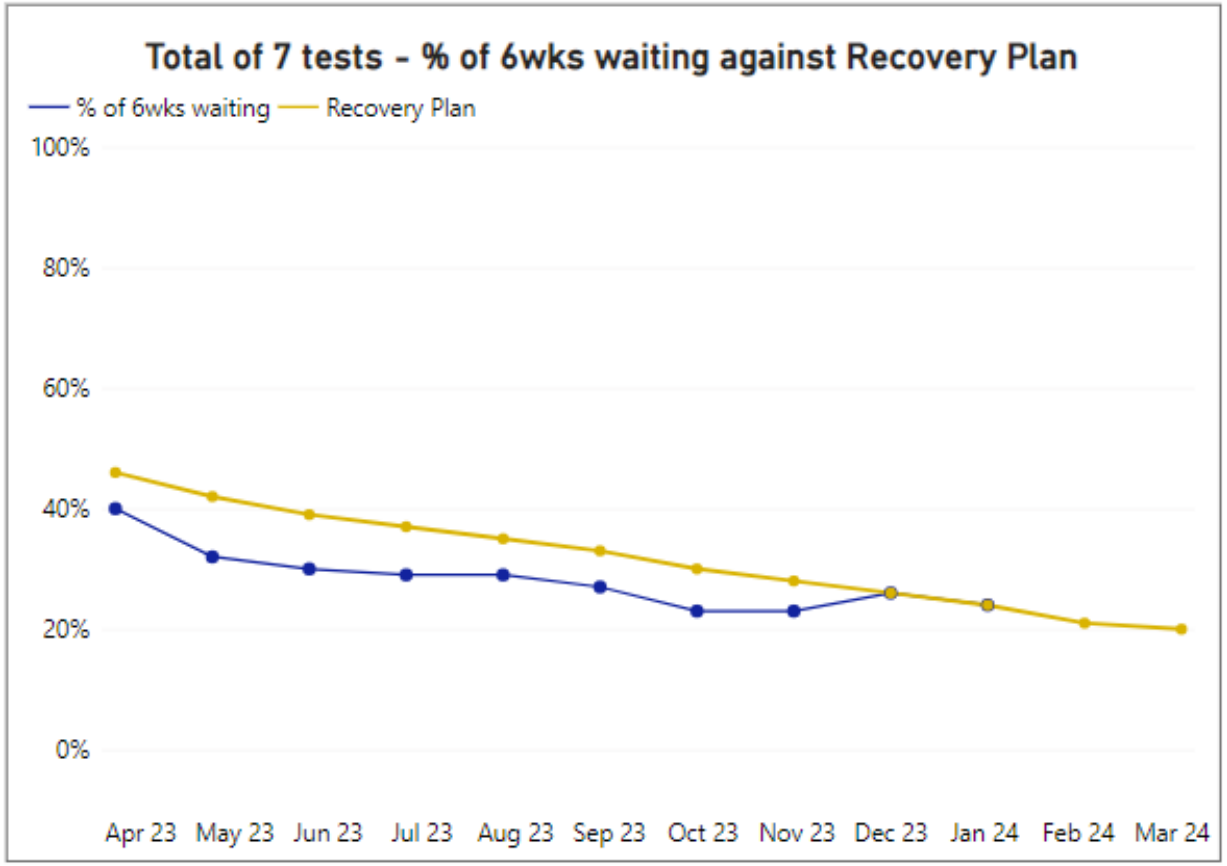
Metric	Risk	Mitigation
• Reduce the number of patients waiting over 62 days • Meet the cancer faster diagnosis standard by March 2024 • (75% of patients referred are diagnosed or have cancer ruled out within 28 days)	• Impact of future Industrial action • Capacity constraints specifically outpatient, diagnostic and clinical administrative time, and workforce to deliver additional capacity • High backlog levels being treated and prioritised having a direct impact on performance • Oncology/Radiotherapy capacity • Emergency pressures	• Continue to clinically prioritise all cancer patients • Clinical review of Urology and Colorectal waiting list • Additional capacity in Skin and Urology • Backlog tool in daily use, reviewed weekly for next steps • Targeted support for backlog reduction and next steps • Review national timed pathways and identify possible areas for improvement • Continued validation of Patient Tracking List (PTLs) and cancer data • Recruitment for Oncology/Radiotherapy/H&N/Dermatology in progress • Radiotherapy mitigations include mutual aid, weekend working and case for a 5th linac • Focus on FDS, reducing backlog and utilisation of capacity maximising capacity wherever possible

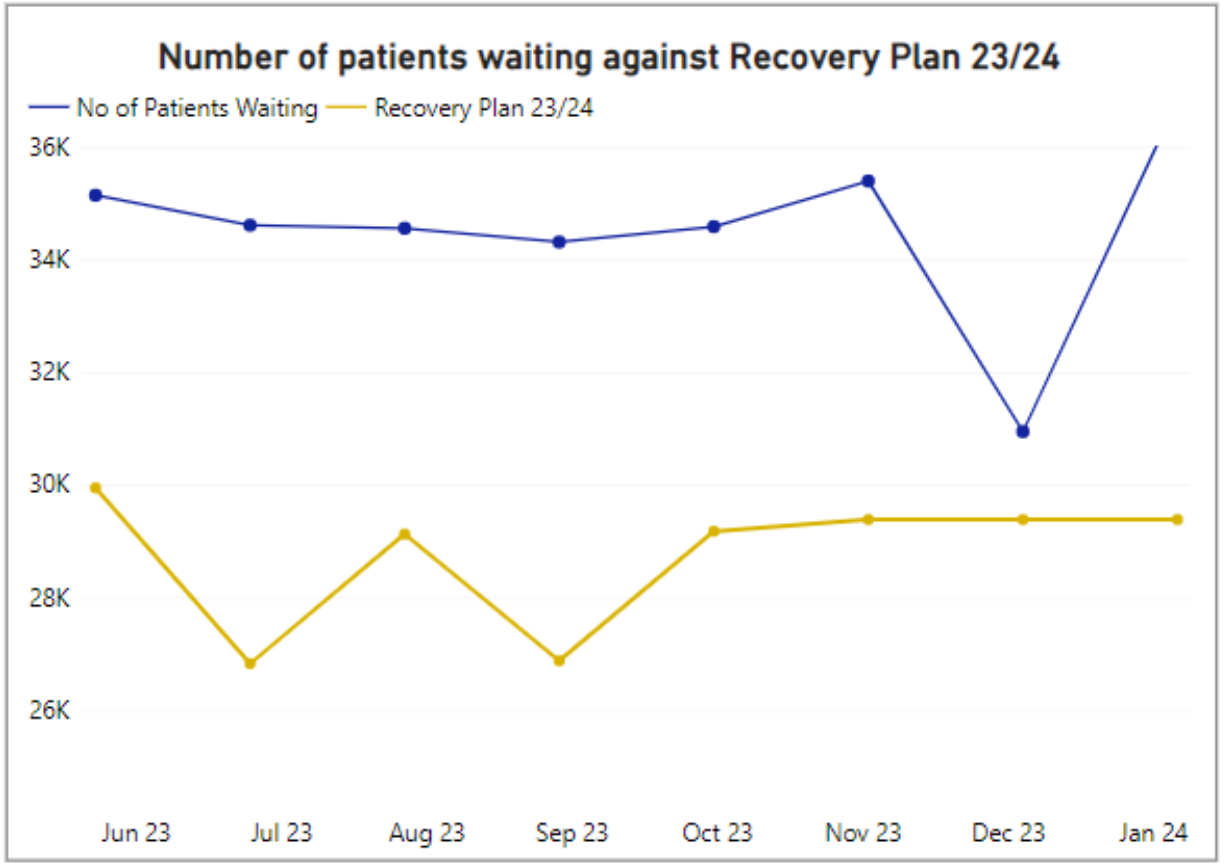
Good news:
- Significant reduction in UHL's 62- day backlog position, now ahead of plan.
- Sustained delivery of FDS >75% standard for most months since September 2023 (UHL)

Patient Outcome: Faster diagnosis or ruling out of cancer and improved waiting times for treatment

Diagnostics

Metric ID	Metric	Latest Date	Value
D1	Total of 7 tests - % of 6wks waiting	Jan 24	24%
D2	Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition	Jan 24	36807





Data
Target
Median
Upper/ Lower Control Limits
No significant change (common cause variation)
special cause variation indicating improvement
special cause variation of particular concern

Link to summary table

Diagnostics

Standard	Month	Plan	Actual	Status	Confidence in recovery / Year-end delivery
Patients that receive a diagnostic test over 6 weeks waiting - as per the Operational Plan 23/24	Jan-24	24%	24%	G	Confidence in delivery of 15% by end of March is medium due to Endoscopy and CT position. LLR operational target set at 20%. Currently at 24%. Monitored via NHSE Tiering.
Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition	Jan-24	32,229	36,807	G	Confidence in delivery is high.

Metric	Risk	Mitigation
Increase the percentage of patients that receive a diagnostic test within six weeks Deliver the system – specific activity target (agreed through the operational planning process)	• Pressures from Cancer pathways / emergency and inpatient demand and elective recovery impacting on capacity • Demand exceeding capacity in Endoscopy • Cardiac enabled CT breakdowns • Clinical workforce • Admin recruitment	• Modular Endoscopy has been on site and operational from July 2023 • Endoscopy booking model in place since July 2023 • Diagnostic productivity lead commenced January 2024. Focus is on Endoscopy and Imaging. • Recovery plan for CT in place – will take 20-26 weeks to reach zero 13+ waits.

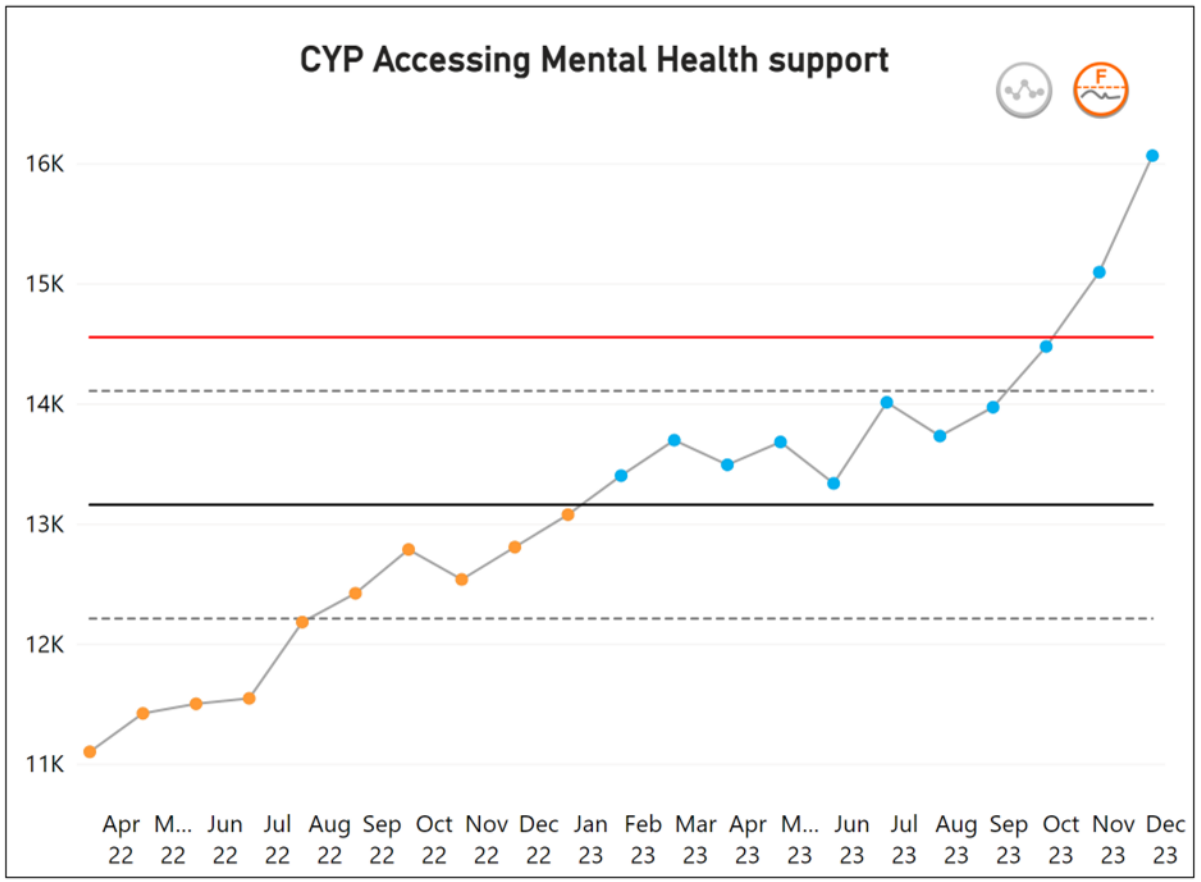
Good news:

