NHS STW Integrated Care Board - Appendices

MEETING

27 November 2024 14:00 GMT

PUBLISHED
26 November 2024

Agenda

Location	Date	Time
Meeting Room 1, Wellington Civic Offices, Larkin Way, Tan Bank, Wellington, TF1 1LX	27 Nov 2024	14:00 GMT

Contents

Agenda Item

ICB 27-11.077

Chair's Report

Appendix 1 - Fit and Proper Test Assurance

Annual NHS FPPT submission reporting template

NAME OF ORGANISATION	NAME OF CHAIR	FIT AND PROPER PERSON TEST PERIOD / DATE OF AD HOC TEST:
NHS Shropshire, Telford and Wrekin	Sir Neil McKay	1st July 2023 - 30th June 2024

Part 1: FPPT outcome for board members including starters and leavers in period

Role	Number Count	Confirmed as fit and proper?			Leavers only	
		Yes	No	How many Board Members in the 'Yes' column have mitigations in place relating to identified breaches? *	Number of Leavers	Board member reference completed and retained?
Chair/NED Board Members (Includes x 1 Associate NED)	6	X			0	

Executive Board Members	8	X			2	Yes
Partner Members (ICBs)	8	X			0	
Total	22					

Part 2: FPPT reviews / inspections

Use this section to record any reviews or inspections of the FPPT process, including CQC, internal audit, board effectiveness reviews, etc.

Reviewer / inspector	Date	Outcome	Outline of key actions required	Date actions completed
CQC				
Other, eg internal audit, review board, etc.				

Add additional lines as needed

Part 3: Declarations

DECLARATION FOR [name of organisation] [year]				
For the SID/deputy chair to complete:				
FPPT for the chair (as board member)	Completed by (role)	Name	Date	Fit and proper? Yes/No
	Senior Independent Director (SID)	Professor Trevor McMillan	12/07/2024	YES

For the chair to complete:		
Have all board members been tested and concluded as being fit and proper?	Yes/No	If 'no', provide detail:
	Yes	N/A
Are any issues arising from the FPPT being managed for any board member who is considered fit and proper?	Yes/No	If 'yes', provide detail:
	Yes	N/A
As Chair of [organisation], I declare that the FPPT submission is complete, and the conclusion drawn is based on testing as detailed in the FPPT framework.		
Chair signature:		
Date signed:	30 September 2024	

For the regional director to complete:	
Name:	
Signature:	
Date:	

Agenda Item

ICB 27-11.080

ICB Chief Executive (CEO) Report

Appendices

Appendix 1 NHS STW Board Amendments to Governance Handbook 27.11.24

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Meeting Name:	NHS STW Integrated Care Board
Agenda item no.	ICB 27-11.080 – Appendix 1
Meeting Date:	27 November 2024
Report title:	Chief Executive Report - Amendments to the Governance Handbook
Report presented by:	Simon Whitehouse, Chief Executive
Report approved by:	Simon Whitehouse, Chief Executive
Report prepared by:	Alison Smith, Chief Business Officer
Meeting report previously presented:	Not applicable

Action Required (please select):									
A=Approval	**X**	**R=Ratification**		**S=Assurance**	**X**	**D=Discussion**		**I=Information**	

Executive Summary

This report presents a number of amendments to the ICB's Governance Handbook; specifically the Scheme of Reservation and Delegation, Remuneration Committee Terms of Reference, Conflicts of Interest Policy, Standards of Business Conduct Policy as a result of:

a) newly published NHS England Statutory Guidance on managing conflicts of interest – 17th September 2024 which requires a number of changes; and

b) a change to the decision making for return and retire applications by ICB staff which has arisen as a result of a review of the ICB's Retirement Policy by Midlands and Lancashire CSU HR function on behalf of the ICB. The amendment of decisions on retire and return applications being taken by Executive Directors and not the Remuneration Committee would ensure the ICB is in line with other ICBs across the country.

A summary of the changes is outlined below. A **full** copy of the draft version 10 of the Governance Handbook with amendments shown in red text can be viewed here NHS-STW-Governance-Handbook-Draft-version-10-25.09.24.pdf

The Board is asked to consider the proposed amendments and approve draft version 10 of the Governance Handbook.

	Proposed amendments	**Reference**
1	**Scheme of Reservation and Delegation:** Approve business cases for staff who wish to retire and return to employment Amend decision making from Remuneration Committee to Executive Directors of the ICB, on submission of a business case by the staff member's line manager	Page 23
2	**Remuneration Committee Terms of Reference:**	Page 148 section 6.1.4

	Delete following reference from list of those delegated decisions the Remuneration Committee is able to make on behalf of the Board: "Consider and make decisions on behalf of the Board on business cases for staff who wish to retire and return to employment of NHS STW that have been considered and recommended by the Executive team."	
3	**Conflicts of Interest Policy:** (i)Replace existing content for identifying conflicts of interest section of the policy with new content set out in the statutory guidance. (ii) Declaring and registering interests – recognition that when a non material interest that does not give rise to a conflict is declared it may not need to be added to the public register (iii) Additional paragraph emphasising the need to manage conflicts of interest proportionately (iv) Amend title of Director of Corporate Affairs to Chief Business Officer in line with new ICB operating structure throughout document – not all changes are identified. (v) Amend title of Raising Concerns at Work Policy to Freedom to Speak Up Policy throughout document – not all changes identified (vi) Additional text added in line with the revised guidance to provide more detail on the types and levels of sanction related to conflicts of interest and bribery: disciplinary, professional regulatory, civic, criminal and reputational. (v) Reviewed Equality Impact Assessment	Page 211 Page 218 – 221 Page 223 Page 226 section 4.6 Page 227 Page 241 Pages 242 – 243 Page 262
4	**Standards of Business Conduct Policy:** (i) Change of Executive Lead for this policy to the CEO in line with the new ICB operating structure (ii) Additional descriptors of types of hospitality the policy includes (iii) amend reference to Raising Concerns Policy to Freedom to Speak Up Policy (iv) Review Equality Impact Assessment of the amended policy	Page 265 Page 268 section 3.2 Page 278 section 14 Page 280 appendix 2

Recommendation/Action Requested:

APPROVE the proposed amendments to the Governance Handbook draft version 10 outlined in the report.

Does the report provide assurance or mitigate any of the strategic threats or significant risks in the System Board Assurance Framework?				
~~No~~		Yes		If yes, please detail:

How does this report support the ICB's core aims:	
Improve outcomes in population health and healthcare	This report supports transparency and probity of decision making by the ICB which contributes to the ICB's core aims.
Tackle inequalities in outcomes, experience, and access	
Enhance productivity and value for money	
Help the NHS support broader social economic development	

Conflicts of Interest
No conflicts of interest identified in this report.

Implications	
Engagement with Shropshire, Telford & Wrekin residents, and communities	Not applicable
Resource and financial	Not applicable
Quality and safety	Not applicable
Sustainability	Not applicable
Equality, Diversity and Inclusion	The Equality Impact assessments for the Conflicts of Interest Policy and Standards of Business Conduct Policy have been reviewed but no amendments or further actions have been identified.

Impact Assessments	Yes	No	N/A
Has a Data Protection Impact Assessment been undertaken?		X	
Has an Integrated Impact Assessment been undertaken?		X	
Has the Integrated Impact Assessment been reviewed by the Equality & Involvement Committee?	X		

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

NHS STW – SYSTEM BOARD ASSURANCE FRAMEWORK

2024/25

Version 3 November 2024

Objective: ALL		Risk score 20 Extreme 4 likely x 5 catastrophic
Strategic Risk No.1: Unable to sustain a culture of strategic collaboration and partnership working and secure delivery of integrated care priorities		
If we are unable to develop and sustain a culture of collaborative working and build effective partnerships	*Then* we will not be able to achieve our aims, focus on our priorities and deliver our objectives.	*Resulting in* poor outcomes for our population, adverse impacts on our partner organisations and increased scrutiny of our effectiveness

Risk Matrix

Consequence						
	5 Catastrophic	**5 Low**	**10 Moderate**	**15 High**	**20 Extreme**	**25 Extreme**
	4 Major	**4 Low**	**8 Moderate**	**12 High**	**16 High**	**20 Extreme**
	3 Moderate	**3 Very Low**	**6 Low**	**9 Moderate**	**12 High**	**15 High**
	2 Minor	**2 Very Low**	**4 Low**	**6 Low**	**8 Moderate**	**10 Moderate**
	1 Negligible	**1 Very Low**	**2 Very Low**	**3 Very Low**	**4 Low**	**5 Low**
		1 Rare	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost Certain**
		Likelihood				

	1 – 3	Very Low risk
	4 – 6	Low risk
	8 – 10	Moderate risk
	12 – 16	High risk
	20 – 25	Extreme risk

NHS Shropshire, Telford and Wrekin Strategic Objectives:

1) Reducing Health Inequalities:

- **Wider determinants**
- **Tackling health inequalities**

2) Improving population health

- **Best start in life**
- **Healthy weight**
- **Alcohol drugs domestic abuse**
- **Mental health and wellbeing**

3) Improving Health and Care

- **Strengthen prevention, early detection and improve treatment outcomes – mental health, heart disease, diabetes, cancers and musculoskeletal disease.**
- **Urgent and Emergency Care**
- **Integrated person-centred care within communities – strong focus on primary and secondary care.**

	Consequence	Likelihood	Score	Risk Trend
Current	5 catastrophic	4 likely	20 Extreme	
Target	4 major	3 possible	12 High	

Risk Lead	ICB Chief Executive Officer	Assurance committee	Board

System Controls	Assurances reported to ICB Board and committees
Strategies and Plans • ICB Constitution • ICP Terms of Reference • Governance Handbook / Functions and Decisions Map • System Development Plan • Better Care Fund Plans • Primary Care Strategy • Clinical and Professional Leadership Programme • Integrated Care Strategy • Joint 5 year forward plan • People Priorities Partnerships and Services • Integrated Care Partnership • ICS Chief Executive Group • ShIPP • TWIPP • Health and Wellbeing Boards • ICS People Strategic Workstreams 2024- 2027 Governance & Engagement Structures • Integrated Care Partnership; Board of the Integrated Care Board and Integrated Delivery Committee • STW Mental Health Collaborative • GGI Review of ICB/ICS governance structures • ICB Strategic Partner on development of ICB version 3.0 • People Culture and Inclusion Committee	First Line of Assurance • Monitoring and oversight at ICB Executive Group and ICS Chief Executive Group • Provider Collaborative Committees in Common Second Line of Assurance • Population Health Board Third Line of Assurance • Integrated Care Partnership oversight • National Health Service England Integrated Care Board Establishment Assessment and Establishment Order
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
1. Independent assessment (NHSE, CQC) 2. Development of provider collaborative and supporting governance structure	1. Self-assessment against NHSE/CQC regulatory framework completed. NHSE Improvement Director attendance at CiC meetings 2a Interim ICS Director of Strategy leading development of STW Provider Collaborative 2b. Creation of dedicated Director level role to support development of Provider Collaborative. 2c. Finalising Provider Collaborative Committees in Common (CiC) ToR and Joint Working Agreement 2d CB CEO co-chair of HWBB's 2e Director of Partnerships and Place supporting delivery of JFP priorities and integrated place Working 2f Creation of PC CEOs group reporting to CiC 3. System Transformation Group working on collaborative workstreams to drive improvement in areas such as MSK, UEC and workforce.

Current Performance – Highlights
Development of provider collaborative and partnerships is now progressing with some dedicated ICB capacity. CiC now in place and key priority areas of work agreed. Provider Collaborative CEOs Group in place. Work programme reporting is embedding Additional workstream areas are being considered. Focus on establishing appropriate resourcing, infrastructure and reporting for the Collaborative is underway. System Transformation Group in place with CEOs to aid drive in several system wide improvement programmes.

Associated Risks on the System Strategic Operational Risk Register	
Risk no.	Description
	Non identified

Relevant risks on system partners risk registers
Description
SaTH - BAF 12 - There is a risk of non-delivery of integrated pathways, led by the ICS and ICP MPFT – BAF B8 - There is a risk to service stability and equity, due to the fragmentary influence of Place Based Partnerships on service commissioning Shropshire Council – Corporate Risk Register - Extreme pressures upon partners (social care, health, and criminal justice) within the system impacting on Shropshire Council through increased expectation, demand, need and complexity.

Strategic Objective: ALL	Risk score 20 Major 4 x Almost Certain 5
Strategic Risk No.2: Risk of not delivering sustainable services within available resources.	

If we are unable to adopt best practice and integrated modelling as rapidly as we need to	*Then* we will be unable to use our budgets and wider resources more effectively and efficiently and share risks and benefits	*Resulting in* challenges in service delivery for our population, poor health outcomes, and increased scrutiny of our effectiveness

	Consequence	Likelihood	Score	Risk Trend
Current	Major 4	Almost Certain 5	20 Extreme	↓
Target	Major 4	Possible 3	12 High	(score reduced reduction due to harmonisation with provider scores)

Risk Lead	ICB Chief Finance Officer	Assurance committee	ICB Finance Committee

System Controls	Assurances reported to ICB Board and committees

Strategies and Plans
• System Financial Strategy, incorporating:
  ○ Healthcare Financial Management Association (HFMA) Financial sustainability checklist
  ○ Triple Aim framework through the Strategic Decision-Making Framework
  ○ Capital Prioritisation Framework
• Financial Revenue Plan
• Financial Capital Plan
• Joint 5 year forward plan
• Financial Recovery Plan inclusive of the Financial Improvement Programme and Efficiency, Productivity and Transformation Plans
• ICS Infrastructure Estates Strategy
• General Practice Estate Programme
 	
Partnerships and Services
• ShIPP
• TWIPP
• ICS Digital Delivery Group
• Strategic Estates Board
• People Board
• Planned Care Board
• UEC Delivery Board
 	
Governance & Engagement Structures
• Finance Committee
• Commissioning Working Group
• Strategic Commissioning Committee
• Audit Committee
• Provider Collaborative Committees in Common
	First Line
	• Monitoring delivery of System Financial Strategy and Financial Plan by CFO group
	• Standing Orders, Standing Financial Instructions and Delegated Financial Limits
	• Financial Accounting Performance Metrics
	• HFMA Financial Sustainability Checklist
	• NHSE Grip and Control Checklist
	• Better Payment Practice Code
	• Productivity review informed by:
	  ○ Getting It Right First Time (GIRFT)
	  ○ Model Health System
	  ○ ICS Patient Level Information and Costing Systems (PLICS) dashboard
	  ○ Health Expenditure benchmarking tool (HEB)
	
	Second Line
	• Finance Report to Finance Committee
	• Integrated Performance Report to the Board
	
	Third Line
	• Monthly Integrated (Care System) Finance Return and Provider Finance Returns reporting to NHSE
	• Quarterly NHSE Financial Stocktake
	• NHSE Annual planning process (and triangulation of Finance, Activity and workforce planning)

Gaps in Controls and Assurances	Actions and mitigations to address control / assurance gaps

1. Joint financial plan across ICS partners 2. Independent assessment (NHSE, CQC)	1. Develop financial recovery plan 2. Complete self-assessment against NHSE/CQC regulatory framework

Current Performance – Highlights (updated)

Long term system financial modelling (10 year) to be completed by March 25 to include the impact of HTP.

Detailed medium-term demand and capacity model and medium-term financial plan based on 24/25 built and presented to Finance Committee in September 24. Updates to the MTFP alongside the FIP and recovery plan by Mar 25.

Development of 25/26 operational plan and refresh of medium-term financial plan for latest financial projections by March 25.

Delivery of the strategic five-year transformation plans reported through Financial Improvement Programme Board to be known as the Recovery Plan - 3-year plan development Sept 24-Mar 25.

Development of system financial strategy document underway to dovetail with long term financial modelling and development of ICB joint forward plan - Jun-Sept 24 and final version to be approved by Mar 25.

Associated Risks on the System Strategic Operational Risk Register

Risk no.	Description
System Risk 6	Financial Plan 23/24 - Closed
System Risk 7	Financial Sustainability
System Risk 21	Financial Plan 24/25 – Revenue and Capital

Relevant risks on system partners risk registers (updated)

Description

SaTH BAF 5 - The Trust does not operate within its available resources (as per Board papers - September 2024 – 4 Consequence and 5 Likelihood)
RJAH BAF 3 - Delivering the financial plan (as per Board Papers - September 2024 - 5 Consequence and 4 Likelihood)
Shropcom BAF 8.1 – Costs exceed plan (as per Board papers Oct 24 - 4 x 3 = 12)
MPFT BAF IB01 – Financial sustainability (as per board papers September 24 – 3 x 5 = 15)

Telford & Wrekin Council – Corporate Risk Register R2 - Inability to:
a) Match available resources (both financial, people and assets) with statutory obligations, agreed priorities and service standards
b) deliver financial strategy including capital receipts, savings and commercial income
c) fund organisational and cultural development in the Council within the constraints of the public sector economy

Shropshire Council – Corporate Risk Register:

a) Extreme pressures upon partners (social care, health, and criminal justice) within the system impacting on Shropshire Council through increased expectation, demand, need and complexity.
b) Sustainable budget

Strategic Aim: Objective 1 Reducing Health Inequalities	Risk score 20 Extreme Likely 4 x Catastrophic 5
Strategic Risk No.3: STW is seeing a growing and ageing population; services and the workforce will need to adapt and shape to meet these needs. There is a risk that this capacity and capability will not be sufficient to meet population needs nor be able to focus on tackling identified and emergent health inequalities in every instance.	

If we are unable to find sufficient staffing or expert/technical resources in ICB and across all system partners	*Then* we will not be able to meet increase health inequalities in our services	*Resulting in* poorer outcomes for our population, adverse impacts on our partner organisations and increased scrutiny of our effectiveness

	Consequence	Likelihood	Score	Risk Trend
Current	Catastrophic 5	Likely 4	Extreme 20	⇔
Target	Major 4	Possible 3	High 12	

Risk Lead	ICB Chief Strategy Officer	Assurance committee	ICB Quality and Performance Committee

System Controls	Assurances reported to ICB Board and committees
Strategies and Plans • 5 Year Forward Plan • System Development Plan • Inequalities Implementation Operational Plan • Primary Care Winter Plan • Integrated Care Strategy Partnerships and Services • CEO Group • Urgent and Emergency Care Delivery Group • Planned Care Delivery Group • Finance Advisory Board • ShIPP • TWIPP • Mental Health Delivery Board • Emergency Preparedness Resilience and Response Framework • System People Board • Local Maternity and Neonatal System • Primary Care Networks • System Quality Group • ICS Digital Delivery Group Governance & Engagement Structures • Integrated Care System CEO Group • ICB Board • ICB Strategy Committee • ICB Quality and Performance Committee • ICB System People Culture and inclusion Committee • ICB Strategy Committee • Integrated Care System Health Inequalities Board • Population Health Board	First Line of Assurance • Routine Quality Monitoring and Triangulation by Quality Team • General Practice Appointment Data Monitoring • Performance Dashboard • Monthly Key Lines of Enquiry for areas of underperformance / concern • Monthly Oversight System Review Meetings • Monitoring and oversight by command structure Second Line of Assurance • Cancer and Planned Care Report to ICB Quality and Performance Committee • Urgent and Emergency Care Report to ICB Quality and Performance Committee • Integrated Performance Report to ICB Quality and Performance Committee • Learning Disability and Autism Assurance Report to ICB Quality and Performance Committee • Performance Report to ICB Quality and Performance Committee • Annual Operating Plans to Finance Committee • Local Maternity and Neonatal System Report to ICB Quality and Performance Committee • Primary Care Quality reporting to Quality and Performance Committee • Integrated Provider Report to ICB Quality and Performance Committee • People Collaborative report to ICB Culture and Inclusion Committee • Quarterly reporting to Board Third Line of Assurance • National System Oversight Framework • NHSE Quarterly System Review Meetings • Core 20 +5 reporting to regional NHSE

Gaps in Controls and Assurances	Actions and mitigations to address control / assurance gaps
1. Independent assessment (NHSE, CQC)	1. Complete self-assessment against NHSE/CQC regulatory framework - CQC - timeframe yet to be published nationally.

Current Performance – Highlights

- Health inequalities – Health Inequalities & Prevention group has established well, with executive and senior representation from across system partners. The work programme is focused on the 24/25 agreed objectives and priorities (as briefed at ICB in summer 24). Group reports to Strategic Commissioning Group.
- ICB Management of change has established substantive staff for health inequalities.
- Population Health Management – clear link with system Population Health Management group. Population Health Board also reports into Strategic Commissioning Committee to clarify assurance reporting lines.
- Work continues to describe the growing gap between healthy life expectancy/ overall life expectancy between different segments of our communities and consider risk in context of multiple completing pressures whilst maintaining/enhancing focus on health inequalities.

Associated Risks on the System Strategic Operational Risk Register

Risk no.	Description
Risk 1	CYP Mental Health
Risk 3	Palliative care/end of life
Risk 4	Maternity services
Risk 5	Urgent and Emergency Care
Risk 7	Diabetes Management
Risk 15	Acute Paediatric pathway
Risk 16	C Diff

Relevant risks on system partners risk registers

Description

RJAH – BAF 3 - Failure to effectively promote equality, diversity and inclusion
MPFT – BAF B4 - The Trust in committed to embedding equality and inclusion in everything we do
Shropshire Council – Corporate Risk Register:

a) Critical skills shortage impacting on Retention, Recruitment & Succession Planning
b) Extreme pressures upon partners (social care, health, and criminal justice) within the system impacting on Shropshire Council through increased expectation, demand, need and complexity.
c) Sustainable Budget (i.e. budget will not keep track with current population projections overlaid with level of need to the demography of the population and long term investment in preventive/demand management approaches needed)

Strategic Objective: Objective 3 Improving health and care	Risk score 16 High
Strategic Risk No.4: Inability to recruit, retain and keep our ICS Workforce well.	

			Major 4 x Likely 4
*If w*ere unable to provide the workforce to deliver clinical and non-clinical services due to inability to recruit, retain and keep our workforce well	*Then* we will not develop our inclusive culture and effectively deploy a workforce with the necessary skills and expertise that meet service requirements	*Resulting* in a failure to deliver services to the population of STW.	

	Consequence	Likelihood	Score	Risk Trend
Current	4 major	4 likely	16 high	↑
Target	3 moderate	3 possible	9 moderate	

Risk Lead	ICS Chief People Officer	Assurance committee	System People Committee

System Controls	Assurances reported to ICB Board and committees
Strategies and Plans • One People Plan Recommendations and Insights Report • workforce information dashboards to consider workforce information (sickness, turnover, vacancies, staff in post, Agency and bank usage etc) • 5 year Joint forward Plan Partnerships and Services • People related workstreams being led by the ICS People Team Governance & Engagement Structures • System People Committee provides oversight of the development of our system people strategy and annual programmes and strategic direction of travel • System People Committee oversight of Annual operational workforce planning process to set direction of travel for next 12 months	First Line of Assurance • Workforce information dashboards outputs Second Line of Assurance • People Plan Programme Progress Report to the People Committee of the Integrated Care Board
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
Gaps in controls: 1 The System People Strategy and priorities are not agreed by system CEOs. 2 The System People Collaborative approach, including HRD SROs and refreshed operational delivery and oversight processes/meetings, is not agreed by system CEOs. 3 An appropriate and resourced structure – within the system People Team and through provider partner employers – is not agreed by system CEOs. 4 The system People Committee is not meeting regularly, and its authority and remit requires a refresh – this gap is now completed and closed. 5 There is no consistent system oversight of workforce metrics, workforce supply or the delivery of our People Strategy, or progress on	1 Finalise our ICS People Strategy and priorities by September 2023 – completed 2 A refreshed People strategy is required as part of NHS Oversight Exit criteria for 24/25 4 GGI Making Meetings matter review includes System People Committee – due to report in September 2023 –completed 5 CEO decisions on system people collaborative approach, structures and resources – following discussion papers taken to CEOs meetings and HRD meetings for consideration an external review of HR/peopel funciton across NHS partners (except MPUFT) is taking place and due to conclude December 24. .

the delivery of the 10 people outcomes – this gap is now completed and closed. Gaps in assurances: 2) Regular minutes from the System People Committee – this gap is now closed	4. Refresh of the System People Committee as the oversight function – in progress from September 24. 5. Refresh of the People Delivery Committee as the operational delivery programme board – completed. 2. see (4) above

Current Performance – Highlights
A system workforce dashboard is now in place providing robust insights into NHSE workforce data intelligence and oversight to inform against the annual NHS workforce plan. There is a system workforce assurance and planning steering group chaired by the SRO for Reform from which workforce intelligence reports into several system committees and groups including System Transformation Committee, Quality Committee, Finance improvement committee, Agency workforce group, ICS People Culture and inclusion committee and ICS People collaborative. The workforce assurance group has now merged with the agency workforce reduction group which has Director chair . This aims to brings together workforce planning, monitoring, finance and productivity leads from across the system. Workforce data dashboard has enabled greater visibility of fragile workforce groups against 24/25 plan and there are greater opportunities to undertake targeted actions to attract and train fragile workforce groups. There is an agreed overarching STW ICS people strategy 2023- 2027 signed off at STW Strategy Committee 18th May 2023. With this are an agreed suite of annual people delivery priorities and delivery against these can be seen on the 23/24 annual People Programmes report presented to ICB Board in June 24. CEO's have agreed to the SRO leadership arrangements across the four strategic people programmes. This is further strengthened by the CEO SRO for people chairing STW ICS People collaborative from August 24. CEOs had not agreed to invest in the ICB people team infrastructure, further compounded by NHSE financial oversight scrutiny during 24/25. An external review of HR/people services and the ICB people team is commencing September 2024, expected to take around 8 weeks with anticipated recommendations for consideration. System Committee was meeting quarterly and from October 24/25 is now meeting monthly and has renewed chairmanship Whilst there has been no robust secretariat support to this Committee or to the People delivery collaborative and as of September 2024 which has now been addressed, there is evidence of minutes and actions from Committee, and it has been subject to a good governance review with positive feedback.

Associated Risks on the System Strategic Operational Risk Register	
Risk no.	Description
Risk 10 Risk 12 Risk 13 Risk 14	ICB Financial staff capacity Chief People Officer for the system Deputy Chief People Officer capacity Capacity to deliver 10 people pledge outcomes

Relevant risks on system partners risk registers
Description
SaTH – BAF 3 - If the trust does not ensure staff are appropriately skilled, supported and valued this will impact on our ability to recruit/retain staff and deliver the required quality of care

SaTH BAF 4 - A shortage of workforce capacity and capability leads to deterioration of staff experience, morale, and well-being.
RJAH – BAF 1 – Lack of effective engagement with workforce
RJAH – BAF 2 - The workforce does not have the required capacity and capability
Shropcom – BAF 3.1 – Recruitment challenges
MPFT- BAF F1 - There is a risk to the health and wellbeing of staff due to existing workforce shortages, high acuity and demand, and the long-term effects of the pandemic; leading to staff burnout, absence and increased turnover.
MPFT – BAF F2 - There is a risk to the delivery of Trust services due to national workforce supply issues and skills shortages; leading to an inability to recruit and retain sufficient numbers of clinical, technical and managerial staff.
Telford & Wrekin Council – Corporate Risk Register – R3 - Losing skills, knowledge and experience (retention & recruitment) in relation to staffing.
Shropshire Council - Corporate Risk Register - Critical skills shortage impacting on Retention, Recruitment & Succession Planning

Strategic Objective: ALL			Risk score 16 High Major 4 x Likely 4
Strategic Risk No.5: Lack of capacity and strategy to develop and use digital and data systems to enable efficient and effective care across the ICS			
If we are unable to develop and use our digital and data systems	*Then* we will not be able to make informed decisions, develop integrated services that are digitally enabled and monitor their effectiveness against our aims	*Resulting in* challenges in service provision, staff dissatisfaction, and poorer health and care outcomes for our local population	

	Consequence	Likelihood	Score	Risk Trend
Current	Major 4	Likely 4	High 16	↑
Target	Moderate 3	Possible 3	Moderate 9	

Risk Lead	ICB Chief Medical Officer	Assurance committee	ICB Strategic Commissioning Committee

System Controls	Assurances reported to ICB Board and committees
Strategies and Plans • Integrated Care Strategy • Clinical Strategy • Infrastructure and Estates Strategy • Joint Forward Plan • 10 Year Capital Plan • ICS Green Plan • Population Health Roadmap • Joint Strategic Needs Assessments • Local Operational Plan • Big Conversation analysis • ICS Digital Strategy and ICS Digital Portfolio Plan • Health Inequalities Plan – KLOE for Digital Inclusion • NHSE What Good Looks Like/Digital Maturity Assessment • NHSE Digital Capability Framework for Electronic Patient Records • NHSE GP IT Operating Model • NHSE Cyber Assessment Framework Partnerships and Services • Population Health Management Board • Telford & Wrekin Integrated Place Partnership (TWIPP) • Shropshire Integrated Place Partnership (ShIPP) • People's Network • Shropshire Digital Inclusion Network • MLCSU Contracted Technology Support Services – GPIT, Corporate IT, Cybersecurity, IG, Procurement, BI/Analytics • ICB Senior Leadership Team • ICB Digital Strategy Group • Commissioning Working Group • ICS Strategic Programme Boards • ICS Climate Change Group • ICS Digital Delivery Group	First Line of Assurance • ICB Digital Operations Group reports to ICB Digital Strategy Group and ICB Digital Strategy Group report to ICS Digital Delivery Group • ICB Digital involvement in ICB Senior Leadership Team • Regular ICS partner portfolio updates including programmes, projects and group reports to the ICS Digital Delivery Group • Regular involvement in the Commissioning Working Group • Regular engagement and involvement in community and place-based partnership groups • Regular engagement and involvement with clinical and care professional networks • Routine progress reports from key workstreams • Regular Population Health Management Workstream Update to the Population Health Board • Regular Inequalities Workstream Update to the Population Board Second Line of Assurance • ICB Digital updates to SBAF and SSORR to Audit Committee • IG updates on DSPT and Cybersecurity to Audit Committee • ICS Digital Delivery Group report to Strategic Commissioning Committee • Population Health Report to Integrated Delivery Committee • Regular engagement via regional and sub-regional digital transformation and related national programme groups/networks Third Line of Assurance

• ICB Operating Model • System Digital Governance Model (Recommended, not in place) Governance & Engagement Structures • Audit Committee (Cybersecurity, ICB IT) • Strategic Commissioning Committee • Integrated Care Board • NHS Midlands Digital Transformation • NHSE Programme Networks	• Audit Committee on Cybersecurity and ICB IT to the Board • Strategic Commissioning Committee report on ICS Digital to the Board
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
Gaps in controls: 1. ICB and ICS Executive roles - remit, authority/span of Data, Digital and Technology (DDAT) decision-making 2. Involvement and alignment of digital and technology requirements in prioritisation, funding allocation, organisational development e.g. workforce literacy, strategic programmes and functional operations and working groups for 2nd and 3rd line assurance 3. Single view of digital/technology spend within the ICB and across the system - BAF Risk 2 4. Insufficient ICS partner reporting into Digital Portfolio 5. Insufficient resources to support delivery of the Digital Portfolio 6. Unclear commitment to implement a Digital Inclusion framework 7. Aligned ICS Digital Procurement Framework and Plan 8. Unclear timeline for an information, data, analytics and intelligence strategy across ICP 9. Independent assessment (NHSE, CQC) 10. Lack of system policy on use of AI technologies and embedded solutions Gaps in Assurances: 11. System data, digital and technology governance with aligned system digital operating model, evolving from ICB management of change programme	1. Confirm approach and timeline to develop an information and data strategy across ICP 2. Clarify and agree the ICB and ICS Executive digital roles 3. Commit to a board development programme for data and digital 4. Update the Integrated Impact Assessment to include digital inclusion and digital sustainability 5. Incorporate Digital voice in prioritisation and decision-making - strategic commissioning, financial planning and budget allocation, service design, quality improvement, leadership development and public involvement for digital inclusion 6. Commit to specific funding principles for digital operations financial sustainability and digital inclusion services 7. Commit to a system funding allocation model to ensure adequate digital resources to support delivery of the agreed Digital Portfolio and management of operationalised services 8. Involve ICB Digital in Infrastructure and Estates programme design 9. Involve Digital in the design of the Provider Collaborative 10. Commit resources to a system digital operating model for controls that address assurance gaps

Current Performance – Highlights
• ICS Digital Strategy approved by the Board March 2024 as a culture lever to enable change • Delivered a restructured ICS Digital Portfolio to surface known priorities and show relationships amongst initiatives and programmes to inform gap analysis • Met deadlines for system submission for NHSE What Good Looks like Digital Maturity Assessment for the ICS including Primary Care • Identified key work on core digital and data capabilities and high priority STW ICS digital programmes - One Health & Care (our integrated care record), Digital Inclusion, Cybersecurity, while working within unclear, reduced financial envelope, increased delivery pressure and reduced workforce capacity. • Maintained ICB Digital during management of change programme and completed recruitment of substantive ICB Head of Digital role to support ICB and ICS digital priorities.

- Raised awareness of key opportunities and challenges for ICB and ICS Digital through ICB prioritisation and strategic commissioning workshops.
- Raised awareness of need for ownership of undocumented risks related to operating model design, capacity and experience challenges and prioritised mitigation of issue impacts related to finance/budgeted spend, unmanaged, contracted services and legacy projects/programmes with unclear ownership and reporting.
- Raised awareness and shared opportunities for digital innovation and research.
- Developed relationships across care setting and functional role specialisms to open doors for collaboration, innovation, and joint delivery with a focus on problem assessment, promoting the use of standards and good practice for inclusive engagement, options assessment before solution design and working within known financial and workforce constraints.
- Established first iteration ICB Digital function and role protocols with a focus on service, continuous improvement, and risk management rigour, while ICB undertook management of change.
- Actively practiced and advocated respectful check and challenge within existing governance structure to existing norms, transparent reporting, and continuous sharing of opportunities for learning and improvement.

18.11.24 Update

- ICB Head of Digital commenced in post which completes full recruitment to the digital structure
- Has undertaken stocktake of digital workstreams and achievements and identified challenges and opportunities, based on ICS Digital Strategy (approved March 2024)
- Annual work plan for 25/26 under construction based on the 7 strategic areas of focus in the Strategy
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Associated Risks on the System Strategic Operational Risk Register		
Risk no.	Description	Current score
Risk 8	Emergency Planning, Resilience and Response	16
Risk 14	System Digital Operating Model	16
Risk 15	Difficulty of finding patient information across different systems	20
Risk 16	System digital inclusion framework	16
Risk 17	System capacity and funding to support digital clinical risk management	20
Risk 23	System-wide Cybersecurity Operating Model and Strategy	16

Relevant risks on system partners risk registers
Description
SaTH BAF 7A - Failure to maintain effective cyber defences impacts on the delivery of patient care, security of data and Trust reputation. SaTH BAF 7B - The inability to replace implement modern digital systems impacts upon the delivery of patient care. RJAH BAF 6 - IT unable to support new ways of working. RJAH BAF 7 – Loss of data/unable to restore services following a cyber-attack. MPFT BAF risk that the appropriate cyber security controls are not in place services following a cyber-attack. Shropshire Council - Corporate Risk Register - Critical skills shortage impacting on Retention, Recruitment & Succession Planning

Strategic Objective: ALL			Risk score 16 High major 4 x likely 4
Strategic Risk No.6: Inability to respond strategically to ICS objectives due to the impact of external factors beyond the influence of the ICS (e.g. Emergencies, Incidents and Disruptive Events such as: climate change, adverse weather, cyber-attack, utilities failure, transport accidents, malicious attacks, industrial action, infectious disease, economic and political changes).			
If we are unable to respond collectively to the external challenges facing our local area	*Then* we will not be able to, meet our ICS objectives to improve the health and wellbeing of our population.	*Resulting in* poorer outcomes for our population and with further pressure on health and care services.	

	Consequence	Likelihood	Score	Risk Trend
Current	4 - Major	4 - Likely	16 High	⇔
Target	3 - Major	3 - Possible	9 Moderate	

Risk Lead	ICB Accountable Emergency Officer (AEO)	Assurance committee	ICB Board Audit Committee (EPRR Programme Group)

System Controls	Assurances reported to ICB Board and committees
Strategies and Plans • Integrated Care Strategy • Joint Forward Plan • Health and Wellbeing Strategies • Local Authority Strategies • Civil Contingencies Act 2004 (CCA), NHS Act 2006, Health and Care Act 2022, NHS Standard Contract. • NHS EPRR Framework • NHS England Incident Response Plan • Local Authorities EPRR Response Plans and Business Continuity Management Plans. • ICB EPRR Policy, Incident Response Plan, Business Continuity Management Plans (Corporate & Directorate), EPRR Communications Plan • ICB On-Call Policy • STW Health Protection Strategy • ICS Green Plan • Individual NHS organisations EPRR Policies, Incident Response Plans, and Business Continuity Management Plans. • Individual NHS organisations Green Plans • ICB Risk Management Policy • NHS Shropshire, Telford and Wrekin ICS West Mercia Local Resilience Forum Representation Agreement • ICB EPRR Training and Exercise Programme (includes systemwide exercising) • West Mercia Local Resilience Forum (LRF) response and recovery plans. Partnerships and Services • Integrated Care Partnership • West Mercia Local Resilience Forum (LRF)	First Line of Assurance • Audit Committee Second Line of Assurance • ICB EPRR Programme Group. • NHSE Annual Assurance Process of NHS Core Standards for EPRR. • NHSE Quarterly Green meetings.

• West Mercia Local Health Resilience Partnership (LHRP) • West Mercia Health Emergency Preparedness Operational Group (HEPOG) • STW Health Protection Quality Assurance Board • ICS IPC & AMR Group • Population Health Board • Shropshire Integrated Place Partnership (ShIPP) • Telford and Wrekin Integrated Place Partnership (TWIPP) • Primary Care Networks • ICS Climate Change Group Governance & Engagement Structures • Integrated Care Partnership • Health and Wellbeing Boards • ICB EPRR Programme Group • Individual NHS organisations EPRR committees/groups • West Mercia Local Resilience Forum (LRF) • West Mercia Local Health Resilience Partnership (LHRP)	
Gaps in Controls and Assurances	Actions and mitigations to address control / assurance gaps
1. Limited ICB and individual NHS organisations EPRR resource. 2. No existing system level EPRR frameworks, policies, plans for organisations to align own policies and plans to enhance a coordinated response. 3. Lack of documented Standard Operating Procedures for the System Coordination Centre (SCC) 4. Low level of compliance with NHS Core Standards for EPRR. 5. Recent combining of STW LHRP & HEPOG and Herefordshire & Worcestershire LHRP & HEPOG to form the West Mercia LHRP and HEPOG.	1. ICB EPRR work programme has actions to produce system level EPRR policies, frameworks and plans for organisations to align own policies and plans. 2. Individual NHS organisations EPRR work programmes. 3. LHRP work programme 4. ICB EPRR lead meets with provider EPRR leads monthly. 5. STW ICB EPRR lead to work closely with H&W ICB EPRR lead to drive the LHRP and HEPOG work programme ensuring links to system/locality risks, issues, and challenges. 6. Accountable Emergency Officers (AEO) for each NHS organisation to review EPRR resourcing to ensure it is adequate for the size, type, and services of their organisation and duties placed on them under the CCA, NHS Act 2006, Health and Care Act 2022, and the NHS Standard Contract. 7. Systemwide exercise schedule 8. Completion of NHS Core Standards for EPRR. 9. Complete self-assessment against NHSE/CQC regulatory framework

Current Performance – Highlights
• The ICB and individual NHS organisations have an annual EPRR work programmes in place to ensure there is a continuous cycle of improvement. These work plans cover review and updates of policies and plans, training, exercising, business continuity management systems and incident response arrangements. • The ICB and individual NHS organisations submitted their annual self-assessment against the NHS Core Standards for EPRR at end of August 2024. These self-assessments will be reviewed by the ICB and NHSE during September with final outcomes of the assessment and assurance levels confirmed in early October 2024. Following the issuing of the final assurance levels, the ICB will work with all organisations to develop individual and systemwide improvement plans. These improvement plans will be overseen by the ICB EPRR Senior EPRR Lead reporting to the ICB Accountable Emergency Officer (AEO) via the West Mercia LHRP, ICB EPRR Programme Group through to Audit Committee and Board

- Detailed review of Greener NHS progress in STW against the NHSE national objectives and priorities carried out in Aug 24, and discussed with NHSE regional leads. Plan to enhance link to ICS Infrastructure group (chair – ICB Director of Finance). Follow up review with NHSE in late autumn 24, with objective of improving ICS rating.

Associated Risks on the System Strategic Operational Risk Register	
Risk no.	Description
Risk 8	EPRR

Relevant risks on system partners risk registers
Description
NHS STW ICB – SORR 24 – EPRR. **ShropCom** – BAF 4.1 External pressures impact on capacity (wider system escalation or rising pandemic levels) **Telford & Wrekin Council** – Corporate Risk Register – R4 - Significant business interruption affecting ability to provide priority services, e.g. critical damage to Council buildings, pandemic, etc. **Telford & Wrekin Council** – Corporate Risk Register R7 - Inability to respond adequately to a significant emergency affecting the community and/or ability to provide priority services. **Telford & Wrekin Council** – Corporate Risk Register R8 - Inability to respond to impact of climate emergency on severe weather events including heat, cold and flood. **Shropshire Council** – Corporate Risk Register: a) Responding and Adapting to Climate Change b) Delivery of the Economic Growth Strategy c) Sustainable Budget **The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust** – BAF 7 – ***if*** *the Trust does not have adequate plans in place to respond to a significant disruptive event beyond the control of the Trust, such as a pandemic, or cyber-attack,* ***then*** *it will be unable to provide an adequate response to the immediate need and/or maintain other key services due to unavailability of the required resources/staff,* ***resulting in*** *potential patient harm, increased waiting times etc.*

Strategic Aim: ALL			Risk score 16 High Major 4 x Likely 4
Strategic Risk No.7: Inability to contribute effectively as a system to support broader social and economic development			
If we are unable to respond collectively to the social and economic challenges facing our local area,	*Then* we will not be able to make a difference to wider economic growth across our system	*Resulting in* poorer longer-term outcomes for our local population in relation to health and wellbeing	

	Consequence	Likelihood	Score	Risk Trend
Current	Major 4	Likely 4	16 High	
Target	Major 4	Possible 3	12 High	

Risk Lead	ICB Chief Executive Officer	Assurance committee	Board

System Controls	Assurances reported to ICB Board and committees
Strategies and Plans • Integrated Care Strategy • 5 year Joint Forward Plan • Health and Wellbeing Strategies Partnerships and Services • TWIPP • ShIPP • Provider Collaboratives • ICS Chief Executives Group • Networks Governance & Engagement Structures • Integrated Care Partnership and Integrated Care Board and associated committees • ICB – agreed values and behaviours • Health and Wellbeing Boards	First Line of Assurance • Joint Strategic Needs Assessments • Workforce mapping Second Line of Assurance • Population Health Board report to ICB Integrated Delivery Committee Third line of Assurance • Health and Wellbeing Boards
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
Gaps in Controls: 1. Strategic partnership focus on broader social and economic development of the area has been limited to date. Gaps in Assurances: 2. No clear committee that has this oversight in its remit.	1. Population health management approach needs to be adopted. 2. GGI review of meetings and governance structure – phase 1 October 2023

Current Performance – Highlights
• GGI review phase 1 due to report proposed revised governance structure for ICB/ICS in October 2023. • Population Health - Population Health analysts capacity secured in Planning and Performance directorate. Population Health Board now reports into Strategic Commissioning Committee to clarify assurance reporting lines.

- Initial meeting held in July 24 with Office of West Mids/Centre for Economic development to consider areas of development.
- ICB working to support major Local Authority-led initiative – Marches Forward Partnership (Shropshire, Powys, Monmouthshire and Hereford & Worcester). Range of workstreams including health, housing, skills and energy, with focus on economic development.

Associated Risks on the System Strategic Operational Risk Register	
Risk no.	Description
	None identified

Relevant risks on system partners risk registers
Description
Shropshire Council – Corporate Risk Register: a) Delivery of the Economic Growth Strategy b) Extreme pressures upon partners (social care, health, and criminal justice) within the system impacting on Shropshire Council through increased expectation, demand, need and complexity.

Strategic Objective: ALL			Risk score 12 High Major 4 x Possible 3
Strategic Risk No.8: Patient and Public Involvement			
If the ICB fails to meet its statutory duty to involve patients and the public in planning and commissioning arrangements, and in the development of proposals to change or cease existing services	*Then* services will not be tailored to local people's health and care needs	*Resulting* in potential judicial review, not meeting the population's health needs, increasing health inequalities and leading to poorer health outcomes	

	Consequence	Likelihood	Score	Risk Trend
Current	Major 4	Possible 3	High 12	⟷
Target	Moderate 3	Unlikely 2	Moderate 8	

Risk Lead	ICB Chief Business Officer	Assurance committee	Strategic Commissioning Committee Equality and Involvement Sub Committee

System Controls	Assurances reported to ICB Board and committees
Strategies and Plans • Integrated Care Strategy • 5 Year Forward Plan • Big Health and Wellbeing conversation comms and engagement plan socialised and approved by Board • Communications and Engagement Strategy for STW ICB approved by the Board Partnerships and Services • Presence of Healthwatch for both areas at Board meetings and Quality and Performance Committee • System Involvement and Engagement Network established • Communications and Engagement teams working jointly across ICB, ICS and Providers providing more capacity and expertise in planning and delivery • Board meetings are held in public and board papers published to the ICB website to increase transparency. • In house ICB Comms and Engagement team supplements capacity of partner organisations	First Line of Assurance • Reporting on Engagement as part of wider reporting and decision making at SCC and Q&P Committee on commissioning decisions Second Line of Assurance • Reporting to Equality and Involvement Sub-Committee. EIC receives comms and engagement plans from commissioners and Integrated Impact Assessments (IIA), Chair provides reports to SCC Third Line Assurance • Health and Overview Scrutiny Committees (HOSC) • NHSE review of ICB Annual Report which must include content on patient and public engagement over the period of reporting. • NHSE Annual ICB assessment includes component on statutory responsibility to engage with the local population and partners.

• System-wide Integrated Impact Assessment (IIA) tool developed to streamline the way we identify the impact of change on equality groups which are then presented to the ICB's Equality and Involvement Sub-committee for scrutiny. Governance & Engagement Structures • Integrated Care Partnership and Integrated Care Board and associated committees • Reports to Governing bodies/Committees require section completing on Patient involvement • Equality and Involvement Sub-Committee as part of ICB Governance • Non Executive Director for Inequalities in place on Board to act as specific check and balance with regard to patient involvement	
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
Gaps in Controls: 1) Limited engagement capacity within the comms and engagement team 2) Development of advice, guidance and training resources for commissioners, partner organisations Gaps in Assurances: None	1a) CSU comms and engagement capacity is used when required. 1b) People's network needs focus to add in more diversity to enable ongoing engagement on a regular basis with a wide range of citizens. 1c) Need for ICB C&E team to focus on ICB prioritised areas of work (currently being undertaken by SLT and planning team) 2) ICB C&E team to develop guidance on statutory consultation and non-statutory engagement and on managing media enquiries

Current Performance – Highlights
• Currently planning use of CSU resources for remainder of 24/25 - Quarter 3 • Additional recruitment to the People's Forum has started, particularly focussing on groups that are under-represented – currently we have low numbers of young people and men. - end of Quarter 3 • Work on support resources to new commissioning teams and partners delayed due to need for ICB to prioritise commissioning objectives via Senior Leadership team – end of quarter 3. • Team have started to collate existing guidance resources and information and identifying gaps to then develop new resources to communicate out to Senior Leadership team and ICB generally via staff huddle. Quarter 4

Associated Risks on the System Strategic Operational Risk Register	
Risk no.	Description
23	Patient and Public Involvement - risk of not meeting statutory duty.

Relevant risks on system partners risk registers
Description
MPFT – BAF P2 - There is a risk that the Trust will not be able to adequately measure and respond to the

experiences of our service users due to the limitations of the current feedback systems and approaches. This may impact on the Trust reputation due to reduced confidence in the ability to learn, respond and improve services in response to customers voice / views

NHS STW - Strategic Operational Risk Register for the System (System SORR) 2024/25

Appendix A

1 Risk ID	2 Strategic Objective	3 Opened / added by	4 Risk and description	5 Opportunity	6 Existing key controls	7 Existing sources of assurance	8 Gaps in controls or assurances	9 Risk score (consequences x likelihood)	10 Risk score trend	11 Action plan / cost / action lead /(target date) /sufficient mitigation	12 Target risk score for end of financial	13 Director or Risk Owner	14 Risk Owner	15 Committee/ ICB oversight	16 Amendments: name and date	17 Rationale for amendments/increasing or decreasing risk levels
3 (SQG4)	2 & 3	Vanessa Whatley Chief Nursing Officer, NHS STW	If there are delays to **urgent and emergency care** caused by lack of flow through unscheduled care creating congestion in the ED and related areas, lengthy ambulance off load delays and extended lengths of time in the emergency departments then patients are more likely to deteriorate and/or come to harm in ambulances, in the Emergency Department or in the community whilst waiting for an ambulance.	Urgent and emergency care is delivered in a timely and effective manner that supports urgent care pathways and high quality care.	1) There is an UEC Delivery Group that directs UEC performance and resources (Mar 24). 2) Providers have an established risk register with relevant escalation to the Board. This includes WMAS (Mar 24). 3) Serious incidents from WMAS are shared with STW via Black Country ICB (Mar 24) 4) SaTH have completed the first round of harm reviews (Mar 24) 5) SaTH patients who are subject to an ambulance off load delay will undergo a harm review and this will continue for as long as there are ambulance offload delays (Mar 24). 6) Plan devised through the Discharge Alliance Group (Mar 24) 7) Winter schemes for 24/25 informed by success in 23/24 (Nov 24) 8) A revised harm review process has been agreed with SaTH and system partners as relevant in line with PSIRF (Mar 24) 9) The ICS has moved into Tier 1 and has associated oversight and metrics from GIRFT/NHSE (Mar 24) 10) There is a harm review process in place (Mar 24) 11) CQC and Channel 4 Dispatches programme action plan and quality visits to provide oversight (Aug 24)	1) Contract Review Meetings hold performance data with Quality support and oversight (Mar 24). 2) Each organisation is represented at SQG and is able to escalate any quality concerns (Nov 23). 4) Healthwatch are engaged and monitoring patient experience including UEC (Nov 23). 5) Each organisation has a quality governance process to escalate risks and concerns to the Board for consideration and direction (Nov 23). 6) Findings from Exemplar and Quality Assurance visits (Nov 23). 7) Virtual ward uptake, constantly at >80% capacity (Mar 23)	**Gaps in Controls:** 1) GIFT has identified there are gaps in 1a) Acute Medicine: Ward process, ensuring consistency and starting at 8am. 1b) Frailty: Delirium/Frailty recognition and response at the front door. 1c) Emergency Medicine: Specialty engagement and Ambulance handover threshold. System: 1d) Care coordination improvements Gaps in Assurances: None	Likely 4 x Catastrophic 5 = Extreme 20	↔	Deliver UEC improvement plan (ICB, SaTH and ICS) Delivery of System Winter Plan and outcomes Establish workstreams with clear aims and objectives which can be monitored, to address GIRFT recommendations (April 24) Workstream progress monitored via UEC Board	3 possible x 3 moderate = 9 Moderate	Ian Bett Interim Executive Director - Director of Delivery and Transformation	Gareth Wright - Head of Clinical Ops	Quality and Performance Committee	Vanessa Whatley Jan 24 Vanessa Whately Mar 24 August update to SQG completed Gareth Wright Nov 24	
4 (SQG8)	2 & 3	Vanessa Whatley Chief Nursing Officer, NHS STW	Failure to deliver the 9 care processes outlined NICE Guidance and delivery of the 3 treatment targets consistently could contribute to poor outcomes and harm to our population diagnosed with diabetes.	To have a cohesive integrated diabetes pathway to improve clinical outcomes and patient experience. Moving to a prevention approach, supporting care closer to home and optimising the use of digital solutions. Implement a population health approach to managing diabetes as part of a multi-disciplinary team. Codevelop with stakeholders and experts by experience an integrated neighbourhood approach to proactive and personalised care in diabetes. To be able to release specialist diabetes teams to manage the more complex people living with diabetes. Reduce long term complications and admissions to hospital. To reduce inequalities and variations in health outcomes.	Submissions to the national diabetes audit. Monthly oversight of diabetes data dashboard ICB Lead oversight Regular reports to Quality and Performance Committee and National teams.	Quality and Performance Committee	**Gaps in Controls:** We are in transition from the historic governance arrangements under the previous operating model to the new. Gaps include: Signed off strategy and transformation plan Recruitment of Clinical Lead Clinical engagement infrastructure and associated governance arrangements **Gaps in Assurances:** As above	4 consequence x 3 likely = 12 High	↓	These actions are going to QPC in November 1.1.Through a discussion with the senior leadership team (SLT) and subsequent input from the CMO team, a refreshed approach to diabetes transformation has been designed that will be presented to the SLT for a further review and approval on 3rd December 2024. 1.2.It has been agreed that funding available for a diabetes clinical lead should be utilised to recruit a suitable lead through the CMO team. The S&D team will support in the structuring of a suitable JD and person specification for the role over the next 2 weeks for the CMO to sign off. 1.3.Recruitment will be led by the CMO, as the right candidate will be crucial to the delivery of the diabetes transformation approach. Timelines for recruitment are yet to be agreed but it will be likely over the next 4-6 weeks. 1.4.Once the clinical lead is in post, the project plan will be redesigned to ensure it is clinically led and collaboratively designed to deliver the integrated pathway service redesign and co-production approach. 1.5.The transformation programme will be overseen by a Strategic Diabetes Group, and this will report to the Health and Care Models Transformation Group (formerly the Local Care transformation group but now combined with the Hospital Transformation Programme). The governance reporting outline will support the programme and will be presented to SLT in early December as part of the overall approach. Assurance on progress will be through the usual system governance.	4 major x 4 likely = 16 High	Diabetes Programme Board	Claire Parker Director of Strategy and Development	Quality and Performance Committee	Nov 23 Fiona Smith July 24 Reviewed at QPC	Risk redefined by Claire Parker 20.11.24
6	1, 2 ,3	Laura Clare, Deputy CFO Now Angela Szabo, DOF	**Financial Sustainability** Failure to deliver long term system financial sustainability and exit NOF4 arrangements	Opportunity to create a financially sustainable system	Strategies and Plans - System Financial Strategy, incorporating: Healthcare Financial Management Association (HFMA) Financial sustainability checklist , Triple Aim framework through the Strategic Decision Making Framework, Capital Prioritisation Framework, Financial Revenue Plan, Financial Capital Plan , Joint 5 year forward plan, Financial Recovery Plan inclusive of the Financial Improvement Programme and Efficiency, Productivity and Transformation Plans, ICS Infrastructure Estates Strategy, General Practice Estate Programme. Partnerships and Services – ShIPP, TWIPP, ICS Digital Delivery Group, Strategic Estates Board, People Board, Planned Care Board, UEC Delivery Board. Governance & Engagement Structures - Finance Committee, Commissioning Working Group, Strategic Commissioning Committee, Audit Committee, Provider Collaborative Committees in Common.	First Line - Monitoring delivery of System Financial Strategy and Financial Plan by CFO group, Standing Orders, Standing Financial Instructions and Delegated Financial Limits, Financial Accounting Performance Metrics, HFMA Financial Sustainability Checklist, NHSE Grip and Control Checklist, Better Payment Practice Code, Productivity review informed by: Getting It Right First Time (GIRFT), Model Health System, ICS Patient Level Information and Costing Systems (PLICS) dashboard, Health Expenditure, benchmarking tool (HEB). Second Line - Finance Report to Finance Committee, Integrated Performance Report to the Board. Third Line - Monthly Integrated (Care System) Finance Return and Provider Finance Returns reporting to NHSE, Quarterly NHSE Financial Stocktake, NHSE Annual planning process (and triangulation of Finance, Activity and workforce planning)	**Gaps in controls:** Long term financial plan now out of date System transformational projects ('big ticket items') in place but at varying stages of maturity. Existing transformation plans do not fully address the target savings position. Lack of overarching system financial strategy **Gaps in assurances:** None	Almost Certain 5 x Major 4 = Extreme 20	↓	Long term system financial modelling (10 year) to be completed by March 25 to include the impact of HTP. Detailed medium term demand and capacity model and medium term financial plan based on 24/25 built and presented to Finance Committee in September 24. Updates to the MTFP alongside the FIP and recovery plan by Mar 25. Development of 25/26 operational plan and refresh of medium term financial plan for latest financial projections by March 25. Delivery of the strategic five year transformation plans reported through Financial Improvement Programme Board to be known as the Recovery Plan - 3 year plan development Sept 24-Mar 25. Development of system financial strategy document underway to dovetail with long term financial modelling and development of ICB joint forward plan - Jun-Sept 24 and final version to be approved by Mar 25.	Possible 3 x Major 4 = High 12	Claire Skidmore	Angela Szabo	Finance Committee	27/10/23 Laura Clare 17/01/2024 Laura Clare 22/04/2024 Angela Szabo 23/07/2024 Angela Szabo 21/10/2024 Angela Szabo	Alignment of risk scores across the system,system integrated improvement plan in place. Risk reduced 21/10/24 Angela Szabo
8	1,2,3	Sam Tilley	**Emergency Planning, Resilience and Response (EPRR)** If the ICB does not have system level plans in place to respond to emergencies, incidents, or disruptive events (e.g. adverse weather, cyber-attack, utilities failure, transport accidents, malicious attacks, industrial action, etc) impacting on the healthcare system and communities of Shropshire, Telford and Wrekin, there is a risk of an inadequate and/or uncoordinated response by the NHS, and the potential for a confused and/or misrepresented attendance at multiagency coordinating groups.	Opportunity to work collaboratively across the STW ICS and the West Mercia LHRP footprint in our approach to Emergency Preparedness, Resilience and Response (EPRR), and with West Mercia Local Resilience Forum (LRF) partners.	•ICB EPRR Programme Group (with oversight of EPRR related risk register). •West Mercia Local Health Resilience Partnership (LHRP) with oversight of EPRR and health related risk register. •West Mercia Health Emergency Preparedness Operational Group (HEPOG) reporting to LHRP. •LHRP and HEPOG work programme. •Risks and risk registers linked to National Risk Register (NRR) and LRF Community Risk Register (CRR). •Reporting to ICB Audit Committee and Board. •Civil Contingencies Act 2004 (CCA) and National NHS EPRR Framework, NHS Act 2006, Health and Care Act 2022, and the NHS Standard Contract. •Attendance at LRF working groups, including an approved NHS Shropshire, Telford and Wrekin ICS West Mercia Local Resilience Forum Representation Agreement.		**Gaps in assurance:** •Very limited ICB EPRR resource. •No existing system level EPRR frameworks, policies, plans for organisations to align own policies and plans to enhance a coordinated response. •Lack of documented Standard Operating Procedures (SOPs) for the System Coordination Centre (SCC). **Gaps in Controls:** •Recent combining of STW LHRP & HEPOG and Herefordshire & Worcestershire LHRP & HEPOG to form the West Mercia LHRP and HEPOG. •Low level of compliance with NHS Core Standards for EPRR.	Consequence 4 (Major) x Likelihood 4 (Likely) = 16 HIGH RISK	↔	1.ICB EPRR work programme has actions to produce system level EPRR policies, frameworks and plans for organisations to align own policies and plans. 2.ICB to continue with monthly meetings with EPRR leads for each organisation. 3.STW ICB EPRR lead to work closely with H&W ICB lead to drive the LHRP and HEPOG work programme ensuring links to system/locality risks, issues, and challenges. 4.Continue with systemwide exercising schedule. 5.Accountable Emergency Officers (AEO) for each organisation to review EPRR resourcing to ensure it is adequate for the size, type, and services of their organisation and duties placed on them under the CCA, NHS EPRR Framework, NHS Act 2006, Health and Care Act 2022, and the NHS Standard Contract.	Consequence : 3 (Moderate) x Likelihood: 3 (Possible) = 9 **MODERATE RISK**	Ian Bett, Interim Executive Director – Director of Delivery and Transformation / Accountable Emergency Officer (AEO) (NHS STW ICB)	Ian Bett, Interim Executive Director – Director of Delivery and Transformation / Accountable Emergency Officer (AEO) (NHS STW ICB)	ICB EPRR Programme Group – Audit Committee – Board.	19/01/24 Sam Tilley. 13/09/2024 - Stuart Allen, Senior EPRR Lead (NHS STW ICB) (Approved by Ian Bett 17/09/2024).	
9	3	Alex Brett	**System CPO** If we do not have a substantive CPO for the system then our ability to implement the people agenda in a timely and effective manner will be affected, resulting in a failure to deliver the 10 statutory People outcomes.	This is an opportunity to enable the ICS to meet its statutory and People Plan obligations and facilitate collaboration and organisational development across all system employers.	Ad hoc discussion at ICB Board , Remuneration Committee and Executive Team meetings Regional NHSE People Director engagement The system CEO SRO provides leadership for the four strategic portfolio's and from August 24 chairs the system People Collaborative a sub meeting of the system People Culture and Inclusion Committee. The Deputy CPO is on secondment and this role has been backfilled with a Head of People Programmes role providing a leadership function to operational delivery of the people priorities. The Head of People programmes reports directly to the ICB CEO for additional leadership. Head of People programmes attends regional CPO meetings and monthly 1:1 with NHSE regional workforce transformation lead. There is also additional leadership capacity with SRO's with accountability and delivery to each of the four strategic people priorities.	3)Quarterly hybrid closed loop (HCL) submissions to National Diabetes Audit.	**Gaps in Controls:** 1) There is no routine control mechanism to understand the impact of the current model, or the necessary actions - this gap is now closed . 2) The System People Committee does not consider the system's CPO resource requirements - 3) The 23/24 People annual report evidences progress against the ICS People strategy with significant assurance provided to illustrate improved outcomes against agreed plans 4) Advert for CPO has gone out twice plus an additional reach out by the ICB CEO to identify opportunities to appoint to this role, with no success as COP roles are difficult to fill nationally. 5) An alternative to a CPO role will be part of one of the recommendations proposed as part of the external review. Gaps in assurance: 4) There is inadequate evidence of this risk being identified and addressed - this gap is now closed. 5) There is evidence of this risk being addressed with an external review of HR/People/ ICB people team function and infrastructure commencing September 24. Gaps in resources to deliver the people strategy have been mitigated by SaTH supporting with infrastructure where there have been opportunities to do so .	Likely 4 x Major 4= High 16	↑	1) Interim CPO working with ICB CEO and system CEOs to finalise a collaborative approach to people structures, programmes etc. 2 and 3) Interim CPO working to refresh System People Committee, its ToR and its work programme - to include regular discussion of demand & capacity. 4)CEO's were not able to agree a collaborative approach to people structures either a proportionate investment across providers into the peopel team resources hosted by ICB or providers identifying necessary infrastructure from own resources . There is now an external review of HR/People / ICB eopel team commencing September 24.	Possible 3 x Moderate 3 = Moderate 9	Alex Brett Simon Whitehouse	Sara Hayes Alison Trumper	People, Culture and Inclusion Committee People Collaborative	S Hayes 28/07/23 Existing key controls updated 04/09/34 - Alison Trumper Existing sources of assurance updated 04/09/34 Gaps in controls or assurance -Alison Trumper 04/09/24 Action plan updated - 04/08/24 -Alison Trumper Director risk owner - Alison Trumper 04/09/24 Risk owner -Alison Trumper 04/09/24	
10	3	Alex Brett	**Deputy CPO capacity** If the size of portfolio of the Deputy CPO (programmes, team management and People function for the ICB as an employer)is not more manageable then this will affect our ability to implement the people agenda in a timely and effective manner, resulting in a failure to deliver the 10 statutory People outcomes.	This is an opportunity to enable the ICS to meet its statutory and People Plan obligations and facilitate collaboration and organisational development across all system employers. This is an opportunity to strengthen the leadership of the People Function which is vital in supporting, enabling and leading the workforce transformation programmes.	Ad hoc discussion at ICS meetings Ad hoc discussion at ICS CEO meeting The current CPO is on secondment which has provided opportunity to pilot a different approach to this role which the Deputy has been instrumental in securing before secondment. To ensure capacity to deliver there is now a separate temporary resource for workforce planning and assurance, system leadership across the four external people programmes and the internal ICB facing HR resource and leadership. This has provided sufficient resource to effectively manage and lead these three areas.		**Gaps in Controls:** 1) There is no routine control mechanism to understand the impact of the current model, or the necessary actions. 2) The System People Committee does not consider the system's collaborative approach to people structure, priorities or resource requirements. 3) People Culture and Inclusion Committee has received regular updates on available capacity across the four strategic people portfolio's . Where there has been opportunity providers have identified some additional leadership capacity . **Gaps in assurance:** 4) There is inadequate evidence of this risk being identified and addressed. 5) There is assurance that this risk has been managed by the addittional leadership across the three areas of the CPO role to increase capacity	Likely 4 x Major 4= High 16	↑	1) Interim CPO working with ICB CEO and system CEOs to finalise a collaborative approach to people structures, programmes etc. 2 and 3) Interim CPO working to refresh System People Committee, its ToR and its work programme - to include regular discussion of demand & capacity. 4) The interim CPO has now left the role .The PeopleCommitte has reviewed itsToR, reviewed its governance reporting arrangements and has been subject to observation as part of the ICB's good governance assessment process - awaiting formal feedback with iniital review indiated as being positive . 5) Where there have been opportunities provider partners have provided some temporary infrastructure across one of the programmes. The People infrastructure is subject to a wider review and will commence September 24 with anticipated recommendations to present to the system CEO's . This will also include opportunity to review Director leadership at the CPO level in response to the post being challenging to appoint too.	Possible 3 x Moderate 3 = Moderate 9	Alex Brett Simon Whitehouse	Sara Hayes Alison Trumper	People, Culture and Inclusion Committee People Collaborative	S Hayes 28/07/23 Existing key controls - 04/09/24 -Alison Trumper Level of assurance 04/09/34-Alison Trumper Gaps in control -04/09/24 Actionplan - 04/09/24 Risk owner Director - 04/09/24Where there has been opportunity providers have identified some additional leadership capacity .owner - Alison Trumper 04/09/24 Risk owner Director - Alison Trumper 04/09/24	
11	3	Alex Brett	**Capacity (including appropriate administrative capacity) to deliver the 10 People outcomes.** If there is lack of clarity on the shape, size, priorities, structures and sustainable funding for system people collaboration, then this will impact on our system's ability to deliver the 10 statutory people outcomes, resulting in continuing capacity pressures in our primary community and acute settings: - Supporting the H&WB of staff - Growing the workforce for the future & enabling adequate workforce supply - Supporting inclusion & belonging for all & creating a great experience for staff - Valuing and supporting leadership at all levels and lifelong learning - Leading workforce transformation & new ways of working - Educating, training & developing people and managing talent - Driving & supporting broader social & economic development - Transforming people services & supporting the people profession - Leading coordinated workforce planning & intelligence - Supporting system design & development	This is an opportunity to support and enable our system employers and people to make progress towards our strategic ambition of one workforce and workforce transformation for patient service transformation.	Ad hoc discussion at ICB Executive Team meetings Ad hoc discussion at ICS CEO meetings. Updates on available infrastructure reported to People collaborative and to People Culture and inclusion Committee Additional temporary capacity (up to March 25) to deliver the workforce planning, monitoring and assurance requirement as part of the REFORM portfolio. Where there has been opportunity , additional temporary capacity has been identified by Sath to support one of the portfolio's .	4) Diabetes classified as a clinical priority within the STW ICS	**Gaps in Controls**: 1) The ICS does not have an appropriate mechanism to discuss and agree the shape of people services and structures for the future. 2) The System People Committee does not consider the system's collaborative approach to people structure, priorities or resource requirements.3) People Culture and Inclusion Committee has received regular updates on available capacity across the four strategic people portfolio's . Where there has been opportunity providers have identified some additional leadership capacity . 3) People Culture and Inclusion Committee has received regular updates on available capacity across the four strategic people portfolio's . Where there has been opportunity providers have identified some additional temporary leadership capacity . 4) There is growing evidence of this risk being identified and addrressed through the commissioning of an external review or HR/ICB People infrastructure across the ICB, SCHT and SaTH commenced September 24 5) There is assurance that this risk has been managed by the addtiional leadership across the three areas of the CPO role to increase capacity. Gaps in assurance: 3) There is inadequate evidence of this risk being identified and addressed.	Likely 4 x Major 4= High 16	↔	1) Interim CPO working with ICB CEO and system CEOs to finalise a collaborative approach to people structures, programmes etc. 2) Interim CPO working to refresh System People Committee, its ToR and its work programme - to include regular discussion of people services and structures across all ICS employers. 3a) Focus current People Team resources on programmes that enable the greatest value to be added 3b) Explore all opportunities for collaborating and sharing workload with system partners. 4)Where there has been opportunity providers have identified some additional temporary leadership capacity . 5) Additional temporary resource has been funded to provide capacity for workforce planning and assurance, internal ICB HR function and leadership across the people Programmes and at this item this has been identified as being cost neutral from vacant posts. 6) Await outcomes of external review commenced September 24	Possible 3 x Moderate 3 = Moderate 9	Alex Brett Simon Whitehouse	Sara Hayes Alison Trumper	People, Culture and Inclusion Committee People Collaborative	S Hayes 28/07/23 Existing key controls - Alison Trumper 04/09/24 Existin sources of assurance - Alison Trumper 04/09/24 Gaps in control - AlisonTrumper 04/09/24 Action plan - Alispn Trumper 0409/24 Director /risk owner - Alison Trumper 04/09/24 Risk Owner - AlisonTrumper 04/09/24	
12 (SQG9)	2 & 3	Vanessa Whatley Chief Nursing Officer, NHS STW	If there is not an effective **acute paediatric pathway** for Shropshire Telford and Wrekin including clear access to the wider KIDS Network and assurance that there are not inequalities in access with health and care partners then Children requiring the support of their health needs may experience harm or delays in accessing treatment.	To have assurance of a sustainable, safe and effective paediatric health and social care for the population of Shropshire Telford and Wrekin.	1) All incidents are reviewed in line with the Patient Safety Incident response Framework and policy (PSIRF) (Oct 24) 2) Paediatric sepsis pathway is audited monthly at SaTH (Oct 24) 3) SaTH have provided assurance on immediate actions from Quality visit and immediate actions from incidents in Sept and Oct 23 (Oct 24) 4) Chid death cases are shared with the SaTH patient safety Specialist (Oct 24) 5) SaTH are members of the quarterly child mortality meetings (Oct 24) 6) SaTH continue to make progress in the Peadiatric Transformation Assurance Committee with ICB oversight (Oct 24) 7) System oversight of paediatric meaures (Oct 24)"	"1) Monthly joint meeting to oversee risk and actions and liaise with SaTH/other partners to support progress including continuous oversight in line with National Guidance on Quality Risk Response and Escalation in Integrated Care Systems, NQB,22. (ICB and Regional NHSE team.(Nov 24) 2) There is a plan in place to progress current ICB action plans which is on track (Nov 24) 3) A Rapid Quality Review has been undertaken with appropriate stakeholders (Nov 24) 4) The Sepsis Trust Paediatric tool has been launched at SaTH with education and training in May 23 (Nov 24) 5) SaTH have completed and presented a thematic review on 3 cases in June 23 (Nov 24) 6) Sath have reviewed Sepsis pathway and implemented the Sepsis Trust's padiatric assessment tool in May 23(Nov 24) 7) Sath are reviewing all actions relating to Paediatric Pathways via PTAC meeting with ICB rep (Nov 24) 8) SaTH delivered action plan addressing immediate actions and actions identified in the Quality visit undertaken on 1st February, Assurance to be given at PTAC (Nov 24) 9) SaTH have identified senior medical leadership for paediatrics for July 23(Nov 24) 11) Rapid Quality Review Action Plan delivered (Nov 24) 12) Vital Pac implementation has been completed (Nov 24) 13) CQC rated the Paediatric services as Good, awaiting	1) There is no efficient system for GP's to communicate with Paediatricians for advice and support.(June 24) 2) There is a lack of assurance on the timeliness of response from the KIDS Team. (June 24) 3) There is a gap in the reporting against newly signed contractual quality measures in paediatric dept (June 24) 4) There is a gap in the reporting of paediatric sepsis audit and training in the emergency department(June 24)	3 possible x 5 catastrophic = 15 High	↓	1) SaTH to continue to review all paediatric actions via PTAC and they are completed and assured (SaTH, June 24) 3) KIDS /NHSE teams to provide assurance on the response to children in STW. (KIDS/NHSE specialist commissioning NHSE, June 23) 5) Await sign off of the Review of Paediatric Commissioning oversight at system level (ICB, Dec 23) Completed 6) Await findings of CQC inspection Oct/Nov 23 (ICB/SaTH March/April 24) Completed 7) Sath to present paediatris quality metrics as per contract (June 24) 8) Sath to provide infomraitno relating to the susccesful introufction of electronic PEWs in line wth Nov 23 published version 9) Clinical lead for STW to work with clnical director at SaTH to identify improved communcation for piloting (ICB, June 24)	catastrophic 5x Rare 1= 5 Low	Ian Bett PTAC, SaTH, ICB Group TBD.	Vanessa Whatley Director for Safety and Quality/ Chief Nurse ICB	Quality and Performance Committee	21.06.23 Reviewed at QPC July 24 Reviewed at QPC November 2024	
13 (SQG 10)	1	ICS IPC Meeting 07/23	If Clostridioides difficile cases continue to increase at the current rate there will be increased harm to patients, resulting in poorer outcomes, loss of reputation and inefficient in best use of resources.	To bring new C diff cases back in line with monthly trajectory	1) IPC resources for all parts of the system with implementation of policies including the below(June 24) : 2) National guidance supporting best practice (Mar 24) 2) Quality Walk arounds (June 24) 3) Commode audits (June 24) 4) HPV cleaning of side rooms and equipment (June 24)		1) There is a gap in controls as Sath are unable to report on deep clean programme completion due to UEC pressures (June 24)	Likely 4 x Major 4 = High 16	↔	2) System action plan to be delivered to regain monthly trajectory (July 24) 3)AMR sub group of IPC AMR group to deliver plan to address prescribing in high risk antibiotics for CDI (Sept 24) 4) SaTH Developing revised plan in line with regonal lead visit (May 24).	Unlikely 2 x Moderate 3 = Low 6	ICS IPC/AMR Group Chair: Vanessa Whatley	ICS IPC/AMR Group Chair: Vanessa Whatley	ICS IPC/AMR Group	Vanessa Whatley Jan 24 Vanessa Whately Mar 24 Reviewed QPC July 24	
15	5	Tristi Tanaka	Patients/users harmed due to **difficulty of finding information across different systems** within and across settings (Self-referral, Primary Care, POD, Community Services, Mental Health, Specialist Acute Services, Acute Services, Social Care and Children's Services	Review the value, benefits and gaps of the One Health & Care (integrated care record) platform for direct care.	* BAF Strategic Risk 5 * ICS Digital Strategy * ICS Digtial Portfolio entry for Shared Care Records		**Gaps in Controls:** 1) Resources are limited **Gaps in Assurances:** 2) Sources are assurance are limited as part of Group reporting up to the ICS Digital Delivery Group.	Almost Certain 5 x Major 4 = 20 Extreme	↔	1a) Complete the STW OHC Review with the purpose of enabling the integrated care record to 1b)Connect our staff and organisations to one source of truth for citizen information" and support "Support better multi disciplinary working, as clinical data follows the patient and encourages a collaborative approach to care" 1c) Review OHC overnance, stakeholder involvement and communications, finance and budget Change management, Supplier management and OHC roadmap and strategic alignment 1d) Ensure clinical and care digital solutions are selected for integration, funded for development and ongoing support for user training, quality improvement and aligned to use cases that support patient safety and improved health and care outcomes	Likely 4 x Major 4 = 16 High	Lorna Clarson CMO	Tristi Tanaka	Quality and Performance Committee	30.01.2024. Tristi Tanaka	
16	5	Tristi Tanaka	Lack of a **system digital inclusion framework** increases the likelihood that digital transformation programmes may exacerbate digital inequalities, not only affecting access health and care services as well as the ability to achieve the desired patient outcomes	Develop a system digital inclusion framework to guide the prioritisation, design, implementation and evaluation of digital health and care services	* ICS Strategic Commissioning Intentions * ICS Digital Strategy * ICB Prevention and Health Inequalities Board Quarterly Highlight report	7) There is a monthly published diabetes dashboard for the STW ICS.	**Gaps in controls:** 1) Resources are limited **Gaps in Assurances:** None	Likely 4 x Major 4 = 16 High	↔	1a) Develop a system digital inclusion framework for digitally-enabled health and care services 1b) Update the STW ICS Full Integrated Impact Assessment 1c) Update the STW Business Case requirements 1d) Update commissioning requirements for the procurement of digital health and care products and services 1e) Ensure supplier contracts include mechanisms for monitoring, reporting, improvement metrics and assurance 1f) Update the prioritisation guidance for the Investment Panel	Possible 3 x Moderate 3 = 9 Moderate	Lorna Clarson CMO	Tristi Tanaka	Strategic Commissioning Committee	30.01.2024. Tristi Tanaka	
17	5	Tristi Tanaka	Lack of **system capacity and funding to support digital clinical risk management** increasing likelihood of non-compliance with compliance with NHSE digital clinical risk management standards	Develop a system-wide approach to clinical safety including the integration of incident management	* ICS Strategic Commissioning Intentions *ICS Clinical Leadership development programmes * ICS Digital Strategy * ICS Digtial Portfolio		**Gaps in controls:** 1) Resources are limited **Gaps in Assurances:** 2) Sources are assurance are limited a part of Group reporting up to the ICS Digital Delivery Group	Almost Certain 5 x Major 4 = 20 Extreme	↔	1a) Develop a fund to enable the development of the role of clinical safety officers and the tools for clinical risk management 1b) Develop a programme of training and support 1c) Review existing clinical incident management processes for opportunities to align incident reporting related to digital clinical risks 1d) Identify opportunities to align the clinical risk management framework and alignment with compliance with best practice technology standards to commissioning and procurement processes for digital health and care tools and solutions e.g. DCB0129 (developers) and DCB0160 (adopters), DTAC, NICE TA recommendations, MHRA Approval, TCoP 1e) Ensure link to clinical risk management in the development of the SCC and EPRR 1f) Develop guardrails for emerging technologies like AI for risk stratification, automated or embededed clinical decision support tools, etc.	Likely 4 x Major 4 = 16 High	Lorna Clarson CMO	Tristi Tanaka	Quality and Performance Committee	30.01.2024. Tristi Tanaka	
18 (SQG 11)	1	Vanessa Whatley CNO NHS STW	If there is no effective **clinical triage of the current Adult ADHD waiting list** in STW ICB people who are waiting are at risk of significant harm including behavioural, emotional, social, academic and vocational problems which will result in mental health deterioration, self-harm and inappropriate prescribing impacting on cost and services across the ICS.	To implement the initial clinical triage of the adult ADHD waiting list to ensure safe care and mitigation of harm. Followed by the development of a commissioned service.	1) Weekly internal ICB task & finish group , membership from ICB contracts team, quality team, medicines management, transformation, Primary care 2) Part of regional task and finish group 3) In discussions with local provider re triage service 4)Plan for communication to be sent to primary care week commencing 19th February 24 - update provided to PC 5) Work is progressing between MPFT and MHWBS develop pathway around patients with comorbidities meeting to be scheduled February 24 6) Quality visit to MHWBS to be undertaken in early March 24 - completed (report can be made available)	8) There is ongoing oversight that NICE NG 17, NG18, NG28 guidance is implemented.	1) No control on the number of people being referred for an adult ADHD assessment (April 24). 2) No control on the clinical assessment prior to referral (April 24) - consider screening tool 3) 4) No control over the quality of the right to choose process (Jan 24) high on agenda for regional task and finish group 5) No control over the associated costs following the right to choose process (April 24)	Likely 4 x Major 4 = High 16	↔	1) Scope options for a GP screening process to ensure appropriate referral, also being looked at by regional task & finish group on 5th December 23, STW ICB will utilise learning/recommendations to take forward in ICB 2a) Develop an affordable triage system which mitigates harm (ICB, Nov 23)- Triage proposal has been agreed with a local provider,- date to commence confirmed as 1st December 23 2b) Meeting with provider on Dec 1st 23 – explore potential assessment capacity in addition to the triage 2c) Undertake market engagement exercise to determine procurement route for the commissioning of an assessment service (ICB, date TBC) 2d) Procure a clinical service to deliver the assessments (ICB, date TBC). 3a) Establish provider harm review process in case of unmitigated harm to ensure appropriate incident response, escalation, and learning (1st December 23) 3b) Ensure that provider/Primary care is compliant with shared care agreed pathways including where there is a decline to prescribe - Shared care agreement to be included in MOU 3c) Take part in regional discussions and actions as they develop (ICB, Dec 23) 3d) following implementation of triage service undertake a quality visit from ICB Quality team 4a) Undertake market engagement exercise to determine procurement route for the commissioning of an assessment service (ICB, date TBC) 4b) Procure a clinical service to deliver the assessments (ICB, date TBC). 1) Scope options for a GP screening tool/process to be explored in alignment with the regional task & finish group. 2) Market engagement exercise completed, 12 providers attended 3) Shared care agreed pathways - ongoing discussions with PC (ref SQG12) and discussion at GP board (March 24) 4) Take part in regional discussions and actions as they develop	Likely 4 x Moderate 3 = High 12	ADHD task and finish group Vanessa Whatley CMO	Helen Rowney Dr Priya George Tracey Slater	Quality and Performance Committee	V Whatley	
20	1, 2, 3	Angela Szabo, Director of Finance	**Revenue Financial Plan 24/25** Failure to deliver 24/25 ICS revenue financial plan limit, delivery of the financial improvement programme and management of risk. **Capital Financial Plan 24/25** Failure to deliver plans within the capital limit in year, given the cap reduction of 10% of operational capital £2.8m, shortfall of 3.25m IFRS16 allocation, SCHT frontline digital £0.7m, RJAH EPR capital overspend not mitigated.	Opportunity to create a financially sustainable system Adherence with the Financial Frameworks, Revenue and Capital	**Revenue and Capital** System financial principles and risk management framework in place across the system as part of development of system financial recovery plan approach as set out within the financial strategy. System governance arrangements in place through finance committee and system strategic committee and commissioning working group to ensure that new investments are not made unless recurrent resource is available. **Revenue** System workforce programme and agency reduction group implemented, weekly agency reporting and action plan to reduce agency expenditure in line with system cap Financial Improvement Programme and System Transformation Group Organisation self assessments of plan conditions/financial controls in place - Triple Lock, vacancy controls, HFMA sustainability and NHSE Grip and Control. System vacancy panel in place. Workforce monitoring of vacancies in place. Capital Capital Prioritisation Oversight Group	Regular System level financial reporting to ICS finance committee and Integrated Care Board Finance Committee across the system to oversee efficiency and transformation programme delivery. System productivity and FIP group in place for efficiency. FIP reports into System Transformation Group which provides Assurance to the Board Provider collaborative in place. System agency reduction group implemented, weekly agency reporting and action plan to reduce agency expenditure in line with system cap. NOF organisation self assessments of plan conditions/financial controls, Triple lock in place.	**Gaps in Control:** STW 12th June Revenue Financial Plan Limit £90m deficit, Efficiency is 7.14% for the ICS - Fully identified efficiency plans for 24/25 now in place. Key areas of risk to delivery are: 1.a Efficiency delivery - delivery risk 31% of plan 1b Escalation costs due to UEC pressure and links to discharge 1c Costs and inflation pressures 1d New NICE appraisals with significant implementation costs e.g. Obesity - Tirzepatide could have huge financial impacts (circa £81M if 70% eligible patients were able to access at current list price) **Gaps in Assurances:** A forecast that does not have risks fully mitigated means that there is limited assurance that the financial forecast can be met.	Almost Certain 5 x Major 4 = Extreme 20	↓	**Revenue** Financial Framework/Strategy sets out the Recovery Plan Recovery plan - Oversight through the Financial Improvement Programme Group 1a) Financial Improvement Programme governance to ensure delivery of 24/25 efficiency plans including oversight and monitoring. Fully identified programme by 31/07 and implemented by 30/09. IB/KO - completed 1b) Multi year plans to be reviewed and pipeline developed by Sept 24-Mar 25. IB/KO 1c) UEC Tier 1 PIDS to be updated - GR May 24 - completed 1d) Quarterly SCHT/SaTH/ICB review of Sub acute/VW/IDT/Escalation - GS/JG Ongoing 1e) Strategic Decision Making Framework in development - approved Sept 24 1f) CHC/Medicines assurance oversight meetings in place - meet bi-monthly - VW/AS - ongoing. Escalation of new NICE medicines high cost through Medicines Best Value Group, commissioning policies/pathways and use of blueteq. **Capital** Joint Capital Plan agreed and published Capital Strategy in place Capital Prioritisation Framework in Place 10 Year Capital Plan prioritised	Possible 3 x Major 4 = High 12	Claire Skidmore	Angela Szabo	Finance Committee	22/04/2024 Angela Szabo 23/07/2024 Angela Szabo 21/10/2024 Angela Szabo	Alignment of risk scores across the system,system integrated improvement plan in place. Fully identified efficiency plan. Risk reduced 21/10/24 Angela Szabo.
21 (SQG 13)	1	Clare Stallard Medicines Management and Dr Priya George	If the increasing numbers of rejections for **shared care prescribing** which would otherwise be suitable for Primary Care prescribing is maintained then this will lead to further capacity pressures at specialist provider level and impact on patients accessing their medicines in a timely way, creating inequity of access where some practices accept prescribing and others do not. MHWB ADHD services have reported a 25-30% rejection rate which is further increasing.	Address the concerns of primary care through the LMC, GP board with the support and oversight of Nick White (CMO) to improve uptake of share care prescribing particularly for MH/ADHD services	1)Implementation of National Documents to standardise approach across all specialties 2) specialist provider led with GP input for approval via IMOC 3) working group in place to ensure clear pathways for MH and ADHD services 4) safe prescribing of medicines LCS with exisiting funding reinvested to support MH and ADHD prescribing 5) Communication of implementation process via newsletter and formulary newsfeed/update e.g. routine review or proactive	9) Funding for Continuous Glucose monitoring NG28&17 in place with oversight.	1) Absence of clear pathway for support for Primary Care from specialist teams MH ADHD services and how the services interlink (MDT approach) 2) inconsistent use of language/terminology relating to discharge and continued specialist oversight 3) growth being seen in ADHD/MH services and prescribing- additional funding considerations/drug budget impacts/primary care capacity 4) Knowledge/competency gap for primary care 5)lack of assurance of adoption and communication at provider level of agreed shared care documents and specialist responsibilities due to absence of operational management input in development, approval and circulation 6) Limited practice sign up to LCS due to ongoing discussions with LMC and Primary Care	4 Likely x 4 Major = 16 High	↔	1) comorbidities pathway developed to outline patient pathway, GP support/escalation and ongoing care/supervision- changing language avoiding discharge and reframing acute specialist oversight--> community specialist oversight when prescribing transferring to primary care. Contract negotiations being held with MPFT- ongoing 2) operational management involvement in shared care document development and clinical lead MH representative on future relevant IMOC-complete 3) New decline to prescribe process in place for provider reporting and identification of trends to allow for addressing any issues-complete May 4) as part of ADHD assessment and diagnosis service, consider capacity and funding/budget impacts for primary care increasing prescribing numbers, consider as part of procurement process. CWG paper presented 4) met with LMC and issue joint statement from commissioning, medicines, LMC to practices with CMO sign off/endorsement to provide current assurances of the above financial uplift for LCS once approved- July/Aug 5) specialist education/networking/support session for primary care -24/25 6) User guide for new shared care documents format approved to present to GP board on 19th June and circulate following this 7) position statement to clarify position of non-medical prescribers in shared care prescribing - to present to GP board 19th June 8) Meeting held with Primary Care and LMC, follow up actions with Nicola Williams in Primary Care- update to be provided July 24.	3 possible x3 moderate = 9 Moderate	Task and Finish Group ADHD Lorna Clarson CMO	Andrew Riley, Senior Pharmaceutical Advisor	Quality and performance committee	Accepted onto RR March 24 Reviewed QPC July 24	
22	1, 2, 3	Tristi Tanaka, interim Head of Digital	**System-wide Cybersecurity Operating Model and Strategy** The ICB does not have a cyber operating model, system-wide cybersecurity strategy or ICS plan in place for cyber reslience for known vulnerabilities and attack methods proportionate to the risk profile, with all operators of essential services (OESs) in the sector and across the ICS digital and technology supply chain, making ICS partners vulnerable in meeting their statutory obligations	Opportunity to work collaboratively across the system in our approach to cybersecurity	Each ICS partner has cybersecurity capabilities Working action plan from November 2023 Cyber Resilience event		**Gaps in Controls:** 1) Unclear funding to develop a ICS Cyber Target Operating Model (TOM) and ICS Cybersecurity Strategy 2) Unclear resources and capabilities to achieve functional Cyber Assessment Framework outcomes 3) Unclear commitment from ICS partners to develop an ICS TOM **Gaps in Assurance:** 1) The ICS Cyber Operations working group has not been re-established. 2) ICB Cybersecurity services are wholly outsourced and reporting through Information Governance 3) Existing reporting does not have Digital involvement or oversight	4 Likely x 4 Major = 16 HIGH	↔	1) Confirm ICS Cyber Lead who will attend NHSE/Midlands Cyber meetings, promote NHSE Cyber service offer and agree to participate in any study 2) Deliver Board approved ICS Cyber Strategy by April 2025 3) Deliver and integrate ICS Cyber Risk Register 4) Produce and issue ICS Cyber Allocation Quarterly Reports From our ICS Digital Strategy's "Cyber Security Portfolio" and "Collaborative Ways of Working" • Respond to identified need and risk/gap that the ICS are not providing Cyber security support to organisations on a 24/7 basis. • Review options and agree solutions to protect medical devices. • Increase capabilities in office 365 and enhancing licensing within the specialty area. • Respond to need for all organisations to work together to achieve collective goals... establishing key groups where lessons can be learned and where sensible the joining up of resources can be utilised. From our ICS Digital Strategy's pledge "Upskilling workforce and communities in data literacy" • Conduct current capability analysis across ICS workforce and community digital, data and cyber security literacy via surveys. • Support all staff to attain a basic level of data, digital and cyber security literacy, followed by continuing professional development. • Address BAF Strategic Risk No.2: Risk of not delivering sustainable services within available resources and Strategic Risk No.5: Lack of capacity and strategy to develop and use digital and data systems to enable efficient and effective care across the ICS	Possible 3 x Moderate 3 = 9 Moderate	Lorna Clarson	Head of Digital	Strategic Commissioning Committee	Tristi Tanaka 30/08/24	
23	1,2, 3	Alison Smith CBO	**Patient and Public Involvement** There is a risk that the system and ICB fail to undertake necessary engagement and statutory consultation where this is required to support strategic commissioning leading to services that have not be adequately designed for and by service users.	Consistent approach to patient and public involvement across the STW system utilising resources in a more efficient way	IIA process has been adopted by the system which includes consideration of engagement and involvement for changes to services. PMO for transformation efficiency programmes includes requirement to consider and plan involvement activity early in the process. ICB has a Communications and Engagement Framework which sets out the approach to involvement. CSU SLA [rovides some hours of comms and engagement support to the ICB Monthly system Comms and Engagement leads meeting to share intelligence and seek support. People's Forum Existing networks with partners and third sector in place	10) Diabetes Management in Pregnancy is part of the Saving Babies Lives Care Bundle version 3 (SBLCBv3) and is monitored as part of the SBLCBv3 and CNST successful submission.	Gaps in controls: 1) Lack of comms and engagement capacity across the system 2) The need for guidance and support across the ICB and other partners to provide basic undertanding of the requirements around engagement and statutory consultation Gaps in Assurance: None	3 possible x 4 Major = 12 High	↔	1) Confirm ICS Cyber Lead who will attend NHSE/Midlands Cyber meetings, promote NHSE Cyber service offer and agree to participate in any study 2) Deliver Board approved ICS Cyber Strategy by April 2025 3) Deliver and integrate ICS Cyber Risk Register 4) Produce and issue ICS Cyber Allocation Quarterly Reports From our ICS Digital Strategy's "Cyber Security Portfolio" and "Collaborative Ways of Working" • Respond to identified need and risk/gap that the ICS are not providing Cyber security support to organisations on a 24/7 basis. • Review options and agree solutions to protect medical devices. • Increase capabilities in office 365 and enhancing licensing within the specialty area. • Respond to need for all organisations to work together to achieve collective goals... establishing key groups where lessons can be learned and where sensible the joining up of resources can be utilised. From our ICS Digital Strategy's pledge "Upskilling workforce and communities in data literacy" • Conduct current capability analysis across ICS workforce and community digital, data and cyber security literacy via surveys. • Support all staff to attain a basic level of data, digital and cyber security literacy, followed by continuing professional development. • Address BAF Strategic Risk No.2: Risk of not delivering sustainable services within available resources and Strategic Risk No.5: Lack of capacity and strategy to develop and use digital and data systems to enable efficient and effective care across the ICS	Unlikely 2 x 4 major = 8 Moderate	Alison Smith CBO	Head of Governance and Corporate Affairs	Equality and Involvement Sub Committee Strategic Commissioning Committee	Alison Smith 29/08/24	
24 SQG 14 (date risk entry October 24)	Pledge 1 - Improving safety and quality - making sure our services are clinically safe throughout the system, delivering the System Improvement Plan and tackling the backlog of elective procedures as a system.	Vanessa Whatley STW CNO	If the only Oral Maxilla Facial (OMF) service in STW system(SaTH provider) cannot provide timely assessment or surgery for patients with suspected OMF cancer then people will come to harm as a result potentially resulting in cancers pregressingfrom operable to inoperable	For the System to have strengthened OMF pathways through a revised pathway integrating with other partners/systems/regions to provide a robust and reliable service meeting the treatment targets and 2 week waits for first appointment and subsequent treatment required	1) SaTH consultants has risk stratified patients referred into Cat 1 and Cat 2 on initial presentation (Sept 24) 2) Waiting list initiatives are in place (Sep 24) 3) Dentists and GPs have been commubicated with to inform of current position	1) Cat 1 traiged patients are all booked into waiting list initiatives(26/09/24) 2) Offce of the West Midlands/Spec Com MD supporting mutual aid	**Gaps in Control** 1) There is no mutial aid offer available despite 8 Trusts being approached by the Office of the West Midlands (26/09/24) 2) There are other similarly fragile servcies in the west midlands which revents closure as additional patinet will cause unknown risks to their services. 3) STE/SaTH do have sight of the extent of waiting lists/times in other trysts and Systems 4) UHNM and RWT have declined mutual aid **Gaps in Assurance** None	3 possible x 5 catastrophic = 15 High Risk	New Risk	1) Maintain rhythm of twice weekly calls with SaTH/NHSE and daily review of OMFS sitrep (ICB sept/oct 24) 2) Seek outstanding responses to mutual aid requests North West Midlands and provuate providers (ICB/NHSE Sep 24) 3) Provide a rajectory of referrals, waiting list initiatives and remaining patients who v=cannot be seen to provide others witj a clear view of patients (SATH Sep 24) 4) Prov ide EQIA rto ICB for full assessment of risk (SATH Sep 24) 5) Complete the NHSE Fragile services checklist (SATH the system SEP/OCT 24) 6) Escalate the lack of mutual aid and growing backlog resulting in no progress to NHSE (Sep 24)	1 rare x 5 catastrophic = 5 Low Risk	Task and Finish group OMFS	Vanessa Whatley STW CNO	Quality and Performance Comittee	Entered onto RR Sept 24 Updated by V Ehatley for November 24 SQG	