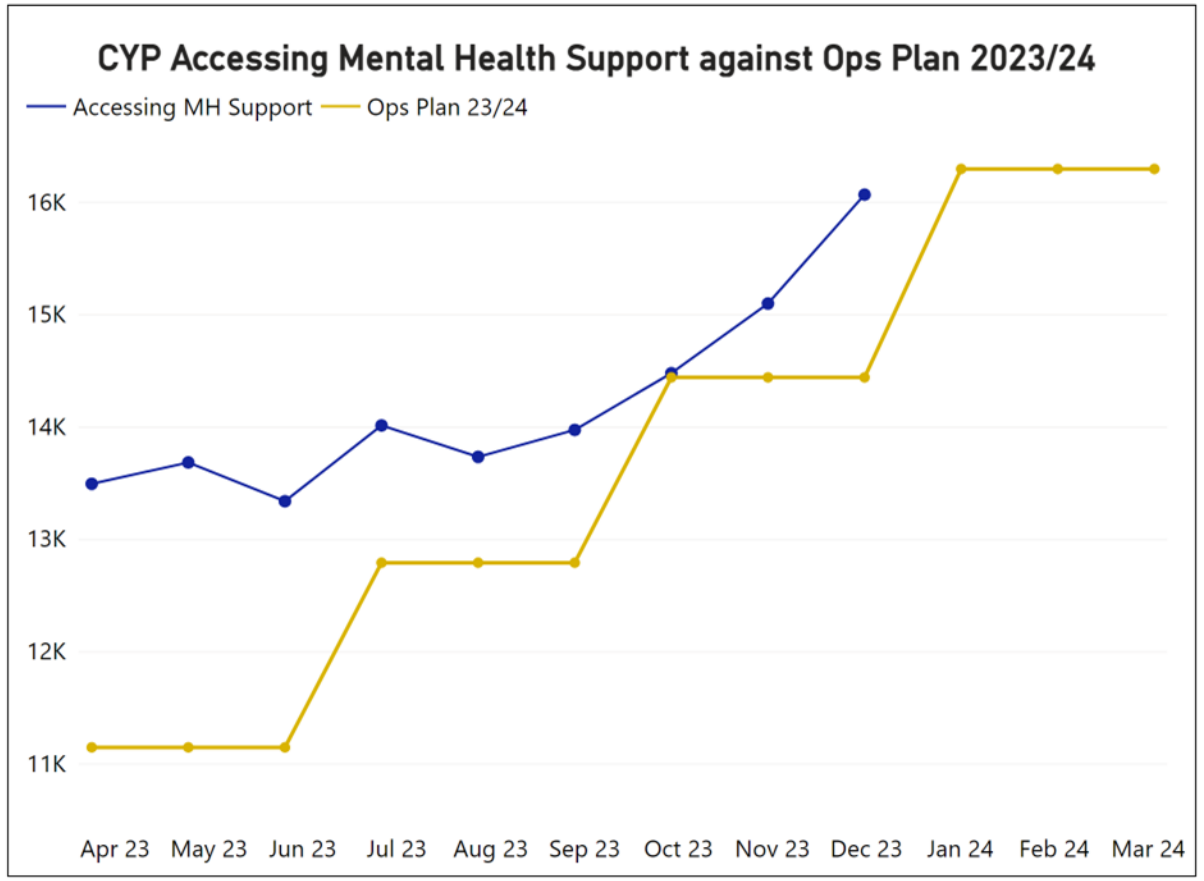
- In October 22 UHL had the largest and longest diagnostic waiting list in the country. By the end of January 24 (when compared to October 22) there has been a 43% reduction in the overall waiting list and long waits have reduced by 71% for 6+ weeks and 80% for 13+ week waits.
- Overall, 4,000 more tests in January 2024 compared to January 2023

Patient Outcome: The time to wait for a diagnosis and a decision on treatment plan continues to reduce

Mental Health

Metric ID	Metric	Latest Date	Value	Target	Variation	Assurance
MH1	CYP accessing Mental Health support (12 months rolling)	Dec 23	16065	14553		



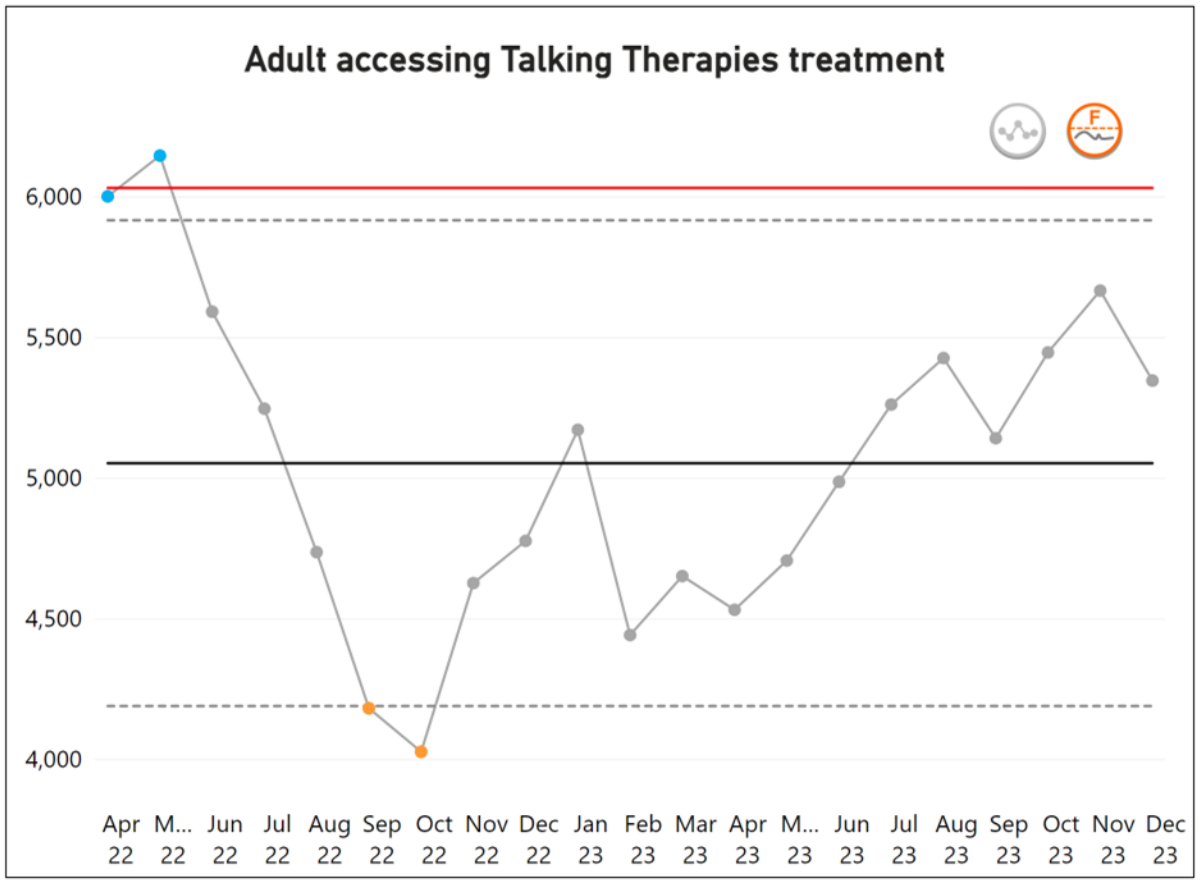


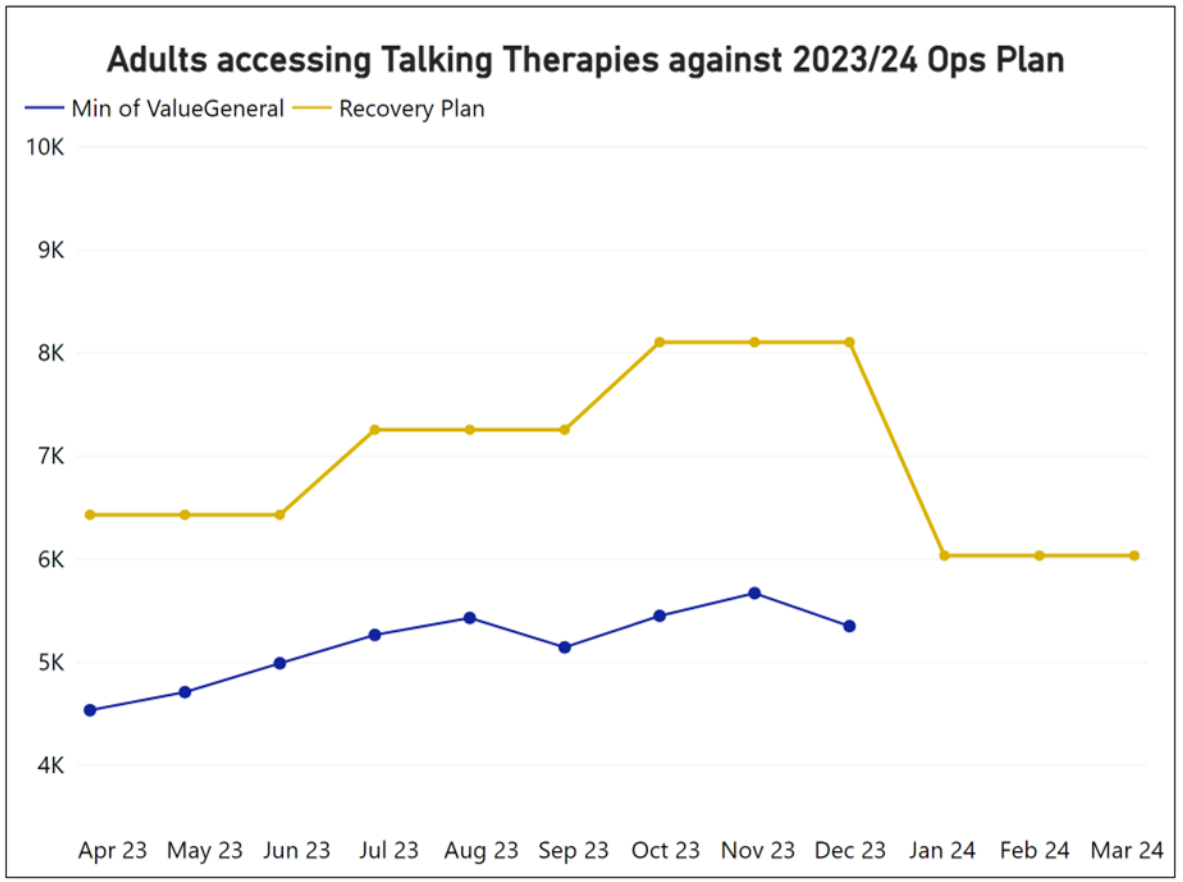
Data
Target
Median
Upper/ Lower Control Limits
No significant change (common cause variation)
special cause variation indicating improvement
special cause variation of particular concern

Link to summary table

Mental Health

Metric ID	Metric	Latest Date	Value	Target	Variation	Assurance
MH2	Adult accessing Talking Therapies treatment	Dec 23	5345	6030		