14. New Cheif Medical Officer appointed for NHS STW. Sept 24.

NHS STW - ICB Strategic Operational Risk Register (ICBSORR) 2024/25 November 2024

Appendix B

ICB Statutory Purpose:

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**

1 Risk ID	2 S P u r r a p t o e s g e i c	3 Opened / added by	4 Risk and description	5 Opportunity	6 Existing key controls	7 Existing sources of assurance	8 Gaps in controls or assurances	9 Risk score (consequences x likelihood)	10 Risk score trend	11 Action plan / cost / action lead /(target date) /sufficient mitigation	12 Target risk score for end of financial year	13 Director or Risk Owner	14 Risk Owner	15 Committee/ICB oversight	16 Amendments: name and date	17 Amendments: name and date
1	1, 2 ,3	Laura Clare, Deputy CFO Now Angela Szabo, DOF	**Financial Sustainability Failure to deliver long term system financial sustainability and exit NOF4 arrangements**	Opportunity to create a financially sustainable system	Strategies and Plans - System Financial Strategy, incorporating: Healthcare Financial Management Association (HFMA) Financial sustainability checklist , Triple Aim framework through the Strategic Decision Making Framework, Capital Prioritisation Framework, Financial Revenue Plan, Financial Capital Plan , Joint 5 year forward plan, Financial Recovery Plan inclusive of the Financial Improvement Programme and Efficiency, Productivity and Transformation Plans, ICS Infrastructure Estates Strategy, General Practice Estate Programme. Partnerships and Services – ShIPP, TWIPP, ICS Digital Delivery Group, Strategic Estates Board, People Board, Planned Care Board, UEC Delivery Board. Governance & Engagement Structures - Finance Committee, Commissioning Working Group, Strategic Commissioning Committee, Audit Committee, Provider Collaborative Committees in Common.	First Line - Monitoring delivery of System Financial Strategy and Financial Plan by CFO group, Standing Orders, Standing Financial Instructions and Delegated Financial Limits, Financial Accounting Performance Metrics, HFMA Financial Sustainability Checklist, NHSE Grip and Control Checklist, Better Payment Practice Code, Productivity review informed by: Getting It Right First Time (GIRFT), Model Health System, ICS Patient Level Information and Costing Systems (PLICS) dashboard, Health Expenditure, benchmarking tool (HEB). Second Line - Finance Report to Finance Committee, Integrated Performance Report to the Board. Third Line - Monthly Integrated (Care System) Finance Return and Provider Finance Returns reporting to NHSE, Quarterly NHSE Financial Stocktake, NHSE Annual	**Gaps in controls:** **Long term financial plan now out of date** **System transformational projects ('big ticket items') in place but at varying stages of maturity.** Existing transformation plans do not fully address the target savings position. Lack of overarching system financial strategy **Gaps in assurances:** None	**Almost Certain 5 x Major 4 = Extreme 20**	↓	Long term system financial modelling (10 year) to be completed by March 25 to include the impact of HTP. Detailed medium term demand and capacity model and medium term financial plan based on 24/25 built and presented to Finance Committee in September 24. Updates to the MTFP alongside the FIP and recovery plan by Mar 25. Development of 25/26 operational plan and refresh of medium term financial plan for latest financial projections by March 25. Delivery of the strategic five year transformation plans reported through Financial Improvement Programme Board to be known as the Recovery Plan - 3 year plan development Sept 24-Mar 25. Development of system financial strategy document underway to dovetail with long term financial modelling and development of ICB joint forward plan - Jun-Sept 24 and final version to be approved by Mar 25.	**Possible 3 x Major 4 = High 12**	Claire Skidmore	Angela Szabo	Finance Committee	27/10/23 Laura Clare 17/01/2024 Laura Clare 22/04/2024 Angela Szabo 23/07/2024 Angela Szabo 21/10/2024 Angela Szabo	Alignment of risk scores across the system,system integrated improvement plan in place. Risk reduced 21/10/24 Angela Szabo
18	1, 2, 3	Angela Szabo, Director of Finance	**Revenue Financial Plan 24/25** Failure to deliver 24/25 ICS revenue financial plan limit, delivery of the financial improvement programme and management of risk. **Capital Financial Plan 24/25** Failure to deliver plans within the capital limit in year, given the cap reduction of 10% of operational capital £2.8m, shortfall of 3.25m IFRS16 allocation, SCHT frontline digital £0.7m, RJAH EPR capital overspend not mitigated.	Opportunity to create a financially sustainable system Adherence with the Financial Frameworks, Revenue and Capital	**Revenue and Capital** System financial principles and risk management framework in place across the system as part of development of system financial recovery plan approach as set out within the financial strategy. System governance arrangements in place through finance committee and system strategic committee and commissioning working group to ensure that new investments are not made unless recurrent resource is available. **Revenue** System workforce programme and agency reduction group implemented, weekly agency reporting and action plan to reduce agency expenditure in line with system cap Financial Improvement Programme and System Transformation Group Organisation self assessments of plan conditions/financial controls in place - Triple Lock, vacancy controls, HFMA sustainability and NHSE Grip and Control. System vacancy panel in place. Workforce monitoring of vacancies in place. Capital Capital Prioritisation Oversight Group	Regular System level financial reporting to ICS finance committee and Integrated Care Board Finance Committee across the system to oversee efficiency and transformation programme delivery. System productivity and FIP group in place for efficiency. FIP reports into System Transformation Group which provides Assurance to the Board Provider collaborative in place. System agency reduction group implemented, weekly agency reporting and action plan to reduce agency expenditure in line with system cap. NOF organisation self assessments of plan conditions/financial controls, Triple lock in place.	**Gaps in Control:** STW 12th June Revenue Financial Plan Limit £90m deficit, Efficiency is 7.14% for the ICS - Fully identified efficiency plans for 24/25 now in place. Key areas of risk to delivery are: 1.a Efficiency delivery - delivery risk 31% of plan 1b Escalation costs due to UEC pressure and links to discharge 1c Costs and inflation pressures 1d New NICE appraisals with significant implementation costs e.g. Obesity - Tirzepatide could have huge financial impacts (circa £81M if 70% eligible patients were able to access at current list price) **Gaps in Assurances:** A forecast that does not have risks fully mitigated means that there is limited assurance that the financial forecast can be met.	**Almost Certain 5 x Major 4 = Extreme 20**	↓	**Revenue** Financial Framework/Strategy sets out the Recovery Plan Recovery plan - Oversight through the Financial Improvement Programme Group 1a) Financial Improvement Programme governance to ensure delivery of 24/25 efficiency plans including oversight and monitoring. Fully identified programme by 31/07 and implemented by 30/09. IB/KO - completed 1b) Multi year plans to be reviewed and pipeline developed by Sept 24-Mar 25. IB/KO 1c) UEC Tier 1 PIDS to be updated - GR May 24 - completed 1d) Quarterly SCHT/SaTH/ICB review of Sub acute/VW/IDT/Escalation - GS/JG Ongoing 1e) Strategic Decision Making Framework in development - approved Sept 24 1f) CHC/Medicines assurance oversight meetings in place - meet bi-monthly - VW/AS - ongoing. Escalation of new NICE medicines high cost through Medicines Best Value Group, commissioning policies/pathways and use of blueteq. **Capital** Joint Capital Plan agreed and published Capital Strategy in place Capital Prioritisation Framework in Place 10 Year Capital Plan prioritised	**Possible 3 x Major 4 = High 12**	Claire Skidmore	Angela Szabo	Finance Committee	22/04/2024 Angela Szabo 23/07/2024 Angela Szabo 21/10/2024 Angela Szabo	Alignment of risk scores across the system,system integrated improvement plan in place. Fully identified efficiency plan. Risk reduced 21/10/24 Angela Szabo.
24	1, 2, 3	Stuart Allen, Senior EPRR Lead	**Emergency Preparedness, Resilience and Response (EPRR)** If the ICB does not have plans in place to respond to emergencies, incidents, or disruptive events (e.g. adverse weather, cyber-attack, utilities failure, transport accidents, malicious attacks, industrial action, etc) impacting on the ICB and/or local healthcare system, the ICB will not meet its statutory obligations and therefore fail in the duties placed on the organisation under the Civil Contingencies Act 2004 (CCA), NHS EPRR Framework, NHS Act 2006, Health and Care Act 2022, and the NHS Standard Contract.	Opportunity to work collaboratively across the STW ICS and the West Mercia LHRP footprint in our approach to Emergency Preparedness, Resilience and Response (EPRR), and with West Mercia Local Resilience Forum (LRF) partners.	•ICB EPRR Programme Group (with oversight of EPRR related risk register). •ICB EPRR work programme. •ICB EPRR Training and Exercise Programme. •Reporting to ICB Audit Committee and Board. •Civil Contingencies Act 2004 (CCA), National NHS EPRR Framework, NHS Act 2006, Health and Care Act 2022, and the NHS Standard Contract. •West Mercia Local Health Resilience Partnership (LHRP) with oversight of EPRR and health related risk register. •West Mercia Health Emergency Preparedness Operational Group (HEPOG) reporting to LHRP. •LHRP and HEPOG work programme. •Risks and risk registers linked to National Risk Register (NRR) and LRF Community Risk Register (CRR).	•Review of risk registers as a standing agenda item at every meeting for ICB EPRR Programme Group, LHRP, HEPOG. •Annual assurance of NHS Core Standards for EPRR. •Regular review of progress of work programmes at every meeting for ICB EPRR Programme Group, LHRP, HEPOG. •ICB exercising schedule. •Systemwide exercising schedule. •ICB holds monthly meetings with EPRR leads for each organisation.	**Gaps in controls:** •Very limited ICB EPRR resource. •Lack of documented Standard Operating Procedures (SOPs) for the System Coordination Centre (SCC). **Gaps in assurance:** •Rated non-compliant with NHS Core Standards for EPRR. •Recent combining of STW LHRP & HEPOG and Herefordshire & Worcestershire LHRP & HEPOG to form the West Mercia LHRP and HEPOG. •The ICB does not currently have a permanently employed EPRR Practitioner in post; role is currently provided by an Interim on a fixed term contract to end September 2024.	Consequence: 4 (Major) x Likelihood: 5 (Almost Certain) = **20 EXTREME RISK**	↔	1.Continue with newly established ICB EPRR Programme Group to provide strategic level oversight of EPRR function and compliance with NHS Core Standards for EPRR. 2.Recently reviewed and updated key EPRR policy and plans; consulted with NHSE, Providers, and reviewed as part of annual assurance of NHS Core Standards for EPRR. 3.ICB EPRR work programme has actions to further develop existing policy and plans and introduce new documentation to improve compliance with NHS Core Standards for EPRR. 4.ICB EPRR work programme has actions to produce system level EPRR policies, frameworks and plans for organisations to align own policies and plans. 5.ICB to continue with monthly meetings with EPRR leads for each organisation. 6.STW ICB EPRR lead to work closely with H&W ICB lead to drive the LHRP and HEPOG work programme ensuring links to system/locality risks, issues, and challenges. 7.Continue with ICB and systemwide exercising schedule. 8.Accountable Emergency Officer (AEO) to review EPRR resourcing to ensure it is adequate for the size, type, and services of the ICB and duties placed on the organisation under the CCA, NHS EPRR Framework, NHS Act 2006, Health and Care Act 2022, and the NHS Standard Contract. 9.Accountable Emergency Officer (AEO) to undertake recruitment campaign for a permanent EPRR Practitioner; and extend current Interim to cover	Consequence: 3 (Moderate) x Likelihood: 3 (Possible) = **9 MODERATE RISK**	Ian Bett, Interim Executive Director – Director of Delivery and Transformation / Accountable Emergency Officer (AEO) (NHS STW ICB)	Ian Bett, Interim Executive Director – Director of Delivery and Transformation / Accountable Emergency Officer (AEO) (NHS STW ICB)	ICB EPRR Programme Group – Audit Committee – Board.	13/09/2024 – Stuart Allen, Senior EPRR Lead (NHS STW ICB) (Approved by Ian Bett 17/09/2024).	

Appendix D

RISK MANAGEMENT MATRIX

	Likelihood				
Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5 LOW	10 MODERATE	15 HIGH	20 EXTREME	25 EXTREME
4 Major	4 LOW	8 MODERATE	12 HIGH	16 HIGH	20 EXTREME
3 Moderate	3 VERY LOW	6 LOW	9 MODERATE	12 HIGH	15 HIGH
2 Minor	2 VERY LOW	4 LOW	6 LOW	8 MODERATE	10 MODERATE
1 Negligible	1 VERY LOW	2 VERY LOW	3 VERY LOW	4 LOW	5 LOW

	1 – 3	Very Low risk
	4 – 6	Low risk
	8 – 10	Moderate risk
	12 – 16	High risk
	20 – 25	Extreme risk

	Consequence score (severity levels) and examples of descriptions				
Domains	1. Negligible	2. Minor	3. Moderate	4.Major	5. Extreme
Impact on the safety of patients, staff or public (physical/psychological harm).	Minimal injury or illness, requiring no/minimal intervention or treatment. No time off work.	Minor injury or illness, requiring minor intervention. Requiring time off work for >3 days. Increase in length of hospital stay by 1-3 days.	Moderate injury requiring professional intervention. Requiring time off work. Increase in length of hospital stay by 4-15 days. RIDDOR/agency reportable incident. An event which impacts on a small number of patients.	Major injury leading to long-term incapacity/disability. Requiring time off work for >14 days. Increase in length of hospital stay by >15 days. Mismanagement of patient care with long-term effects.	Incident leading to death. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.
Quality/complaints/audit	Peripheral element of treatment or service suboptimal. Informal complain/injury.	Overall treatment or service suboptimal. Formal complaint. Local resolution. Single failure to meet standards. Minor implications for patient safety unresolved. Reduced performance rating if unresolved.	Treatment or service has significantly reduced effectiveness. Formal complaint. Local resolution (with potential to go to independent review). Repeated failure to meet internal standards. Major patient safety implications if findings are not acted on.	Non compliance with national standards with significant risk to patient if unresolved. Multiple complaints/independent review. Low performance rating. Critical report.	totally unacceptable level or quality of treatment/ services. Gross failure of patient safety if findings not acted upon. Inquest/ombudsman inquiry. Gross failure to meet national standards.
Human resources/organisational /development/staffing/ competence	Short term low staffing that temporary reduces services quality (1< day).	Low staffing level that reduces the services quality.	Late delivery of key objectives/service due to lack of staff. Unsafe staffing level or competence (>1 day). Low staff morale. Poor staff attendance for mandatory/key training.	Uncertain delivery of key objective/service due to lack of staff. Unsafe staffing level or competence (>5 days). Loss of key staff. Very low staff morale. No staff attending mandatory/key training.	Non-delivery of key objectives/service due to lack to staff. On-going unsafe staffing levels or competence. Loss of several key staff. No staff attending mandatory training /key training on an on-going basis.
Statutory duty/inspections	No or minimal impact or breach or guidance/statutory duty.	Breach of statutory legislation. Reduced performance rating if unresolved.	single breach in statutory duty. Challenging external recommendation/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low performance rating. Critical report.	Multiple breaches in statutory duty. Prosecution. Complete systems change required. Zero performance rating. Severity critical report.
Adverse publicity	Rumours. Potential for public concern.	Local media coverage. Short term reduction in public confidence. Elements of public expectation not being met.	Local media coverage - long-term reduction in public confidence.	National media coverage with >3 days service well below reasonable public expectation.	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions raised in the House). Total loss of public confidence.
Business objectives/projects	Insignificant cost increase/schedule slippage	<5 per cent over project budget. Schedule slippage.	5-10 per cent over project budget. Schedule slippage.	Non-compliance with national 10-25 per cent over project budget. Schedule slippage. Key objectives not met.	Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met.
Financial Risk in relation to CCGs	Insignificant cost increase	1-2% over plan/target	2-5% over plan/target	5-10% over plan/target	>10% over plan/target
	On assessing impact, consideration will also be given to other key financial objectives including but not limited to cash management and receivables/payables control				
Service/business interruption/environmental impact	Loss/interruption of >1 hour. Minimal or no impact on the environment.	Loss/interruption of >8 hours. Minor impact on environment.	Loss/interruption of >1 day. Moderate impact on environment.	Loss/interruption of >1 week. Major impact on environment.	Permanent loss of service or facility. Catastrophic impact on environment.

Agenda Item

ICB 27-11.081

System Board Assurance Framework

Appendix 1 - NHSSTW System BAF 2024.25 - Nov 24
Appendix 2 - NHS STW System SORR 202425 Nov 24
Appendix 3 - NHS STW ICB SORR Nov 202425 Nov 24
Appendix 4 - NHS STW App D Risk Management Matrix SORR 202425

Agenda Item

ICB 27-11.083

System EDI Update

NHS Confederation

Date
14/11/2024

For the attention of
Vanessa Whatley
Chief Nursing Officer
NHS Shropshire Telford and Wrekin

Proposal

Shropshire Telford and Wrekin Integrated Care Board

Delivering Equality through Quality

About the NHS Confederation

The NHS Confederation is the only membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.
We use our skills in facilitation, coaching, OD and use improvement methodologies to inform the design of our offer. We use our subject matter expertise in place-based working/system working methods to achieve success and scale good practice.

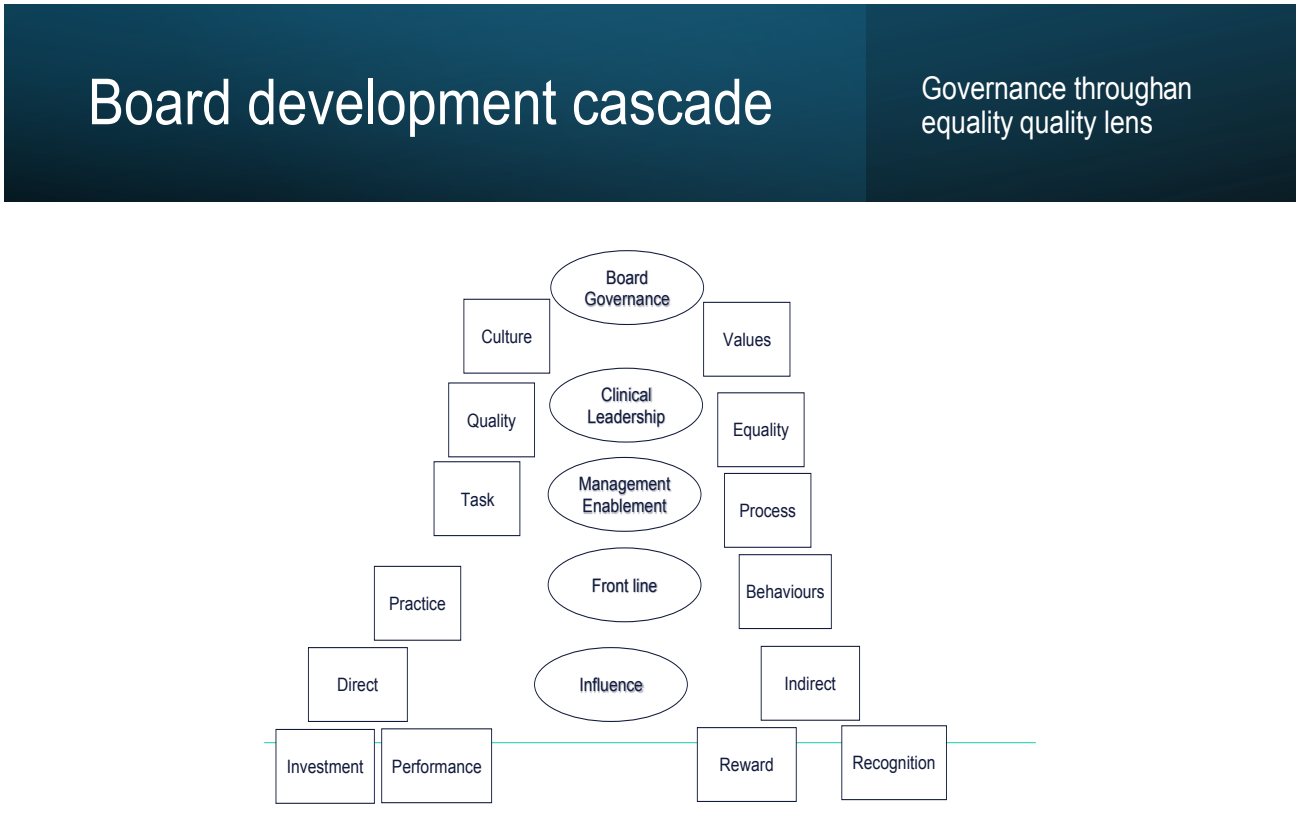
We work with members, our health inequalities policy leads, leading thinkers, using our stakeholder relationships to ensure we provide our members with the space and opportunity to innovate. Examples include:

- Peer learning/action learning set for workforce ICS leads
- Non-executive diversity taskforce focus groups
- Health inequalities leadership seminars
- HR director networks: development programme focused on member priorities
- Practitioner networks (OD professionals, health and wellbeing, education and skills, total reward)
- Facilitation of strategy and learning events with the chief nursing officers black and minority ethnic group.
- Chief executive action learning sets
- WRES regional practice events for non-executives, CEOs and executive directors.

The Confederation has a range of experience delivering action focused learning with NHS leaders throughout the country. System leadership, peer learning, partnership working, and collaboration are the cornerstones of our varied national networks and programmes led by NHS Chairs and CEO's; such networks support the spread of good practice and ownership of practical next steps and implementation for those involved in programmes and their peers.

Scope

The Confederation's EtQ board development cascade model supports delivery of quick wins and medium-term SMART goals. The model specifically links leadership, management and frontline action as a basis for partnership improvement actions where governance, culture and values drive improvement through an Equality through Quality (EtQ) lens.



This proposal will assist NHS Shropshire Telford and Wrekin Integrated Care Board (STWICB) to develop and deliver a system-wide Equality Diversity and Inclusion programme particularly tackling racism, in line with its statutory duties and local commitment to clinically safe systems, segmented population health management and enhanced stakeholder engagement.

Confed's equality through quality framework will also align to the NHS Confederation's award winning 5-Step and Ninety Days' improvement approach.

NHS Confederation EtQ model will support the STW ICB to:

- Identify and align EDI across all partners
- Specify partner wide shared improvement targets
- Deliver an aligned improvement development session with an equality through a quality framework
- Develop core improvement goals and deliver follow up support coaching towards agreed goals.

	NHSC Phase 1 schedule to meet project outputs & outcomes	**Tasks**
1.	Support Chief Nurse to review outputs of STW stakeholder to prepare for board *workshop - Nov /Dec2024*	SWOT & PESTLE analysis of STW EDI approach: • What are current systems EDI challenges • What are existing EDI strategies and agreed objectives? • Examples of good practice
2.	Partnership board workshop *Dec/Jan 2024*	Applying smart improvement processes to equality through quality action planning: • Utilise the CROW improvement model by facilitating a Board workshop that delivers smart objectives linked to core identified issues across the partnership noting resources required and risk appetite
3.	Support Chief Nurse in delivery of agreed improvement plan	Ensuring effective delivery of agreed improvement plan:

	April 25	• Facilitated monthly improvement support through the 90-day cycle • Success presentation to board

Agenda Item

ICB 27-11.084

EPPR Update including Self-Assessment
Appendix 1 - NHS STW EPRR Programme Group Terms of Reference

Appendix 2 - STW ICB STW ICB EPRR Policy V5.2

Appendix 3 - STW ICB Incident Response Plan V5.1

Appendix 4 - NHS STW ICB Business Continuity Management System V1.1

Appendix 5 - NHS STW ICB Business Continuity Management Plan V0.6

Appendix 6 - NHS STW EPRR Communications Plan V4.2

NHS
Shropshire, Telford and Wrekin

Emergency Preparedness, Resilience and Response (EPRR)

EPRR Programme Group

Terms of Reference

Preparing for Emergencies in the NHS in England

Emergency Preparedness, Resilience and Response

1 Contents

2 Aim and Objectives

The NHS Shropshire, Telford and Wrekin Integrated Care Board (NHS STW) Emergency Preparedness, Resilience and Response (EPRR) Programme Group will provide strategic level oversight of organisational, local, regional, and national risks and priorities in relation to EPRR as part of the duties of a Category 1 Responder under the Civil Contingencies Act 2004 (CCA), to ensure a high state of preparedness for, response to, and recovery from, situations of interest, events of disruption, and incidents that may have a direct impact on NHS STW, the Shropshire, Telford and Wrekin (STW) Integrated Care System (ICS), the West Mercia Local Resilience Forum (LRF) and Local Health Resilience Partnership (LHRP) footprint, or the NHS in general.

The EPRR Programme Group will:

- Drive implementation of and monitor an annual, NHS STW focused, EPRR Work Programme, including a training and exercising schedule.
- Facilitate the implementation of Corporate and Directorate business plan objectives for the EPRR programme.
- Ensure there are appropriate levels of governance, assurance, and risk assessment in place to support the prevention of, preparedness for, and response to, situations of interest, events of disruption, and incidents.
- Collaborate with other Category 1 and 2 Responders identified under the Civil Contingencies Act 2004 (CCA), including identified key partners and stakeholders, in planning for emergencies and incidents, ensuring appropriate representation in the multiagency environment (i.e. Integrated Care System (ICS), Local Resilience Forum (LRF), Local Health Resilience Partnership (LHRP), Health Emergency preparedness Officers Group (HEPOG), Midlands Health Resilience Partnership Board (MHRPB), and Emergency Preparedness in Integrated Care Boards (ICB) Leads (EPICBL)).
- Maintain a record of constructive debriefs and associated outcomes of lessons and areas of development and continual improvement relating to incident response, exercise play, and ICS Operations; this will include mechanisms for monitoring review, implementation, and training.
- Oversee compliance with the NHS EPRR Core Standards and provide an annual report to the Executive Board outlining the ICB's EPRR level of assurance.

3 Accountability and Meeting Arrangements

The EPRR Programme Group will be co-chaired by the Accountable Emergency Officer (AEO).

The EPRR Programme Group will be accountable to the Executive Board via the Audit Committee. The Group will provide regular updates to the Audit Committee and through to the Executive Board of the ICB, and will feed into local and regional NHS ICS groups and reporting arrangements as required.

The EPRR Programme Group will meet quarterly with the frequency reviewed at each meeting. Meetings will have a minimum default timing of 90 minutes to ensure enough time is held in diaries to cover a flexible agenda (meetings may take less time depending on size of agenda).

In the event of a large-scale protracted incident impacting on business operations, the EPRR Programme Group will continue to meet no less than every 3 months as a minimum.

This group will interface with other organisations, local health & care systems, and key stakeholders as required by the nature of incidents, situations of interest and multiagency response arrangements.

4 Membership and Quoracy

The core membership will include representatives from the following areas of the organisation. Attendees must be able to appropriately represent the Directorates, Departments, Services and membership listed at a strategic level with background and detail, and able to make decisions and commit on behalf of their Directorate(s)/Department(s)/Service(s):

Core Membership:

- *Accountable Emergency Officer (AEO) – (Chair)
- *Senior EPRR Lead
- Secretariat – Minute Taker (SCC Support Officer)
- Representatives from:
    - Directorates
        - Chief Delivery Officer
        - Chief Business Officer
        - Chief Medical Officer
        - Chief Nursing Officer
        - Chief Strategy Officer
        - Chief People Officer
        - Chief Finance Officer
    - Chief Pharmacist
    - Communications and Engagement Team
    - Infection Prevention and Control Team (IPC)
    - Health Inequalities Lead
    - Governance Team
    - Risk Management Team
    - Digital / Information Management & Technology (IM&T)

Optional membership will include:

- Business Intelligence (BI)
- External Partners and Stakeholders by invitation

The EPRR Programme Group will be quorate when at least 50% of the core membership, including the AEO and Senior EPRR Lead, are present for the whole meeting. Members marked with '*' are required to meet quoracy.

One of the key findings from the Manchester Arena Inquiry was poor attendance by multi-agency partners at Local Resilience Forum (LRF) collaborative preparedness meetings/groups; it recommended that attendance and participation of membership be monitored, and escalated to

senior leadership. *See relevance from the findings and recommendations from Manchester Arena Inquiry – R100 and R101.* It is highly recommended that NHS providers also monitor attendance and participation of their EPRR Groups/Committees/Boards and record this as evidence for multi-disciplinary collaborative working and planning, and quoracy for decision-making. Therefore, NHS STW EPRR Programme Group will monitor attendance and participation of its membership and include this as part of the annual Core Standards compliance report to the Executive Board.

5 Secretariat

The secretariat function for the EPRR Programme Group will be provided by the System Coordination Centre (SCC) Support Officer. The secretariat team will ensure all invites are issued and oversee the management of invitees and distribution lists. They will also work with the Chair and Senior EPRR Lead to produce agendas and accurate minutes of meetings, including appropriate documentation of risks and actions.

The secretariat is responsible for ensuring meeting agendas and papers are circulated a minimum of two weeks prior to meetings and for ensuring meeting minutes are reviewed, approved, and signed off by the Chair and core membership.

6 Standing Agenda for Programme Group

The following is an example of the standing agenda for the group.

1 Apologies and Quoracy Check
2 Minutes of last meeting
3 Action Tracker
4 TBA
5 TBA
6 TBA
7 Core Membership Updates
8 Issues and Risks
9 Communications
10 Training & Exercising
11 Review of work programme progress
12 AOB
13 Agree actions and items for escalation
14 Date of next meeting

7 ToR Review

These Terms of Reference (ToR) will be reviewed quarterly, or on request by a core member.

Last reviewed: 28/08/2024

8 EPRR Contact Details

The EPRR Team can be contacted at stw.eprr@nhs.net.

NHS
Shropshire, Telford and Wrekin

Emergency Preparedness, Resilience and Response (EPRR)

END OF DOCUMENT

stw.eprr@nhs.net

Emergency Preparedness, Resilience and Response

Preparing for Emergencies in the NHS in England

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Shropshire, Telford & Wrekin ICB Emergency Preparedness, Resilience & Response (EPRR) Policy

Document Reference Information

Version	V5.2
Status	APPROVED
Author	Stuart Allen
Directorate responsible	Delivery
Directorate lead	Stuart Allen, Senior EPRR Lead
Ratified by	EPRR Programme Group
Date ratified	28 August 2024
Date effective	28 August 2024
Date of next formal review	April 2025
Target Audience	All permanent and temporary employees of the ICB, Governing Body members, contractors and agency staff.

Version Control Record

Version	Description of changes	Reason for changes	Author	Date
V1.0	New Policy to align with creation of ICB and requirement to discharge Category 1 responder duties	New STW Policy reflecting new guidance and ICB responsibilities	EPRR Lead	August 2022
V2.0	Final version with some small amendments ratified by Audit Committee	Some minor wording adjustments to ensure full alignment with NHSE guidance and noting approval by Audit Committee	EPRR Lead	September 2022
V3.0	Policy updated in line with feedback from NHSE Core Standards Submission 2022	Compliance with NHSE Core Standards Submission	EPRR Lead	August 2023
V5.1	Policy review and update. Change of version number. Removal Appx 1 Staffing Structure, and Appx 2 Training Plan. Add page numbering in footer. Move header title to footer.	Previous version was saved as V5 in document file path but listed within document as V3; no records of versions 4 or 5 saved anywhere or by previous EPRR Lead so document updated to V5.1 to have one version number for the document. Staffing structure is not needed as is out of date and being dynamically reviewed – there is a dedicated permanent resource allocated. Training plan was a separate document embedded within with separated governance information supporting the individual section. A new separate training and exercising programme document has been created.	Senior EPRR Lead (SA)	June 2024
V5.2	Amendments made following consultation with STW NHS Providers and NHSE Midlands EPRR.	Following good practice of consulting with partners and stakeholders.	Senior EPRR Lead (SA)	August 2024

Table of Contents

1. Introduction

The NHS defines Emergency Preparedness Resilience and Response (EPRR) as the NHS need to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. This programme of work is referred to in the health community as emergency preparedness resilience and response (EPRR).

In the NHS, EPRR is designed to meet the statutory requirements placed upon responding organisations under the Civil Contingencies Act 2004 (CCA 2004). The CCA 2004 defines specific statutory duties for responding organisations depending on them being a Category 1 or Category 2 responder. Since 1st July 2022, all ICBs have become Category 1 responders, and therefore have the maximum number of statutory duties placed upon them. These being:

- Assess risk of emergencies occurring and use this to inform contingency planning
- Put in place emergency plans
- Put in place Business Continuity Management arrangements to meet organisational needs.
- Share information with other local responders to enhance co-ordination.
- Cooperate with other local responders to enhance coordination.
- Warn and inform the public.

As EPRR is a statutory duty placed upon ICBs it is a key priority for the organisation and it is essential that the required resources are in place and focus are appropriately given.

The ICB brings together the NHS locally to improve population health and establish shared strategic priorities within the NHS. The ICB is comprised of a Board and a set of Sub-Committees. For STW ICB, EPRR reports to the Audit Committee and then to the Board. This Policy relates to the work of the ICB delivered by its staff working from an office location or remotely. Implementation of this Policy is not dependent on individual staff members but is developed so it can be adopted by any member of staff who is given EPRR responsibilities and is trained to do so to mitigate against the risk of changing personnel.

This policy is a requirement under the NHS EPRR Framework and NHS Core Standards for EPRR requirements as it clearly demonstrates how ICBs will manage their EPRR and Business Continuity responsibilities.

The NHS EPRR Framework objectives:

- To prepare for common consequences of incidents and emergencies rather than for every individual scenario
- To have flexible arrangements for respond to incidents and emergencies which can be scalable and adapted to work in a wide range of specific scenarios
- To supplement this with specific planning and capability building for the most concerning risks as identified as part of the wider UK resilience
- To ensure that plans are in place to recover and learn from incidents and emergencies to provide appropriate support to affected communities

1.1. Integrated Care Board EPRR role and responsibilities:

- Fulfil the relevant duties under the CCA 2004 and the requirements in respect of emergencies within the NHS Act 2006 and the Health and Care Act 2002.
- The Accountable Emergency Officer (AEO) will co-chair the Local Health Resilience Partnership (LHRP) and maintain the involvement and support of LHRP partners at strategic and tactical level
- Ensure appropriate director level representation at the Local Resilience Forum (LRF)
- Establish a mechanism to provide NHS strategic and tactical leadership and support structures to effectively managed and coordinate the NHS response to, and recover from, incidents and emergencies, 24/7. This will include representing the NHS at Strategic Coordinating Groups and Tactical Coordinating Groups.
- Support NHS England in discharging their EPRR functions and duties locally including supporting ICS tactical coordination during incidents (levels 2-4)
- Ensure robust escalation procedures are in place to respond to disruption to delivery of patient services
- Provide a route of escalation for resilience planning issues to the LHRP in respect of commissioned provider EPRR preparedness
- Develop and maintain incident response arrangements in collaboration with all NHS funded organisations and partner organisations
- Ensure that there is an effective process for the identification, recording and implementation and sharing of lessons identified through response to incidents and emergencies and participation in exercises and debrief events
- Provide annual assurance against the NHS Core Standards for EPRR, including by monitoring each commissioned providers compliance with their contractual obligations in respect of EPRR and with applicable NHS Core Standards for EPRR.
- Ensure contracts with all commissioned providers (including independent and third sector) contain relevant EPRR elements, including business continuity

1.2. Equality Statement

Shropshire, Telford and Wrekin (STW) ICB aims to design and implement policy documents that meet the diverse needs of our services, population, and workforce, ensuring that none are placed at a disadvantage over others. It takes into account current UK legislative requirements, including the Equality Act 2010 and the Human Rights Act 1998, and promotes equal opportunities for all. This document has been designed to ensure that no-one receives less favourable treatment due to their personal circumstances, i.e. the protected characteristics of their age, disability, sex, gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy, and maternity. Appropriate consideration has also been given to gender identity, socio-economic status, immigration status and the principles of the Human Rights Act.

In carrying out its functions, Shropshire, Telford and Wrekin ICB must have due regard to the Public Sector Equality Duty (PSED). This applies to all the activities for which Shropshire, Telford and Wrekin ICB is responsible, including policy development, review, and implementation. A copy of the Equality Analysis Initial Assessment document can be found in Appendix 1.

2. Purpose

This policy will clearly define how the ICB will manage its responsibilities for EPRR as the system health lead in the ICS. It will define among other things:

- ICB role and responsibilities
- EPRR resourcing requirements
- The ICB's commitment to EPRR, Business Continuity Planning, training, and exercising
- Annual work programme management
- On-call procedures
- Clarity of roles and responsibilities
- How continuous development / improvement will be achieved
- EPRR governance process.

3. Scope

This policy is for all STW ICB employees, Board members, contractors and agency workers, as it details the ICB's commitment to EPRR and Business Continuity.

4. Definitions

LHRP – Local Health Resilience Partnership. The strategic Planning Group made up of Health Economy Accountable Emergency Officers and Directors of Public Health with responsibility for EPRR.

HEPOG – Health Emergency Preparedness Officers Group (System Health and Social Care Emergency Planning Group). Tactical level group of Emergency Planning specialists from the same organisations who attend LHRP who work together to provide solutions to the strategic issues arising from LHRP across the ICS.

EPRR Programme Group – Emergency Preparedness, Resilience and Response Group – Internal STW ICB Group to review, manage delivery and enhance Business continuity across the organisation.

ICB Audit Committee – The committee charged with responsibility for oversight and approval of EPRR work Plans, Policies and Procedures. In addition, it will receive a minimum of bi-annual reports on the EPRR status of the ICB.

ICB Board – Sign off formally the ICB's annual NHS Core Standards for EPRR declaration statement in line with the timescales stipulated in NHSE Guidance and receive no less than an annual report on EPRR progress.

NHS Core Standards for EPRR – established set of standards which all NHS funded organisations must meet with regards to Emergency Preparedness, Resilience and Response activities, these vary by organisation type and are broken into 11 Domains.

NHS Core Standards for EPRR Annual Assurance – Annual audited assessment with evidence provided against the NHS Core Standards for EPRR, which all commissioners and providers of NHS Care are required to complete. On completion, following the issuing of an Assurance rating and an agreement on remedial actions, if necessary, a report

including any actions required must be made to the ICB no later than December of the same year. Any actions will inform the forthcoming ICB EPRR workplan.

5. Training & Competencies

Training and competencies and expected standards have been identified for those carrying out EPRR type roles separately in the EPRR Training and Exercising Programme. These requirements have been developed utilising the Skills for Justice National Occupational Standards and the NHS minimum standards framework published July 2022. This includes the frequency and type of training and exercising required and documents if mandatory or optional for roles in the ICB. The courses and course names can vary and dependent on availability but denote a level of competency required for specific roles.

The EPRR Training and Exercising Programme associated with this Policy identifies the required roles in order to fulfil the EPRR duties and associated training requirements for those roles to be carried out. Training needs assessments are carried out and training aligned to the National Occupational Standards for Civil Contingencies. Within the plan it defines how the training will be delivered, the type of training that will be delivered, and the frequency required. The ICB will work with the LRF partners to ensure there is ongoing access to comprehensive multi agency training and exercising.

It is the responsibility of any staff member with an identified role in an incident affecting the ICB, to make themselves available for any identified debriefing, training and exercising and to ensure they complete any appropriate training. Training will be aligned to the required National Occupational Standards and Minimum Occupational Standards for EPRR

All training associated with EPRR has been identified via a training needs analysis. All training is aligned to the requirements of the National Occupational Standards (NOS) for Civil Contingencies. Attendance and attainment of training standards are recorded by the EPRR Team in the training records document and compliance levels are monitored and discussed where required at the Executive Leadership meetings, updates will be provided bi-annually to the Audit Committee. As a minimum, all On-Call Executives and Managers must complete the Principles of Health Command (PHC) Course. Details of all training can be found in ICB EPRR Training and Exercising Programme document.

Exercises will be carried out in line with the requirements of the EPRR Framework and LRF partners, and as detailed in the ICB EPRR Training and Exercising Programme document.

6. Responsibilities and duties

The ICB is committed to ensuring it has adequate resource and infrastructure to discharge its Statutory duties. This section sets out the roles and duties of ICB employees in fulfilling the ICB responsibilities. More broadly the EPRR agenda is supported via the roles set out below. It is the responsibility of the ICB Executive and specifically the AEO to assess the EPRR resourcing needs of the ICB and to make proposals on this basis to the wider Executive, the Audit Committee and ultimately the Board if this resourcing needs adapting. It is the responsibility of individuals supporting EPRR duties and response to ensure they access the relevant training and that this is recorded in a training log.

6.1. ICB Executive Board

- Ensure that the ICB is discharging its EPRR responsibilities in line with statutory requirements
- Receive reports no less frequently than annually, regarding EPRR, including: reports on exercises undertaken by the ICB, business continuity, critical and major incidents, lessons identified, and learning implemented, training and;
- Ensure that adequate resources and funding are made available to enable the organisation to meet the requirements of its ICB EPRR duties and fulfil the NHS EPRR Framework duties and NHS Core Standards for EPRR assessments. Both access to and adequacy of budget should be reviewed by the Accountable Emergency Officer and should be proportionate to the size and scope of the organisation and to meet the ICB duties of a Category 1 provider and fulfil its statutory duties.
- Receive and approve the self-assessment outcome following NHSE Audit of compliance with the annual NHS Core Standards for EPRR process from the STW ICB's Accountable Emergency Officer.
- Receive and approve assessments of Health NHS partners NHS Core Standards for EPRR as ICB system health lead required to oversee delivery and compliance of NHS Core Standards for EPRR.

6.2. Non-Executive Director for EPRR

- Organisations are not required to have an individually identified non-executive director (NED) as an EPRR sponsor, however, it is the responsibility of all ICB Board members and NEDs to assure themselves the ICB is meeting their obligations with respect to EPRR and the Civil Contingencies Act 2004.
- NEDs should provide a supporting role and seek assurance that the ICB has allocated appropriate resources to meet these requirements, including the support of trained and competent staff as appropriate to support its enhanced responsibilities as a Category 1 responder, and that the ICB has the capability to lead the system for health and undertake further NHSE assurance responsibilities.

6.3. ICB Accountable Emergency Officer (AEO)

- The NHS Act 2006 places a duty on service providers to appoint an individual to be responsible for discharging the duties under section 252A(9).
- Executive Board authority and responsibility for ensuring the ICB complies with legal and policy requirements sits with the Accountable Emergency Officer. For STW ICB this role will be discharged by the Chief Delivery Officer (CDO) supported directly by the Senior EPRR Lead.
- The ICB AEO holds specific responsibility for discharging the duties set out in the NHS Emergency Preparedness, Resilience and Response Framework.
- It is the responsibility of the AEO to ensure the ICB resource for Emergency Planning and Business Continuity is sufficient and that relevant staff are trained appropriately to fulfil the statutory EPRR requirements of a Category 1 responder and meet the ICB's duties as set out in the NHS EPRR Framework.
- The AEO will chair the Local Health Resilience Partnership in a Co-Chair arrangement with the Local Authority's Director of Public Health and will deputise for each other as chair as required. The AEO will assume the role of System Strategic Commander in the event that a system incident is declared or will

nominate an appropriate person to fulfil this role. The AEO will represent the STW ICS at the Local Resilience Forum.

6.4. ICB Senior EPRR Lead

- Assume responsibility for the operational delivery of EPRR and Business Continuity
- Assume strategic and operational oversight of all ICB matters relating to EPRR
- Assume responsibility for reporting to the ICB Board/Audit Committee to ensure compliance with EPRR Core Standards for EPRR.
- Provide a strategic lead on EPRR and Business Continuity (drawing in expertise where it is needed such as digital and IG business continuity) matters including attendance at Local Health Resilience Partnership (LHRP) meetings.
- Provide and present twice-yearly reports to the ICB Audit Committee and annually to the ICB on the status of EPRR in STWICB, including the NHS Core Standards for EPRR annual assurance and provider statements.
- Ensure an EPRR statement is included in the ICB Annual Report
- Ensure the ICB and sub-contractors it commissions have robust business continuity arrangements in place that align to ISO 22301 or subsequent guidance
- Ensure the ICB and sub-contractors are compliant with EPRR requirements as set out in the CCA 2004, the 2005 Regulations, the NHS Act 2006, the Health and Care Act 2022 and the NHS Standard Contract, including the NHS EPRR Framework and NHS Core Standards for EPRR.
- Ensure compliance with any requirement of NHS England, in respect of monitoring compliance
- Provides NHS England with information it may require for the purpose of discharging its EPRR functions
- Ensure the ICB is appropriately represented by director-level engagement with an effective contribution to any governance meetings, subgroups or working groups of the LHRP and or LRF Executive as appropriate
- Provide strategic leadership for the ICS health system for EPRR and system preparedness
- To provide strategic advice to on-call directors to discharge ICB responsibilities as a Category 1 responder
- Ensure that an annual EPRR work programme is developed, delivered and monitored
- Ensure Policies and arrangements are aligned to guidance, regularly reviewed and maintained, updated and distributed, including regular testing and exercising.
- Ensure that the appropriate governance, risk management, training and exercising and continuous improvement arrangements are in place
- Support the Accountable Emergency Officer in fulfilling their duties.
- Identify, assess, and where required manage, EPRR risks across the ICB and ICS.
- Ensure training needs are identified and appropriate training is provided/sourced when available.
- Liaise with staff at all levels as appropriate to assist with their understanding of EPRR requirements and support providers as ICB lead for health.
- First point of call for NHS England and for EPRR health partners in the ICS during business as usual/peacetime activities.
- Represent the ICB and NHSE at external meetings and exercises notably within the Local Resilience Forum as a Category 1 responder.
- Co-chair HEPOG with partner NHS Herefordshire and Worcestershire ICB EPRR

Lead

- Provide operational leadership to the ICB and ICS health partners regarding EPRR matters in the event of a Business Continuity, Critical or Major Incident.
- Attend TCGs and operational response cells as required.
- Support the workstreams associated with the LRF and attend relevant meetings as required.
- Represent the AEO as requested/applicable.
- Support Contracting with Business Continuity Plan reviews as requested.
- Support the management of the on-call Rota, and on-call documentation in partnership with urgent care
- Manage the EPRR and Business Continuity resource required to fulfil the NHS EPRR Framework requirements and Category 1 responder requirements, and appropriately raise to the AEO when concerns of non-compliance due to resource and staffing is delaying delivery of the EPRR work plan.

6.5. On-call Managers

- The ICB ensures that they have the necessary on-call arrangements in place covering 24 hours a day 365 days a year.
- All those identified with roles to fulfil will make themselves available for the required training, exercising and workshops as defined in the ICB's' EPRR Training and Exercise Programme and detailed in the ICB on-call policy and will ensure that they maintain a training and competency portfolio of EPRR learning and involvement.

The on-call manager will:

- Manage Operational, Tactical and Strategic issues and incidents out of hours
- Act as a single point of contact out of hours for health providers and NHSE, and the LRF/multi-agency partners.
- Be the first point of contact out of hours regarding Business Continuity issues affecting the ICB's ability to deliver services
- Be the first point of contact out of hours regarding Major Incident Declarations/Notification management of response
- Be the first point of contact for out of hours surge Management/Capacity Issues
- Lead system Conference calls as required and in line with the relevant escalation policies
- Be the first contact point for communications out of hours
- Report to NHSE and Accountable Emergency Officer as per Incident Response policy/Business Continuity Plan status or activation requests
- Ensure they have the relevant access to on-call folder documentation for STW system providers.
- Keep records relating to their role in an incident and while on-call.

On-call requirements are set out in detail in the ICB's On-Call Policy document

6.6. System Coordination Centre (SCC) Staff

During incident response and recovery the SCC will operate as the Incident Coordination Centre (ICC) and will undertake the roles of 'ICC and Information Manager' and 'Incident Manager' and 'ICB Incident Loggist'. The SCC staff will be responsible for:

- Supporting the Incident Director to undertake tasks relating to the ICB's incident

management.

- Assess information received into the ICC/SCC/SPOC and brief or escalate to the Incident Director as required.
- Coordinate the receipt of and dissemination of information to and from the ICC.
- Providing loggist duties to the Incident Director; this may involve attending multiple meetings with the Incident Director.
- Recording and documenting all issues/actions/decisions made by the ICB Incident Director.
- Provide support to the Incident Director as requested/required.
- Specifically, the Head of Clinical Operations and SCC Senior Commander are responsible for ensuring all SCC staff receive appropriate training in EPRR and Incident Management aligned to the ICB's EPRR arrangements and plans and identified roles for SCC staff.

6.7. All Staff

- All ICB staff are required to have awareness of the Business Continuity plan and Incident Response Plan and know where they are located and know how to access EPRR advice and guidance in the ICB.
- 24/7 Access to the STWICB on-call manager is via SaTH switchboard on 01743 216000 requesting connection to the ICB Director on-call
- All staff are required to read and understand any EPRR information that is issued by the EPRR team and carry out any required actions.
- All staff are required to attend EPRR awareness training sessions.

6.8. Access to Funds

The AEO has overall responsibility for the allocation and deployment of funds to support incident response should this be required. However, all on-call staff also have delegated authority to allocated funds in the event of an incident and can action this on behalf of the ICB. All funding allocation decisions should be reported to the AEO as soon as is practically possible. Any agreed expenditure should be recorded on the Expenditure Log included in the On-Call Policy and provided to the System Co-ordination Centre for archiving.

6.9. Incident Co-ordination/ Incident Co-ordination Centre (ICC)

For all incidents, the System Co-ordination Centre (SCC) will be the primary route for receiving and disseminating information (with the on-call manager the point of contact for notification of an incident). Depending on the nature of the incident the AEO/On-Call Executive or Senior EPRR Lead will make a decision regarding the standing up of a separate Incident Co-ordination Centre (ICC). It is anticipated that for most incidents other than Business Continuity events that this will be the case. In the event that an ICC is stood up this will be managed by the SCC Team.

For level 1 and level 2 incidents, incident co-ordination and any requirement for an Incident Co-ordination Centre (ICC) will be managed within the SCC Team.

For level 3 and 4 regional and National incidents the Incident Director will liaise with NHSE Regional EPRR Lead/ First On-Call to establish incident management arrangements. The ICB SCC Team will manage the ICC. The AEO/On-Call Executive and/or Senior EPRR

Lead will be responsible for mobilising the ICC and establishing the necessary resourcing as determine by the incident.

6.10. Loggists

Loggists will support the ICC and incident response as required. Loggists will in the first instance be drawn from across the organisation on a voluntary basis. Loggists will be given the appropriate training to perform their duties with training being refreshed no less than every three years. Loggists duties will be performed on a rota basis as deemed appropriate for the prevailing incident. Loggist requirements and rota arrangements will be determined and supported by the SCC and EPRR Teams. Should a Loggist be required, in hours the request should be made via the SCC and On-Call Executive.

6.11. Contracting

The contracting team will support EPRR assurance via the annual contract assurance framework and ensuring providers have a relevant Business Continuity Plan that aligns with EPRR requirements, STWICB priorities and wider system resilience.

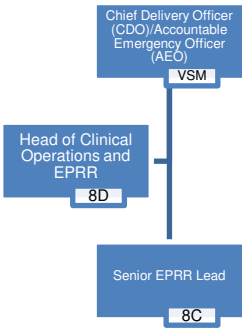
7. Commitment to EPRR and Business Continuity Management

The STWICB is fully committed to discharging its EPRR and Business Continuity responsibilities and holds the safety of its patients and staff as paramount.

STWICB has put in place the required resources in order to fully discharge its responsibilities as a Category 1 responder and remains committed to this position.

7.1. Governance

STW ICB has an EPRR Programme Group to provide strategic oversight and governance for EPRR within the ICB and to support the ICS EPRR agenda. The EPRR Programme Group will be chaired by the AEO and will report into the Audit Committee and through to the ICB Executive Board; this governance line will be used to review and ratify all EPRR documents and arrangements. The EPRR Programme Group must be quorate when ratifying documents with the overall responsibility and authority to sign off the ICB's EPRR Policy, Incident Response Plan (IRP), and Business Continuity Management System (BCMS) resting with the AEO at Executive Board. Resourcing and Line Management for EPRR within the ICB is:

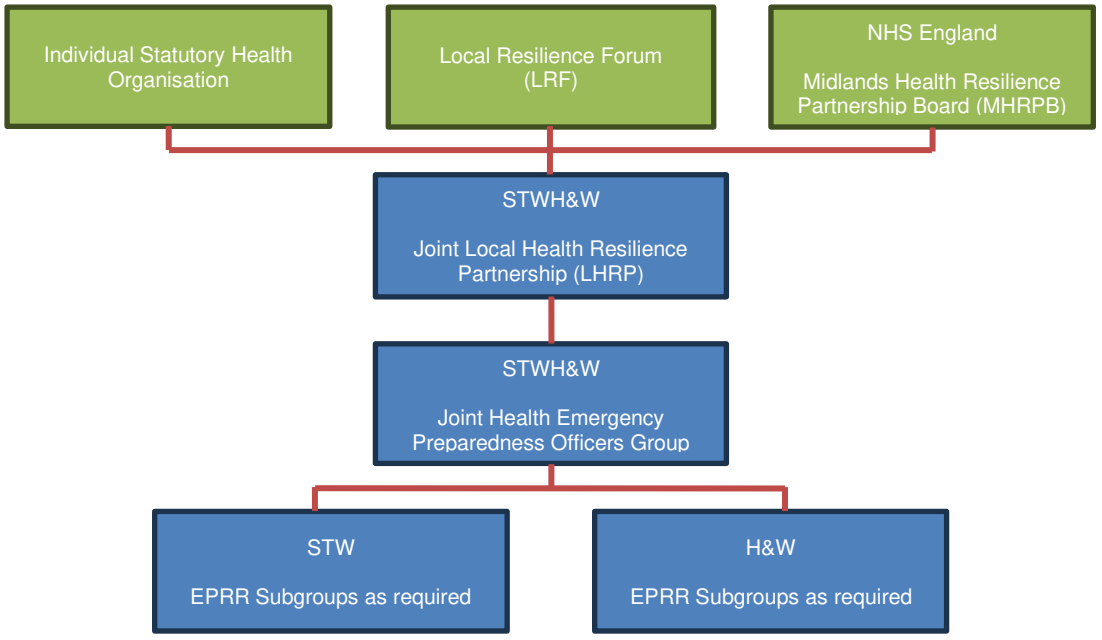


STW ICB will operate a joint LHRP Governance and reporting structure with NHS

Herefordshire and Worcestershire ICB. This recognises the commonality of the Local Resilience Forum footprint and the improved sustainability and resilience that comes from pooling resources and expertise in this way.

The diagram below sets out the governance structure to support this whilst acknowledging the need for STW to maintain its individual statutory responsibilities and associated reporting. The ICB will engage with the Midlands Health Resilience Partnership Board (MHRPB) and its subgroups and will participate in the regional processes for sharing lessons with other partners.

To support this process and ensure sound governance and oversight the EPRR function will report directly to the ICB Audit Committee and Board to include incidents, lessons learned, training and exercising and any other pertinent information.



7.2. Continuous Learning and Collaborative Planning

The ICB is committed to continuous EPRR learning and development and will review its EPRR performance and arrangements regularly, implementing improvement actions where necessary, linking with regional networks where appropriate to utilise a broad base of learning and monitoring.

STWICB will maintain continuous development and improvement by ensuring:

- Debriefs are held following any incident of significant scale, lessons identified, and actions assigned and owned by the appropriate team in the ICB.
- Participation in any multi agency debriefs that may be held following an incident and owning any lessons identified and actions to improve response and resilience. The ICB follow the LRF debrief policy and will follow the NHS Framework debrief and review process.
- Participation in any exercise opportunities, both within the health economy and in a wider multi-agency context such as in the Local Resilience Forum or TCGs to gain experience and learn different approaches and enhance planning
- Training is current, specific, targeted, and relevant to the roles people are performing.

- Attendance at relevant health specific preparedness meetings
- Action plans are monitored for implementation and progress by the Senior EPRR Lead and will be reported through the ICB Audit Committee on a bi-annual basis.
- Processes meet the requirements of the regional lessons process (e.g. reporting and assessment of shared lessons)
- That reporting of progress on lessons to the LHRP and or HEPOG is in place in accordance with guidance and that there is oversight of reporting from partner organisations
- There are regular reviews of Joint Organisational Learning to capture organisational learning from national partner organisations incidents

EPRR plans and policies for the ICS where appropriate will be developed in partnership with ICS health and social care and wider system partners as required to ensure the EPRR planning, and response pathways and processes are fully considered across the system. The LHRP will oversee the workplan for the ICS EPRR health and social care pathways and will oversee the testing programme of ICS health plans across the Health system.

Where appropriate planning for incidents will be carried out in a coordinated way across the system at a multi-agency, NHS England and ICBs will co-ordinate health service reviews at the LRF level, and ICBs (via the Senior EPRR Lead) will ensure co-ordination across the local ICS facilitated by the LHRP and local EPRR planning groups.

The ICB will work collaboratively with partners both within the ICS and across the LRF footprint and will consult with partners in the development of its plans as they are developed but at least on an annual basis as well as supporting partners in the development of their plans. Where this consultative approach or where learning per se leads to changes to plans this will be documented.

Within the ICB the Senior EPRR Lead will be responsible for the continuous learning and consultation programme, ensuring the appropriate consultation is carried out and that there is appropriate documentation of the consultation undertaken, feedback received and how this has been utilised. Consultation of EPRR related documents will be through the ICB EPRR Programme Group, local NHS organisations and NHSE Midlands. In particular overall Emergency Planning learning including local, regional and national learning will form part of the LHRP and HEPOG work programme with a view to ensuring this is embedded in enhancements to local practice and is tracked and monitored. A centralised learning and improvement tracker will be maintained by the EPRR Team.

To further support continuous learning and improvement there is an agreed NHSE Midlands Region EPRR Lessons Identified process for the sharing of learning from incidents, exercises and events. The sharing of learning from other organisations will enable good practice to be embedded across the region. NHSE Midlands share this information with organisations on a monthly basis. The full process is documented in the 'Midlands EPRR Lessons Identified' document available on NHSFuture or from the ICB' Senior EPRR Lead.

7.3. EPRR Testing and Exercising

Plans should be tested by organisation and by roles to ensure they are fit for purpose, ensuring that individuals can safely practice their skills and increase their confidence and

knowledge in the preparation for responding to an actual incident. All exercises should include an outcome log identifying learning and any areas where improvements can be made with corresponding procedures and documentation updated accordingly

ICBs are required to undertake the following:

- Communications exercise every 6 months which test the organisation's ability to communicate urgent information and instructions to staff generally but also specifically to staff who may be required to assist in an incident response both in and out of hours. The Business Continuity Plan details the communications cascade method to be undertaken by the ICB.
- Tabletop Exercise a minimum of once every 12 months This may be as an ICB or in conjunction with ICS partner organisations.
- A Business Continuity Exercise a minimum of once every 12 months. This may be as a single ICB, in conjunction with ICS partner organisations or other ICBs
- A Live Exercise once every 3 years to include operational, tactical, and strategic elements of a plan. These could take place as a single organisation exercise with the option for partners to participate or jointly planned with partner organisations in recognition of the interconnectedness and linked impact on the health and social care system of many incidents (i.e. mass countermeasure, mass evacuation working with the local LRF and system partners) in order to ensure they emulate a real incident as far as possible and as such are likely to be delivered as a collaborative multi agency piece of work rather than in isolation.
- If an organisation activates its plan in response to 'live incident', the exercise will not be required in that time period providing the lessons are identified and logged and an action plan is developed
- Command post exercise (CPX). Every 3 years minimum to test operational command and control which requires the establishment of the ICB's ICC testing processes and equipment. It can be incorporated into other live play exercises. If an ICB activates its ICC in a live incident, this replaces the need to run an exercise providing lessons are identified and logged and an action plan is developed.
- ICC Equipment test. Every six months minimum to test the functionality of any equipment used in the ICC.

7.4. Annual Work Programme

The ICB will develop an ICB Annual EPRR Work Programme which identifies the schedule for reviewing, maintaining and testing plans and policies to support the delivery of the NHS Core Standards for EPRR. This will be supported by the necessary training and exercising programme. Progress against the work plan will be reported by the Senior EPRR Lead to the EPRR Programme Group quarterly and to the Audit Committee twice a year.

7.5. Information Sharing

The ICB under the CCA 2004 regulations for responders have a duty to share information with partner organisations. The ICB Information Governance Staff Code of Conduct Policy and procedures cover the requirements of EPRR. Further data sharing guidance is available on the Civil Contingencies Secretariat page of Resilience Direct which can be accessed by the EPRR Team. Where necessary advice should be sought from the ICB Information Governance Team. However, it is an underpinning principle of EPRR that agencies should share data as required to support the response to an incident or emergency.

7.6. Types of Incidents:

7.6.1. Business Continuity Incident

A business continuity incident is an event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, below acceptable predefined levels and where special arrangements are required to be implemented until services can return to an acceptable level. (This could be a surge in demand requiring resources to be temporarily redeployed within the organisation or within the ICS). Please refer to the ICB Business Continuity Plan.

7.6.2. Critical Incident

A critical incident is any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services, patients may have been harmed or the environment is not safe, requiring special measures and support from other agencies, to restore normal operating functions.

7.6.3. Major Incident

A major incident is any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties, as to require special arrangements to be implemented.

7.7. EPRR Reporting Templates

The ICB incident response Plan and the Business Continuity plan contain the current reporting and sit rep templates for EPRR and Business Continuity incidents to escalate to NHSE and LRF. They can also be located in the Teams online on-call folder.

7.8. Business Continuity Management System

The ICB has a Business Continuity Management System (BCMS) in place which addresses Business Continuity related Impact Assessment, Testing and Exercising, Evaluation, Monitoring and continuous improvement and Audit. This can be found as an addendum to the Business Continuity Plan. The ICB's BCMS will be aligned to ISO22301.

7.8.4. Business Impact Analyses

The ICB Business Continuity Plan includes Business Impact Analyses which help identify the critical activities that they deliver in their function. These analyses identify and document the resources that are required in order to continue or recommence delivery of the identified activities during a time-of-service delivery impact. It is the responsibility of all staff / team managers to ensure their teams understand their plans and to update and review them no less than yearly or when activities or teams change and inform the EPRR team.