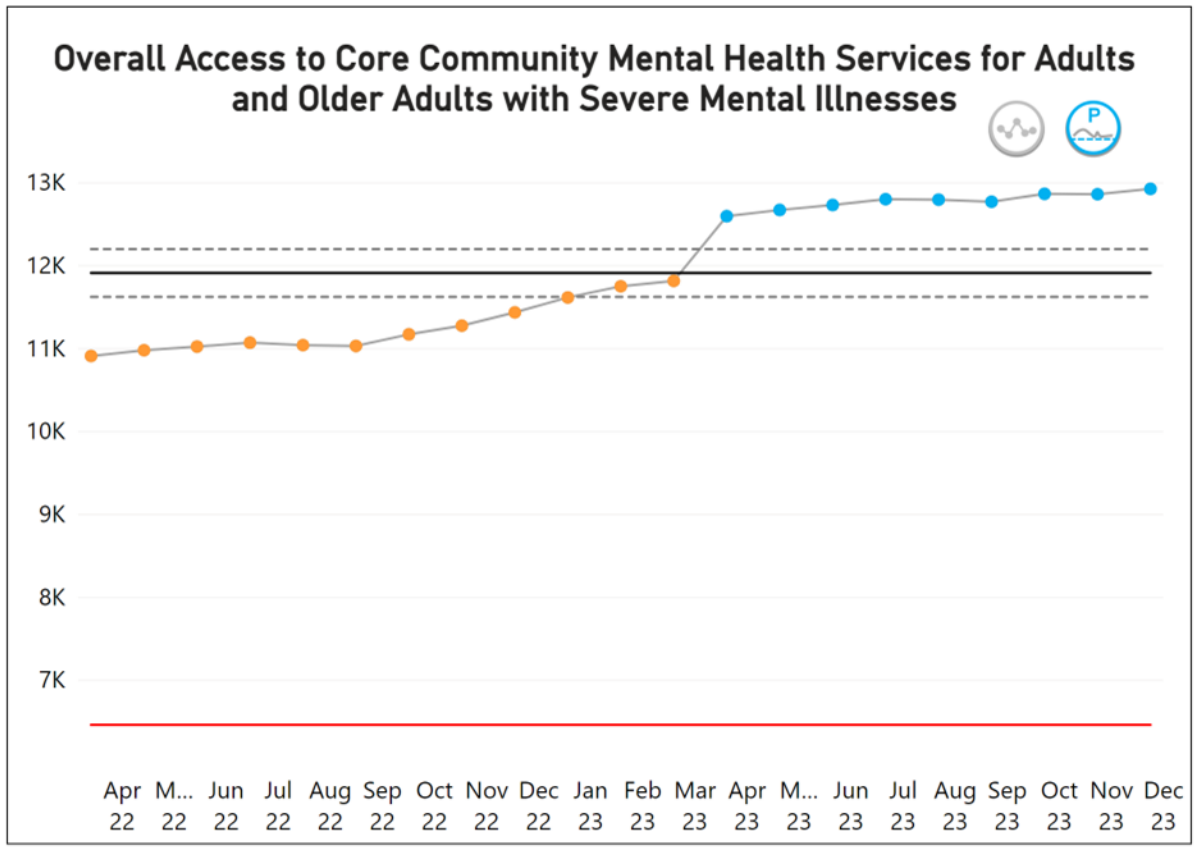


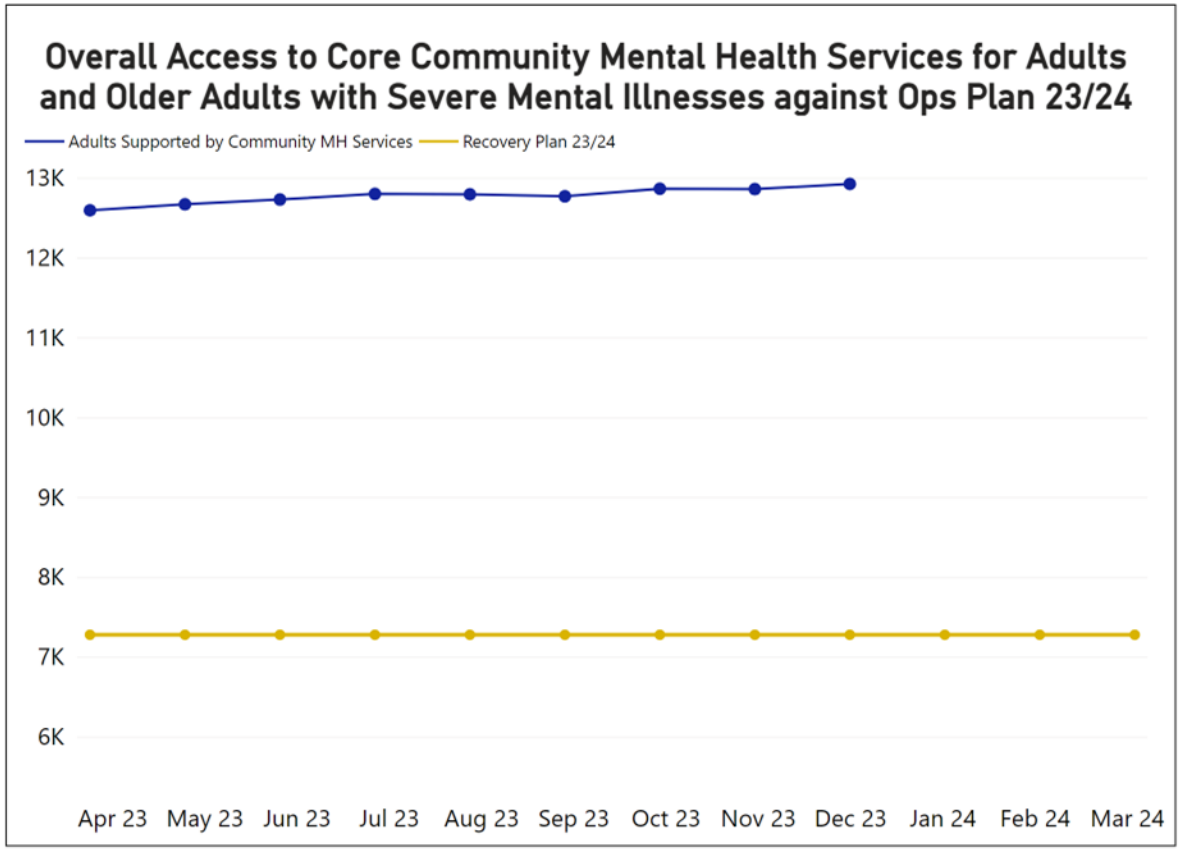
Data
Target
Median
Upper/ Lower Control Limits
No significant change (common cause variation)
special cause variation indicating improvement
special cause variation of particular concern

Link to summary table

Mental Health

Metric ID	Metric	Latest Date	Value	Target	Variation	Assurance
MH3	Overall Access to Core Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses	Dec 23	12920	6456		



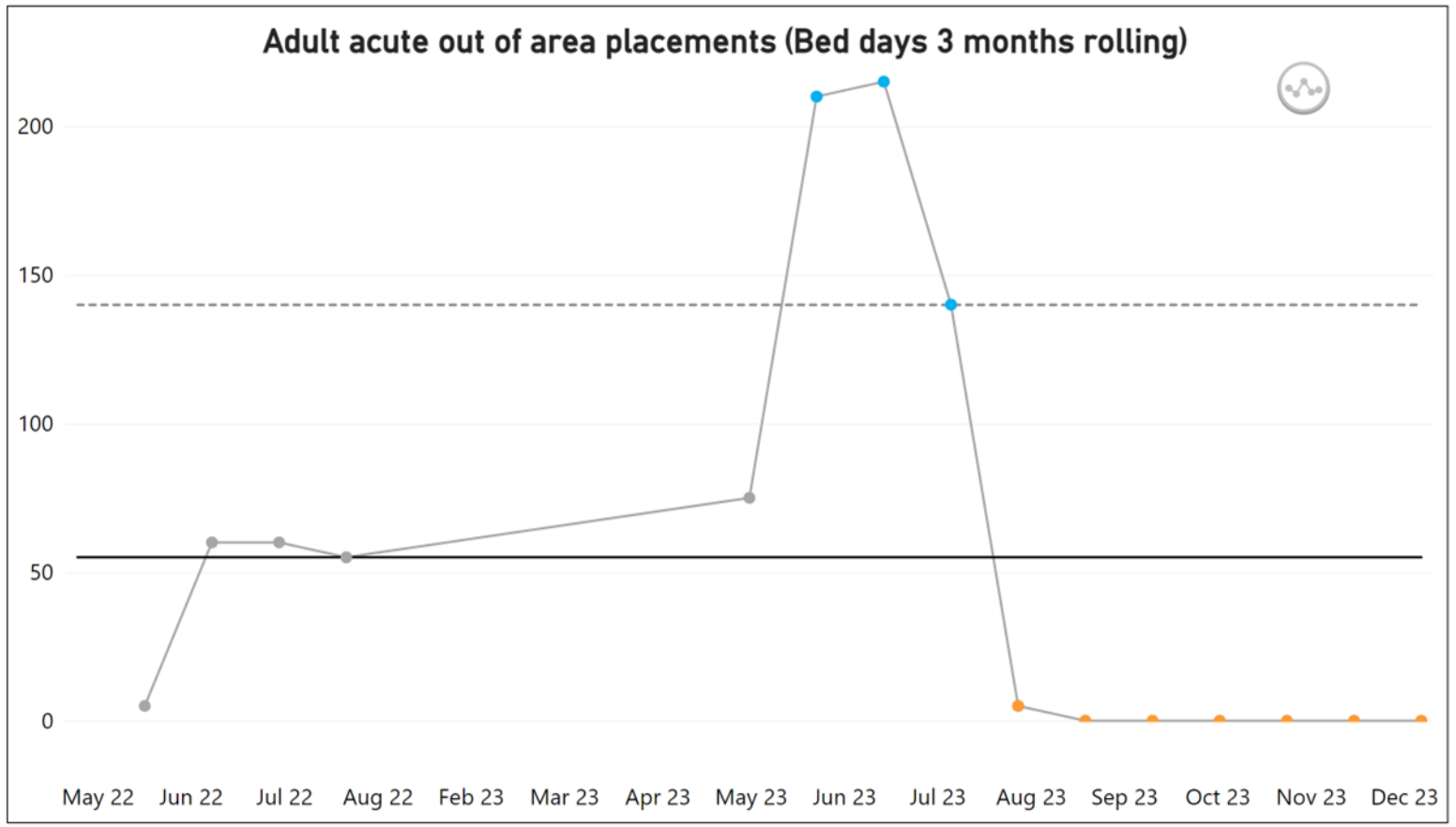


Data
Target
Median
Upper/ Lower Control Limits
No significant change (common cause variation)
special cause variation indicating improvement
special cause variation of particular concern

Link to summary table

Mental Health

Metric ID	Metric	Latest Date	Value	Variation
MH4	Adult acute out of area placements (Bed days 3 months rolling)	Dec 23	0	