Team leaders should ensure that they have contact details of staff and emergency contacts for cascades as per the Business Continuity Policy and Communications Emergency Plan and ensure staff are aware of their role in a Business Continuity incident.

7.8.5. Business Continuity Plan

The ICB Business Continuity Plan (BCP) documents the suggested response arrangements for a Business Continuity Incident in and out of hours for the ICB. This is a dynamic document. The BCP will be reviewed annually to ensure continuous improvement.

All NHS Commissioned providers are required, under the NHS Standard Contract, to have their own Business Continuity Plan in place which should be reviewed via the annual contracts review process. The ICB as EPRR system health leads will work with providers to align and support development of plans across health system.

7.9. Incident Response Plan

STWICB has an Incident Response Plan (IRP) in place which sets out the different types of incidents that may occur and the ICB's role and responsibility as a Category 1 responder. It provides suggested response arrangements, structures, situation reporting templates, key roles and responsibilities, along with standard operating procedures for those who perform a key on-call or EPRR role. The Incident Response Plan also contains documentation and guides relating to the Joint Emergency Services Interoperability Principles (JESIP) and includes the ICB Mutual Aid and Military Aid guidance for staff managing an incident.

Other specific incident plans have also been developed separately by the LRF to address risks that have been identified in a multi-agency context across West Mercia and STW. The plan also details how the ICB would step up an ICC and Incident Management Team (IMT) in response to an incident leading the ICS health economy.

Every NHS commissioned provider organisations are required to have their own Incident Response Plan. The ICB as EPRR system health leads will work with providers to align and support development of plans across health system.

7.10. EPRR Risks

All identified corporate risks associated with EPRR for STWICB are managed via the ICB Strategic and Operational Risk Registers with responsibility overseen by Audit Committee. Any new EPRR or Business Continuity risks identified will be discussed at the Executive Leadership meeting and if agreed will follow the appropriate process to be added to the appropriate risk register.

The LHRP will hold a system EPRR risk register which will be reviewed at each meeting and updated as required. The LHRP will be responsible for the relevant horizon scanning and intelligence gathering, including review of community risk registers and updates via West Mercia Local Resilience Forum (WMLRF), to adequately assess risk and develop mitigations. All partners can raise a risk for inclusion on the register with agreement via the LHRP.

Risk and risk appetite will be assessed against the formula and set out in the ICB Risk Management Policy; for the LHRP, this will be against the formula attached to the LHRP risk register.

7.10.6. Management and Reporting of Risks

The ICB Risk Management Policy sets out the thresholds for escalation of risks as follows: *The following categories of risk grading provide a high-level view of management and reporting requirements. Expected management of risks at each grading has been designed in consideration of NHS STW's risk appetite.*

- ***NHS STW Board*** *will oversee all risks with an overall score of 15+ (e.g., any high and/or extreme operational risks from the Operational Risk Register) at regular meetings.*
- ***Committees*** *will oversee all risks relevant to their remit with an overall score of 8+ (e.g., medium rating and upwards) from the Operational Risk Register and System BAF at each of their meetings.*
- **The Audit Committee** will receive bi-annual risk management updates, including the full Operational Risk Register, which will enable any risk themes and trends to be reviewed; ensuring any multiple, similar risks of a low impact and likelihood are not ignored. This will support their duty to provide the Board with assurance on the robustness and effectiveness of NHS STW's risk management processes.

The Risk Management Policy sets out the following in terms of risk escalation:

Risk Level	Rating	Actions required	Responsibility
Low (green)	1 - 3	Normal local measures.	Line manager/team leader/Project lead/Programme lead to prepare plan. Head of Service to approve plan.
Moderate (yellow)	4 - 6	Formal risk assessment.	Head of Service to prepare plan. Directorate meeting and Director to approve plan.
High (amber)	8 - 12	Action plans required. Reporting to designated Committee.	Director to prepare plan. Committee to approve plan
Extreme (red)	15 – 25	Immediate action required to reduce risk. Reporting to CEO and Board.	Executive Director to prepare plan. Board to approve plan

Where appropriate the LHRP will escalate risk to Midlands Health Resilience Partnership Board (MHRPB) via its representative on this Board

Where there is a prolonged incident, such as COVID19 then it may be determined that an incident specific risk register is required. In this case this risk register will be managed by the Incident Management Team (IMT).

The UK has a National Risk Register (NRR) which is HM Government's assessment of the most serious risks facing the UK. The NRR is the external version of the National Security Risk Assessment (NSRA) and can be accessed online. LRFs use the NRR to inform and produce a Community Risk Register (CRR) localised to their area. LHRPs jointly identifies and assesses all health specific risks and associated impacts aligned to both the NRR and CRRs to inform and produce a health specific risk register for the local health economy and Integrated Care Systems (ICS). Providers of NHS-funded care are expected to align their EPRR risks to the NRR, CRR and the LHRP risk registers.

7.11. NHS Core Standards for EPRR

The purpose of the NHS Core Standards for EPRR is to:

- Enable health agencies across the country to share a common approach to EPRR

- Allow co-ordination of EPRR activities according to the organisation's size and scope
- Provide a consistent and cohesive framework for EPRR activities
- Inform the organisation's annual EPRR work programme.
- Ensure organisations are operating to an appropriate standard in discharging their EPRR duties

The minimum requirements which ICBs and providers of NHS funded services must meet are set out in the NHS England Core Standards for EPRR document. These standards are in accordance with the CCA 2004 and the NHS Act 2006 and cover 11 domains:

- Governance
- Risk Assessment and Management
- Maintaining Plans
- Command and Control
- Training and Exercising
- Response
- Warning and Informing
- Cooperation
- Business Continuity
- HazMat/CBRN
- CBRN Support to Acute Trusts

The NHS Core Standards for EPRR are used as the basis of the annual NHS England assurance process. The ICB has enhanced duties as a Category 1 responder and will form part of the EPRR work plan working with system partners for delivery of EPRR functions. The assessment process undertaken by the ICB and NHSE includes evidence submission and audit reviews.

The NHS Standard Contract Service Conditions require providers to comply with EPRR Guidance. STWICB, will support providers to be compliant with the requirements of the NHS Core Standards for EPRR as part of the annual national assurance process and monitor the delivery action plan outputs. Currently this excludes primary care and other specialised services.

NHS England will ensure that all ICBs are compliant with the requirements of the NHS Core Standards for EPRR as part of the annual ICB assurance framework and approvals process. STWICB will support partners to deliver the NHS Core Standards for EPRR requirements and will ensure that the annual compliance of the ICB and relevant health partners is set out within the Annual EPRR Report to the ICB Board and the twice-yearly report to the ICB Audit Committee.

8. Monitoring and implementation

All monitoring and implementation will be through STWICB's formal governance structure through Audit Committee, and when required will include the LHRP and HEPOG.

Actions arising from the NHS Core Standards for EPRR assessment, learning from de-briefing and exercising and progress against action plans will form part of this monitoring.

Area for monitoring	KPI	How	Who by	Reported to	Frequency
Adherence of this policy to NHS England EPRR Framework and other government guidance.	Policy rated as compliant via NHS Core Standards for EPRR Assessment process	Monitor NHS England EPRR and all EPRR guidance	Senior EPRR Lead	ICB Audit Committee	Reported twice yearly and annually to the ICB board. For Business continuity 3-year internal audit required
Progress against the EPRR work plan	Actions on work plan are shown as complete Where actions are not complete there is a clear rationale, and mitigations are noted	Written report to ICB Audit Committee/ LHRP	Senior EPRR Lead	ICB Audit Committee	Twice Yearly to ICB Audit Committee
Compliance of STWICB with NHS Core Standards for EPRR	Compliance rating supplied by NHSE as an outcome of the annual assurance process	Written report to ICB Audit Committee and annually to ICB Annual NHSE and reported to LHRP assessment reviews	Senior EPRR Lead	ICB Audit Committee and ICB Board	Twice yearly to ICB Audit Committee Annually to ICB Board Annually to NHSE and LHRP
Consultation/ Production and Revision of EPRR Policy and Business Continuity plans and Policies as required by NHS Core Standards for EPRR.	Evidence of updated policies and their ratification	Plans and policies to be sent to appropriate internal and external partners (Business Continuity) and ICB Audit Committee ICB inequalities	Senior EPRR Lead	ICB Audit Committee On-call Policy –consultation required for HR changes	Annual reviews to be undertaken or as required (policy change/lesson learnt/change of guidance)

		team			
STW has an appropriate set of policies in place to ensure appropriate infrastructure and governance in relation to discharging EPRR duties	Ratified policies in place: Incident Response Plan, EPRR Policy, Business Continuity Plan, On-call Policy, EPRR Communications Plan	Annual Review process and updates completed Consultation with partners annually	Senior EPRR Lead	LHRP ICB Audit Committee	Annually
ICB assesses Training and competencies of relevant staff	Training Plan Training Log Evidence of CPD for relevant staff	Annual Review process	Senior EPRR Lead	LHRP ICB Audit Committee	Annually
ICB has a process for debriefing from incidents and absorbing learning into practice	Policy in place which sets out requirements for debriefing Evidence of debriefing participation and inclusion of learning in practice	Annual review process	Senior EPRR Lead	LHRP ICB Audit Committee	Annually

9. Climate Adaption Planning

The ICB is committed to support the Climate Change Act and the Greener NHS programme which has been introduced into the NHS Core Standards for EPRR and will work with NHS Greener programme leads in the ICS system to:

- Ensure consideration of reasonable worst-case scenario and extreme events for adverse weather as a core component of community risk registers.
- Ensure adverse weather arrangements are reflective of climate change risk assessments and cognisant of extreme events.
- Ensure climate change adaption planning is considered as a longer-term impact on an organisation as part of a business continuity policy statement.

The West Mercia LRF currently review climate adaption in risk strategy reviews and STW will utilise this to inform its own climate adaption planning. For STW ICS oversight of the Green Agenda is via the Climate Change Delivery Group, reporting to the Population Health Operational Board and into the ICB. The EPRR Team will work alongside members of staff responsible for the delivery of the Green Agenda for the ICB to ensure appropriate alignment of policy and procedural positions and to ensure that sharing of intelligence.

10. Associated Documentation

Other useful documentation supporting ICB EPRR and Business Continuity are listed below. These documents are available on the ICB's intranet (restricted documents are only accessible via the On-Call Executive MS Teams site).

- ICB Incident Response Plan
- ICB Business Continuity Plan
- NHS STW EPRR Communications Plan
- Emergency Contacts Directory (restricted)
- ICB Health and Safety Policy
- ICB Lone Working Policy
- ICB On-Call policy
- NHS England EPRR Framework

Other useful legislation and guidance:

- The Civil Contingencies Act 2004 (CCA) and associated Cabinet Office guidance
- NHS Act 2006
- Health and Social Care Act 2012
- Health and Care Act 2022
- The NHS Constitution
- Requirements for EPRR as set out in the NHS Standard Contract(s)
- NHS England EPRR guidance and supporting materials including: – NHS Core Standards for Emergency Preparedness, Resilience and Response – other guidance available on the NHS England website
- Minimum Occupational Standards for NHS Emergency Preparedness, Resilience and Response (MOS)
- ISO 22301:2019 Security and resilience – Business continuity management systems
- National Risk Register
- Equality and health inequalities legal duties

11. Appendices

Appendix 1 – Equality Analysis Initial Assessment

Appendix 1 - Equality Analysis Initial Assessment

Title of the change proposal or policy:

Shropshire, Telford and Wrekin ICB Emergency Preparedness, Resilience and Response (EPRR) Policy

Brief description of the proposal or policy:

This policy defines how STWICB will manage its responsibilities for EPRR and Business Continuity.

Name(s) and role(s) of staff completing this assessment:

Stuart Allen, Senior EPRR Lead

Date of assessment: June 2024

Please answer the following questions in relation to the proposed change: Will it affect employees, customers, and/or the public? Please state which.

Yes, it will be applicable to all employees.

Is it a major change affecting how a service or policy is delivered or accessed?

Policy reviewed and updated removing separate training plan to create as a specific Training and Exercising Programme document. Small amounts of formatting done.

Will it have an effect on how other organisations operate in terms of equality?

No

If you conclude that there will not be a detrimental impact on any equality group, caused by the proposed change, please state how you have reached that conclusion:

From an initial assessment of this policy and consideration of employees with protected characteristics under the Equality Act 2010 there is no anticipated detrimental impact on any equality group. There are no statements or conditions within this policy or requirements of this policy that disadvantage any particular group of people with a protected characteristic.

END OF DOCUMENT

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Incident Response Plan

Author(s) (name and post):	Stuart Allen, Senior EPRR Lead
Version No.:	Version 5.1
Approval Date:	28th August 2024
Review Date:	April 2025

Document Control Sheet

Title:	Incident Response Plan		
Version:	V5.1		
Placement in Organisational Structure:	Emergency Preparedness, Resilience and Response (EPRR).		
Consultation with stakeholders:	*Draft Plan provided for comment to ICB Staff, STW providers and NHSE.*		
Equality Impact Assessment:	*Provided at the end of the plan*		
Approval Level:	*EPRR Programme Group (through to Audit Committee and Board)*		
Dissemination Date:	*03 September 2024*	Implementation Date:	*03 September 2024*
Method of Dissemination:	*Email, upload to relevant Teams site, Website and Intranet*		

Document Amendment History

Version	Date	Brief Description
Version Draft 1.0	May 2022	*First draft shared with STW partners and NHSE for comment*
2.0	September 2022	Final draft incorporating comments from stakeholders and final refinements
3.0	July 2023	Annual review and update to incorporate guidance changes, feedback from Core Standards assessment and partner agency feedback
4.0	August 2023	Annual review and update to incorporate guidance changes, feedback from Core Standards assessment and partner agency feedback
4.0	February 2024	Updated to reflect new ICB office location
5.0	June 2024	Annual review and update to incorporate guidance changes and feedback from Core Standards assessment. Added page numbering to footer. Document formatting amended and updated to match throughout document and to allow section headers to follow sequentially and link to table of contents including bookmarking key areas/items. Appendices reviewed and updated including moving 'Specific Incident Scenario Based Information' into the body of the document. Action Cards reviewed and updated to align with current/actual roles within the ICB (this included combining some Action Cards to have one card for one role and not 4 separate cards for On-Call Executive). Images/Figures and names of organisations brought up to date.
5.1	August 2024	Amendments made following consultation with STW NHS Providers and NHSE Midlands EPRR.

Printed copies of the Incident Response Plan (IRP) or those locally saved electronically must be checked to ensure they match the current online version.

Table of Contents

1. Introduction

The aim of this Incident Response Plan (IRP) is to set out how Shropshire, Telford and Wrekin ICB (NHSSTW) co-ordinate the organisation's incident response and that of the wider Integrated Care System NHS response, in the event of an emergency or major incident. It is underpinned by the detailed guidance contained within the Civil Contingencies Act 2004 (CCA), NHS Act 2006, Health and Care Act 2022, and NHS England EPRR Framework. This plan may operate in conjunction with other NHSSTW plans such as Communications Emergency Plan and Business Continuity Plan.

The plan has been developed to ensure that staff from NHSSTW are able to carry out their respective functions when responding to major incidents or during emergency situations on behalf of NHS England (NHSE) or supporting NHSE depending on the incident level. It is important staff in NHSSTW understand this plan and are aware of their specific roles and responsibilities.

INCIDENT RESPONSE ACTION CARDS CAN BE FOUND IN APPENDIX 3 OF THIS DOCUMENT

2. Purpose

The purpose of the plan is to:

- Set out roles and responsibilities within the ICS health system.
- Define what a major incident is and outline the types of emergencies that the local NHS might be expected to respond to.
- Outline the command, control and co-ordination arrangements both internally within the ICB including local NHS partner and in the multiagency context by identifying stakeholders and operational plans, including the decision-making process.
- Establish how the ICB will work with the NHS England Midlands region in response to regional and national incidents.
- Identify the arrangements for communicating information to staff, patients and stakeholders both prior to, during and after a major incident.
- Outline the process for recovery from a major incident.

3. Legal Framework

The CCA establishes a statutory framework of roles and responsibilities for local responders. The CCA is supported by Regulations (The CCA 2004 (Contingency Planning) Regulations 2005) and associated Cabinet Office guidance. Responsibilities of service providers are set out in the NHS Act 2006, the Health and Social Care Act 2012, the Health and Care Act 2022, and in the NHS EPRR Framework, NHS Core Standards for EPRR; NHS England's website for EPRR also publishes a document giving an overview of the key strategic EPRR guidance documents.

The CCA divides local responders into two categories imposing a different set of duties on each; responders will be either Category 1 (primary responders) or Category 2 (supporting agencies). Category 1 Responders with responsibility for health and public health are:

- UK Health Security Agency (UKHSA)
- NHS England
- Integrated Care Boards (ICB)
- NHS Trusts (with the function of providing Ambulance Services or hospital accommodation and services in relation to accidents and emergencies).
- Local Authorities (specifically Directors of Public Health (DPH)
- Port Health Authorities

NHSSTW is classed as a Category 1 Responder from 1 July 2022 and is therefore subject to the full set of civil protection duties placed on Category 1 Responders and is required to:

- Assess the risk of emergencies occurring and use this to inform contingency planning.
- Put in place emergency plans.
- Put in place business continuity management arrangements.
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency.
- Share information with other local responders to enhance co-ordination.
- Co-operate with other local responders to enhance co-ordination and efficiency.

Aside from the ICB and NHSE other Category 1 Responders include:

- Police
- Fire
- Environment Agency
- Maritime and Coastguard Agency

Some of the Category 2 Responders who are key to supporting an incident or emergency with impacts to health and social care are The Met Office, utility providers, transport organisations including National Highways, and The Health and Safety Executive.

4. Defining a Major Incident

The CCA defines an emergency as:

an event or situation which threatens serious damage to: (a) human welfare in a place in the UK; (b) the environment of a place in the UK, or; (c) war or terrorism which threatens serious damage to the security of the UK.

The definition is concerned with consequences rather than the cause or source. For the purposes of this definition, an event or situation threatens damage to human welfare only if it causes or may cause:

- Loss of life

- Human illness or injury
- Homelessness
- Damage to property
- Disruption of a supply of money, food, water, energy or fuel
- Disruption of a system of communication
- Disruption of facilities for transport; or
- Disruption of services relating to health

The NHS is accustomed to normal fluctuations in daily demand for services. Whilst at times this may lead to facilities being fully stretched, such fluctuations are managed without activation of special measures by means of established management procedures and escalation and surge policies. It therefore follows that a major incident is any event where the impact cannot be handled within routine service arrangements. What is classed as a major incident may not be the same for different responding agencies and the NHS can therefore declare a major incident when its own facilities and/or resources or those of partner organisations are overwhelmed.

A major incident may arise in a variety of ways and the response will be sufficiently flexible to assess and respond appropriately to any of these situations.

4.1. Classifications of types of Major Incident

The following table provides commonly used classifications for types of Major Incidents. This list is not exhaustive and other classifications may be used as appropriate to describe the nature of the incident.

Type	Examples
Rapid onset	A sudden incident, such as a major road traffic incident, explosion or series of smaller incidents.
Rising Tide	A developing infectious disease epidemic, or capacity/staffing crisis or forecast of severe weather.
Cloud on the Horizon	A serious threat such as a major chemical or nuclear release developing elsewhere, needing preparatory actions.
Headline News	Public or media alarm about an impending situation, significant reputation management issues, e.g. unpopular patient treatment plan which gather significant publicity.
Chemical, Biological, Radiological, Nuclear and explosives (CBRNe)	CBRNe terrorism is the actual or threatened dispersal of CBRNe materials (one or several, or in combination with explosives), with deliberate criminal, malicious or murderous intent.
Hazardous materials (HAZMAT)	Accidental incident involving hazardous materials.
Cyber security incident	A breach of a systems security policy to disrupt its integrity or availability or the unauthorised access or attempted access to a system.
Organisation Incidents	Anything that affects a provider's ability to deliver services such as fire, breakdown of utilities, major equipment failure, hospital acquired infections, violent crimes.

Type	Examples
Mass Casualties	An incident (or series of incidents) causing casualties on a scale that is beyond the normal resources of the emergency and healthcare services ability to manage.
Pre-planned Major Events	Major events that require planning, such as sports fixtures, mass gathering of people, demonstrations etc.

The EPRR Framework defines three main types of incidents which may require activation of these co-ordination arrangements:

4.1.1. Business Continuity Incident

An event or occurrence that disrupts, or might disrupt an organisation's normal service delivery to below acceptable pre-defined levels. This would require special arrangements to be put in place until services can return to an acceptable level.

Examples include surge in demand to a point that requires temporary re-deployment of resources within the organisation, breakdown of utilities, significant equipment failure or hospital acquired infections. There may also be impacts from wider issues such as supply chain disruption or provider failure.

4.1.2. Critical Incident

Any localised incident where the level of disruption results in an organisation temporarily or permanently losing its ability to deliver critical services or where patients and staff may be at risk of harm. It could also be down to the environment potentially being unsafe, requiring special measures and support from other agencies, to restore normal operating functions.

A Critical Incident is principally an internal escalation response to increased system pressures/ disruption to services.

4.1.3. Major Incident

The Cabinet Office and the Joint Emergency Service Interoperability Principles (JESIP) define a Major Incident as an event or situation with a range of serious consequences that require special arrangements to be implemented by one or more emergency responder agency.

In the NHS this will cover any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties as to require special arrangements to be implemented.

5. NHS Incident Response Levels

The level and type of incident will determine which agency holds lead responsibility. The following table provides a reference point regarding incident levels and lead responsibility arrangements. These levels are specific to the NHS in England and are not interchangeable with other organisation's incident response levels.

As an event evolves it should be described in terms of its level as shown below. For clarity, these levels must be used by all organisations across the NHS when referring to incidents. All incidents and emergencies resulting in the activation of central government response arrangements will be managed as a Level 4 incident. The level of incident may change as the incident evolves. Upon declaration the declaring officer will confirm the incident level being declared. The ICB can declare incidents for Levels 1 and 2 and are responsible for coordinating the response to, and recovery from, incidents are described in the table below (and Section 6.1).

Level 1	An incident that can be **responded to and managed by an NHS-funded organisation** within its respective business as usual capabilities and business continuity plans.
Level 2	An incident that requires the response of a number of NHS-funded organisations within an Integrated Care System (ICS). **NHS coordination by the Integrated Care Board (ICB)** in liaison with the relevant NHS England region.
Level 3	An incident that requires a number of NHS-funded organisations within an NHS England region to respond. **NHS England (Regional) to coordinate the NHS response in collaboration with the ICB.** Support **may** be provided by the NHS England Incident Management Team (National).
Level 4	An incident that requires NHS England national command and control to lead the NHS response. **NHS England Incident Management Team (National) to coordinate the NHS response at the strategic level.** NHS England regions to coordinate the NHS response, in collaboration with the ICB, at the tactical level.

Incidents can escalate as well as de-escalate; the incident level should be frequently reviewed and amended as appropriate.

5.1. Escalation and De-escalation

Escalation or de-escalation of the incident does not necessarily occur sequentially. It can be driven by the nature and scale of the incident and the appropriate response. Reasons for escalation / de-escalation can include:

Criteria for escalation to NHSE Director On-Call	Criteria for de-escalation
• Increase in geographic area or population affected (pandemic, flooding etc.) • The need for additional internal resources • Increased severity of the incident	• Reduction in internal resource requirements • Reduced severity of the incident • Reduced demands from partner agencies or government departments • Reduced public or media interest.

• Increased demands from government departments, the service or from partner agencies or other responders • Heightened public or media interest. • MACA required. • Mutual aid required cross border. • Evacuation and shelter plans need to be triggered	• Decrease in geographic area or population affected

5.2. UK Threat Levels

UK National Threat Levels are designed to give a broad indication of the likelihood of a terrorist attack and are set by the Joint Terrorism Analysis Centre (JTAC) and the Security Service (MI5). Awareness and monitoring of these threat levels can assist in EPRR preparedness. There are 5 categories at which threat levels could be set:

- **LOW** - an attack is unlikely.
- **MODERATE** - an attack is possible, but not likely.
- **SUBSTANTIAL** - an attack is likely.
- **SEVERE** - an attack is highly likely.
- **CRITICAL** - an attack is highly likely in the near future

See Section 12.3 'UK Threat Level Changes – Move to Critical' for more detail on the actions and response to changes in UK Threat Levels.

6. Governance Response

6.1. Organisation Responsibilities

This plan operates on the NHS principle of subsidiarity in that an incident should be managed at the level closest to the people affected as far as is reasonably practicable. Decisions relating to the management of an incident should be taken at the lowest appropriate level, with co-ordination and oversight at the highest necessary level. For the ICB, this means that while the ICB Strategic Commander retains overall responsibility for an incident (up to a level 2 incident, after which NHSE assume responsibility), the Provider Strategic Commanders will continue command and control of their organisations at their local level.

6.2. Routine Management

The NHS is accustomed to normal fluctuations in daily workload. Whilst at times this may lead to services and facilities being stretched, such fluctuations are managed through established management procedures and the surge management plans. This plan is not intended to deal specifically with these situations; however, this plan *could* be activated when National NHS level reaches Level 3 or 4 – Extreme Pressure across the whole system. NHSE Regional Team are responsible for co-ordinating Level 3 healthcare emergencies and NHSE National Team are responsible for co-ordinating healthcare emergencies at Level 4.

Local NHS provider organisations have 24/7 management arrangements in place through On-Call systems. NHSSTW also has an On-Call system in place to provide their commissioned providers and NHSE with a route of escalation on a 24/7 basis 365 days a year, whether the issue relates to capacity or is incident related.

6.3. Leadership of the response to Public Health incidents

Most public health incidents are contained locally and do not require activation of Local Resilience Forum (LRF) or NHS EPRR regional level plans. However, all incidents have the potential to require NHS resources. The route of escalation in public health incidents (including High Consequence Infectious Diseases (HCID)) will be from UK Health Security Agency (UKHSA) to the ICB Director On-Call who will sanction any expenditure required; the ICB should notify NHSE Regional Incident Manager (first On-Call for the Midlands) to discuss the mobilisation and co-ordination of the local NHS response. The NHSE Regional EPRR team will determine at what point command of the incident passes to the NHSE Regional team.

The STW system has an over-arching Health Protection Strategy in place. This combined Health Protection Strategy, applies to all organisations, and sets out the vision for Health Protection for the population of Shropshire, Telford and Wrekin. It recognises the importance of strong health protection measures being at the forefront of everything we do to ensure good population health outcomes. The Strategy outlines how we will adapt and extend our existing business as usual (BAU) health protection models and responses to include the many health issues that have been highlighted and exacerbated throughout the pandemic. The lessons learned have been incorporated in the aims and objectives of the strategy.

The Strategy has a number of priorities: Considering health inequalities, it pro-actively promotes the uptake of immunisations and screening; reduce the inequalities in the burden of communicable food and water borne diseases and protect our local populations from threats and hazards to human health, including air quality issues and extreme weather planning. The strategy can be accessed on the ICB Intranet and in the On-Call Directors area on MS Teams.

6.4. Major Incident Management

ICBs are required to comply with Category 1 Responder responsibilities and NHS EPRR Framework. The Framework sets out the role of the ICB in an incident, which includes:

- Supporting the NHS in discharging its EPRR functions and duties locally.
- Attending the Local Resilience Forum (LRF) /Tactical Coordination Group (TCG) /Strategic Coordination Group (SCG). The ICB is the ICS health lead for NHS partners and providers.
- Co-operating and sharing relevant information with other multiagency responders.
- Provide their commissioned providers with a route of escalation on a 24/7 basis, 365 days of the year and specifically during an incident.
- Leading and co-ordinating the incident response on behalf of health partners.
- Mobilisation of an Incident Management Team and Incident Co-ordination Centre as required.

- Ensuring appropriate arrangements for recording actions and decisions.
- Initiating arrangements of Mutual Aid if required.
- Overseeing and approving deployment of resource and funding.
- Ensure appropriate arrangements are in place for hot and cold debriefing and learning from incidents which contributes to continuous improvement.

The ICB will be the first point of contact for providers in unfolding incidents for the health economy in Shropshire, Telford and Wrekin, whether they are capacity related or because of another matter. This will ensure that the ICB is aware of what is taking place within the wider ICS and enable support to be offered to their provider organisations appropriately as well as the co-ordination of the response with NHSE in line with command and control arrangements.

Where an incident is widespread category 1 and 2 organisations may convene Strategic Co-ordinating Groups (SCG) and Tactical Co-ordinating Groups via agreement with the LRF which will help co-ordination and co-operation between responders at the local level.

During the response phase of an incident ICBs will:

- Represent the local health economy including at the Shropshire, Telford and Wrekin Tactical Co-ordinating Groups (TCG) in the event that the incident requires multiagency command and control arrangements to be instigated on a county level or across the ICS.
- Attend Strategic Co-ordinating Group (SCG) if activated representing ICS health partners.
- Support the NHS England EPRR Regional Team should any out of county emergency require local NHS health resources to be mobilised.
- Ensure the appropriate command and control structures are mobilised by following the processes set out in this policy, including the mobilisation of an Incident Management Team (IMT) and an Incident Co-ordination Centre (ICC), appropriate arrangements for record keeping and communications (full details are set out in the Action Cards at the end of this document.)
- Establish a schedule for system calls (tactical and strategic) and participation in any regional or national calls.
- Have a mechanism in place to mobilise all applicable providers that support primary care services should the need arise.
- Have a mechanism in place to co-ordinate, log and share information in an incident – central ICC with partners across the ICS. The ICB operates a Single Point of Contact.
- Support health partners to maintain service delivery across the local health economy to prevent business as usual pressures and minor incidents from becoming significant incidents or emergencies.
- Have systems to manage their provider health organisations to effectively co-ordinate increases in activity across the local health economy.
- Escalate incidents and emergencies to the NHSE Regional EPRR team.
- Co-ordinate across the ICS health system emergency situational reporting (SitReps)/assurance as requested via the ICC process (if stood up to support incidents).

- Document ICS health mutual aid processes as agreed by health partners supporting an incident.
- Request mutual aid via West Mercia LRF Mutual Aid Policy, NHSE Mutual Aid Policy, via the health system tactical and strategic incident meetings or via Shropshire, Telford and Wrekin TCG. MACA (Military Assistance to the Civil Authorities) can be called for healthcare but only via NHSE.
- Participate and where appropriate facilitate debrief (hot debrief within 48 hours and cold debrief with 2 weeks of incident stand down) and learning events related to incidents to support continuous improvement.
- Lead the ICS health economy to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an incident and as agreed by the lead organisation.
- Responsibility for the Governance Response.

Based on the scale of the incident, its potential to impact on NHS services, and the anticipated volume of communications likely to be flowing up and down the chain of command it may be necessary to convene:

- Multi-agency groups including Strategic Co-ordinating Group (SCG), Tactical Co-ordinating Group (TCG) and/or Scientific and Technical Advice Cell (STAC) (these will be convened via West Mercia Local Resilience Forum Secretariat with notification to the ICB).
- An Incident Management Team (ICB responsibility to convene).
- The ICB Incident Co-ordination Centre (ICC) (ICB responsibility to convene).
- A local NHS Strategic Health Coordination Group (ICB to convene and lead).

6.5. Declaring an Incident

The following individuals can declare a health related incident on behalf of the ICB:

- Accountable Emergency Officer (AEO)
- Chief Executive Officer (CEO)
- On-Call Executive/Director

6.6. Incident Management Team (IMT)

The primary function of the ICB Incident Management Team (IMT) is to collate information regarding the operational/tactical response across the local NHS, gather intelligence from wider sources relating to the incident and ensure the efficient flow of information between the chain of command and partner agencies.

The membership of the Incident Management Team should include the following as a minimum:

- On-Call Executive (Incident Director).
- SCC Duty Manager (Incident Manager)
- Communications Lead
- Administrator
- Loggist

Other roles may be included in the IMT depending on the nature of the incident and its likely length, such as subject matter experts, administrative and support staff. Action Cards are provided in Appendix 3 for all the potential IMT roles.

The ICB Incident Management Team is chaired by the ICB On-Call Executive or the Accountable Emergency Officer (AEO). Membership will depend on the incident complexity and specifics of the particular incident, but should aim to:

- Support the lead director for the incident in directing and co-ordinating the ICB and the system wide response (strategy and operations).
- Provide a forward look to issues that may arise and their consequences and forecast the NHS response to mitigate these issues.
- Be the route through which tasking is actioned.
- Act as the conduit for information requests.
- Manage information relevant to the incident and share/disseminate as necessary with strict consideration of governance and records management policies.
- Provide Situation Reports (SITREP). **SitRep template is saved in the On-Call Executives MS Teams site.**
- Operate the Incident Coordination Centre (ICC).
- Establish a Recovery Cell during the early stages of incident response.

The ICC would be established to support the Incident Management Team in co-ordinating the incident response. The circumstances for establishing the ICC are outlined in section 6.8.

Out of hours the ICB Incident Management Team may initially be restricted to the available ICB On-Call members of staff, but if Strategic On-Call decides a formal Incident Management Team needs to be convened, the contact numbers for all On-Call staff can be used to alert them and request they join the Incident Management Team. Contact numbers for On-Call are held in the On-Call Director Teams platform under emergency contacts.

The recipient of information regarding a potential incident or an incident declaration should refer to the Action Cards set out in Appendix 3 to determine if the scenario requires the convening of an IMT; NHSE Midlands region (via their On-Call system) should be notified within 15 minutes of the ICB's own declaration of an incident and within 1 hour if the incident is being escalated.

The reporting of ALL health data should be to NHSE (through to the Department for Health and Social Care (DHSC)) in the first instance and only ratified data should be shared with the LRF (LRF will report concurrently to the Ministry of Housing, Communities and Local Government (MHCLG) and DHSC are the owners of health data not MHCLG) and other partners/stakeholders once agreed by NHSE.

6.7. Interface with the System Co-ordination Centre (SCC)

Each ICS area has been mandated by NHSE to have in place an SCC which is operational 7 days a week from 8am to 6pm supported by On-Call arrangements covering 24/7. The SCC forms part of the support and delivery architecture of the ICB.

The SCC is the primary conduit for the daily ICS engagement with NHSE Regional Urgent and Emergency Care (UEC) teams who are in turn supported by the NHSE National Integrated Urgent and Emergency Care operational team (iUEC).

The SCC primary function is to manage pressures on the UEC pathway, overseeing and co-ordinating the ICS response to escalation and managing patient flow across the system. In addition to this the SCC, incorporating the ICB's Single Point of Contact (SPOC) is the main conduit for correspondence from NHSE and as such for EPRR messages including those related to incidents.

Should there be a need to stand up an Incident Control Centre, the SCC as a default, will be utilised for this purpose. In the event that an incident is related to a non-UEC issue then a decision will be made on a case by case basis regarding the specific arrangements to setup an ICC to ensure the SCC can continue to focus on daily UEC pressure management whilst the SCC infrastructure is used to also manage the incident at hand.

6.8. ICB Incident Co-ordination Centre

In the event of a major incident or similar disruptive event, especially if likely to be prolonged or additional resources may be required, it may be necessary for the ICB to establish and maintain a separate Incident Co-ordination Centre (ICC).

The ICC comprises:-

- ICB Incident Management Team convened to oversee the ICB response.
- ICB Incident Co-ordination Centre (ICC) to receive emails and calls and all incident related information. Incoming information will be logged and brought to the attention of the Incident Director.

The ICB ICC serves as a focal point for all liaison with NHSE and partner agencies regarding the incident. The Incident Co-ordination Centre may be virtual utilising Microsoft Teams capability. If a physical Incident Control Centre is required this would usually be **Meeting Room 4, Second Floor, NHS Shropshire, Telford & Wrekin, Wellington Civic Offices, Larkin Way, Wellington, TF1 1LX**. The NHSSTW ICC will be managed by the Incident Management Team either in person or via digital technology as required and supported by other relevant personnel redeployed from within the organisation to support the incident in line with ICB redeployment plans. The ICC should be established within 1 hour of the decision that it is to be stood up is made.

The functions of the ICC include:

- Co-ordination – matching capabilities to demands.
- Liaison – act as the key point of liaison with partner organisations, the LRF and NHSE for the duration of an incident.
- Information gathering, processing, sharing and archiving.
- Determining the nature and extent of the incident to ensure shared situational awareness.
- Dissemination of information across the NHS.
- Dispersing public information – informing the community, news/media and partner organisations.

- Ensuring appropriate documentation is completed and submitted as required, including relevant SitReps, action and decision logs.
- Report ALL health data to NHSE (through to DHSC) in the first instance and only ratified data should be shared with the LRF (LRF will report concurrently to MHCLG and DHSC are the owners of health data not MHCLG) and other partners/stakeholders.

NHSE Regional MIDSROC and provider ICCs would need to be informed of the opening of the ICB ICC, including confirmation of email address and phone number to be used.

If a Shropshire, Telford and Wrekin TCG is activated by the LRF the default physical location for the group is Shropshire Fire and Rescue Service Headquarters (but this may change depending on activity of the day and/or the type of incident); there will usually be an option for virtual attendance via Microsoft Teams or phone, but this will depend on the type of incident and any security requirements enacted.

If an LRF SCG is called due to the geographical footprint this will either be by MS Teams conference calls or physical attendance; details will be issued to participants at the time.

6.9. Health and Social Care System Pressures

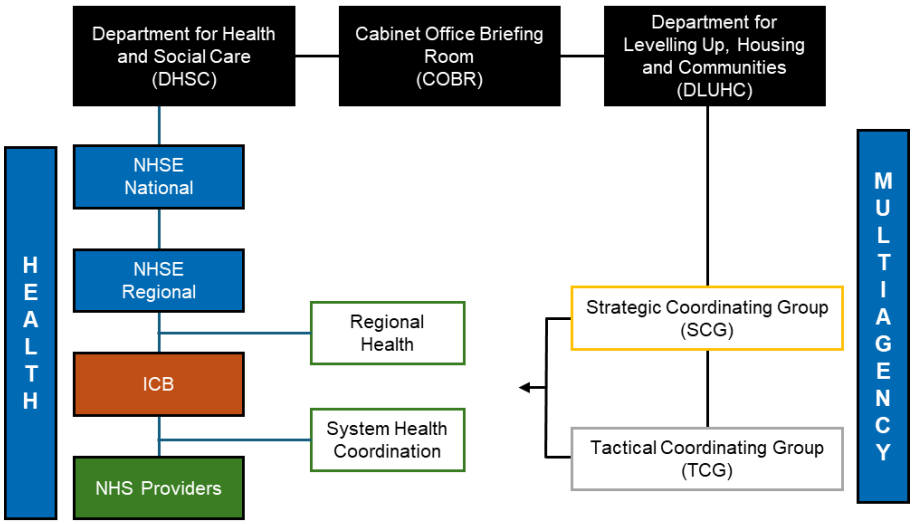
In the event of significant and sustained pressure on the system or in the event of a major incident, it may be necessary to convene a system health and social care tactical or strategic meeting.

The overarching aim of the meeting is to coordinate the response of the local health and social care system to an incident or severe pressure on the health & social care system. This would require Chief Executive / Strategic/ Director level representation from across health and either Chief Executive/ Director/ Assistant Director from the Local Authorities.

The meeting can be held either virtually (MS Teams / teleconference) or at a specific location. It will be the responsibility of the ICB to organise and provide secretariat support.

Depending on the nature of the incident a decision may be taken to utilise the SCC infrastructure to facilitate and manage these system calls.

6.10. Multiagency command and control principles



The management of the multiagency response and recovery effort is undertaken at one or more of three ascending levels (Operational-Tactical-Strategic):

Operational

Refers to those who provide the immediate 'hands on' response to the incident, carrying out specific operational tasks either at the scene or at a supporting location such as a hospital or rest centre or support cells on the ground nearer the incident reporting to the TCG.

Tactical

Refers to those who are in charge of managing the incident on behalf of their organisation. They are responsible for making tactical decision, determining operational priorities, allocating staff and physical resources and developing a tactical plan to implement the agreed strategy.

Strategic

Refers to those responsible for determining the overall management, policy, and strategy for the incident whilst maintaining normal services at an appropriate level. They should ensure that appropriate resources are made available to enable and manage communications with the public and media. Additionally, they will identify the longer-term implications and determine plans for the return to normality once the incident is brought under control or is deemed to be over.

Not all of these command levels are necessarily activated – depending on the scale of the incident and response. The general approach is to escalate the levels with the increasing size and complexity of the response required.

In complex, large-scale incidents, there is a need to co-ordinate and integrate the strategic, tactical and operational response of each responder. The LRF establishes a Strategic Co-ordinating Group (SCG) with the default Chair being a senior ranking police officer; the Chair of the SCG could change depending on the type of incident. The local NHS will be represented by the ICB Strategic Lead (On-Call Executive who has the authority to commit significant resources).

The Scientific and Technical Advice Cell (STAC) provides technical advice to the Strategic Coordinating Group. The STAC, which is usually chaired by UKHSA or a LA Director of Public Health, would be expected to advise on issues such as the impact on the health of the population, public safety, environmental protection, and sampling and monitoring of any contaminants.

In the event of a major incident the STAC is activated by the SCG through the cell lead or relevant duty officer. However, a public health professional (i.e. Director of Public Health or the UKHSA Director) may recommend to the SCG Chair that a STAC needs to be established due to the potential impact on the health of the local population from an actual or evolving incident.

The LRF may also convene a Communications Cell to co-ordinate communications to the public if an overarching communications response is required. Local communications cells would be represented at the LRF cell.

The Shropshire, Telford and Wrekin Multiagency Tactical Co-ordinating Group (TCG) will be convened to determine the tactical response to an emergency/major incident through examination of the circumstances prevailing, identifying priorities, and making tactical decisions. The default Chair for the TCG will be a senior ranking police officer from the STW area; the Chair of the TCG could change depending on the type of incident. A TCG can be convened independently of the SCG. However, if the SCG is sitting it may make policy and strategy directions to the TCG. The ICS local health NHS organisations will be represented by the ICB On-Call Executive.

Multiagency partners will require updates via any sitting Strategic Coordinating Group (SCG), this should always reflect the latest NHS reported position. Any information passed to the TCG or SCG must be reported to NHSE in the first instance in order for them to brief DHSC if required. Health representatives at SCGs are asked to ensure only formal NHS figures from the whole health service are used, and for clarity a time stamp of reporting should be added to these.

Responsibility for reporting of deaths to the media and public may be dependent on the nature of the incident, with the Police often taking the lead in major incidents and the NHS in health incidents such as infectious diseases. Where patient numbers are low or fall to a small number, potentially making individuals identifiable the NHS will stop reporting these publicly. The reporting of ALL health data should be to NHSE (through to DHSC) in the first instance and only ratified data should be shared with the LRF (LRF will report concurrently to MHCLG and DHSC are the owners of health data not MHCLG) and other partners/stakeholders once agreed by NHSE.

At scene, during the early stages of an incident, it is often not possible to provide accurate casualty figures. However, where indications of numbers involved are available, these should be shared but heavily caveated as a best estimate based on the circumstances emergency services are responding to at that time. Once a scene is cleared and all patients have been received to hospital, NHSE is responsible for the publication of patient numbers affected by the incident. Depending on the nature of the incident, this may be delegated to a local NHS organisation.

Multiagency command and control structures exist in passive form and may be convened as such during a slow burn/cloud on the horizon event to enable multiagency partners to prepare.

6.10.1. Mutual Aid

During an incident response an organisation's capacity and / or capability to provide safe and effective patient care may be exceeded. Once internal business continuity arrangements have been exhausted, it may be necessary to seek support from other organisations in a formal, documented way within our ICS or wider. This formalised support is referred to as 'mutual aid'. Agreement(s) for mutual aid provision should exist between organisations in advance of the requirement. Mutual aid arrangements can exist between providers of NHS funded care and external partners e.g. public, private, or voluntary sectors. Mutual aid can vary in need from staff, equipment, supplies of laundry, advice, capacity, pharmacy, estate for relocation, mortuary etc.

NHSE will support the brokering of mutual aid requests if the health system led by the ICB is unable to resolve this and will mediate multiple provider requests and go wider than the ICS footprint when escalated by the ICB. All NHSE requests for mutual aid need to follow NHSE command and control arrangements in the NHS EPRR Framework.

ICBs are required to support NHSE in discharging its EPRR function. This includes providing leadership in the agreement and activation of mutual aid arrangements across its geography to support its population and commissioned providers.

ICBs will hold copies of the written mutual aid arrangements for any arrangements across their ICS for health and will also maintain centralised records of requests made and declines across their providers even if no financial implication is involved. ICBs will review active mutual aid arrangements in place working with partners in the LRF to identify and plan for mutual aid eventualities and look to identify impacts these may have on patient services in the responding and health supporting organisations.

To activate mutual aid the health organisation must have exhausted all internal business continuity arrangements and have formally declared a business continuity, critical, or major incident as defined by NHS EPRR Framework in response to an incident.

The NHS Mutual Aid guide (March 2022) is available in the ICB On-Call pack which details the key information of the expectation and requirements of assisting the call for mutual aid.

The requesting of Mutual Aid should be done by completing the 'Mutual Aid Request Template' found at Appendix 9. All requests for Mutual Aid (whether receiving or providing) must be approved by the On-Call Executive/Incident Director.

6.10.2. Evacuation and Shelter

All providers of NHS-funded care are required to have plans to support part or full evacuation of a site and the immediate sheltering of patients, specifically providers of

inpatient accommodation. If a situation/incident occurs where there is a need to evacuate part or all of a NHS Providers site, they are responsible for enacting their evacuation and shelter plans, with the ICB coordinating systemwide response/support as required following the processes and structures outlined in this IRP.

Depending on the scale and length of disruption of the incident mutual aid may also be considered in and out of county/across other ICS's. This could also potentially include STW ICS providing mutual aid to another system(s).

For evacuation situations affecting the ICB only (i.e. HQ offices), reference should be made to the ICB's Business Continuity Plan which can be found on the ICB Intranet or in the On-Call Executive's area on MS Teams.

6.10.3. Infectious Disease

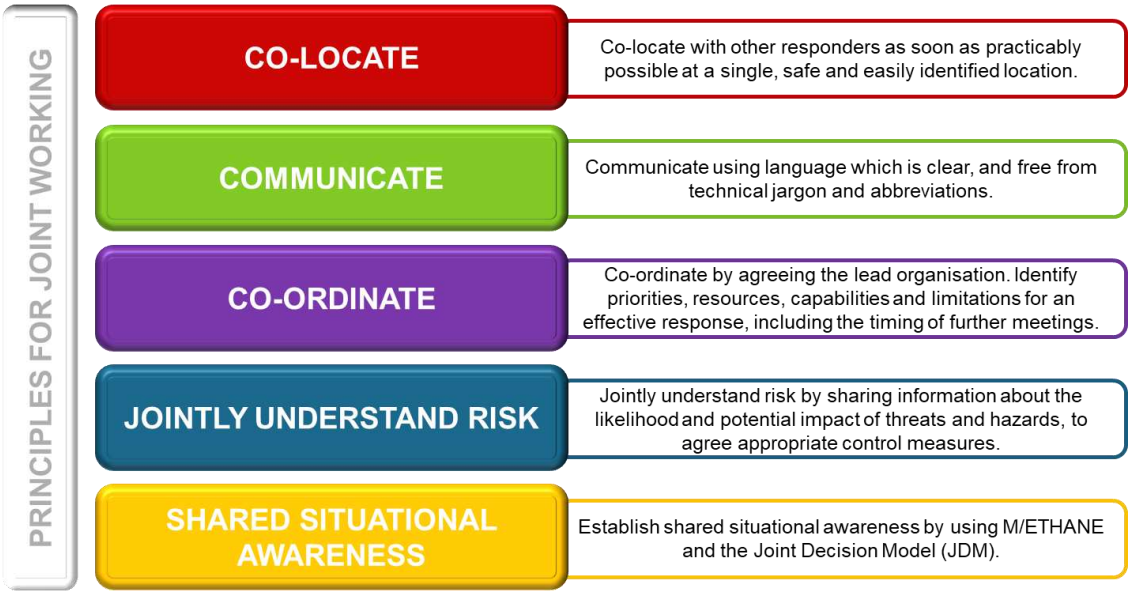
NHSSTW has a system wide Health Protection Strategy which includes plans for addressing infectious diseases, in the event of an outbreak or infectious disease. The plans will be activated as required by UKHSA or the Local Director of Public Health and the health response will be supported and co-ordinated by the ICB for the health partners in the system.

7. Joint Emergency Services Interoperability Principles (JESIP)

The Joint Emergency Services Interoperability Principles (JESIP) are principles applying to all emergency responders and have become the standard for interoperability in the UK. Whilst the initial focus was on improving the response to major incidents, JESIP is scalable, and the five joint working principles and models can be applied to any type of multiagency incident.

7.1. Principles for Joint Working

The principles for joint working is a tool that supports the way agencies work together effectively to save lives and reduce harm by providing structure during the response. The principles can also be applied during the recovery phase. The figure below illustrates the five joint working principles presented in an indicative sequence, although they can be applied in a different order if necessary. The application of simple principles for joint working are particularly important in the early stages of an incident, when clear, robust decisions and actions need to be taken with minimal delay, often in a rapidly changing environment.



7.2. M/ETHANE

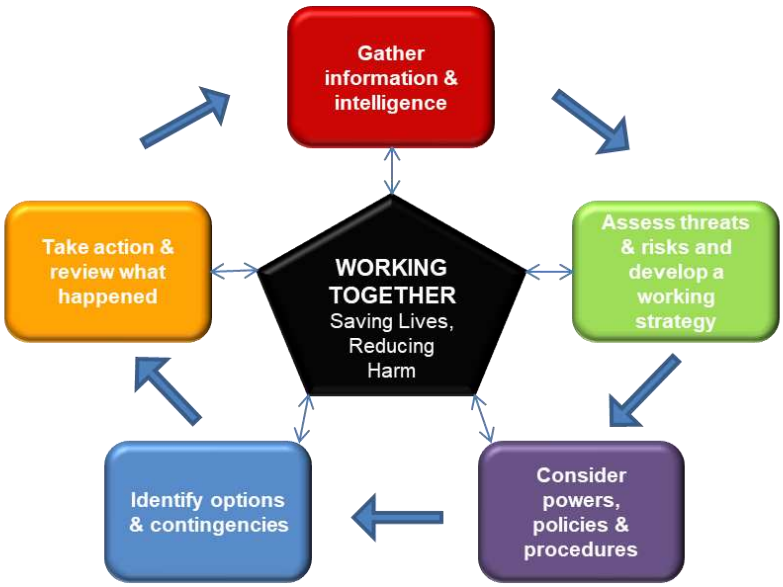
In order to help all agencies gather and share initial information about an incident in a consistent manner, a common approach is required. The M/ETHANE model, outlined in figure below, brings structure and clarity to the initial stages of managing any multiagency or major incident. For online access to this and a range of standard incident management tools it is recommended to download the JESIP App for handy reference guide access or via the website https://www.jesip.org.uk/uploads/media/app/Jesip-web-version/

M	Major Incident Declared?	Has a major incident been declared? (Yes/No – If 'No', then complete ETHANE message)
E	Exact Location	What is the exact location or geographical area of the incident?
T	Type of Incident	What kind of incident is it?
H	Hazards	What hazards or potential hazards can be identified?
A	Access	What are the best routes for access and egress?
N	Number of Casualties	How many casualties are there, and what condition are they in?
E	Emergency Services	Which, and how many, emergency responder assets and personnel are required or are already on-scene?

In the event of a Major Incident being declared by either the ICB, a Provider, or the LRF requiring a health response, a written M/ETHANE form must be completed and submitted to NHSE Midlands within 1 hour of the declaration. The M/ETHANE form is provided at Appendix 1 and On-Call Executive MS Teams folders.

7.3. Joint Decision Model (JDM)

One of the difficulties facing responders is how to bring together the available information, reconcile potentially differing priorities and then make effective decisions together. The Joint Decision Model (JDM), outlined in the figure below, was developed to resolve this issue. The JDM is designed to help make effective decisions together.



Decision-makers are expected to use their judgement and experience when deciding what additional questions to ask and what to consider in order to reach a decision.

All decisions, the rationale behind them and subsequent actions, should be recorded in a joint decisions log. Recording of decisions and the rationale for the decision alongside any agreed actions is critical and where possible should be undertaken by a trained loggist. When using the JDM, the priority is to gather and assess information and intelligence. Responders should work together to build shared situational awareness, recognising that this requires continuous effort as the situation, and responders understanding, will change over time. Understanding the risks is vital in establishing shared situational awareness, as it enables responders to answer the three fundamental questions of 'what, so what and what might?' Once the process of building shared situation awareness has begun, the desired outcomes should be agreed as the central part of a joint working strategy.

Responders should be free to interpret the JDM for themselves, reasonably and according to the circumstances they face at any given time. Achieving desired outcomes should always come before strict adherence to the stepped process outlined in the JDM, particularly in time sensitive situations.

7.4. IIMARCH

Once decisions have been made and actions agreed, information should be relayed in a structured way that can be easily understood by those who will carry out actions or support activities. This is commonly known as briefing. In the initial phases of an incident, the JDM may be used to structure a briefing. As incidents develop past the initial phases or if they are protracted and require a handover of responsibility, then a

more detailed briefing tool should be used. The mnemonic IIMARCH is a commonly used briefing tool. The IIMARCH template can be found in Appendix 6.

I	INFORMATION
I	INTENT
M	METHOD
A	ADMINISTRATION
R	RISK ASSESSMENT
C	COMMUNICATIONS
H	HUMANITARIAN ISSUES

During a multi-agency response, organisations and individuals should ensure they are aware of their obligations to retain, and potentially disclose in the future, material relating to the incident. Much of this material may be relevant in a wide range of proceedings, including criminal and coronial proceedings and public inquiries. Material could include:

- Incident logs
- Briefing and debriefing sheets
- Policy files or decision books
- Operational or tactical advice notes
- WhatsApp messages or information on other forms of communication tools

Retention requirements for documentation relating to incidents is 30 years.

7.5. Completion of SBAR

In the event of a health related incident NHSE will require the completion of an SBAR. This must be completed on the agreed SBAR template included at Appendix 7. An SBAR must be submitted to NHSE MIDSROC at the point the incident is declared and each day by 1300hr until the incident is stood down (unless otherwise agreed or requested). At the point that the incident is stood down an SBAR should be sent to NHSE which includes the rationale for stepping the incident down. Each SBAR should be signed by the Incident Director before being submitted and submitted in PDF form. The ICB Incident Lead should review and sign off any provider SBAR before it is submitted to NHSE. The ICB SCC Duty Manager, or On-Call Executive out-of-hours, should ensure the co-ordination of SBARs for submission in the event of there being SBARs from multiple agencies. A copy should be sent to the SCC in order that it can be stored via the SCC archiving system.

S	Situation
B	Background
A	Assessment
R	Recommendation

8. Role of ICB On-Call Executive

Please refer to the Action Cards in Appendix 3 of this document for more specific information regarding actions and requirements of staff supporting the incident response

8.1. Role of ICB On-Call Executive

The ICB On-Call will:

- Refer to the Action Cards, which can be found in the On-Call folder and make an initial risk assessment of the situation to determine what action needs to be taken informing provider organisations and NHSE accordingly (A M/ETHANE Report or alternative Initial Risk Assessment template for recording the initial information available on which to make this assessment can be found in Appendices 1 and 2).
- Commence a personal Log.
- Inform the NHSE Regional On-Call using the M/ETHANE/ Initial Risk Assessment. An SBAR should be completed and submitted to NHSE for Business Continuity/ Critical Incidents. Determine the chain of command for the incident, Level 1 and Level 2 remains with the ICB to lead. An incident identified at Level 3 will need to be escalated to NHSE Regional Team who would be the co-ordination lead for health emergencies at this level and for Level 4 NHSE National Team would be the lead – refer to Section 5 Incidents Response Levels)
- At Level 2, the ICB On-Call Executive assumes the role of the Incident Director for the local NHS health system, setting the strategic aim and objectives, and ensuring the mobilisation and co-ordination of local NHS resources as required. NHSE EPRR first On-Call should be informed of the incident and may wish to be involved in any relevant meetings which are convened or to be kept appraised of the situation.
- Where the situation requires it, convene an Incident Management Team (IMT) and activate the ICB's Incident Coordination Centre (ICC) – this decision should be based on the scale of the incident, its potential to impact on NHS services, and the anticipated volume of communications likely to be flowing up and down the chain of command, or as advised by NHSE.
- Ensure that the strategic aim and objectives are in line with NHS direction and are reviewed regularly.
- Appoint a Loggist (if available) and ensure appropriate documents and records (and logbooks) are being kept and all ICS health organisations are aware of the need to capture accurate financial information of any expenditure incurred as a result of the incident.

- Ensure accurate records are kept, in particular recording of decisions, their rationale and actions. These decisions and actions should be circulated to attendees promptly and at least prior to the next meeting taking place to ensure actions are clear and can be completed.
- Ensure where possible that the response can be maintained within the ICS health system; additional resources should be requested through the NHSE EPRR first On-Call where required.
- Ensure the ICB's and ICS health providers critical services are maintained.
- Access copies of associated local plans and policies from providers involved with incident as required from ICS partners and providers to support response.
- Attend the multiagency Tactical Co-ordinating Group (TCG) as lead for health in the ICS and ensure that the NHSE Director On-Call is aware and agree the SCG attendance arrangements. Provide up to date status of incident aligned to TCGs including stand down.
- Ensure that the M/ETHANE / Initial Risk Assessment is revisited regularly and that any significant issues are escalated to the NHSE EPRR first On-Call immediately.
- Ensure that during the course of the incident ICB On-Call staff are kept informed (by using an SBAR template) of the details of the incident and how it is evolving. This should be done daily by 5pm
- Advise when the incident is over and stand down the local system NHS response and inform NHSE first On-Call.
- Make arrangements for a hot debrief (within 48 hours) and cold debrief (within 2-3 weeks) of the incident concluding) in conjunction with the Senior EPRR Lead. During a prolonged incident 'in-action reviews' (debriefs) should occur regularly throughout the response (with the outputs of this recorded) to ensure the response remains appropriate and adjustments can be made if needed
- Ensure that all ICB staff who have been involved in the response to the incident are debriefed and feed into the lead organisation and capture debrief forms if not led by TCG. Ensure Senior EPRR Lead is provided with copies of debrief reports/logs etc. and documentation and that this is stored in line with agreed arrangements through the SCC.
- Ensure that any lessons learned are incorporated into future incident response arrangements and an incident report (where appropriate) is written by lead organisation and shared with health partners for review at HEPOG and LHRP.
- Ensure that the Chief Executive Officer, Accountable Emergency Officer, Directors, Board and Clinical Leads are informed in a timely manner.
- Ensure communications representative are included in the incident response (a Category 1 organisation to lead health response as required).

Escalation or de-escalation of the incident does not necessarily occur sequentially. It can be driven by the nature and scale of the incident and the appropriate response. Triggers for escalation and de-escalation are included in section 5 of this Plan. The ICB Incident Director will determine, in conjunction with NHSE when de-escalation can commence.

9. Process

9.1. System Co-ordination

Providers are required to have 24/7 ability to provide and coordinate their response to an incident impacting on their service delivery or a major incident. Small scale incidents not causing any impact on the local system are unlikely to require ICB coordination, with responsibility on the provider to manage the response. The ICB would monitor the situation, taking up coordination of a system response if the situation deteriorated and impact on the system increased.

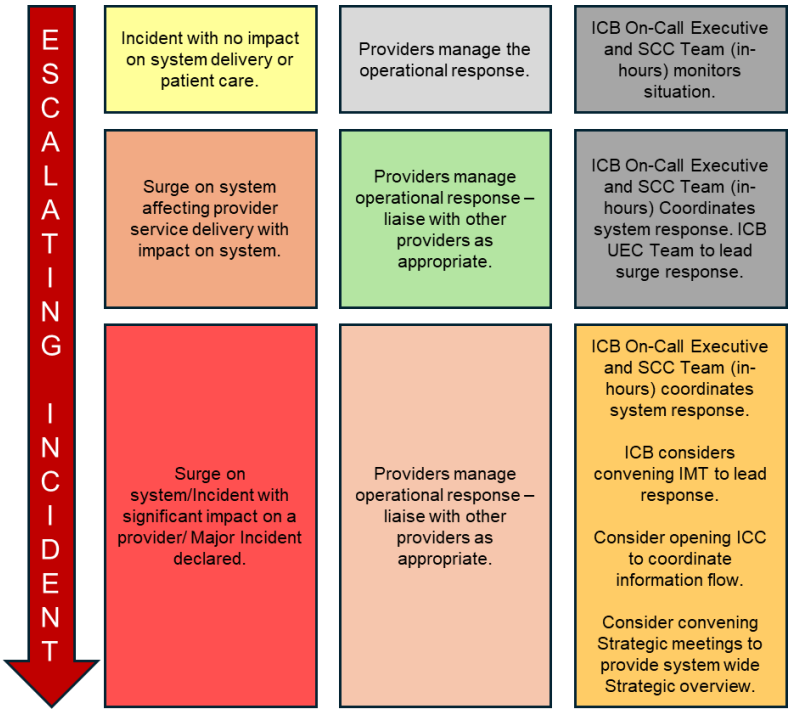
Where surge on the system or an incident is resulting in increased pressure on the health and social care system, it is the responsibility of the ICB to liaise with providers and coordinate the system response.

Out of hours this is the responsibility of the ICB On-Call Executive; it may be appropriate to use pre-arranged or specially convened System Tactical Level Capacity and Flow Calls for the coordination of the response if a potential incident is predicted or there is a rising tide.

In hours, the ICB SCC Team would be expected to lead on coordinating the response to Capacity and Flow pressure on the system caused by the Incident. This would be through pre-arranged or specially convened System Tactical Level Capacity and Flow/health co-ordinating call. The ICB SCC Duty Officer would brief the ICB On-Call Executive on the situation. Where appropriate the ICB On-Call Executive would join in-hours system Capacity and Flow calls.

In the event of a major incident requiring a health response or an incident causing significant impact / disruption on the system, the ICB On-Call Executive may decide that it is necessary to convene an ICB Incident Management Team to support system coordination. (Refer to Action Cards).

Furthermore, if the necessary system response to the incident or the disruption to the system is of such a scale, the ICB On-Call Executive (or Accountable Emergency Officer in-hours if available) may decide, in discussion with the strategic leads in partner organisations, that health and social care coordination at an executive level is required and convene an ICS Executive Level meeting, coordinated and managed by the SCC (in-hours) or On-Call Executive (out-of-hours).



9.2. Alerting the ICB

The ICB operates a single tier On-Call Executive mechanism available 24/7 by phone. (via SaTH switchboard).

All providers of NHS funded care must inform the ICB of a Business Continuity, Critical or Major Incident, as well as incidents with significant local profile. This includes informing the ICB that the organisation is on 'stand-by' to declaring an incident.

Type of Incident/Alert	Method Alerting
Business Continuity Incident	**The organisation declaring a Business Continuity Incident must inform the ICB within 15 minutes of the incident being declared.** Where the business continuity disruption is having implications for the wider health service, the ICB as local health system leader would co-ordinate the health response. **Where a Business Continuity Incident is declared a SBAR report must be provided.**
Critical Incident (i.e. internal disruption to Trust)	**The organisation declaring Critical Incident must inform the ICB within 15 minutes of the incident being declared.** The ICB as local health system leader would co-ordinate the health response.

	Where a Critical Incident is declared a SBAR report must be provided by the declaring organisation to the ICB within 1 hour of declaration. The ICB should submit to NHSE within 1 hour of receipt. The **SBAR should be completed and submitted to NHSE each day that the incident is live no later than 1300hr** or as otherwise agreed with NHSE.
Major Incident	For Major Incidents external to Trusts (e.g. in the community/industry/terrorism) the Ambulance Service would notify receiving hospitals and the ICB. Other Emergency Services may also be notified and the ICB will also receive notification from the LRF. Key information about the incident will be provided in the form of a M/ETHANE report. The ICB should make contact with Acute Trusts to ensure the declaration has been received, understood and to confirm any actions/issues. The ICB will contact NHSE First On-Call within 1 hour of the incident being declared. The ICB should alert the following as they may be required to support the health response: • Patient Transport Services provider. The ICB should alert the following as they could see an increase in presentations / surge on the system: • ICB SCC, including Urgent and Emergency Care Team (in hours). • GP out of hours provider. • NHS 111 provider. • ICB Primary Care Team so general practices are aware (in hours). • Shropshire Community Health NHS Trust. • The Robert Jones and Agnes Hunt NHS Foundation Trust. If a Trust is declaring a Major Incident the declaring organisation should provide a M/ETHANE report. NHSE will agree with the ICB if the NHS Situational Reporting Template or the SBAR will be used for continued reporting.
Infectious Disease Outbreak	UK Health Security Agency (UKHSA) would follow local infectious disease action cards / plans, and alert those NHS providers required to provide resources to support the response to the outbreak.

	UKHSA would also alert the ICB (via IPC in-hours and On-Call Executive out-of-hours). An Outbreak Incident Management Team may be convened by UKHSA. The ICB as local health system leader would support UKHSA in co-ordinating the local health response to the outbreak. Where the outbreak originates within a provider organisation that organisation will have responsibility for alerting the ICB.
Adverse Weather (including storms / winter weather / heatwave)	All NHS organisations should be alerted to the risk of severe weather through the receipt of Met Office weather warnings and UKHSA's Weather-Health Alerts. The ICB would be alerted by the Local Resilience Forum to any multi-agency meetings called ahead of or in response to adverse weather. The ICB as local health system leader would coordinate the local health response to any impact on local health services caused by the adverse weather.
Flooding	All NHS organisations should be alerted to the risk of flooding by the receipt of Environment Agency flood warning alerts. The ICB would be alerted by the Local Resilience Forum to any multi-agency meetings called ahead of or in response to flooding. The ICB as local health system leader would coordinate the local health response to any impact on local health services caused by the flooding.
Evacuation and Shelter	NHS organisations would alert the ICB to an evacuation, especially if the evacuation is of such a scale support is required and/or the evacuation will have a knock on effect to the wider health system. The Local Authority emergency planning teams / LRF will alert the ICB to a community evacuation where support is required.

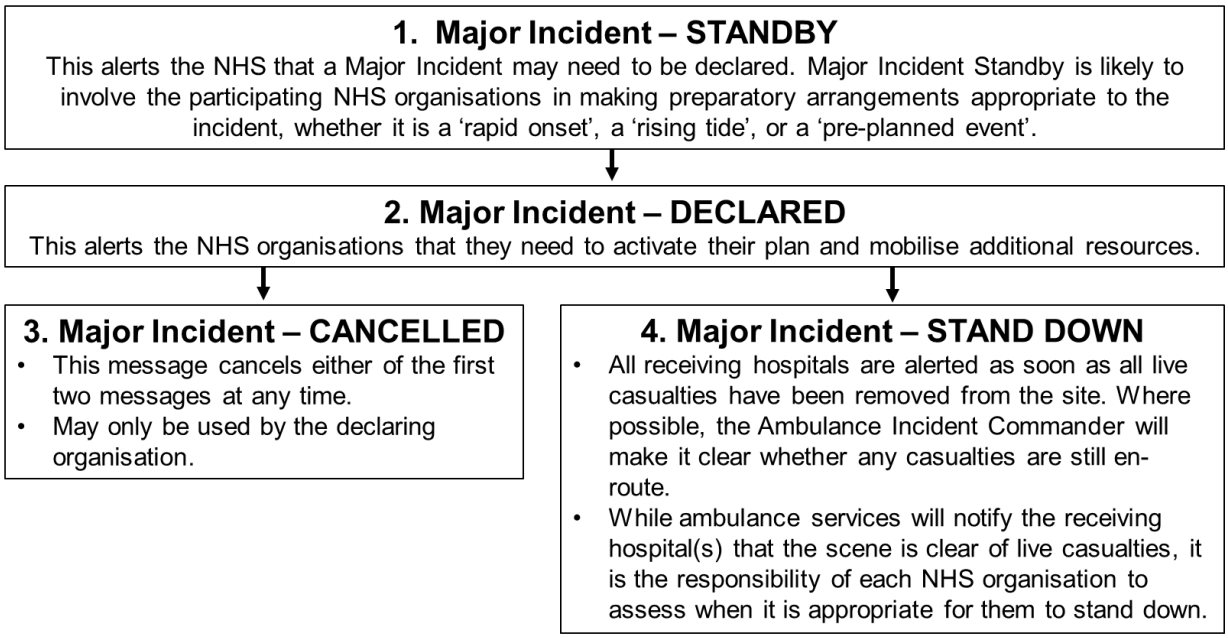
9.3. Triggers, alerting process and activation of the plan

The ICB Incident Response Plan can be triggered in several ways in response to a potential or actual incident as follows. Those individuals who can declare an incident on behalf of the ICB are set out in Section 6.5 – Declaring an Incident:

- Internal alert in response to internal pressure within the NHS in response to a local incident.
- External alert that a multiagency TCG is being convened (LRF).
- External alert that a multiagency SCG is being convened (LRF).

- External alert that an agency has called a Major Incident "Stand By".
- External alert that a major incident has been "Declared/implemented".
- In response to a national or regional NHS direction.

To avoid confusion about when to implement plans it is essential that standard messages are used. The following figure provides these standard messages in bold text.



NHSSTW has ensured support is offered to the ICS health system in Shropshire, Telford and Wrekin by having 24/7 On-Call arrangements in place. This is to support the system pressures, incidents within provider organisations, and multiagency/LRF activation. The ICB On-Call Executive can be accessed via SaTH switchboard and asking to be connected to the ICB On-Call Executive.

NHSSTW will be the single point of contact in the event of major incident standby or a major incident being declared within the county for:

- ICS health
- TCG/SCG
- Partner organisations

In line with the LRF multiagency TCG plan, external alerts are most likely to come via Police control but can be declared by any partner party of the LRF and will include any incident triggering the establishment of the Shropshire, Telford and Wrekin TCG such as:

- Major incidents (including road, rail or aircraft accidents)
- Explosion
- Evacuations involving a number of people or where additional medical support may be required.
- Large fires in residential areas
- Fires in residential areas where asbestos is suspected or confirmed.
- Flooding with potential for evacuation

- Flooding causing significant transport disruption.
- Burning of non-natural wastes at agricultural premises with potential exposure to large numbers of people
- Toxic chemical release with the potential of affecting the population.

To ensure the decisions made during an incident are clear and defensible, it is vital for the ICB to have accurate, clear and up to date information concerning the incident. The provision of situation reports are also key in the establishment of a clear shared situational awareness which is vital in coordinating the system response.

Initial information may be limited, but the ICB On-Call Executive should aim to establish:

- The type of incident
- The current and projected impact of the incident on NHS service delivery or the nature of the required response
- How many casualties are involved?
- Ability for the organisation to cope – any additional support or resources require.
- Which other agencies/partners are involved in the incident?
- Any media interest

9.4. Onward alerting

The ICB On-Call Executive will be responsible for ensuring ICB staff, provider organisations, and the NHSE EPRR First On-Call are alerted in line with the action cards set out at the end of this document. (Within 1 hour of incident declaration).

9.5. Situational Reporting (SITREPs)

There will be a requirement to undertake situational reporting (SitRep) and assurance returns to provide updates and information. This should be undertaken by the On-Call Executive/Incident Director. The Incident Director (On-Call Executive) is responsible for collating and signing off all SitReps. When the ICC and additional roles are established, the 'ICC and Information Manager' and 'Incident Manager' will support the Incident Director with the collation of SitReps.

Where there are multiple organisations responding to the same incident the ICB is expected to collate all provider SitReps into a single return to NHSE; NHSE may still request individual organisational reports to the ICB. NHSE will agree timescales for reporting.

The situation reporting (SitRep) template is saved in the On-Call Executives MS Teams site. Briefing templates can be found in the appendices of this document.

The reporting of ALL health data should be to NHSE (through to DHSC) in the first instance and only ratified data should be shared with the LRF (LRF will report concurrently to MHCLG and DHSC are the owners of health data not MHCLG) and other partners/stakeholders once agreed by NHSE.

9.6. Information Sharing

Under the CCA 2004 responders have a duty to share information with partner organisations. This is seen as a crucial element of civil protection work, underpinning all forms of cooperation. In the event of an incident the ICB, along with partner organisations, should formally consider the information that will be required to plan for, and respond to the incident.

The ICB Information Governance Staff Code of Conduct Policy and procedures cover the requirements of EPRR. Further data sharing guidance is available on the Civil Contingencies Secretariat page of Resilience Direct which can be accessed by the EPRR Team. Where necessary advice should be sought from the ICB Information Governance Team. However, it is an underpinning principle of EPRR that agencies should share data as required to support the response to an incident or emergency.

Data sharing in the event of an incident should support an appropriate incident response based on the principles set out in the HM Government 'Data Protection and Sharing – Guidance for Emergency Planners and Responders' document as well as compliance with the Freedom of Information Act 2000, Data Protection Act 2018 and UK General Data Protection Regulations (GDPR), Caldicott Principles and Safeguarding requirements:

- Data protection legislation does not prohibit the collection and sharing of personal data – it provides a framework where personal data can be used with confidence that individuals' privacy rights are respected.
- Emergency responders' starting point should be to consider the risks and the potential harm that may arise if they do not share information.
- Emergency responders should balance the potential damage to the individual (and where appropriate the public interest of keeping the information confidential) against the public interest in sharing the information.
- In emergencies, the public interest consideration will generally be more significant than during day-to-day business.
- Always check whether the objective can still be achieved by passing less personal data.
- Category 1 and 2 Responders should be robust in asserting their power to share personal data lawfully in emergency planning, response and recovery situations.
- The consent of the data subject is not always a necessary pre-condition to lawful data sharing.

All information shared during an incident must be approved by the Incident Director (On-Call Executive), especially when outside of normal working hours. During normal working hours, the sharing of information can be approved by the AEO or another Executive Director with the Incident Director kept informed of what information has been shared.

9.7. Records Management

An essential element of any response to an incident is to ensure that all records and data are captured and stored in a readily retrievable manner. These documents will form the definitive record of the response and may be required at a future date as part of an inquiry process (judicial, technical, inquest or others). It may be necessary to

provide all documentation, therefore robust and auditable systems for documentation, decision making, decision rationale and actions must be maintained. A robust document archiving system should be used for storing incident related documentation which allows easy retrieval should documents be required in the future. All documents must be dated. The document retention period is 30 years.

ICB On-Call Executive should maintain a personal log during an incident. If a decision is made by the ICB On-Call Executive to establish an Incident Management Team (IMT), a Loggist would be required (or as a minimum a competent administrator/note taker) to maintain a formal log of the Incident Management Team's decision and actions. These decisions and actions should be circulated to attendees promptly and at least prior to the next meeting taking place to ensure actions are clear and can be completed. A Loggist is an integral part in any IMT. The ICB has a cohort of trained Loggists which can be found in the On-Call folder under emergency contacts.

In addition, wherever possible, and particularly when using virtual arrangements, calls should be recorded with the recording secured securely in line with archiving arrangements. The recording of incident related meetings does not negate the requirement for actions and decisions to be documented (in typed format) and shared (in PDF format).

Although a TCG and SCG may be stood up and leading an incident response, specific ICB records (both for the ICC and those personal to individuals involved in the incident) should be maintained.

Where significant decisions are to be made, particularly those that will affect other organisations, the record should include the following factors in addition to normal logging of decisions:

- Details about the incident, including potential for escalation or de-escalation.
- A record of threats and risks including mitigation measures.
- Polices, plans and procedures taken into account.
- Options considered.
- Decision taken, including both rationale for option chosen, and rationale for not taking options dismissed.
- Timescale for review.

9.8. Maintaining a Formal Log

- The Chair should hold a brief meeting with the Loggist prior to the Incident Management Team meeting to allow the Loggist an opportunity to ask any questions and to ensure both are clear on the Log to be kept.
- The loggist will be responsible for recording and documenting all key information / actions / decisions and decision rationale made by the Incident Director / Incident Manager.
- In the event of a physical incident room, the loggist must use the logbook provided (held within the ICC Store) – The exception is where the IMT is held virtually; in this case the IMT should be operated via MS Teams with the meeting recorded. In addition, attendance, actions and decisions and any other relevant situational information should be recorded and approved by the Chair. A PDF

copy should be circulated. Recordings and documentation associated with the virtual ICC should be sent to the SCC for storage.

- If a physical Incident Management Team has been convened, then on arrival all staff must wear identification badges. If the badges are unclear the loggist must ask for clarification of who is present within the room and their job role. In the event of a virtual ICC staff must identify themselves or they may be asked to do so.
- The log must be clearly written, dated and initialled by the loggist at start of shift and include the location.
- All persons in attendance to be recorded in the log.
- The log must be a complete and continuous record of all key information / decisions / actions as directed by the Incident Director/Incident Manager
- Timings are recorded each time information is received or transmitted. If individuals are tasked with a function or role this must be documented and when the task is completed this must also be documented
- If notes or maps are utilised these must be noted within the log and retained
- At the end of each session of the IMT, the Incident Director will check and sign the log to formally approve the log as a fair and accurate record. If an electronic log Is taken this must be sent to the IMT Chair for checking.
- *All* documentation is to be retained for evidence for any future proceedings. Retention should be for 30 years.
- Where something is written in error changes must be made by a single line scored through the word and the amendment made and signed by the loggist.

Any form of log including WhatsApp and personal notebooks can be used as evidence, all decisions and the reasons for these decisions must be logged by On-Call Executives/Incident Directors and Incident Managers. Such records are also invaluable in identifying lessons that would improve future response and support incident debriefs. The TCG manages and maintains the TCG incident log. All information should be retained for 30 years or longer if an inquiry is running.

The Incident Director is formally responsible for signing off the decision log and all briefing papers and documents relating to the incident.

Loggists are available in the ICB to support system health NHS partners and can be activated by contacting the On-Call Executive/SCC (in-hours).

9.9. Shift Arrangements / Staff Welfare

In the event of a significant / Major Incident or emergency having a substantial impact on the population and health services in the ICS, it may be necessary to continue operation of the Incident Management Team for several days or weeks. In the early phase of an incident, the Incident Management Team may be required to operate continuously 24/7. Responsibility for deciding on the scale of response, including maintaining teams overnight, rests with the ICB On-Call Executive (or AEO in-hours) and assuring alignment to NHSE EPRR Team directions.

A robust and flexible shift system will need to be in place to manage an incident through each phase pulled across the ICS health NHS partners. These arrangements

will depend on the nature of the incident and must take into consideration any requirements to support external (e.g. TCG/SCG) meetings and activities. The Incident Manager is accountable for ensuring appropriate staffing of all shifts and will be responsible for compiling and populating a rota for this purpose. Staff should not work for extended periods and should have access to refreshments and breaks. It is advisable that Loggists should not work for more than 3 hours at a time.