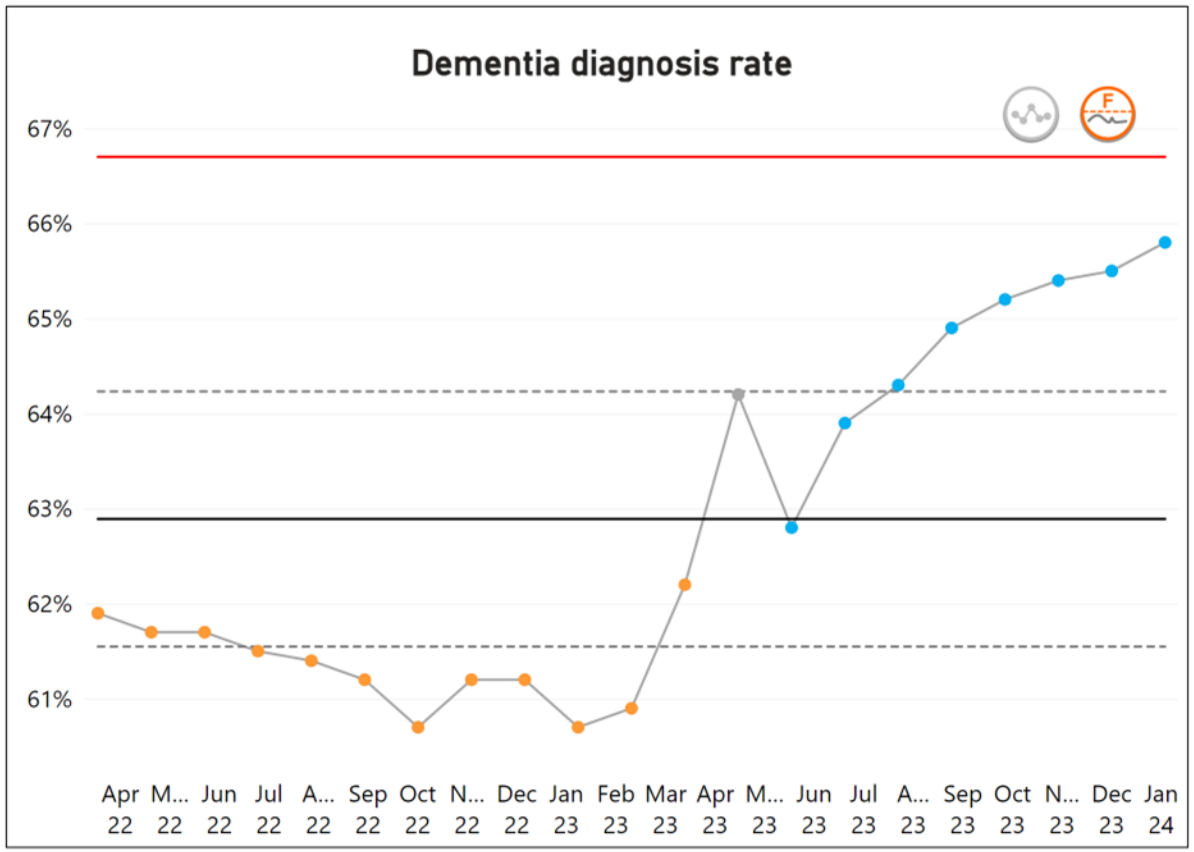


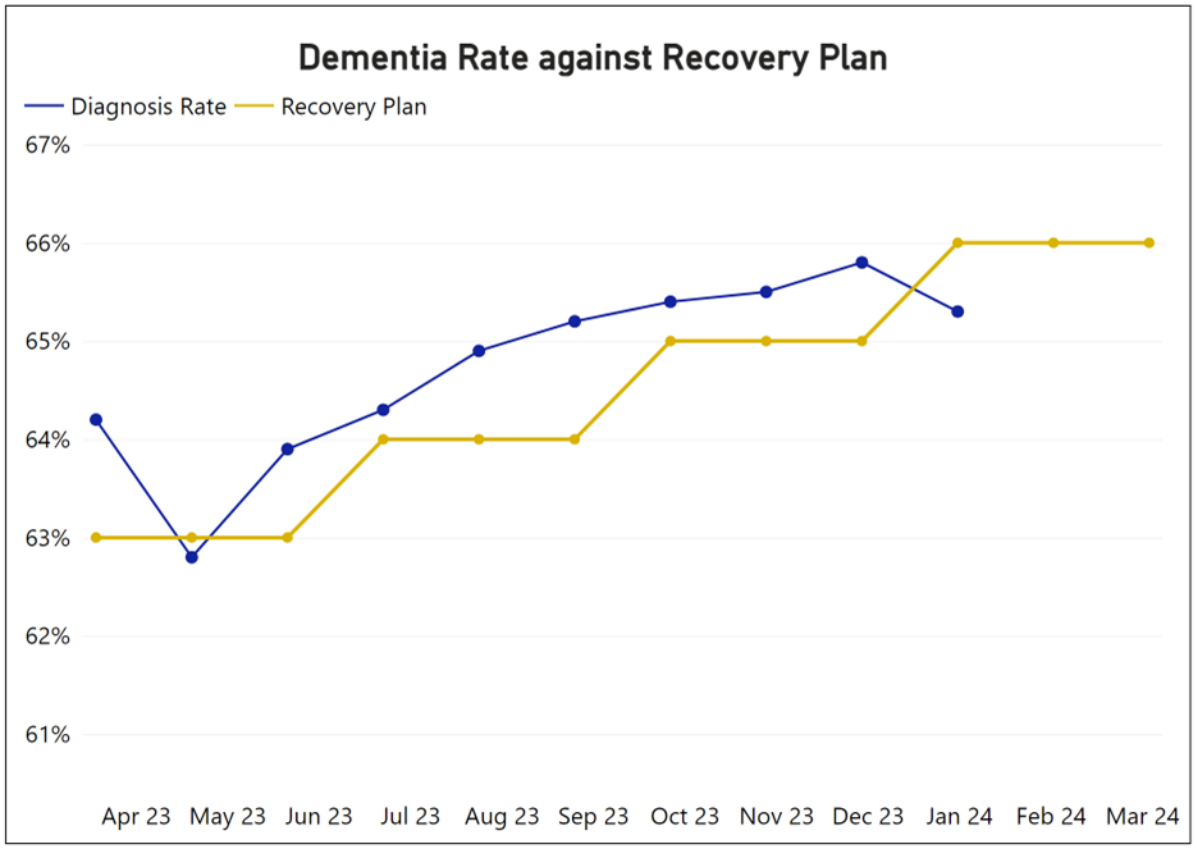
Data
Target
Median
Upper/ Lower Control Limits
No significant change (common cause variation)
special cause variation indicating improvement
special cause variation of particular concern

Link to summary table

Mental Health

Metric ID	Metric	Latest Date	Value	Target	Variation	Assurance
MH5	Dementia diagnosis rate	Jan 24	65%	67%		





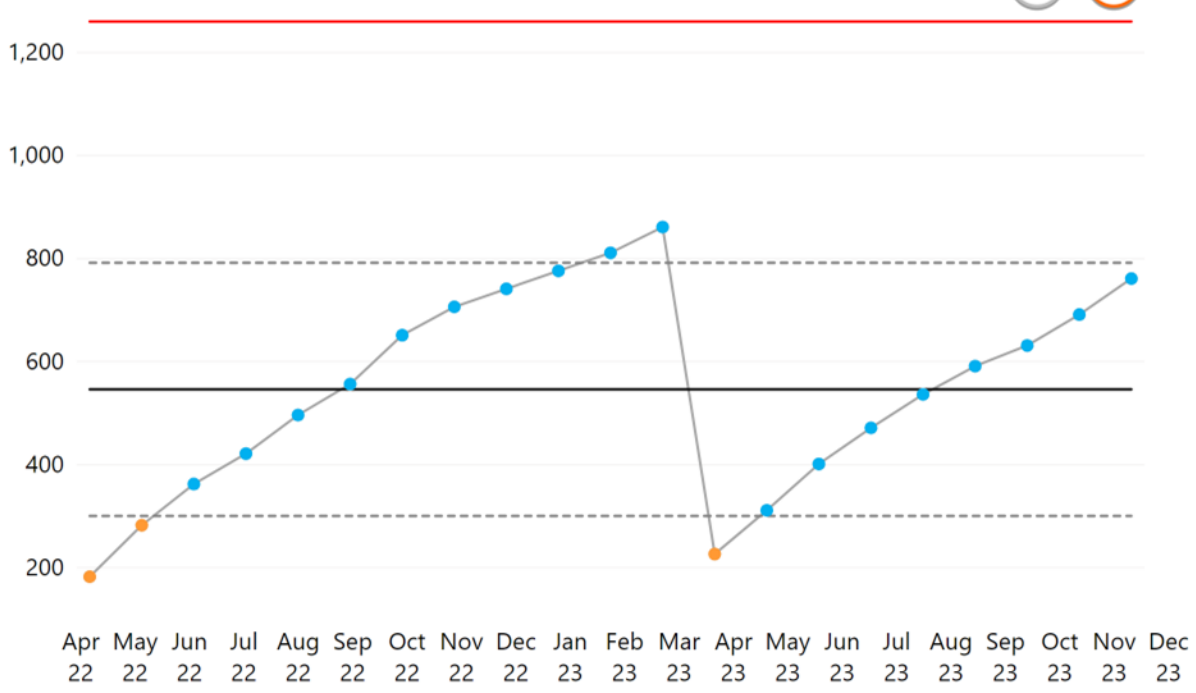
Data
Target
Median
Upper/ Lower Control Limits
No significant change (common cause variation)
special cause variation indicating improvement
special cause variation of particular concern

Link to summary table

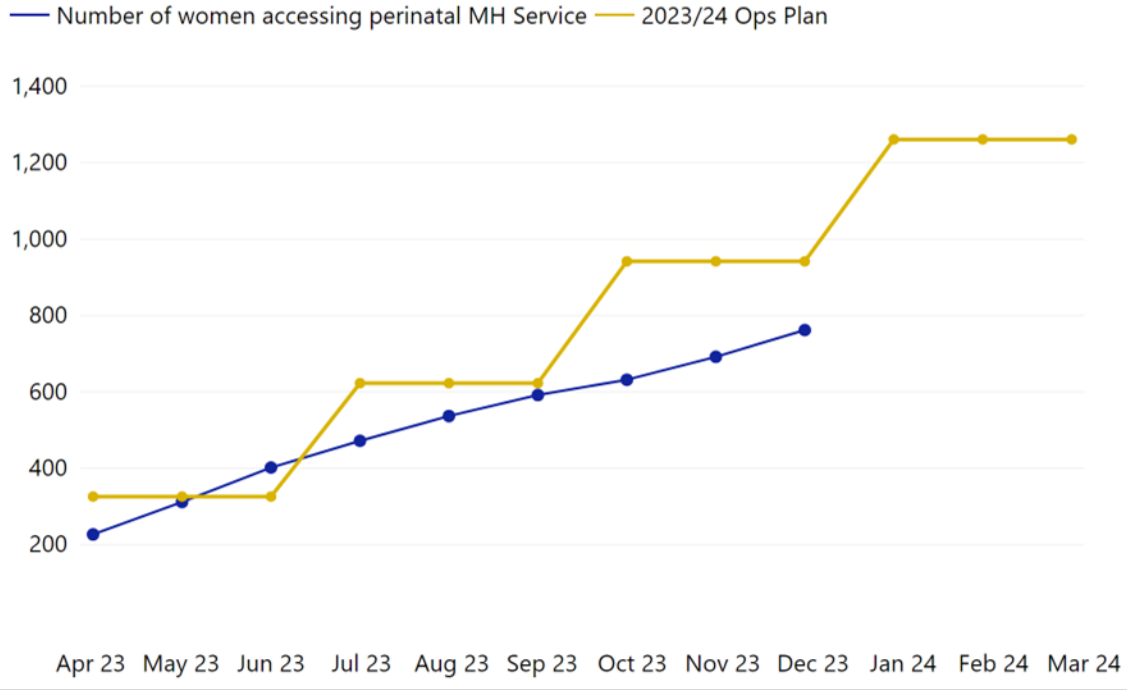
Mental Health

Metric ID	Metric	Latest Date	Value	Target	Variation	Assurance
MH6	Number of women accessing specialist perinatal mental health services	Dec 23	760	1259		

Number of women accessing specialist perinatal mental health services



Number of women accessing specialist perinatal MH Service against 2023/24 Ops Plan



Data
Target
Median
Upper/ Lower Control Limits
No significant change (common cause variation)
special cause variation indicating improvement
special cause variation of particular concern

Link to summary table

Mental Health

Metric	Risk	Mitigation
Improve access to MH support for Children and Young People (CYP)	CYP mental health inpatients much higher than expected trajectory. Numbers of children with Autism Spectrum Disorder (ASD) and eating disorders in crisis has increased and there is a lack of appropriate community provision causing delayed discharges.	• Improving Access to C&YP's Mental Health and bringing services closer to the C&YP's in neighbourhood. • Triage and Navigation - Run by Derbyshire Health United (DHU). Online Self-referral for C&YP and their parents and/or carers to improve access to MH services for C&YP. • Eating Disorders - First Steps ED is an online service for Eating Disorders. They work closely with CAMHS providing support for those discharged by CAMHS.
Increase the number of adults and older adults accessing IAPT	NHS Talking Therapies new pathways embedded as BAU, the benchmarking data due in quarter 4 (Jan-Mar 2024) which will indicate levels of patient access and impact. 1) Waiting Well -Support for LLR patients awaiting treatment- Target audience data has been received from UHL which has been used to inform and support the development of the intervention. Pathway officially launched and marketing collateral complete. 2) Menopause pathway booking 50 women per month. 3) Mental Health Support for LLR Funded Voluntary, Community, and Social Enterprise (VCSE)-Pathway launch complete and intervention currently open for LLR Crisis Mental Health cafes. Ambition to expand the offer to reach other VCSE workforce in LLR.	
Increase in the number of adults and older adults supported by community mental health services	Currently above and achieving target	
Adult acute out of area (OOA) placements	The risk to maintaining 0 from April is if Operational Pressures Escalation Levels (OPEL) level hits level 4 and flow reduces. Also impacted if Clinical Ready for Discharge (CRFD) numbers climb.	• Weekly meetings in place with all partners • Twice weekly escalation calls with all partners, stepped up to daily if OPEL4