If any employee involved in the incident needs to access support they should, in the first instance, speak to their Line Manager if possible; if contact with Line Manager is not possible, they should contact the On-Call Executive/Incident Director or Incident Manager. External support for staff wellbeing is available via the Care First employee assistance programme which provides confidential, impartial advice and support 24 hours per day, 365 days a year. To access the service call 0800 174319 or visit https://carefirst-lifestyle.co.uk. To access the service online use the following username and password:

Username: mlc001
Password: shire1234

The ICB also has access to the Psychological Wellbeing Hub which is a safe and confidential space to check in, see how the individual is feeling, discuss what additional support they may need and help them access the identified support if required.

Both of these support and wellbeing offers are free to employees of the ICB and do not require a referral.

9.10. Stand Down

As an incident develops, there will come a time when it is possible to stand down an incident and the response to it. Local incidents may be stood down by the emergency services / Local Authority / Trusts / ICB as the lead of the local health system.

Incidents on a regional or national scale (Level 3 and 4) the decision to stand down will come from NHSE Incident Director. Any decision to stand down will need to be logged and communicated immediately to all relevant internal and external partners/agencies as is necessary.

If a Level 4 or 3 Incident is stood down by NHSE, this could mean the incident remains declared but falls back to a Level 2 Incident meaning the ICB would continue to coordinate the response.

If a Level 2 Incident is stood down, it could remain declared as an individual provider Level 1 Incident until such time as they stand down as the final responding organisation.

9.11. Recovery

Recovery and returning to normal ways of working is a crucial part of the management of all Major Incidents / emergencies. This process is the responsibility of the Incident

Director who will ensure that it happens in a timely manner. To achieve this, they may appoint an Executive level 'Recovery Lead' who can commit significant financial and staff resource over a prolonged period as required or return to the business as usual team in order to return functions and systems to business as usual. Recovery is not manged by the SCC or EPRR Teams. The recovery process will utilise ICB processes already in place and adapting them case by case. The transition to the recovery stage will happen as soon as is feasible.

Following an incident, the ICB may need to undertake a number of organisational recovery activities which may include (but not be limited to) the following:

- Supporting the recovery of GP practices, including co-ordinating access across Shropshire, Telford and Wrekin.
- Identifying appropriate support mechanisms which can be made available to staff and their families, recognising that staff may be affected directly by the incident through death, illness or disability.
- Temporary reallocation of staff and resources across all ICB bases.
- Staffing and resources to address new locations, environments, organisational changes, reduction of resources, etc.
- Reviewing key priorities for critical functions and restoration.
- Financial implications, remunerations and commissioning agreements.
- Impact on routine performance and assurance reporting to NHSE.
- Funerals and memorials.
- The on-going need for assistance to NHSE.

In addition, the ICB may have to commission health related functions (i.e. Clinical Services) during recovery to support the affected community or other organisations involved in recovery activities, which may include (but not be limited to) the following:

- Mid to long term community support and medical services.
- Commissioning of psychosocial support following a traumatic event (access to post incident mental health services).
- Direct or indirect support to affected communities through primary care.
- Staffing and resourcing needs to support other health organisations affected by the incident/emergency or recovery function.

Business Continuity Management Plans (BCMP) will assist in identifying priority functions and their Recovery Time Objectives (RTO).

If a multi-agency response is in place, a Recovery Coordinating Group may be established under the leadership of the relevant local authority.

The ICB On-Call Executive/Incident Director (or AEO in-hours) will decide when an emergency or Major Incident stand down should be declared for the local health system, which may be long after the emergency services response is over. This could be either a full or partial stand down of all partners/agencies with one or more individuals monitoring the situation.

9.11.1. Initial 'Stand Down'

All response level changes need to be agreed by NHSSTW On-Call Executive/Incident Director (or AEO in-hours) with communication both internally and externally as appropriate.

9.11.2. Administration

Once the decision has been taken to 'stand down', NHSSTW will ensure that all appropriate elements of the local response are stood down. This may be a staged process. It is important to ensure that where communication channels have been specifically created for the incident, forwarding mechanisms are in place to ensure that no communication traffic is lost. This will also ensure that people trying to contact the ICC if established have an alternative access route (this would normally be the SCC).

All logs, records and other details from the incident will be collected and secured from all personnel involved and kept safe by all teams involved in supporting the incident to be called on request.

9.12. Communication

Communication in an incident is vital. It is a responsibility of Category 1 Responders to warn and inform the public and staff. The On-Call Executive/Incident Director should ensure that the Communication Team lead is briefed at the beginning of an incident to ensure the health system has clear leadership ensuring joined up communication with management teams, stakeholders, providers, media, staff, NHSE and other parties. The lead in a multiagency incident will be agreed at the SCG or TCG depending on the nature of the incident; for the NHS, this should be confirmed with NHSE Regional Team.

Effective communication by responders can reduce negative impacts of incidents by:

- Reducing unnecessary care-seeking by unthreatened populations.
- Enhancing likelihood that at-risk populations will take protective actions.
- Reducing rumours and fear.
- Maintaining public trust and confidence.
- Increasing co-operation with authorities co-ordinating the response.

The level of coordination of communications messages will reflect the NHS Incident Level. In an Incident at Level 1 to 2 there should be coordination between providers affected and the ICB. At Incident Level 3 or 4, then NHS England take on this coordinator role. Where a TCG and/or SCG has been convened they may also stand up a Communications Cell with which the ICB will need to interface.

Where a multi-agency response to an incident is in place, media output may be coordinated by the lead agency, often the Police or Local Authority but agreed at the relevant TCG. There are three locality TCGs for the LRF covering; Shropshire, Telford and Wrekin, Herefordshire, and Worcestershire. Where an incident spans the full West Mercia LRF area then communications will be co-ordinated at SCG level.

Due regard should also be paid to ensuring that ICB staff are also informed about an incident; as well as being involved as NHS staff they are also members of the public and as such useful links to the community.

Social media is an important tool to enhance the effectiveness of communications as outlined above, particularly challenging incorrect messages. The ICB has a 'Communications Emergency Plan' (available on the ICB Intranet and MS Teams site for On-Call Executives) which should be read in conjunction with this IRP.

9.13. Debrief

To identify lessons from any incident or exercise, it is important to capture as much detail about the incident and the experiences of those involved as soon as is reasonably practicable. A series of debriefs post incident is good practice.

The purpose of the debrief is to identify key learning and issues that need to be addressed. They must be attended by all staff who had a part in the response to review 'what went well', 'what did not go well' and 'what needs to change/next steps'. The process of debrief should provide a support mechanism and identify staff welfare needs.

The ICB should ensure they use appropriately trained staff to facilitate debriefs to ensure they are as effective as possible. Where possible this should be facilitated by a person independent of the incident itself. The West Mercia LRF Secretariat can be contacted for support to source an independent debrief facilitator.

A hot debrief will normally be held within 48 hours of the closedown of the incident by way of a form for completion sent by the Incident Manager or SCC/EPRR Team to all persons involved in the health partners which could be from a health provider or the ICB. A full debrief will be held usually within 28 working days of the incident being stood down. The initial incident report will be produced within 28 days of the debrief. Timings may be dependent on the TCG and multi- agency debrief schedules as they will lead the debrief for TCG incidents which would involve ICB health partners and providers providing individual organisation feedback as appropriate.

Structured debriefs should be held with involved staff as soon as possible after de-escalation and stand down. Participants must be given every opportunity to contribute their observations freely and honestly. The ICB On-Call Executive/Incident Director (or AEO in-hours) must ensure that the full debriefing process is followed. The ICB should be sent all debrief reports from NHS health providers and providers in ICS and support as required and these should be stored in line with Incident Management document archiving arrangements.

The ICB will provide debrief reports (non-TCG) to NHSE for evaluation and learning. TCG debriefs are managed by LRF and should be available on Resilience Direct for NHSE access.

As part of the debriefing process a post incident report may be produced to reflect the actual events and actions taken throughout the response. Typically, this will include:

- Nature of the incident

- Involvement and lead actions of the ICB
- Involvement of other responding agencies
- Implications for strategic management of the NHS
- Actions undertaken.
- Future threats/forward look
- Chronology of events

The AEO and EPRR Team should ensure post incident reports are supported by action plans, with timescales and accountable owners, and recommendations to update any relevant plans or procedures and identify any training or exercise requirements.

9.14. Lessons Identified

A Lessons Identified report is required following the debrief which will focus on areas where response improvements can be made in future. This report should include the following sections:

- Introduction.
- Observations.
- Action plan (detailing recommendations, actions, timescales and owners).

Throughout the incident there will need to be an agreed process in place to evaluate the response and recovery effort and identify lessons. The On-Call Executive/Incident Director is responsible for activating the lessons identified process and may delegate this responsibility within the ICB. Staff involved in the incident should be mindful of the need to review lessons learned at the end of the incident and as such should ensure that personal logs make note of any learning related information so it can be relied on later to inform this process and improvements.

10. Preparedness

10.1. Training

To enable staff within NHSSTW to effectively support a response to a Major Incident they will need to be appropriately trained. Training requirements and how these will be met are set out in the ICB's EPRR Policy and EPRR Training and Exercising Programme which can be found on the Intranet and in the On-Call Executive's Platform on MS Teams. As a minimum, the Principles of Health Command (PHC) Course is required to be undertaken by all staff who are part of the On-Call rota or who work within EPRR.

10.2. Exercising

The ICB will undertake exercises against the Incident Response Plan. An exercise is a simulation of an emergency situation and has three main purposes:

- To validate plans.
- To develop staff competencies and give them practice in carrying out their roles in the plan.

- To test well-established procedures.

Planning for emergencies cannot be considered reliable until it is exercised and has proved to be workable. Generally, participants in exercises should have an awareness of their roles and be reasonably comfortable with them before they are subject to the stresses of an exercise. Exercising is designed so procedures and policies are tested and not to catch people out. An important aim of an exercise should be to make people feel more comfortable in their roles and to build morale.

There are three main types of exercises outlined in the table below.

Type	Description
Discussion based	Can be used at the policy formulation stage as a 'talk-through' of how to finalise the plan. More often, they are based on a completed plan and are used to develop awareness about the plan through discussion. They are often used for training purposes. These are the cheapest to run and easiest to prepare.
Tabletop	Based on simulation, not necessarily literally around a tabletop. They usually involve a realistic scenario and a timeline which may be real time or may speed up in time. Usually run in a single room, or in a series of linked rooms which simulate the division between responders who need to communicate and be co-ordinated. The players are expected to know the plan and are invited to test how the plan works as the scenario unfolds. This type is particularly useful for validation purposes, particularly for exploring weaknesses in procedures. Table-top exercises are relatively cheap to run, except in the use of staff time. They demand careful preparation.
Live	Live exercises are a live rehearsal for implementing a plan. Such exercises are particularly useful for testing logistics, communications and physical capabilities. These are the most expensive to run and the most resource intensive to set up.

It is also possible to combine elements of the three types of exercises to develop a hybrid model. The choice of which one to adopt depends on what the purpose of the exercise is, the lead in time and the available resources.

Details of the ICB's approach to exercising is set out in its EPRR Policy and EPRR Training and Exercising Programme which can be found on the Intranet and also in the On-Call Executive's Platform on MS Teams.

11. Supporting Documents

This document should be considered in conjunction with the ICB set of EPRR policies and guidance. Other ICB policies in addition to the Incident Response Plan can be found virtually in the On-Call section on MS Teams and on the staff Intranet. The On-

Call platform also contains a range of tools, guidance and templates for use whilst On-Call and/or participating in an incident response.

12. Specific Incident Scenario Based Information

Actions to address Business Continuity impacts resulting from specific scenario based incidents will be covered by the ICB's Business Continuity Plans. Where these scenarios have a wider impact, they will be addressed via the initiation of this Incident Response Plan.

Scenario based risks and their impact on the ICS are set out in the LHRP Risk Register. Where these risks corporately have an impact on the ICB transacting its business they will be added to the corporate risk register in line with the ICB's Risk Management Policy.

12.1. Cyber Security Incident

No organisation can be completely immune from a cyber-attack and there is no room for complacency. The occurrence of cyber-attacks across the UK economy is increasing so, in the judgement of most industry experts, it is not a question of "if" but "when" the next cyber-attack strikes the health and social care system.

A cyber security incident is defined as:

- A breach of a system's security policy in order to affect its integrity or availability
- The unauthorised access or attempted access to a system

Activities commonly recognised as security policy breaches are:

- attempts to gain unauthorised access to a system and/or to data.
- the unauthorised use of systems and/or data.
- modification of a system's firmware, software or hardware without the system-owner's consent.
- malicious disruption and/or denial of service.

The National Cyber Security Centre defines a significant cyber security incident as one which may have:

- impact on UK's national security or economic wellbeing.
- the potential to cause major impact to the continued operation of an organisation.

From this, any incident affecting the NHS would be classified as a significant cyber security incident.

The ICB On-Call Executive may be alerted to a Cyber Security Incident or significant IT disruption by:

- MLCSU having identified a Cyber Security Incident / disruptive IT incident has occurred to the ICB or wider.
- A provider due an incident affecting them.
- NHS England of a cyber-incident affecting other parts of the country.

The ICB On-Call Executive should contact NHSE Regional On-Call to alert them to a situation/incident affecting STW ICS and determine what is understood about the extent of the issue.

In the event that a cyber-attack is affecting the NHS on a regional or national scale, NHS England may declare a Level 4 incident, with command and control initiated from NHS England at a regional or national level.

The ICB Digital/IT team will support the Incident Director.

12.2. Mass Casualty Incidents

NHS England (NHSE) defines a Mass Casualty incident for the health services as an incident (or series of incidents) causing casualties on a scale that is beyond the normal resources of the emergency and healthcare services' ability to manage.

A Mass Casualty incident may involve tens, hundreds or thousands of casualties with a range of injuries, the response to which will be beyond the capacity of normal major incident procedures to cope and require further measures to appropriately deal with the casualty numbers.

In the event of a CBRN incident casualties may be contaminated. The casualties may require de-contamination at scene, or at the receiving Emergency Department (ED).

Casualties are classified as:

P1	Casualties in need of immediate life saving measures and techniques
P2	Casualties who require treatment but some delay may be acceptable
P3	Casualties who require minimal treatment

West Midlands Ambulance Service University NHS Foundation Trust (WMAS) and/or NHSE are responsible for declaring a Mass Casualty Incident. WMAS would alert receiving hospitals, the ICB and other emergency services. The ICB may also be alerted by NHS England or it may come to the attention of the ICB through media / social media reports.

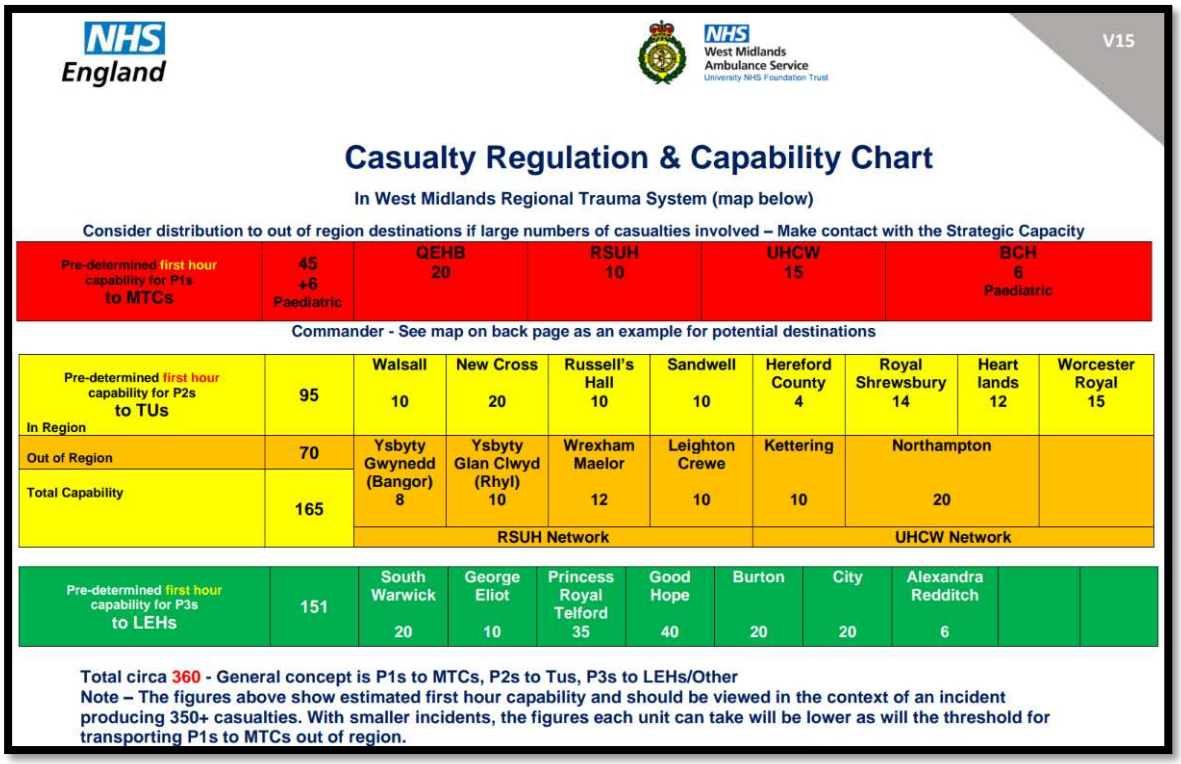
A Mass Casualty incident is likely to be declared as a Level 3 or 4 Incident, with command and control from NHSE due to the need to potentially coordinate the distribution of casualties across the region.

A Mass Casualty incident would lead to the convening of a multi-agency Strategic Coordination Group (SCG) (ICB to attend), a Tactical Coordination Group (TCG) in Shropshire, Telford and Wrekin (ICB to attend) and a Health Co-ordination Group (ICB to convene and lead).

WMAS has a Casualty Distribution Matrix which outlines the number of patients that hospitals across the West Midlands would expect to receive in the first hour. Dependent on the scale of the incident, the Trusts may be requested to receive an increased number of casualties. ICB Incident Director will request that organisations commence casualty counting at all receiving locations. Under the NHSE CONOPS (Concept of Operations) for managing Mass Casualty, a mass casualty incident is

likely to lead to the use of acute hospitals on a regional/inter regional scale. Similarly, Shropshire, Telford and Wrekin acute hospitals would be expected to receive casualties from incidents in neighbouring counties or regions (including Wales).

The following table provides a screenshot of the Casualty Distribution taken from the 'Casualty Regulation Plan WMAS v15':



NHS England
NHS West Midlands Ambulance Service University NHS Foundation Trust
V15

Casualty Regulation & Capability Chart

In West Midlands Regional Trauma System (map below)

Consider distribution to out of region destinations if large numbers of casualties involved – Make contact with the Strategic Capacity

Pre-determined first hour capability for P1s to MTCs	45 +6 Paediatric	QEHB 20	RSUH 10	UHCW 15	BCH 6 Paediatric

Commander - See map on back page as an example for potential destinations

Pre-determined first hour capability for P2s to TUs	95	Walsall 10	New Cross 20	Russell's Hall 10	Sandwell 10	Hereford County 4	Royal Shrewsbury 14	Heart lands 12	Worcester Royal 15
In Region									
Out of Region	70	Ysbyty Gwynedd (Bangor) 8	Ysbyty Glan Clwyd (Rhyl) 10	Wrexham Maelor 12	Leighton Crewe 10	Kettering 10	Northampton 20		
Total Capability	165								
		RSUH Network				UHCW Network			

Pre-determined first hour capability for P3s to LEHs	151	South Warwick 20	George Eliot 10	Princess Royal Telford 35	Good Hope 40	Burton 20	City 20	Alexandra Redditch 6	

Total circa 360 - General concept is P1s to MTCs, P2s to Tus, P3s to LEHs/Other
Note – The figures above show estimated first hour capability and should be viewed in the context of an incident producing 350+ casualties. With smaller incidents, the figures each unit can take will be lower as will the threshold for transporting P1s to MTCs out of region.

In line with NHSE CONOPS for Managing Mass Casualties, **Acute Trusts must free up 20% of their total bed base, 10% of which should be in the first six hours, and a further 10% within 12 hours of the incident declaration**. Acute Trusts and Mental Health and Community Trusts hold their own mass casualty plans. These plans should calculate what this percentage of beds is numerically as well as how many Critical Care beds the system would need in this scenario. Additionally these plans should profile discharge requirements and where these patients can be decanted to. Trusts may also need to assess the requirement for specialist or burns services.

Shrewsbury and Telford Hospitals NHS Trust (SaTH) expected discharge figures for a mass casualty incident are (as of 20/08/2024):

	Total Bed Base	First 6hrs 10% of bed base discharge figure	Second 6hrs 10% of bed base discharge figure	Total 12hrs 20% of bed base discharge figures
Royal Shrewsbury Hospital	420	**42**	**42**	**84**
Princess Royal Hospital	312	**31**	**31**	**62**
	732	**73**	**73**	**146**

There will be significant amounts of information flow from NHSE to local level (ICB and NHS providers). NHSE will activate a major incident process. The ICB's responsibility will be to ensure all local providers are alerted as appropriate and if requested by NHSE, can provide the capacity required. This will be delivered by coordination at both Strategic and Tactical level.

WMAS will be responsible for triage of casualties at scene and transporting them to the appropriate hospitals. Depending on the scale of the incident, WMAS may request support from neighbouring ambulance services in the transportation of casualties via the National Ambulance Coordination Centre (NACC).

All formal Communications and Media messages will need to be coordinated with NHSE, and individual providers. ICB Communications and Engagement Team should liaise with partner agency Communications Teams to ensure there is a coordinated message to prevent confusion of messages to the public and the media.

A mass casualty incident may lead to walking wounded (P3 type casualties) self-presenting at Urgent Care Treatment Centres, Minor Injury Units (MIU) or GP practices. It is important that these are alerted to the incident so they can be prepared for potential increases of demand/attendees and to ensure casualties from the incident can be identified and counted correctly. WMAS may also call for assistance on the sheltering of P3 patients away from the scene – this request may be made through the TCG and SCG to local authorities.

Supporting Plans / Arrangements:

- NHS England Concept of Operations (CONOPS) for Managing Mass Casualties
- WMAS Mass Casualty Plan
- STW Acute, Community and Mental Health provider plans
- Local Authority Mass Casualty plans
- LRF Humanitarian Assistance Plan
- Psychosocial Support plans

12.3. UK Threat Level Changes – Move to Critical

UK National Threat Levels are designed to give a broad indication of the likelihood of a terrorist attack and are set by the Joint Terrorism Analysis Centre (JTAC) and the Security Service (MI5). Awareness and monitoring of these threat levels can assist in EPRR preparedness. There are 5 categories at which threat levels could be set:

- **LOW** - an attack is unlikely.
- **MODERATE** - an attack is possible, but not likely.
- **SUBSTANTIAL** - an attack is likely.
- **SEVERE** - an attack is highly likely.
- **CRITICAL** - an attack is highly likely in the near future

When the UK Threat Level has increased to Critical (usually in response to a terrorist incident where an attack is expected imminently), NHSE (National) EPRR will seek to ensure the NHS in England has taken all steps possible to prepare itself for a potential terror attack on UK soil. At the increase to CRITICAL, the National EPRR Team will

issue a letter to the NHS in England (ICB and NHS Trusts) outlining the actions that are to be followed. NHSE may contact ICB On-Call Executive requesting assurance that the actions have been met by the ICB and the Trusts.

Unless an incident is on-going, NHS command and control arrangements will not be implemented. Within West Mercia, a multi-agency LRF Strategic Coordination Group (SCG) may be held to review the situation / agree actions / or for the emergency services to provide reassurance to partner agencies on additional measures that have been introduced in response.

The expected actions that ICBs and NHS Trusts are expected to follow:

- Immediately cascade the change in alert level to their staff.
- Review relevant staffing levels and security arrangements across your health facilities, taking account of any additional advice from your local security experts in conjunction with the local police.
- Ensure all staff are aware of their organisation's Incident Response Plans, business continuity arrangements and On-Call notification processes.
- Ensure appropriate senior representation is available to join any NHSE Regional teleconferences that may be called to brief on the situation.
- Notify NHSE EPRR Regional of any current or scheduled works or operational changes currently affecting service delivery within their organisation.
- Review the Home Office advice issued in relation to the threat, and risk assess this against their own organisation, taking steps where possible to mitigate identified risks.
- Review mutual aid agreements with other health services including specialist and private providers.

ICBs are required to:

- Act in support of accelerated discharge and where necessary support Trusts in maintaining their contracted services.

Acute care providers are required to:

- Review Emergency Care, Theatre and Support Services, paying particular attention to staff availability, stocks and current blood stock levels.
- Clearly identify and review patients who could be discharged safely to create capacity if the organisation is required to respond to an incident.
- Review availability of Non-Emergency Patient Transport Service (NEPTS) particularly in the event of the local NHS Ambulance Trust requesting mutual aid from NEPTS provider.
- Assess how they access the Strategic National Reserves of External Fixators and surgical supplies.

Community and Mental Health providers are required to:

- Review staffing availability for crisis intervention teams.
- Prepare to support any accelerated discharge from acute care settings.

ICBs and Trusts should ensure any media enquiries which relate to the change in Threat Level or an incident are redirected back to NHS England.

Supporting Plans / Arrangements:

- NHS UK Terrorism Threat Level Change Protocol

12.4. Requests for Military Aid to the Civil Authorities (MACA) from the NHS

The NHS in England is generally expected to manage emergency response within its own capabilities. However, as a very last resort, having exhausted all other options, where a capacity has been exceeded or the NHS does not have the specific capability to deliver, the military may be required to augment responses.

Military support in an emergency is provided on an assistance basis, known as Military Aid to the Civil Authorities (MACA). MACA support is not guaranteed and may incur a charge for its provision incurred by the requesting organisation, unless it is in response to an immediate threat to life.

The NHS process for requesting Military Aid

Such requests require NHS England Regional and, in turn, ministerial authorisation. However, in very exceptional circumstances, for example, grave and sudden emergencies, where there is an urgent need to protect life, a local (Military) commander is empowered to deploy assets to deal with the situation without recourse to additional ministerial authority. A request for military mutual aid can be made at provider, commissioner, regional and national level. A request originating from a local NHS organisation should be discussed and submitted by the ICB to NHSE Regional EPRR team for submission to NHSE National EPRR team for consideration.

The military have access to troops; specialist skills, and equipment. For example:

- 4x4 vehicles for assisting in the movement of staff and reaching communities in the event of severe weather.
- Remote advice from Clinical staff experienced in dealing with blast and high velocity injuries.

The Joint Regional Liaison Officer (JLRO) can provide advice and support at a local level to inform the request but in the first instance these must come through NHSE EPRR for regional and national agreement (not via LRFs or military colleagues). A request for military mutual aid should be for capability rather than specific assets. For example, the transport of multiple patients with medical support rather than three ambulances with clinical crews. Requesting organisations must have funding identified to cover the associated costs of military deployment, as there may be a charge attached to any approved MACA agreement. The JRLO is a senior military officer that coordinates support to the civil authorities – contact can be made through the Local Authority emergency planners, the LRF, or NHS England Regional On-Call.

Note:-There can be a lead in time of a number of hours before any support can be made available.

Process for Requesting MACA Assistance

In the event of a widespread incident involving multi-agency partners then all requests should be coordinated with the appropriate Strategic Coordinating Group (ICB attends

this on behalf of the NHS). **MACA requests for the NHS must be made to NHS England Regional On-Call for submission to the Department of Health and Social Care (DHSC) as any request will require authorisation from a Health Minister prior to submission to Ministry of Defence (MoD). Failure to do so will result in a delay to the provision of military support.**

Initial requests for MACA should be made to NHSE Regional EPRR Team using the Mutual Aid Request Template – NHSE will then issue a formal MACA request template form for completion.

Supporting Plans / Arrangements

- Requests for Military Aid to the Civil Authorities (MACA) from the NHS in England.

12.5. Adverse Weather Events/Incidents

The STW system has an overarching Health Protection Strategy in place which sets out the systems actions/ response in relation to climate change and adverse weather. This strategy can be found on the ICB Intranet and in the On-Call Executives platform on MS Teams. The ICB will use the UK Health Security Agency (UKHSA) Adverse Weather and Health Plan to inform it's preparedness and response to Adverse Weather Events/Incidents. The UKHSA Adverse Weather and Health Plan aims to prepare for, alert people to, and prevent the major avoidable effects on health during periods of severe heat and cold in England.

The ICB will monitor any long-term climate guidance from NHS England or the UKHSA and update its plans as required. The ICB will also continue to engage with the West Mercia LRF and LHRP to identify and manage adverse weather related risks.

The ICB has signed up to the Met Office and UKHSA Weather-Health Alerts systems and as such is alerted when adverse weather is expected. This will be routinely monitored for advance forecast of any potential adverse weather. Where there is a sudden weather event or where the forecast predicts an adverse weather event, the SCC and/or EPRR Lead will alert the appropriate staff within the ICB and the On-Call Executive. The specifics of the alert or warning and the impact of the information, will guide any initial incident response if required.

The ICB will assess the situation in relation to its own business continuity plans and enact mitigations as per these plans. In addition it will provide a co-ordination role across the STW system and LRF as required in line with the requirements set out in this IRP.

The ICB On-Call Executive is likely to become aware of an adverse weather related incident via the LRF. The ICB On-Call Executive (SCC and/or EPRR Lead during in-hours) will engage with any associated weather related TCGs that may be called and will co-ordinate both health related information to feed into the TCG and co-ordinate the health response should it be required.

12.5.1. Warm/Hot Weather

Alerts will be issued by both the UKHSA and Met Office during times of warmer weather. The ICB receives these alerts directly into the SCC. Upon receiving an alert about increasing temperatures the SCC, in conjunction with the Communications and Engagement Team, will note the level of alert issued and assess the detail of the alert to warn, inform and advise all ICB staff and NHS organisations across STW requesting they take action in accordance with their Adverse Weather Plans/Arrangements.

Should there be significant risks, impacts, or increased demand on (or disruption to) services as a result of increased temperatures, the ICB On-Call Executive will consider establishing formal incident response structures in accordance with arrangements set out in this IRP.

12.5.2. Cold Weather

Alerts will be issued by both the UKHSA and Met Office during times of colder weather. The ICB receives these alerts directly into the SCC. Upon receiving an alert about cooler temperatures, snow, or ice, the SCC will note the level of alert issued and assess the detail of the alert to warn, inform and advise all ICB staff and NHS organisations across STW requesting they take action in accordance with their Adverse Weather Plans/Arrangements.

Should there be significant risks, impacts, or increased demand on (or disruption to) services as a result of cooler temperatures, snow, or ice, the ICB On-Call Executive will consider establishing formal incident response structures in accordance with arrangements set out in this IRP.

12.5.3. Flooding

Flood Alerts and Flood Warnings will be issued by the Environment Agency (EA). These will be supported by multiagency briefings by the EA via the LRF structure (the NHS in STW will be represented by NHSSTW On-Call Executive (SCC/EPRR in-hours). As part of these briefings, the LRF membership will assess the risks to the community of STW based on the information provided by the EA.

Physical flooding, or the impacts of flooding, may not necessarily be immediately obvious based on local weather conditions. Some waterways (rivers, streams, etc) feeding, or running through, Shropshire, Telford and Wrekin originate from outside of the county and also from across the border in Wales. Therefore, the impacts of adverse weather such as severe or prolonged periods of rain in these out of county areas could cause flooding in STW hours or days later as the volume of water works its way downstream. In these cases, particular attention should be given to preparing for flooding in advance, including warning, informing, and advising services/providers/staff.

On-Call Executives (SCC Team during in-hours) can check for flooding by localities by entering postcodes, towns, or city here – Check for Flooding.

Should there be significant risks, impacts, or increased demand on (or disruption to) services as a result of flooding, the ICB On-Call Executive will consider establishing

formal incident response structures in accordance with arrangements set out in this IRP.

Local Risk – Operation Tangent (Ironbridge Gorge Landslide)

Operation Tangent is the LRF multiagency plan for a landslide in the Ironbridge Gorge in Telford. The plan is available on Resilience Direct and aims to support the TCG by providing the framework for a flexible and scalable multiagency response to a landslide event occurring in the Ironbridge Gore. A landslide in the Ironbridge Gorge has the potential to cause instant flooding either by way of the initial landslide displacing river water and then further potential for blocking the river flow. A landslide could also cause flooding downstream from either the initial landslide displacing river water, or if/when a blockage of the river is released.

12.5.4. Travel Disruption from Adverse Weather

Previous adverse weather events have demonstrated that adverse weather can cause severe disruption to local transport networks and that the travel plans of staff can become compromised.

In response to those events, there was a large demand for 4x4 vehicles, military assistance and emergency services support that impeded the service delivery of emergency services to deliver front line services. Due regard must be given to offers from the general public - there may be staff and/or patient safeguarding issues utilising non vetted persons, or liability issues in the event of an accident.

There is no legal obligation for employers to transport staff to and from work, however it is an important consideration as a lack of available staff may have a severe impact on the ICB and partner agencies ability to deliver safe and effective clinical services. If using staff's own vehicles, it is important to ensure they have business use insurance, and are familiar with driving in adverse conditions. Individuals are responsible for assessing their own competence for driving in the weather conditions on the day.

Should there be significant risks, impacts, or increased demand on (or disruption to) services as a result of Travel Disruption, the ICB On-Call Executive will consider establishing formal incident response structures in accordance with arrangements set out in this IRP.

12.6. Chemical, Biological, Radiological, Nuclear (CBRN) / Hazardous Material (HazMat) Incident

The response to a Chemical, Biological, Radiological or Nuclear (CBRN) or Hazardous Material (HazMat) incident requires the use of specially trained members of the emergency services and NHS, and specialist equipment to respond to the incident and treat the casualties.

CBRN is the term used in reference to malicious acts such as the deliberate use of chemicals or biological, radiological or nuclear agents by terrorists. Whereas the use of the term HazMat relates to hazardous materials released during an accident, such as a transport accident or incident at an industrial complex which results in a spillage

or release of a substance; HazMat is usually in relation to known substances and risks and often have approved and tested plans in place to support a coordinated response to an accident or incident involving these substances.

The specialist staff and resources utilised would be the same for a CBRN or HazMat incident, but the emergency services response to a malicious act would be different to an accident. Though by the very nature of a terrorist or malicious act, this may not be initially identified as such.

In the event of a CBRN / HazMat incident casualties may be contaminated. Regional specialist resources can be called upon to de-contaminate casualties and members of the public. However due to the lead time for deploying these resources, the emergency services may undertake more basic de-contamination at scene.

The casualties may also make their own way to an Emergency Department or other NHS site. For this reason, all Trusts are required to have the necessary equipment to decontaminate self-presenters. The decontamination would be undertaken by trained staff using appropriate Personal Protective Equipment (PPE).

Once decontaminated the casualties would then be treated. Isolation of the decontaminated casualties may be necessary dependent on the nature of the casualties.

The process of decontamination takes two forms:

- **Dry decontamination (known as IOR (Initial Operational Response)):** casualties are required to remove their top level of clothing and wipe themselves down with paper towels. If necessary, they would be assisted by staff in PPE. This is the default approach for most contaminants and is proven to remove the majority of the contaminant.
- **Wet decontamination:** in its basic form this is through the use of copious amounts of water (from bottles/buckets/hosepipes) to remove the substance (such as acids). Where necessary, Emergency Departments would set up specialist decontamination tents within which the contaminated casualties can undress and be showered to remove the contaminant.

The normal NHS Command and Control structure would be implemented. It can be anticipated that a multi-agency LRF SCG and TCG would be convened. Where terrorist incident involves the use of a CBRN substance, it is likely that NHS England would declare a Level 3 or 4 major incident enacting national coordination of the NHS response.

In a terrorist incident, the multi-agency coordination would have central government COBR oversight and the involvement of Counter Terrorism operatives. There will be significant amounts of information flow from NHS England to local level (ICB and NHS providers). NHS England will activate a major incident process.

The ICB On-Call Executive/Incident Director would initiate the relevant action card(s). As this type of incident is likely to be multi-agency and at Level 3 or 4, the Incident Director will join multi-agency calls at Tactical and Strategic level and liaise with NHSE regarding incident leadership arrangements.

All formal Communications and Media messages will need to be coordinated with NHSE, and individual providers. ICB Communications and Engagement Team should liaise with partner agency Communications Teams to ensure there is a coordinated message to prevent confusion of messages to the public and the media.

12.6.1. Requesting and Receipt of Countermeasures

UKHSA and NHS Blood and Transplant holds some medications in reserve stocks for use in the response to incidents involving Chemical, Biological, Radiological and Nuclear (CBRN) materials. These stocks are held to be distributed in an incident within either 2 hours or 5 hours for rapid response depending on the stock and holding location. NHS England acts as a relay in the request process to ensure that the requesting Trust is responding to a genuine emergency and has nominated a suitable receiving location

In line with NHS England Guidance for requesting and receipt of countermeasures, any provider organisation with an Emergency Department or other suitable emergency treatment centre may request that countermeasures are delivered to manage patients arriving with exposure symptoms requiring countermeasures.

NHS providers are responsible for:

- Requesting the countermeasures from their NHS England Regional On-Call.
- Ensuring arrangements are put in place for receipt of any countermeasures, including pharmacy support, within the specified time frames for the countermeasures.
- Ensuring arrangements are in place for the distribution of the countermeasures to patients, in a timely fashion, given the amount of countermeasure requested.

ICB is responsible for:

- Rapidly escalating calls from providers to NHSE.
- Monitor distribution centres established to issue countermeasures.
- Monitoring stock use across established countermeasures distribution centres and ensure there are enough operating centres for the populations exposed to enable replenishment.
- Coordination of information relating to distribution.
- Ensure local communications are aligned to national messages.
- Link with LRF planning for antiviral or nuclear release.

The information required by NHS England is outlined in NHS England Guidance for requesting and receipt of countermeasures – this document is not public and is available on Resilience Direct.

Supporting Plans / Arrangements

- NHS England Concept of Operations (CONOPS) for managing Mass Casualties
- WMAS Mass Casualty Plan
- NHS England Chemical Incidents: Planning for the management of self-presenting patients in healthcare settings.
- NHS England: Guidance for the initial management of self presenters from incidents involving hazardous materials.

- UK Reserve National Stock for Major Incidents – How to access stock in England.
- UKHSA CBRN Handbook
- LRF CBRN Plan
- STW Trust plans
- Information on Initial Operational Response (IOR)

12.7. Shropshire, Telford & Wrekin Health Protection Strategy

The STW Health Protection Strategy sets out our partnership approach to addressing a range of health protection matters including:

- Infection Prevention and Control
- New and Emerging Pandemics
- Screening and Vaccination
- Communicable diseases
- Respiratory Diseases
- Waterborne and Foodborne diseases
- CBRN
- Climate Change
- Extreme Weather Planning
- Mass Countermeasures
- Pandemic Planning
- Investigations and Outbreak Policy

This strategy has been supported by the LHRP as the overarching system approach to Health Protection matters. This document will be relied on as the framework for the STW system approach to planning for and responding to incidents in these categories if and when they occur.

13. Appendices

Appendix 1 - METHANE Report
Appendix 2 - Initial Risk Assessment
Appendix 3 - Incident Response Action Cards
Appendix 4 - Incident Management Team Agenda
Appendix 5 - IIMARCH briefing template
Appendix 6 - SBAR reporting template (version 2)
Appendix 7 - Incident Report Sheet
Appendix 8 – Mutual Aid Request Template
Appendix 9 - Acronyms and Abbreviations
Appendix 10 - Equality Analysis Initial Assessment

Appendix 1 - M/ETHANE Report

RESTRICTED ONCE COMPLETE

Time		Date	
Organisation			
Name of Caller		Tel No	

M	Major incident	Has a Major Incident been declared? YES / NO	

E	Exact Location	What is the exact location or geographical area of incident	
T	Type of Incident	What kind of incident is it?	
H	Hazards	What hazards or potential hazards can be identified?	
A	Access	What are the best routes for access and egress?	
N	Number of casualties	How many casualties are there and what condition are they in?	
E	Emergency Services	Which and how many emergency responder assets/ personnel are required or are already on-scene?	