Mental Health

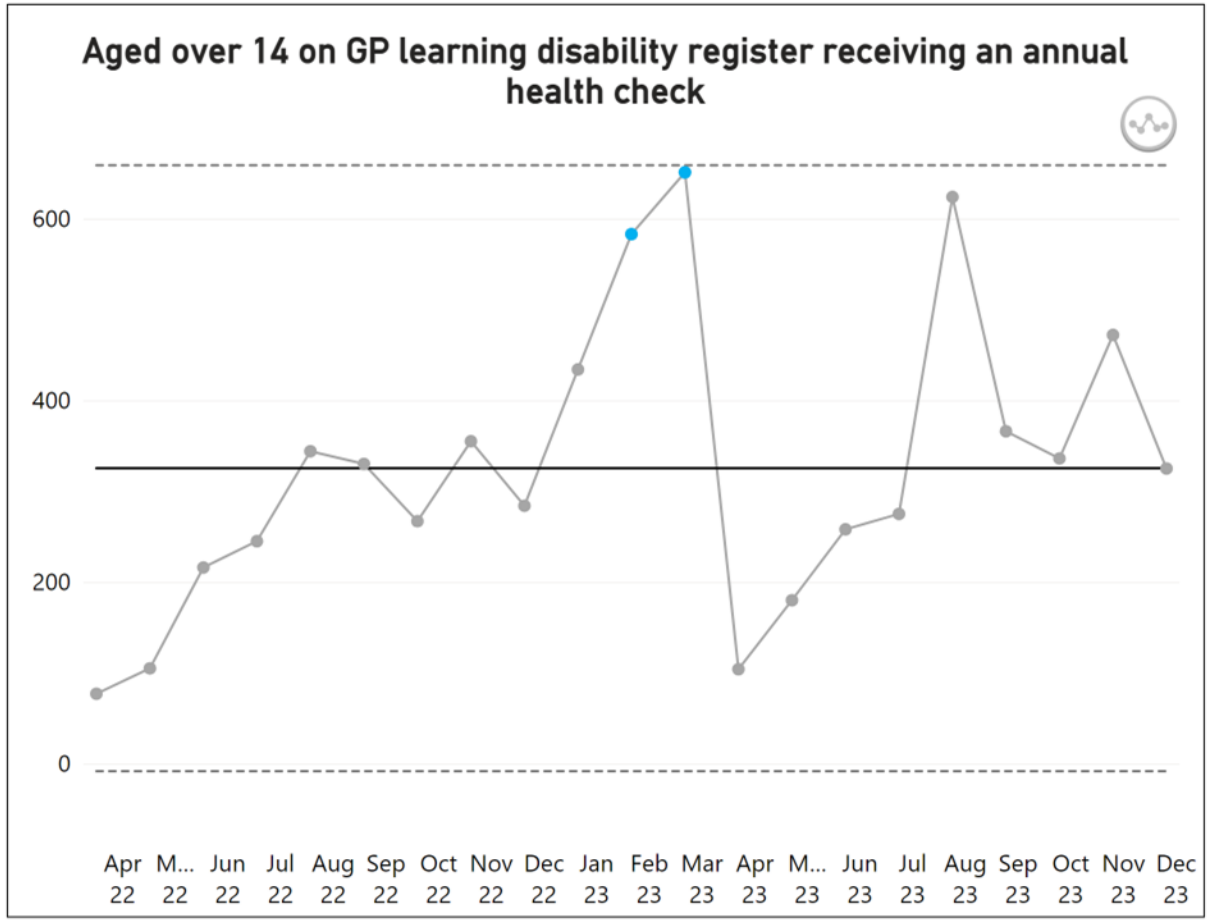
Metric	Risk	Mitigation
• Reduce reliance on inpatient care for under 18's	• Late referral to Dynamic Support Pathway: individuals referred for crisis management rather than crisis avoidance. • All young people on the red cohort of the dynamic support pathway have autism. 90 % on the whole register have autism only (no LD). • Number of individuals admitted due to other co-morbidities, particularly Eating Disorders	• Dynamic Support Pathway (DSP) training sessions are being rolled out to all CAMHS teams and social care children and young people's community teams, to ensure referrals to the DSP are made at an earlier stage and additional support and interventions can prevent escalation • Self-referral to the DSP now live - families are directly referring themselves for support • Specialist Autism Team attending first MAM meetings for those aged 14-25 to see whether they can support

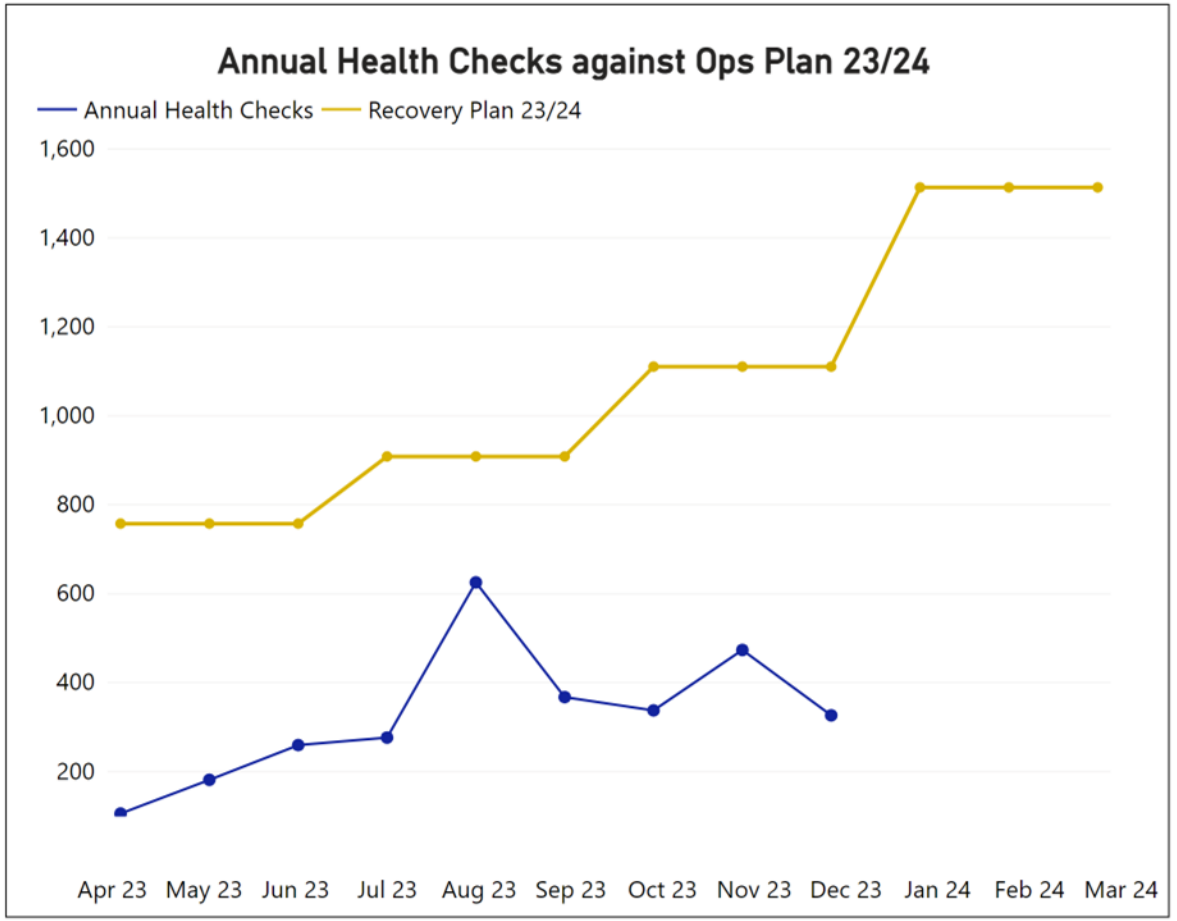
Good News: We successfully trialled a 2-patient pilot at Loughborough hospital working collaboratively with the Alliance, where blood taking was done under oral midazolam sedation successfully, but also some valuable learning points to take forward in developing this whole process were gained. A Band 8a LD Nurse is now working one day a week, until the end of the financial year, dedicated to this project, to liaise with stakeholders, review the legal framework and produce a clear final clinical pathway, and SOP for primary care, LPT and UHL Alliance.

Patient Outcome: Difficulty in blood taking for patients with LD is a long-standing known issue. As a region within LLR we have completed scoping exercises and have 40+ documented patients within primary care with a LD who require a blood test, but this can't be achieved as there is no means to facilitate. This is supported by data from LeDeR around poor patient outcomes and mortality, that could have been prevented if patients had appropriate investigations prior in a timely manner. We have identified the above posed risk to these patients. We formulated a pathway proposal with different stages for patient care in blood taking, from community/home based all the way up to oral sedation in a secondary care setting.

Learning Disabilities

Metric ID	Metric	Latest Date	Value	Variation
LD1	Aged over 14 on GP learning disability register receiving an annual health check	Dec 23	325	



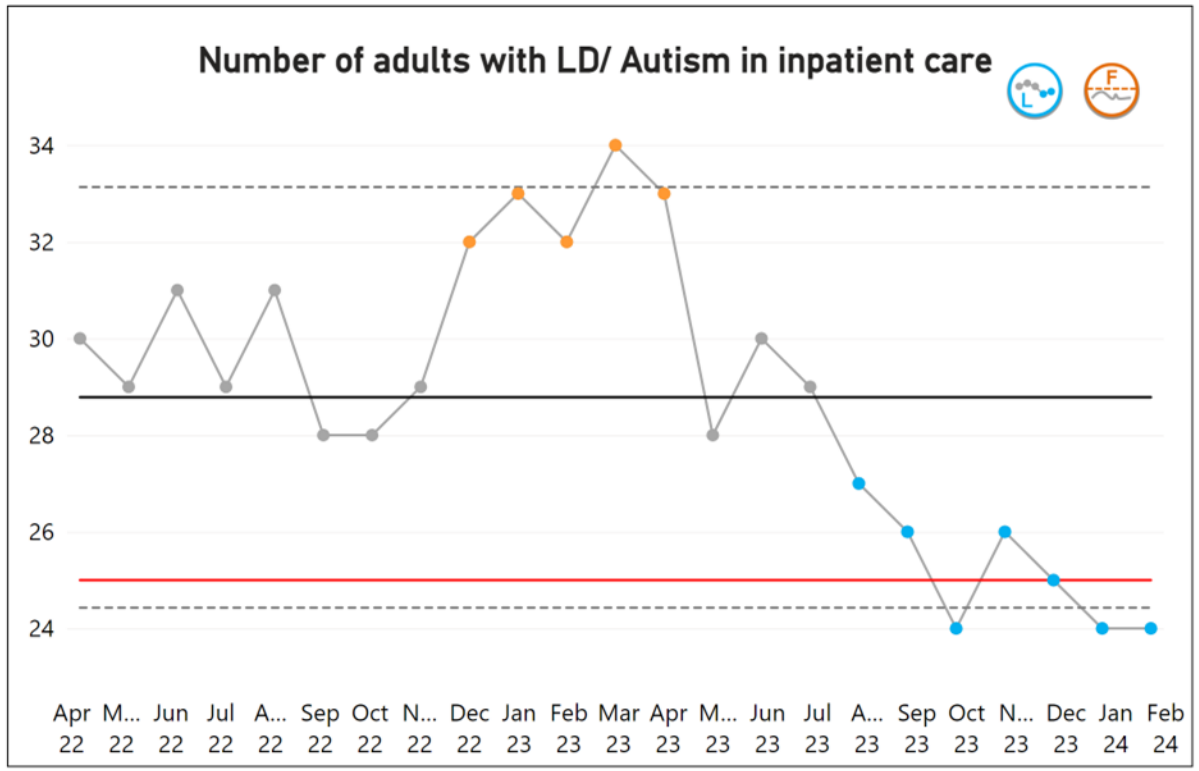


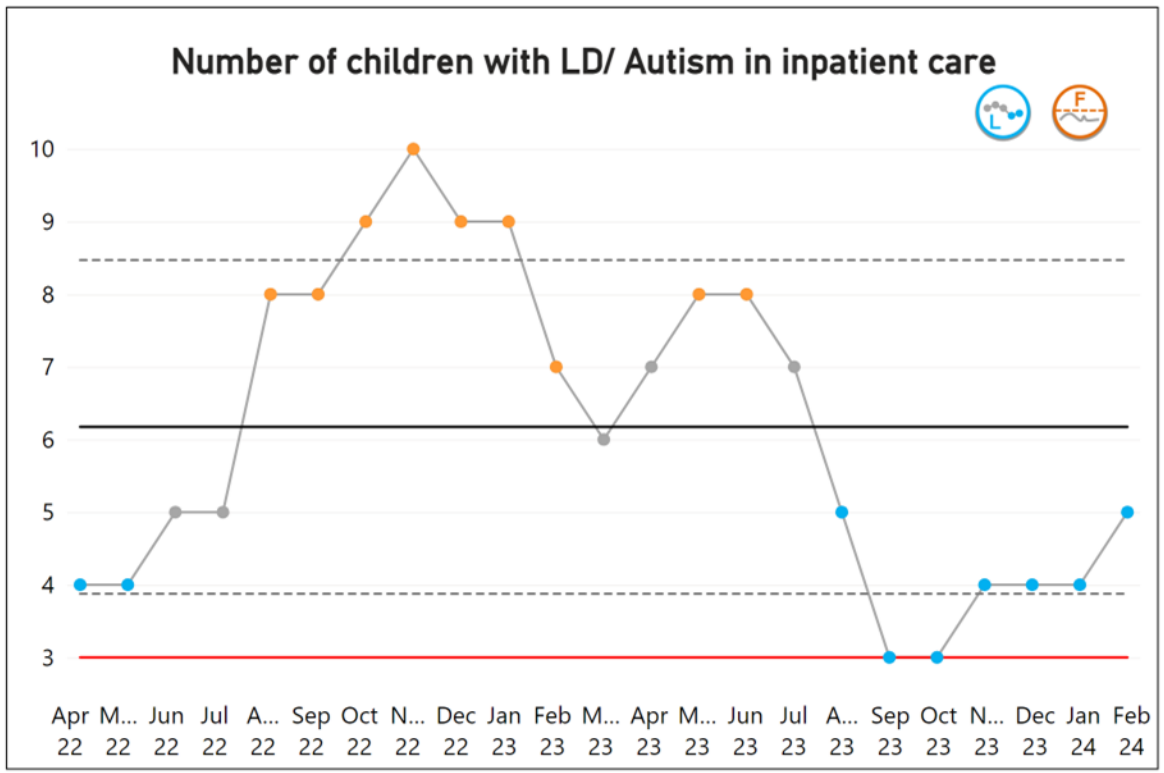
Data
Target
Median
Upper/ Lower Control Limits
No significant change (common cause variation)
special cause variation indicating improvement
special cause variation of particular concern

Link to summary table

Learning Disabilities

Metric ID	Metric	Latest Date	Value	Target	Variation	Assurance
LD2	Number of adults with LD/ Autism in inpatient care	Feb 24	24	25		
LD3	Number of children with LD/ Autism in inpatient care	Feb 24	5	3		





Data
Target
Median
Upper/ Lower Control Limits
No significant change (common cause variation)
special cause variation indicating improvement
special cause variation of particular concern

Link to summary table

People with Learning Disabilities and/or Autism

Metric	Risk	Mitigation
Ensure 75% of people aged over 14 on GP LD registers receive an annual health check and health action plan	• People who continue not to receive their LD Annual Health Checks tend to be white, male with a mild Learning Disability, or from the most deprived areas of LLR	• Additional dedicated LD nurse capacity in place until the end of March 2024, to focus on those people who have not had a health check for 2 or more years and support attendance/identify reasonable adjustments. • Successful pilot to enable blood sample taking for people unable to give a sample after all other interventions. • Work is ongoing to support people who have not accesses a check in the last 2 years. • We have also seen from the LeDeR Programme that more of those whose deaths were reviewed in 2022/23 had received their annual health check, almost double the previous year. We expect to reach the planned target by end of March. • Greater numbers are accessing checks, allowing more preventative work with people
Reduce reliance on inpatient care for adults	• Still several long-stay patients • Individuals with autism and MH (no LD) bypassing the DSP referral process and being admitted to the Bradgate Unit for very short-term admissions – no opportunity for MAM/CTR to put in place actions to avoid admission.	• Liaison with neighbouring ICBs including Birmingham and Solihull to identify individuals in hospital with similar complex needs to support the joint commissioning of highly specialist community provision to enable discharge • Long-stay individuals are primarily in ICB commissioned beds and have forensic sections with restrictions (having stepped down from Impact beds). • Numbers of adults in ICB commissioned 'Out of Area' beds now reduced to 6 and meeting arranged to explore repatriation of appropriate individuals back to LLR (Agnes Unit) • LDA Collaborative members joined the MH LDA Steering Group and regular updates provided to Collaborative's Delivery and Transformation Group • Number of projects in early stages of development focusing on commissioning and support of community care providers to improve quality and sustainability of community providers.

People with Learning Disabilities and/or Autism

Metric	Risk	Mitigation
• Reduce reliance on inpatient care for under 18's	• Late referral to Dynamic Support Pathway: individuals referred for crisis management rather than crisis avoidance. • All young people on the red cohort of the dynamic support pathway have autism. 90 % on the whole register have autism only (no LD). • Number of individuals admitted due to other co-morbidities, particularly Eating Disorders	• Dynamic Support Pathway (DSP) training sessions are being rolled out to all CAMHS teams and social care children and young people's community teams, to ensure referrals to the DSP are made at an earlier stage and additional support and interventions can prevent escalation • Self-referral to the DSP now live - families are directly referring themselves for support • Specialist Autism Team attending first MAM meetings for those aged 14-25 to see whether they can support

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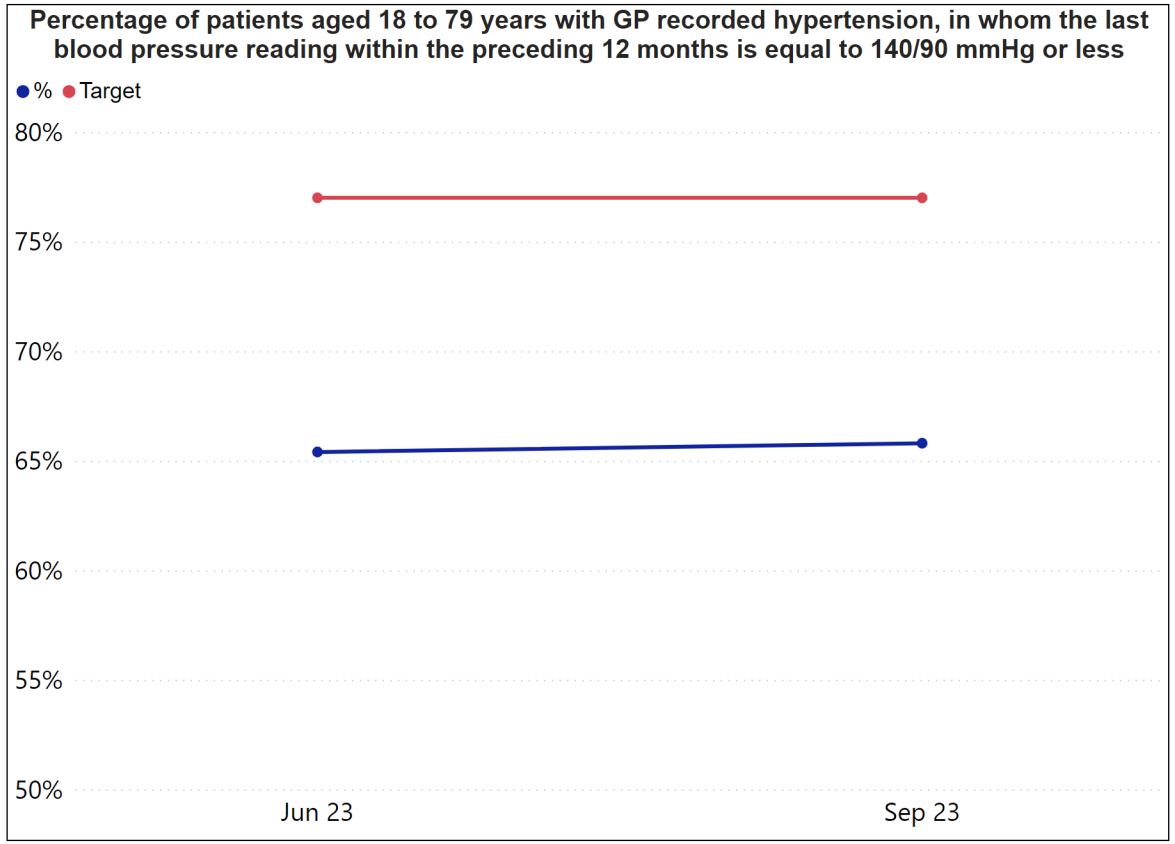
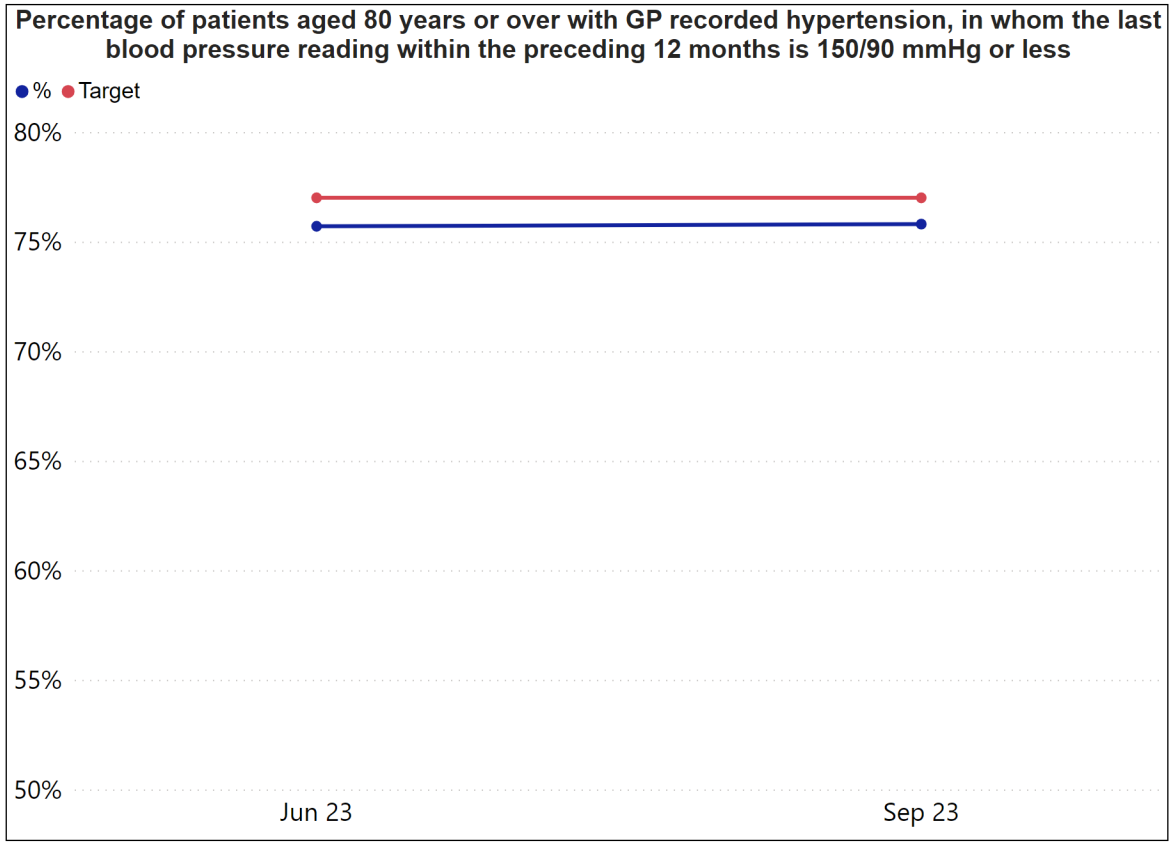
Prevention and Health Inequalities

Metric ID	Metric	Latest Date	Value
PH1	Percentage of patients aged 18 to 79 years with GP recorded hypertension, in whom the last blood pressure reading within the preceding 12 months is equal to 140/90 mmHg or less	Sep 23	66%
PH2	Percentage of patients aged 80 years or over with GP recorded hypertension, in whom the last blood pressure reading within the preceding 12 months is 150/90 mmHg or less	Sep 23	76%

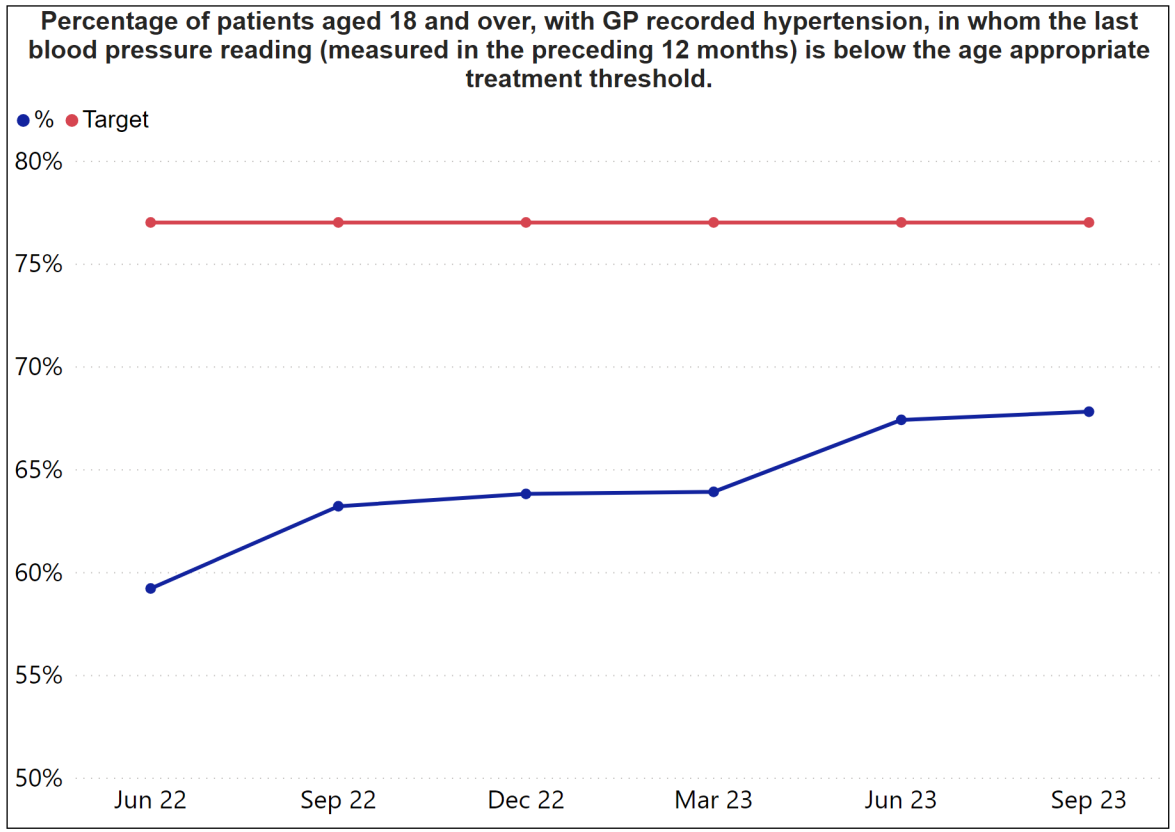


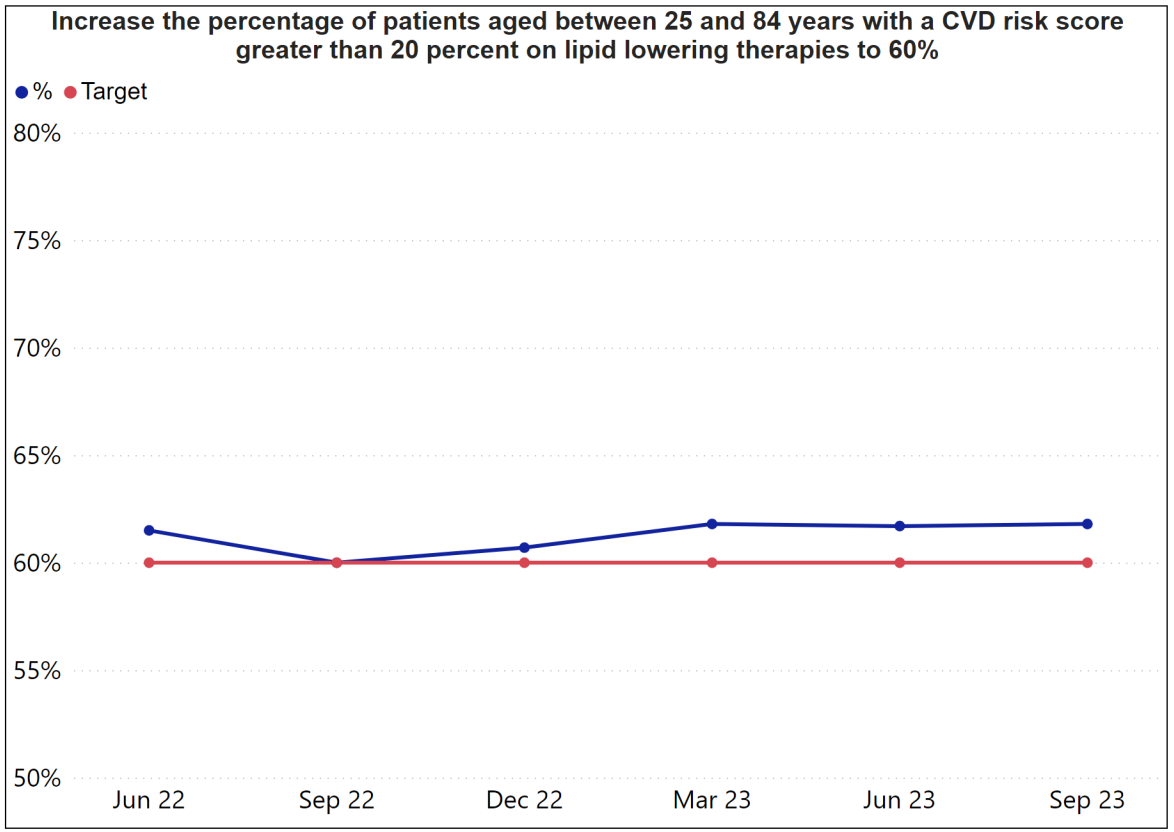


Link to summary table

Prevention and Health Inequalities

Metric ID	Metric	Latest Date	Value
PH3	Percentage of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age appropriate treatment threshold.	Sep 23	68%
PH4	Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%	Sep 23	62%





Link to summary table

Hypertension & Lipids

Metric	Risk	Mitigation
Increase %age of patients with **hypertension** treated to NICE guidance to 77% by March 2024 CVDP007 HYP	• Capacity of general practice to identify and optimise at risk groups • Activated patients to attend and adhere to medication • QOF activity left too late in year to achieve • CVD data is from Q2 23/24 so does not reflect local up-to-date picture	• Searches should be run regularly by practices in order to identify those pts who will benefit by adding to the hypertension register to help optimise their treatment in addition to Place based work being undertaken. • Use of clinical ARRS role to support the practice clinical team – HCA/ practice nurse etc • Practice based pharmacists undertaking the meds reviews and clinics for related chronic conditions can identify people who are at risk of hypertension. • Currently also looking at the age breakdown profile of patients with LHIS/CSU to better understand our local more up-to-date information.
Increase % age of patients aged between 25 - 84 years with a CVD risk score greater than 20 percent on **lipid** lowering therapies to 60%	• Capacity of general practice to identify and optimise at risk groups • Activated patients to attend and adhere to medication • CVD data is from Q2 23/24 so does not reflect local up-to-date picture • Statin adherence once prescribed	• Review of the LLR lipid pathway and updating to reflect prescribing changes. • One potential area identified is statin adherence once a patient has been prescribed. A piece of work is being looked at in conjunction with communications and engagement. • Further exploration through the Health Innovation Network with regards to training and education

Good news:

- City Place Health and Well Being plan has hypertension as one of their 4 priorities for the City, and hence a more targeted approach with City PCNs is developed.
- At a Place meeting in December 2023, the CVDP data for June 23 was shared and it helped to identify the gaps and age band where more focus is required – 5 PCNs with prioritised practices are engaging with the Place Lead and ICB to meet the gaps in supporting the remaining patients needing reviews.
- Practices historically undertake this work at the end of the quarter (March), as part of their QOF work, and we should be able to see an improvement in the activity.

Patient Outcome:

On-going/ annual patient reviews will help reduce the risk of number of serious and potentially life-threatening health conditions such as heart disease, heart attacks and strokes.

Use Of Resources (Finance M10)

System KPI Dashboard	YTD £'000			M1-12 £'000		
	Target	Actual	Rating	Target	FOT	Rating
System Delivery of planned surplus/(deficit)	(18,589)	(75,455)		(10,001)	(67,808)	
System Revenue expenditure not to exceed income	4,498,117	4,573,572		5,371,584	5,439,392	
System Capital expenditure not to exceed allocations	89,098	68,417		128,450	126,294	
System Operates within Cash Reserves	101,055	55,610		115,305	31,183	
ICB Running Costs Allocation not to be exceeded *(included within system position)*	16,988	15,209		20,385	18,246	
ICB Primary Care Co-Commissioning Allocation not to be exceeded *(included within system position)*	168,594	171,019		199,055	202,360	
ICB Newly Delegated Allocation not to be exceeded *(included within system position)*	81,467	79,401		97,859	88,016	
System CIP delivery	109,848	101,589		142,569	146,213	
System Better Payment Practice code % NHS invoices paid within target (£)	95%	95%		95%	95%	
System Better Payment Practice code % NHS invoices paid within target (number)	95%	92%		95%	92%	
System Agency spend within ceiling				45,392	61,447	
ICB MHIS spend requirement to meet target				189,313	189,440	

Metric	Mitigation
Deliver a balanced net system financial position for 2023/24	• The table shows the combined KPI dashboard for the system. Overall, the system is failing to maintain its YTD position with expenditure exceeding revenue and a greater-than-planned YTD deficit.

Link to summary table

Measures

Urgent and Emergency care	Target	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25 (% UHL for types, 1 & 2)	Mar-24 76%	59.0%	55.0%	59.6%	61.1%	60.9%	55.9%	54.7%	51.9%	57.7%	56.8%		
	UHL LRI ED Target	Adjusted Plan				73%	74%	74%	75%	76%	76%	78%	80%
Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25. EMAS performance for LLR ICB	00:30:00	00:30:06	00:32:33	00:39:23	00:29:49	00:31:07	00:36:17	00:53:12	00:46:14	01:01:48	00:57:54		
Reduce adult general and acute (G&A) bed occupancy to 92% or below - Performance data reported at ICB level	92%	91.1%	92.0%	92.0%	87.5%	89.3%	91.2%	94.1%	95.7%	92.9%	92.7%		
		91%	93%	92%	90%	92%	91%	92%	94%	94%	94%	94%	94%

Primary Care	Target	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need *IIF Metric ACC-08: Percentage of patients where time from booking to appointment was two weeks or less - commenced April-23*	Lower threshold 85% Upper threshold 90%	81.5%	81.8%	81.4%	82.4%	81.8%	80.9%	82.7%	83.6%	85.0%	83.8%

	Target	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024	Mar-24 693,532	521,091	600,980	636,914	577,510	610,841	672,025	707,711	667,979	543,882			
	Recovery Plans 23/24	571,560	658,865	622,894	600,753	652,373	686,851	740,323	744,970	603,072	633,225	603,072	693,532
Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024	Mar-24 462	546.1	528.1	379.6									
Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels	Mar-20 1,867,483	1,073,005	1,369,663	1,427,630	1,508,952	1,636,956	1,301,794	1,486,490	1,716,163	1,157,842	1,536,626		

Measures

Elective Care	Target	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties) Number of 65+ Week RTT waits	Mar-24 0	3,626	3,245	2,781	2,533	2,267	2,016	1,523	1,223	1,221	1,010		
	Recovery Plans 23/24	5,911	4,786	4,079	3,546	2,902	2,337	1,821	1,223	1,178	926	545	0
Deliver the system - specific activity target (agreed through the operational planning process) Total elective and day case spells (Ops Plan E.M.10)	23/24 Actual	10,120	11,727	12,056	11,340	12,244	11,657	12,440	13,112	10,705	13,212		
	23/24 Ops Plan	10,864	11,980	11,769	11,581	12,733	12,527	12,596	13,097	10,776	11,255	11,529	12,586
	% of plan delivered	93.2%	97.9%	102.4%	97.9%	96.2%	93.1%	98.8%	100.1%	99.3%	117.4%		
Deliver the system - specific activity target (agreed through the operational planning process) Follow up outpatient attendances without procedure (Ops Plan E.M.38)	23/24 Actual	37,206	45,434	46,090	42,464	45,368	44,342	46,560	50,641	39,582	49,932		
	23/24 Ops Plan	43,738	50,697	47,792	45,786	50,086	49,766	48,846	52,580	45,348	49,653	47,455	52,529
	% of plan delivered	85.1%	89.6%	96.4%	92.7%	90.6%	89.1%	95.3%	96.3%	87.3%	100.6%		

Cancer	Target	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Continue to reduce the number of patients waiting over 62 days (Number of patients waiting 63 or more days after referral from cancer PTL) (UHL Only)	Local UHL 308	466	546	496	467	438	436	390	339	372	351	305	
	Recovery Plans 23/24	450	450	444	425	419	394	375	361	368	391	386	308
By March 2024, 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days (Cancer 28 day waits faster diagnosis standard) % (LLR)	75% March 24	70.5%	71.4%	72.5%	71.3%	72.5%	74.6%	75.1%	76.7%	80.20%			
Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028													

Diagnostics	Target	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Patients that receive a diagnostic test over 6 weeks waiting - Total of 7 tests as per the Operational Plan 23/24	Ops Plan Mar-24 20%	40%	32%	30%	29%	29%	27%	23%	23%	26%	24%		
	Ops Plan 23/24	46%	42%	39%	37%	35%	33%	30%	28%	26%	24%	21%	20%
Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition	Actual			35,142	34,610	34,556	34,312	34,585	35,395	30,946	36,807		
	Plan			32,698	30,996	32,250	31,023	32,277	32,391	28,353	32,229		

Measures

Mental Health	Target	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Improve access to Children and Young People's (CYP) age 0-18 Mental Health Services Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact (Data 12 mth Rolling)	Mar-24 Year End Target 14553	13,490	13,680	13,335	14,010	13,730	13,970	14,475	15,095	16,065			
Increase the number of adults and older adults accessing IAPT treatment (Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy within the reporting period) - 3 Months Rolling data	Target Q4 6,030	4530	4705	4985	5260	5425	5140	5445	5665	5345			
Overall Access to Core Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses	Mar-24 Year End Target 6,456	12,590	12,665	12,725	12,795	12,790	12,765	12,860	12,855	12,920			
Work towards eliminating inappropriate adult acute out of area placements (Number of inappropriate OOP bed days for adults by quarter that are either 'internal' or 'external' to the sending provider) (Quarterly Rolling Bed Days data)	0	215	140	5	0	0	0	0	0	0			
Recover the dementia diagnosis rate to 66.7%	Mar-24 66.7%	64.2%	62.8%	63.9%	64.3%	64.9%	65.2%	65.4%	65.5%	65.8%	65.3%		
Number of women accessing specialist perinatal mental health services (YTD)	Target Mar-24 Year End Target	225	310	400	475	535	590	625	690	760			

People with a Learning Disability and/or Autism	Target	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024 *(Number of Annual Health Checks carried out for persons aged 14+ on GP Learning Disability Register in the quarter) LLR Actual*	Mar-24 4284	104	180	258	275	349	366	336	472	325			
	Quarterly Position		542			990			1133				
	Ops Plan Quarterly Target		756			907			1109			1512	
Number of adults with LD/Autsim in inpatient care - *(The number of adults aged 18 or over from the CCG who have a learning disability and/or autistic spectrum disorder that are in inpatient care for mental and/or behavioural healthcare needs, and whose bed is commissioned by ICB/CCG and NHSE) LLR Actual*	Mar-24 25	33	28	30	29	27	26	24	26	25	24	24	
Number of children with LD/Autsim in inpatient care (*The number of children aged under 18 years from the STP who have a learning disability and/or autistic spectrum disorder that are in inpatient care) LLR Actual*	Mar-24 3	7	8	8	7	5	3	3	4	4	4	5	

Measures

Prevention and Health Inequalities	Target 23/24	Q1 22/23 Jun-22	Q2 22/23 Sept-22	Q3 22/23 Dec-22	Q4 22/23 Mar-23	Q1 23/24 Jun-23	Q2 23/24 Sept-24
CVDP002HYP: Percentage of patients aged 18 to 79 years with GP recorded hypertension, in whom the last blood pressure reading within the preceding 12 months is equal to 140/90 mmHg or less	77%	N/A	N/A	N/A	N/A	65.4%	65.8%
CVDP003HYP: Percentage of patients aged 80 years or over with GP recorded hypertension, in whom the last blood pressure reading within the preceding 12 months is 150/90 mmHg or less	77%	N/A	N/A	N/A	N/A	75.7%	75.8%
CVDP007HYP - Percentage of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age appropriate treatment threshold.	77%	59.2%	63.2%	63.8%	69.0%	67.4%	67.8%
CVDP003CHOL - Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%	60%	61.5%	60.0%	60.7%	61.8%	61.7%	61.8%

NHS System Oversight Framework 22/23

In Jan 22 NHSE/I provided an update on performance data for a number of key metrics from the 22/23 NHS System Oversight Framework (SOF). For LLR ICB the following table provides the Highest 25% rank positions against all reporting ICB's, according to the nationally produced dataset.

Aristotle xi

NHS System Oversight Framework
Metrics on a Page

NHS Midlands and Lancashire Commissioning Support Unit

Region: Midlands | Organisation Type: ICB | Organisation: Leicester, Leicestershire & Rutland ICB | Categories: All | Apply colour coding for National Averages: No

	Indicator	Aggregation Source	Latest Period	Previous	Latest		Good Is	Target / Nat Ave*	National Value	Rank
S000a	NHSOF Segmentation	ICB	2023 12	3	3					
S000d	UEC Tier	ICB	2023 12	3	3					
S007c	Elective Activity - value weighted elective activity growth vs. target	ICB	2023 09	400.0%	400.0%					1/42
S063c	Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, b...	ICB	2022	22.8%	23.1%	↗	Low			1/42
S110a	Access rates to community mental health services for adult and older adults with severe mental illness	ICB	2023 12	222.0%	217.0%	↘	High	100%		1/42
S123a	Adult general and acute type 1 bed occupancy (adjusted for void beds)	Provider	2024 01	92.9%	92.7%	↘	Low	95.7%*	95.7%	2/42
S012a	Proportion of patients meeting the faster cancer diagnosis standard	ICB	2023 12	76.7%	80.2%	↗	High	75%		3/42
S067a	Leaver rate	ICB	2023 11	6.43%	6.44%	↗	Low	7.4%*	7.39%	3/42
S086a	Inappropriate adult acute mental health placement out -of-area placement bed days	ICB	2023 11	20	50	↗	Low	0		3/42
S053c	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins (S053c)	SubICB	2023-09		61.8%		High	45%	59.1%	5/31
S084a	Children and young people (ages 0-17) mental health services access (number with 1+ contact)	ICB	2023 12	112.0%	117.0%	↗	High	100%		5/42
S029a	Adult inpatients with a learning disability and/or autism per million adult population	ICB	23-24 Q3	30	29	↘	High	30	42.1	6/42
S009d	Total patients waiting more than 65 weeks to start consultant-led treatment	Provider	2023 11	1,252	957	↗		2,163.9*	90,884	9/42
S127a	A&E - percentage of patients managed within 4 hours.	ICB	2024 01	0.7	0.7	↗			0.7	9/42
S030a	Proportion of people aged 14 and over with a learning disability on the GP register receiving an annual health check	ICB	23-24 Q2	10.6%	29.9%	↗	High	27.9%*	27.9%	10/42
S040a	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	SubICB	2023 12	9	11	↘	Low	0	868	10/42
S053b	% of hypertension patients who are treated to target as per NICE guidance (S053b)	SubICB	2023-09		67.8%		High	80%	67.2%	11/31
S009d	Total patients waiting more than 65 weeks to start consultant-led treatment	ICB	2023 11	1,523	1,223	↘		2,182.5*	91,666	13/42
S044a	Antimicrobial resistance: total prescribing of antibiotics in primary care	SubICB	2023 11	92.8%	92.7%	↘	Low	87.1%	98.2%	13/42
S075a	Direct patient care staff in GP practices and PCNs per 10,000 weighted patients	ICB	2023-12	7.62	8.55	↗	High	7.7*	7.73	14/42
S107a	Proportion of Urgent Community Response referrals reached within two hours	ICB	2023 11	86.1%	87.0%	↗	High	70%		14/42
S109a	Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted	ICB	2024 01	70.5%	93.5%	↗	High	100%	87.9%	15/42

https://www.england.nhs.uk/nhs-oversight-framework/

NHS System Oversight Framework

For LLR ICB the following table provides the Lowest 25% rank positions against all reporting ICB's, according to the nationally produced dataset.

Aristotle xi

NHS System Oversight Framework
Metrics on a Page

NHS Midlands and Lancashire Commissioning Support Unit

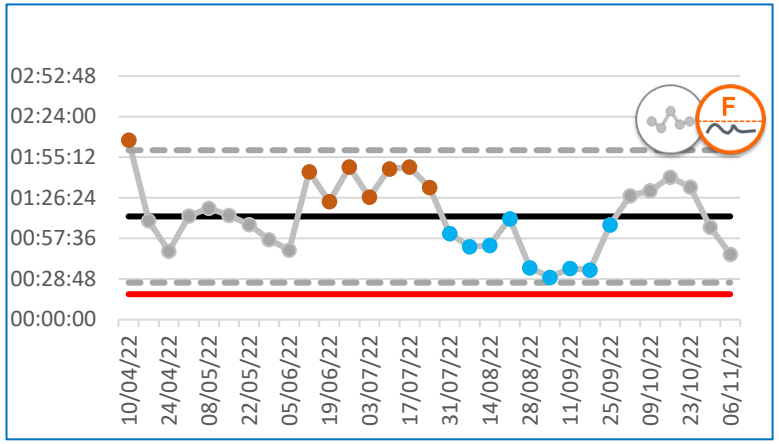
Region	Organisation Type	Organisation	Categories	Apply colour coding for National Averages
Midlands	ICB	Leicester, Leicestershire & Rutland ICB	All	No

	Indicator	Aggregation Source	Latest Period	Previous	Latest		Good Is	Target / Nat Ave*	National Value	Rank
S022a	Stillbirths per 1,000 total births	ICB	2021	4.1	5.05	↗	Low	3.5*	3.52	42/42
S041a	Clostridium difficile infection rate	SubICB	2023 12	161.3%	162.7%	↗	Low	100%	120.6%	41/42
S104a	Neonatal deaths per 1,000 total live births	ICB	2021	1.52	2.41	↗	Low	1.6*	1.6	40/42
S044b	Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care	SubICB	2023 11	9.3%	9.4%	↗	Low	10%	7.7%	39/42
S041a	Clostridium difficile infection rate	Provider	2023 12	172.8%	173.9%	↗	Low	100%	132.2%	37/42
S042a	E. coli bloodstream infection rate	Provider	2023 12	144.2%	144.2%		Low	100%	126.6%	36/42
S042a	E. coli bloodstream infection rate	SubICB	2023 12	127.2%	130.8%	↗	Low	100%	122.2%	35/42
S081a	Access rate for IAPT services	ICB	2023 12	67.0%	44.0%	↘	High	100%		34/42
S037a	Percentage of patients describing their overall experience of making a GP appointment as good	ICB	2023	52.8%	51.0%	↘	High	54.4%*	54.4%	33/42
S050a	Cervical screening coverage - % females aged 25 - 64 attending screening within the target period	SubICB	23-24 Q2	69.7%	69.2%	↘	High	75%	69.4%	30/42
S131a	Women accessing specialist community perinatal mental health services	ICB	2023 12	82.7%	80.5%	↘	High	87.2%*	87.2%	30/42
S133a	Staff survey - compassionate and inclusive theme score.	ICB	2022	7.2	7.2	↗				29/42
S121a	NHS Staff Survey compassionate culture people promise element sub-score	ICB	2022	7	6.9	↘	High			26/42
S047a	Proportion of people over 65 receiving a seasonal flu vaccination	SubICB	2023 02	80.4%	80.8%	↗	High	85%	79.9%	25/42
S126a	Diagnostic activity waiting percentage of patients on the waiting list who have been waiting more than 6 weeks	Provider	2023 11	25.4%	24.6%	↘	Low	22.4%*	22.4%	25/42
S126a	Diagnostic activity waiting percentage of patients on the waiting list who have been waiting more than 6 weeks	SubICB	2023 11	23.4%	23.4%	↘	Low	21.5%*	21.5%	25/42
S069a	Staff survey engagement theme score	ICB	2022	6.78	6.81	↗	High			24/42
S121b	NHS Staff Survey raising concerns people promise element sub-score	ICB	2022	6.5	6.4	↘	Low			22/42
S128a	Virtual ward - percentage capacity occupied.	ICB	2024 01	78.7%	74.8%	↘		70.2%*	70.2%	20/42
S046a	Population vaccination coverage: MMR for two doses (5 year olds)	ICB	23-24 Q2	87.0%	87.0%	↗	High	95%		19/42
S072a	Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless ...	ICB	2022	56.3%	57.2%	↗	High			19/42
S011a	Cancer: 62 days backlog	Provider	w/e 04/02/2024	113.8%	115.0%	↗	Low	116.8%*	116.8%	18/42
S068a	Sickness absence rate	ICB	2023 09	4.56%	4.64%	↗	Low	5.%*	5.04%	18/42
S063b	Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, b...	ICB	2022	17.2%	18.1%	↗	Low			17/42
S130a	Dementia diagnosis rate	ICB	2023 12	65.5%	65.8%	↗	High	64.6%*	64.6%	17/42

Making Data Count Approach

The Making Data Count (MDC) approach uses Statistical Process Control (SPC) charts along with rules and icons to provide a more effective summary of performance. Further details can be found: https://www.england.nhs.uk/publication/making-data-count/

How to read the chart



The charts show:

- data over time
- against a target
- with a median
- upper and lower control limits

The individual data points colour can indicate:

- special cause variation of particular concern
- special cause variation indicating improvement
- no significant change (common cause variation)

The symbols are based on the last 6 data points and show:

Variation (direction of travel):

- concerning special cause
- improving special cause
- no special cause

Assurance (capability):

- failing process
- capable process
- unreliable process (flip flop)