Name:	
Role/Jobe Title:	
Signature:	

Appendix 2 - Initial Risk Assessment

This template is for use at the discretion of a member of staff involved in an incident to aid information gathering and reporting in standby stage or early in an incident.

Questions to consider	Information Collected?*
What is the size and nature of the incident?	
Area and population likely to be affected - restricted or widespread – subarea within the county or across ICS system	
Level and immediacy of potential danger – to public and response personnel	
Timing – has the incident already occurred or is it likely to happen? (Noting in incident log times of events and calls and notifications actions)	
What is the status of the incident?	
Which health organisation reported incident	
What is the status:	
Under control	
Contained but possibility of escalation	
Out of control and threatening	
Unknown and undetermined	
What is the likely impact?	
On people/patients involved, the surrounding area (evacuation required?)	
On property, the environment, transport, communications	
On external interests - media, relatives, adjacent areas and partner organisations	
What policies are to be initiated by health partner	
What specific assistance is being requested from the NHSE?	
Increased capacity - hospital, primary care, community care, other	
Health MACA via NHSE	
Treatment - serious casualties, minor casualties, worried well	
Public information	
Support for rest centres, evacuees, evacuation and shelter plans?	
Mutual Aid support	
Expert advice, environmental sampling, laboratory testing, disease control	
Social/psychological care	
How urgently is assistance required?	
Immediate Within a few hours Standby situation	
***Key √ = Yes X = no ? = Information awaited N/A = Not applicable**	

In making this assessment, it is important to distinguish between:

- Events that can be dealt with using normal day to day arrangements.
- Events that can be dealt with within the resources and emergency planning arrangements of the ICS health providers and partners.
- Events that require a joint co-ordinated response from the organisations across the system
- Events that require a strategic level co-ordinated multiagency response across the Local Resilience Forum or wider health community (i.e. TCG), will follow the command and control of NSHE (matching incident level) but TCG health response will be locally managed and led by the ICB.

Appendix 3 - Incident Response Action Cards

Action Card Colour	Action Card Type Code	Type of Role
	R – Red	**Essential (Core) Role** – to be established immediately.
	O – Orange	**Critical Role** – to be established as soon as staff become available.
	G - Green	**Supporting Role** – as required.
	B – Blue	**Statutory Role** – need to be kept informed of the incident.

Action Card Number	Type of Role	Level of Role	Incident Response Role
01	**R**	Strategic	Incident Director
02	**O**	Tactical	ICC and Information Manager
03	**O**	Tactical	Incident Manager
04	**O**	Administrative	ICB Incident Loggist
05	**O**	Strategic	Communications and Media Officer
06	**O**	Strategic	Quality and Nursing Lead
07	**O**	Strategic	Urgent and Emergency Care (UEC) Lead
08	**G**	Administrative	ICC Administrator
09	**G**	Strategic	Primary Care Lead
10	**G**	Strategic	Commissioning Lead
11	**G**	Strategic	Medicines Management Lead
12	**G**	Strategic	People Team Officer
13	**G**	Strategic	Finance Officer
14	**B**	Executive	Accountable Emergency Officer (AEO)
15	**B**	Executive	Chief Executive Officer (CEO)

Action Card Number:	**01**
Incident Response Role:	**INCIDENT DIRECTOR**
Level of Role:	STRATEGIC
Responsibilities:	• Provide strategic command for the ICB response to incidents and emergencies. • Managing the ICS incident response at Levels 1 and 2, or as tasked by the NHSE Incident Director at Levels 3 and 4. • Assessing initial information and undertake a dynamic risk assessment (DRA) on the context of the overall situation. • Establishing an Incident Management Team (IMT) as early as possible and oversee its operation. • Maintain regular dialogue with NHSE regarding the progress of the incident. • Oversee the health, safety, and welfare of ICB staff involved in the incident/emergency. • Sign off of all Situation Reports, SBARs, communications and media statements. • Represent the local NHS at LRF TCGs and SCGs.
Undertaken by:	On-Call Executive
Accountable to:	Chief Executive Officer (CEO)

Action No.	When	Action to take	Date Completed (dd/mm/yyyy)	Time Completed (hh:mm)
1	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Start a personal log detailing information received and actions taken. *(copies of the logbook can be found in the ICB On-Call pack. Ensure formal logging of your actions and decisions is in place as soon as possible).*	/ /	:
2	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Confirm the declaring organisation has provided a written declaration/briefing in the form of the following? If not, request this is shared asap: ○ M/ETHANE ○ IIMARCH ○ SBAR ○ Situational Report (SitRep)	/ /	:
3	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Assess information provided in the written declaration by the declaring organisation and undertake a dynamic risk assessment considering the potential impacts on the ICS. *(If necessary, verify the information received by contacting the initial caller or appropriate multiagency partner).*	/ /	:

4	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Confirm the Level and Type of Incident and provide incident management and leadership as appropriate to the Level. *(Level 1,2,3,4 – Business Continuity Incident, Critical Incident, Major Incident).*	/ /	:
5	➢ Initial Alert ➢ Standby ➢ Declared	Ensure the incident log is initiated and regularly maintained and signed off.	/ /	:
6	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Inform partners across the ICS of the incident and confirm that the relevant command and control structures have been implemented across the local health economy and individual organisations.	/ /	:
7	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Within 1 hour of the declaration, inform and advise NHSE First On-Call of the declaration and details of the incident. Confirm Aim and Objectives for incident response and recovery.	/ /	:
8	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Consider the need to establish a full ICB IMT and ICC. If needed, this will include the relevant roles listed in Appendix 3 of IRP. An agenda is available in Appendix 4 of IRP.	/ /	:
9	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Establish and lead a system Health Incident Management Team (IMT). You will need to establish a meeting cadence for the IMT with consideration to other meetings such as TCG, SCG, NHSE Regional IMT, reporting requirements/timings.	/ /	:
10	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Inform ICB Communications and Engagement Team of the incident and instruct them to follow their actions.	/ /	:
11	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Develop a Communications and Media Strategy in collaboration with NHSE. Including identifying an appropriate person to engage with media interviews/press conferences.	/ /	:
12	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Ensure all briefing documents and reports (such as M/ETHANE, IIMARCH, SBAR, SitReps) have been reviewed and signed off, and escalated to NHSE as required and by agreed times.	/ /	:
13	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Represent the local NHS at LRF TCGs and SCGs (and other groups as necessary).	/ /	:

14	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Inform the ICB CEO, AEO and EPRR Lead at the earliest possible opportunity. *(NB these roles do not undertake role specific On-Call duties so may not be available out-of-hours).*	/ /	:
15	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Continually review all actions, and assess when appropriate to move into Recovery and/or Stand Down the Incident Response. *(This should be done in consultation with NHSE where appropriate).*	/ /	:
16	➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Ensure a process is in place for an appropriate return to business as usual processes and structures, including when staff involved in the incident should return to their normal duties.	/ /	:
17	➢ Shift Change ➢ Handover	Ensure a full handover is provided to the next Incident Director / On-Call Executive taking over. This should be documented as part of the incident.	/ /	:
18	➢ Declared ➢ Stand Down ➢ Recovery	Consider whether there are any medium to long term impacts on the NHS and assess if it is necessary to commission additional services to support the recovery from the incident or a new demand on the NHS.	/ /	:
19	➢ Stand Down	Hold a 'Hot Debrief' with the IMT, to cover as a minimum: ○ What worked well ○ What did not work so well ○ Areas for improvement	/ /	:
Personal Notes:			/ /	:
END OF ACTION CARD				

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Action Card Number:	**02**
Incident Response Role:	**ICC and Information Manager**
Level of Role:	Tactical
Responsibilities:	• Support the Incident Manager and Incident Director to undertake tasks relating to ICB's incident management. • Assess information received into the ICC/SCC/SPOC and brief or escalate to the Incident Director as required. • Coordinate the receipt of and dissemination of information to and from the ICC. • Oversee and manage the operation of the ICC.
Undertaken by:	SCC Duty Manager
Accountable to:	Incident Manager / Incident Director

Action No.	When	Action to take	Date Completed (dd/mm/yyyy)	Time Completed (hh:mm)
1	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Start a personal log detailing information received and actions taken. *(copies of the logbook can be found in the ICB On-Call pack. Ensure formal logging of your actions and decisions is in place as soon as possible).*	/ /	:
2	➢ Initial Alert ➢ Standby ➢ Declared	Ensure the incident log is initiated and regularly maintained and signed off by the Incident Director.	/ /	:
3	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Establish document control.	/ /	:
4	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Confirm the declaring organisation has provided a written declaration/briefing in the form of the following? If not, work with the Incident Director to request this is shared asap: ○ M/ETHANE ○ IIMARCH ○ SBAR ○ Situational Report (SitRep)	/ /	:
5	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Support the Incident Director to assess information provided in the written declaration by the declaring organisation and document a dynamic risk assessment considering the potential impacts on the ICS.	/ /	:

6	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Gain confirmation from the Incident Director of the Level and Type of Incident and provide incident management support as appropriate to the Level. *(Level 1,2,3,4 – Business Continuity Incident, Critical Incident, Major Incident).*	/ /	:
7	➢ Initial Alert ➢ Standby ➢ Declared	As instructed by the Incident Director, establish the ICC (either virtually or physically).	/ /	:
8	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Support the Incident Director to establish a full ICB IMT and ICC. If needed, this will include the relevant roles listed in Appendix 3 of IRP. An agenda is available in Appendix 4 of IRP.	/ /	:
9	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Support the Incident Director to establish a system Health Incident Management Team (IMT). You will need to establish a meeting cadence for the IMT with consideration to other meetings such as TCG, SCG, NHSE Regional IMT, reporting requirements/timings.	/ /	:
10	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Ensure all briefing documents and reports (such as M/ETHANE, IIMARCH, SBAR, SitReps) are reviewed and signed off by the Incident Director, and escalated to NHSE as required and by agreed times.	/ /	:
11	➢ Initial Alert ➢ Standby ➢ Declared	Establish rotas and call in staff as indicated to support, ensuring appropriate breaks are provided.	/ /	:
12	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Compile an action tracker and ensure action owners are followed up to confirm completion of actions within agreed time frames. Including monitoring all deadlines for submission of SitReps and information to NHSE.	/ /	:
13	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Assist in the preparation of time critical documents including SitRep collation from partners and briefing documents.	/ /	:
14	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Manage the ICC/SCC/SPOC mailboxes to ensure all information relating to the incident is clearly identified, logged, actioned, and escalated to the Incident Director and other senior staff as required.	/ /	:
15	➢ Shift Change ➢ Handover	Ensure a full handover is provided to the next Incident Director / On-Call Executive	/ /	:

		taking over. This should be documented as part of the incident.		
16	➢ Stand Down	Support the Incident Director to arrange a 'hot debrief' with the IMT.	/ /	:
Personal Notes:			/ /	:
END OF ACTION CARD				

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Action Card Number:	**03**
Incident Response Role:	**Incident Manager**
Level of Role:	Tactical
Responsibilities:	• Support the Incident Director to undertake tasks relating to ICB's incident management. • Assess information received into the ICC/SCC/SPOC and brief or escalate to the Incident Director as required. • Coordinate the receipt of and dissemination of information to and from the ICC. • Oversee the management of the ICC. • Provide support to the Incident Director at external meetings and LRF TCGs.
Undertaken by:	Head of Clinical Operations / SCC Senior Commander
Accountable to:	Incident Director

Action No.	When	Action to take	Date Completed (dd/mm/yyyy)	Time Completed (hh:mm)
1	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Start a personal log detailing information received and actions taken. *(copies of the logbook can be found in the ICB On-Call pack. Ensure formal logging of your actions and decisions is in place as soon as possible).*	/ /	:
2	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Provide managerial support to the ICC and Information Manager (Action Card 02).	/ /	:
3	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Support the Incident Director to assess information provided in the written declaration by the declaring organisation and document a dynamic risk assessment considering the potential impacts on the ICS.	/ /	:
4	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Gain confirmation from the Incident Director of the Level and Type of Incident and provide incident management support as appropriate to the Level. *(Level 1,2,3,4 – Business Continuity Incident, Critical Incident, Major Incident).*	/ /	:
5	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Support the Incident Director to establish a system Health Incident Management Team (IMT). You will need to establish a meeting cadence for the IMT with consideration to other meetings such as TCG, SCG, NHSE	/ /	:

		Regional IMT, reporting requirements/timings.		
6	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Attend external meetings and LRF TCGs as directed by the Incident Director, ensuring all information and actions from these meetings are communicated back to the ICC and Incident Director.	/ /	:
7	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Assist in the preparation of time critical documents including SitRep collation from partners and briefing documents.	/ /	:
8	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Ensure all briefing material is available to the Incident Director before each IMT and other identified meetings.	/ /	:
9	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Identify and establish a rota of appropriately trained individuals to undertake the role of 'Loggist' (Action Card 04) and provide managerial support those undertaking this role.	/ /	:
10	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Support the Incident Director with contacting the Communications and Engagement Team and to develop a Communications and Media Strategy in collaboration with NHSE. Including identifying an appropriate person to engage with media interviews/press conferences.	/ /	:
11	➢ Shift Change ➢ Handover	Ensure a full handover is provided to the next Incident Director / On-Call Executive taking over. This should be documented as part of the incident.	/ /	:
12	➢ Stand Down	Support the Incident Director to arrange a 'hot debrief' with the IMT.	/ /	:
Personal Notes:			/ /	:
END OF ACTION CARD				

Action Card Number:	**04**
Incident Response Role:	**ICB Incident Loggist**
Level of Role:	Administrative
Responsibilities:	• Recording and documenting all issues/actions/decisions made by the ICB Incident Director. • Attend the ICB ICC (either virtually or physically depending on setup). • Providing loggist duties to the Incident Director; this may involve attending multiple meetings with the Incident Director (including multiagency LRF TCGs/SCGs.
Undertaken by:	Appropriately trained loggist. Usually administrative staff.
Accountable to:	Incident Director / Incident Manager

Action No.	When	Action to take	Date Completed (dd/mm/yyyy)	Time Completed (hh:mm)
1	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Make contact with both the Incident Director and Incident Manager to confirm requirements of attendance: 1. Names and number of meetings 2. Timings of meetings 3. Venue for meetings 4. Is the loggist required to attend, and if so, is this virtual or physical attendance?	/ /	:
2	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Use the logbook provided by the ICB (or digital version of the form as instructed by the Incident Director or Incident Manager). (Logbooks can be found in the ICC cupboard situated outside Meeting Room 4 at Wellington Civic Offices. If virtual meeting, the Loggist should use the standard meeting templates (stored on the On-Call Executives MS Teams platform) and ensure that all meetings are recorded by using the record facility in MS Teams).	/ /	:
3	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	**PHYSICAL MEETING** – all staff should wear Identification Badges. If the badges are unclear the loggist must ask for clarification of who is present within the room and their title. **VIRTUAL MEETING** – the loggist should ask the Incident Director for everyone to confirm their name, role and organisation in the chat and for them to introduce themselves using their name each time they speak.	/ /	:

4	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Ensure the log is clearly written, dated, and initialled by the loggist at the start of each shift including the location, and throughout the log.	/ /	:
5	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Record all persons in attendance at meetings in the log.	/ /	:
6	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Ensure dates and timings of issues/actions/decisions are recorded accurately.	/ /	:
7	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	All material (notes, maps, data sets, etc) must be noted and referenced correctly in the log in accordance with the Incident Documentation Controls established by the ICC and Information Manager.	/ /	:
8	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	At the end of each session in the log a score and signature to be added underneath the documentation so no alterations can be made at a later date. Virtual logs must be saved as PDF and approved.	/ /	:
9	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	All documentation is to be kept safe and retained for evidence for any future proceedings.	/ /	:
10	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Where something is written in error, changes must be made by a single line scored through the word and the amendment made. For virtual logs, add a new file and record why the log/document was changed and save as PDF.	/ /	:
11	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Ensure the log is not minutes of meetings.	/ /	:
Personal Notes:			/ /	:
END OF ACTION CARD				

Action Card Number:	**05**
Incident Response Role:	**Communications and Media Officer**
Level of Role:	Strategic
Responsibilities:	• Lead and coordinate the health communications and media engagement response to an incident. • Provide communications and media coordination, advice, and support to the Incident Director. • Liaise, and maintain regular dialogue, with NHSE Regional Communications and Engagement Team. • Represent NHS STW and the ICS in multiagency media briefing centre/cells.
Undertaken by:	Communications and Engagement Lead/Team Members
Accountable to:	Incident Director

Action No.	When	Action to take	Date Completed (dd/mm/yyyy)	Time Completed (hh:mm)
1	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Start a personal log detailing information received and actions taken. *(copies of the logbook can be found in the ICB On-Call pack. Ensure formal logging of your actions and decisions is in place as soon as possible).*	/ /	:
2	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Make contact with the Incident Director.	/ /	:
3	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Attend the initial Incident Management Team (IMT) meeting.	/ /	:
4	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Gain confirmation from the Incident Director of the Level and Type of Incident and provide incident management support as appropriate to the Level. *(Level 1,2,3,4 – Business Continuity Incident, Critical Incident, Major Incident).*	/ /	:
5	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Establish a rota of Communications and Engagement Team members to support the incident and Incident Director.	/ /	:
6	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Work with the Incident Director to develop a Communications and Media Strategy in collaboration with NHSE. Including identifying an appropriate person to engage with media interviews/press conferences.	/ /	:
7	➢ Initial Alert ➢ Standby	Invoke NHS STW 'Communications Emergency Plan' and prepare a holding	/ /	:

	➢ Declared ➢ Stand Down	statement or pre-arranged public health/safety messages as outlined in Communications Emergency Plan and with approval from Incident Director, and where necessary NHSE.		
8	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Contact Provider, NHSE, and UKHSA Communications and Engagement Teams to agree a coordinated approach to managing and issues Communications and Press Releases and for engagement with the Media. (Consideration should be given to the Incident Level).	/ /	:
9	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Establish a Communications and Media Log and ensure all communications and media enquiries are logged and actions clearly documented. Ensure the Incident Director and NHSSTW Senior Leadership Team are regularly informed and updated on all requests.	/ /	:
10	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Monitor and actively manage NHS STW and ICS Social Media platforms. Escalate early, any concerns or developing situations/discussions, to the Incident Director and provide regular monitoring reports to the Incident Director/IMT.	/ /	:
11	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Engage with and attend LRF Communications Cell ensuring a coordinated health response with ICS Partners and NHSE.	/ /	:
12	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Attend NHSE Regional and National Communications calls/briefings as required.	/ /	:
13	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Engage with and support all opportunities to warn, inform, and advise the public, staff, and stakeholders.	/ /	:
14	➢ Shift Change ➢ Handover	Ensure a full handover is provided to the next Communications and Media Officer taking over. This should be documented as part of the incident.	/ /	:
15	➢ Stand Down	Arrange debriefs (Hot and Cold) for Communications and Engagement across the ICS and feed into the Incident Hot and Cold Debriefs.	/ /	:

16	➢ Stand Down	Ensure all documentation, emails, social media activity, flipcharts, etc are saved or safely stored in line with records management for incidents.	/ /	:
17	➢ Stand Down ➢ Recovery	Review the 'Communications Emergency Plan' in full and update as required based on learning from the incident and feedback from stakeholders.	/ /	:
Personal Notes:			/ /	:
END OF ACTION CARD				

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Action Card Number:	**06**
Incident Response Role:	**Quality and Nursing Lead**
Level of Role:	Strategic
Responsibilities:	• Provide coordinated and expert quality and nursing advice to support the clinically appropriate management of the incident.
Undertaken by:	Senior Nurse from ICB Quality Team
Accountable to:	Incident Director / ICB Chief Nursing Officer

Action No.	When	Action to take	Date Completed (dd/mm/yyyy)	Time Completed (hh:mm)
1	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Start a personal log detailing information received and actions taken. *(copies of the logbook can be found in the ICB On-Call pack. Ensure formal logging of your actions and decisions is in place as soon as possible).*	/ /	:
2	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Make contact with the Incident Director.	/ /	:
3	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Attend the initial Incident Management Team (IMT) meeting.	/ /	:
4	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Gain confirmation from the Incident Director of the Level and Type of Incident and provide incident management support as appropriate to the Level. *(Level 1,2,3,4 – Business Continuity Incident, Critical Incident, Major Incident).*	/ /	:
5	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Provide Quality, Nursing, and appropriate Clinical, and Infection Prevention and Control (IPC), advice to the Incident Director and IMT.	/ /	:
6	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Support the SCC and ICS partners with Quality, Nursing, and appropriate clinical and Infection Prevention and Control (IPC) advice to maintain capacity.	/ /	:
7	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Act as the Quality, Nursing, and IPC liaison with NHSE, UKHSA, and Directors of Public Health.	/ /	:
8	➢ Shift Change ➢ Handover	Ensure a full handover is provided to the next Quality and Nursing Lead taking over.	/ /	:

		This should be documented as part of the incident.		
9	➢ Stand Down	Attend and input to Hot and Cold Debriefs.	/ /	:
Personal Notes:			/ /	:
END OF ACTION CARD				

Action Card Number:	**07**
Incident Response Role:	**Urgent and Emergency Care (UEC) Lead**
Level of Role:	Strategic
Responsibilities:	• Overseeing the system response to UEC escalation and surge in attendances from the incident. • Provide leadership to the SCC to maintain capacity and flow across the system. • Developing systemwide recovery plan for capacity and flow.
Undertaken by:	Head of Clinical Operations / Senior member of staff the UEC Team
Accountable to:	Incident Director

Action No.	When	Action to take	Date Completed (dd/mm/yyyy)	Time Completed (hh:mm)
1	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Start a personal log detailing information received and actions taken. *(copies of the logbook can be found in the ICB On-Call pack. Ensure formal logging of your actions and decisions is in place as soon as possible).*	/ /	:
2	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Make contact with the Incident Director.	/ /	:
3	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Attend the initial Incident Management Team (IMT) meeting.	/ /	:
4	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Gain confirmation from the Incident Director of the Level and Type of Incident and provide incident management support as appropriate to the Level. *(Level 1,2,3,4 – Business Continuity Incident, Critical Incident, Major Incident).*	/ /	:
5	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Provide advice to the Incident Director and IMT on STW ICS UEC.	/ /	:
6	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Provide leadership to the SCC and lead ICS UEC calls to maintain capacity and flow.	/ /	:
7	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Liaise with other systems and SCC's to support capacity and flow challenges and surge in demand.	/ /	:

8	➢	Develop a systemwide recovery plan for capacity and flow.	/ /	:
9	➢ Shift Change ➢ Handover	Ensure a full handover is provided to the next UEC Lead taking over. This should be documented as part of the incident.	/ /	:
10	➢ Stand Down	Attend and input to Hot and Cold Debriefs.	/ /	:
Personal Notes:			/ /	:
END OF ACTION CARD				

Action Card Number:	08
Incident Response Role:	**ICC Administrator**
Level of Role:	Administrative
Responsibilities:	• Provide comprehensive administrative support to the ICB Incident Coordination Centre (ICC).
Undertaken by:	Administrative Staff
Accountable to:	ICC and Information Manager

Action No.	When	Action to take	Date Completed (dd/mm/yyyy)	Time Completed (hh:mm)
1	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Make contact with the ICC and Information Manager and/or Incident Manager.	/ /	:
2	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Assist with the setting up of the ICC as directed by the ICC and Information Manager and/or Incident Manager.	/ /	:
3	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Maintain a record of who is in, or visits, the ICC at all times.	/ /	:
4	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	**If not already in place**, establish a rota for the ICC Administrator role. **If already in place**, ensure rota is fully covered at all times and continually review the rota for gaps/capacity concerns, escalating any issues to the ICC and Information Manager and/or Incident Manager.	/ /	:
5	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Maintain a record of queries/documents and response.	/ /	:
6	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Minute and fully document any meetings or teleconferences.	/ /	:
7	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Ensure all relevant information received is logged and sent to the relevant party for review and filed.	/ /	:

8	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Support the ICC and Information Manager to manage the ICC/SCC/SPOC mailboxes to ensure all information relating to the incident is clearly identified, logged, actioned, and escalated to the Incident Director and other senior staff as required.	/ /	:
9	➢ Shift Change ➢ Handover	Ensure a full handover is provided to the next UEC Lead taking over. This should be documented as part of the incident.	/ /	:
10	➢ Stand Down	Attend and input to Hot and Cold Debriefs.	/ /	:
Personal Notes:			/ /	:
END OF ACTION CARD				

Action Card Number:	**09**
Incident Response Role:	**Primary Care Lead**
Level of Role:	Strategic
Responsibilities:	• Considering the implications of the incident for Primary Care and Out-of-Hours providers. • Considering the support Primary Care and Out-of-Hours providers can provide to the incident.
Undertaken by:	Senior Member of Staff from the Primary Care Team
Accountable to:	Incident Director

Action No.	When	Action to take	Date Completed (dd/mm/yyyy)	Time Completed (hh:mm)
1	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Start a personal log detailing information received and actions taken. *(copies of the logbook can be found in the ICB On-Call pack. Ensure formal logging of your actions and decisions is in place as soon as possible).*	/ /	:
2	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Make contact with the Incident Director.	/ /	:
3	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Attend the initial Incident Management Team (IMT) meeting.	/ /	:
4	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Gain confirmation from the Incident Director of the Level and Type of Incident and provide incident management support as appropriate to the Level. *(Level 1,2,3,4 – Business Continuity Incident, Critical Incident, Major Incident).*	/ /	:
5	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Provide the Incident Director and IMT with updates on the implications of the incident on Primary Care and Out-of-Hours providers.	/ /	:
6	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Be the liaison between the ICC, IMT and Primary Care/Out-of-Hours providers.	/ /	:
7	➢ Shift Change ➢ Handover	Ensure a full handover is provided to the next UEC Lead taking over. This should be documented as part of the incident.	/ /	:
8	➢ Stand Down	Attend and input to Hot and Cold Debriefs.	/ /	:

Personal Notes:		/ /	:
END OF ACTION CARD			

Action Card Number:	10
Incident Response Role:	**Commissioning Lead**
Level of Role:	Strategic
Responsibilities:	• Providing coordinated Commissioning advice to the Incident Director and IMT.
Undertaken by:	Senior Member of Staff from the Commissioning Team
Accountable to:	Incident Director

Action No.	When	Action to take	Date Completed (dd/mm/yyyy)	Time Completed (hh:mm)
1	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Start a personal log detailing information received and actions taken. *(copies of the logbook can be found in the ICB On-Call pack. Ensure formal logging of your actions and decisions is in place as soon as possible).*	/ /	:
2	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Make contact with the Incident Director.	/ /	:
3	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Attend the initial Incident Management Team (IMT) meeting.	/ /	:
4	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Gain confirmation from the Incident Director of the Level and Type of Incident and provide incident management support as appropriate to the Level. *(Level 1,2,3,4 – Business Continuity Incident, Critical Incident, Major Incident).*	/ /	:
5	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Provide the Incident Director and IMT with advice and updates on Commissioning.	/ /	:
6	➢ Shift Change ➢ Handover	Ensure a full handover is provided to the next UEC Lead taking over. This should be documented as part of the incident.	/ /	:
7	➢ Stand Down	Attend and input to Hot and Cold Debriefs.	/ /	:
Personal Notes:			/ /	:
END OF ACTION CARD				

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Action Card Number:	11
Incident Response Role:	**Medicines Management Lead**
Level of Role:	Strategic
Responsibilities:	• Consider the implications of the incident on Medicines Management.
Undertaken by:	Senior Member of Staff from the ICB Medicines Management Team / Chief Pharmacist
Accountable to:	Incident Director

Action No.	When	Action to take	Date Completed (dd/mm/yyyy)	Time Completed (hh:mm)
1	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Start a personal log detailing information received and actions taken. *(copies of the logbook can be found in the ICB On-Call pack. Ensure formal logging of your actions and decisions is in place as soon as possible).*	/ /	:
2	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Make contact with the Incident Director.	/ /	:
3	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Attend the initial Incident Management Team (IMT) meeting.	/ /	:
4	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Gain confirmation from the Incident Director of the Level and Type of Incident and provide incident management support as appropriate to the Level. *(Level 1,2,3,4 – Business Continuity Incident, Critical Incident, Major Incident).*	/ /	:
5	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Provide the Incident Director and IMT with advice, guidance and updates on the implications of the incident on Medicines Management.	/ /	:
6	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Be the liaison between the ICC, IMT and Hospital Pharmacy Teams and Community Pharmacies, and with NHSE.	/ /	:
7	➢ Shift Change ➢ Handover	Ensure a full handover is provided to the next UEC Lead taking over. This should be documented as part of the incident.	/ /	:
8	➢ Stand Down	Attend and input to Hot and Cold Debriefs.	/ /	:
Personal Notes:			/ /	:

END OF ACTION CARD

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Action Card Number:	12
Incident Response Role:	**People Team Officer**
Level of Role:	Strategic
Responsibilities:	• Considering the implications of the incident for ICB staffing and staff welfare.
Undertaken by:	Senior Member of Staff from the ICB People Team
Accountable to:	Incident Director

Action No.	When	Action to take	Date Completed (dd/mm/yyyy)	Time Completed (hh:mm)
1	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Start a personal log detailing information received and actions taken. *(copies of the logbook can be found in the ICB On-Call pack. Ensure formal logging of your actions and decisions is in place as soon as possible).*	/ /	:
2	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Make contact with the Incident Director.	/ /	:
3	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Attend the initial Incident Management Team (IMT) meeting.	/ /	:
4	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Gain confirmation from the Incident Director of the Level and Type of Incident and provide incident management support as appropriate to the Level. *(Level 1,2,3,4 – Business Continuity Incident, Critical Incident, Major Incident).*	/ /	:
5	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Provide the Incident Director and IMT with advice and guidance relating to Human Resources.	/ /	:
6	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Consider the implications of the incident on ICB staffing, and any potential redeployment.	/ /	:
7	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Consider the implications of the incident on ICB staff welfare.	/ /	:
8	➢ Shift Change ➢ Handover	Ensure a full handover is provided to the next UEC Lead taking over. This should be documented as part of the incident.	/ /	:

9	➢ Stand Down	Attend and input to Hot and Cold Debriefs.	/ /	:
Personal Notes:			/ /	:
END OF ACTION CARD				

Action Card Number:	13
Incident Response Role:	**Finance Officer**
Level of Role:	Strategic
Responsibilities:	• Considering the financial implications of the incident for the ICB.
Undertaken by:	Senior Member of Staff from the ICB Finance Team.
Accountable to:	Incident Director

Action No.	When	Action to take	Date Completed (dd/mm/yyyy)	Time Completed (hh:mm)
1	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Start a personal log detailing information received and actions taken. *(copies of the logbook can be found in the ICB On-Call pack. Ensure formal logging of your actions and decisions is in place as soon as possible).*	/ /	:
2	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Make contact with the Incident Director.	/ /	:
3	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Attend the initial Incident Management Team (IMT) meeting.	/ /	:
4	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Gain confirmation from the Incident Director of the Level and Type of Incident and provide incident management support as appropriate to the Level. *(Level 1,2,3,4 – Business Continuity Incident, Critical Incident, Major Incident).*	/ /	:
5	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Provide the Incident Director, IMT and ICB Senior Leadership Team with regular updates on the financial implications of the incident.	/ /	:
6	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Liaise with ICB Teams on development of new/expanded services to support the response and ensure these are costed appropriately.	/ /	:
7	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Arrange for costs incurred as a direct result of the incident to be recorded and provide budget forecasts and codes.	/ /	:
9	➢ Shift Change ➢ Handover	Ensure a full handover is provided to the next UEC Lead taking over. This should be documented as part of the incident.	/ /	:

10	➢ Stand Down	Attend and input to Hot and Cold Debriefs.	/ /	:
Personal Notes:			/ /	:
END OF ACTION CARD				

Action Card Number:	**14**
Incident Response Role:	**Accountable Emergency Officer (AEO)**
Level of Role:	Executive
Responsibilities:	• Ensure the NHS in STW continues to deliver its core functions during the response and recovery phase of any health-related incident, as directed by the ICB's Chief Executive Officer (CEO) and NHSE. • Ensure all agreed processes for EPRR and Incident Management are being followed in line with Policy and Plans. • Ensure sufficient resources are made available to support the preparedness, response and recovery to incidents within STW. • Provide Executive Level support and guidance to the Incident Director as required. • If not in the role of Incident Director, the AEO should remain separate to the role of Incident Director to enable the AEO to have a systemwide view/assessment of all activity across the system, and where necessary hold ICB/ICS Executive Level meetings to support the response; including liaising with NHSE Executive.
Undertaken by:	Accountable Emergency Officer (AEO)
Accountable to:	Chief Executive Officer (CEO)

Action No.	When	Action to take	Date Completed (dd/mm/yyyy)	Time Completed (hh:mm)
1	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Start a personal log detailing information received and actions taken. *(copies of the logbook can be found in the ICB On-Call pack. Ensure formal logging of your actions and decisions is in place as soon as possible).*	/ /	:
2	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Make contact with the Incident Director.	/ /	:
3	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Gain confirmation from the Incident Director of the Level and Type of Incident and provide incident management support as appropriate to the Level. *(Level 1,2,3,4 – Business Continuity Incident, Critical Incident, Major Incident).*	/ /	:
4	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Confirm the Incident Director, ICC and Information Manager, and Incident Manager are following agreed processes for EPRR and incident management in line with Policy and Plans.	/ /	:
5	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Agree with the Incident Director arrangements for IMT cadence, Situation Reporting, and Recovery from the incident.	/ /	:

	➢ Recovery			
6	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Agree with the Incident Director what resources are required to support the response with consideration to a sustained/protracted response, and make arrangements for the resource to be made available.	/ /	:
7	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Consider the potential for any concurrent incidents and assess the capability of the ICB, and resources required, to respond.	/ /	:
8	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Provide regular updates and briefings to the CEO and ICB Senior Leadership Team. This should be documented as part of the incident.	/ /	:
9	➢ Stand Down	Attend and input to Hot and Cold Debriefs.	/ /	:
Personal Notes:			/ /	:
END OF ACTION CARD				

Action Card Number:	**15**
Incident Response Role:	**Chief Executive Officer (CEO)**
Level of Role:	Executive
Responsibilities:	• Ensure the NHS in STW continues to deliver its core functions during the response and recovery phase of any health-related incident. • Provide Executive Level support and guidance to the Incident Director and Accountable Emergency Officer as required. • Ensure all agreed processes for EPRR and Incident Management are being followed in line with Policy and Plans. • Ensure sufficient resources are made available to support the preparedness, response and recovery to incidents within STW. • The CEO should remain separate to the role of Incident Director to enable the CEO to have a systemwide view/assessment of all activity across the system, and where necessary hold ICB/ICS Executive Level meetings to support the response; including liaising with NHSE Executive.
Undertaken by:	Chief Executive Officer (CEO) / Deputy Chief Executive Officer (DCEO)
Accountable to:	NHS STW ICB Chair

Action No.	When	Action to take	Date Completed (dd/mm/yyyy)	Time Completed (hh:mm)
1	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Start a personal log detailing information received and actions taken. *(copies of the logbook can be found in the ICB On-Call pack. Ensure formal logging of your actions and decisions is in place as soon as possible).*	/ /	:
2	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Make contact with the Incident Director.	/ /	:
3	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down	Gain confirmation from the Incident Director of the Level and Type of Incident and provide incident management support as appropriate to the Level. *(Level 1,2,3,4 – Business Continuity Incident, Critical Incident, Major Incident).*	/ /	:
4	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Confirm the Incident Director, ICC and Information Manager, and Incident Manager are following agreed processes for EPRR and incident management in line with Policy and Plans.	/ /	:
5	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Agree with the Incident Director arrangements for IMT cadence, Situation Reporting, and Recovery from the incident.	/ /	:

6	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Agree with the Incident Director and AEO what resources are required to support the response with consideration to a sustained/protracted response, and make arrangements for the resource to be made available.	/ /	:
7	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Consider the potential for any concurrent incidents and assess, with the AEO, the capability of the ICB, and resources required, to respond.	/ /	:
8	➢ Initial Alert ➢ Standby ➢ Declared ➢ Stand Down ➢ Recovery	Provide regular updates and briefings to the ICB Chair and Senior Leadership Team as required. This should be documented as part of the incident.	/ /	:
9	➢ Stand Down	Attend and input to Hot and Cold Debriefs.	/ /	:
Personal Notes:			/ /	:
END OF ACTION CARD				

Appendix 4 - Incident Management Team Agenda

INCIDENT MANAGEMENT TEAM AGENDA

Time/Date:

Venue/Telecon details:

Note: this is a guide only and may vary depending on nature of event and attendees

1. **Current situation report**
2. **Impact on the NHS/ Impact on STW ICS**
3. **Develop and agree Incident Response Strategy and Objectives**
4. **Current multiagency command arrangements**
5. **Communications**
    a. Reporting arrangements (NHS ENGLAND; DHSC; SCG; TCG)
    b. Public information and media strategy
    c. Internal NHS communications and staff briefings
6. **Staff and other resources required**
7. **Mutual Aid requests/ MACATCG/ MACA health**
8. **Authorisation of expenditure**
9. **Horizon scanning**
10. **AGREED**
    a. NHS ENGLAND command arrangements
    b. NHS ENGLAND Strategy and/or objectives (depending on level of incident)
    c. NHS ENGLAND Actions
    d. NHS ENGLAND Battle Rhythm (linked to SCG/TCG/national rhythm if established)
11. **Next meeting**

Ensure an attendance sheet is completed for every meeting detailing who was present and which role they performed. If they leave meeting or leave teams, please note.

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Appendix 5 - IIMARCH briefing template

The IIMARCH template below may help commanders in preparing a brief. When using IIMARCH, it is helpful to consider the following

- Brevity is important - if it is not relevant, leave it out
- Communicate using unambiguous language free from jargon and in terms people will understand
- Check that others understand and explain if necessary
- Consider whether an agreed information assessment tool or framework has been used

Element	Key Questions and considerations	Action
I	**Information** What, where, when, how, how many, so what, what might? Timeline and history (if applicable), key facts reported	
I	**Intent** Why are we here, what are we trying to achieve?	
M	**Method** How are we going to do it?	
A	**Administration** What is required for effective, efficient and safe implementation?	
R	**Risk Assessment** What are the relevant risks, and what measures are required to mitigate them?	
C	**Communications** How are we going to initiate and maintain communications with all partners and interested parties?	
H	**Humanitarian Issues** What humanitarian assistance and human rights issues arise or may arise from this event and the response to it?	

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Appendix 6 - SBAR reporting template (version 3)

Report Number:

Organisation name			
Site name(s) affected			
Date of report: (dd/mm/yyyy)		Time of report: (24hr)	
Type of Incident declared:			
Date declared: (dd/mm/yyyy):		Time declared: (24hr)	
Completed by (name, role)			
Executive Signed off by (name, role)			
Signature			

Element	Prompts	Description
S	Situation Clearly and briefly describe the current situation.	
B	Background Provide clear, relevant background information on the incident including: • Timings • Media • Exact situation	
A	Assessment State your assessment of the situation based on the situation and background. Include impacts to the hospital and services	
R	Recommendations Explain the actions being taken by the organisation to standdown from the incident/situation alongside any support required of partner agencies, ICB or NHS England	

Integrated Care Board Only	
Additional system actions/commentary:	
Sign off (name, role):	
Signature:	

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Appendix 7 - Incident Report Sheet

For use by On-Call Director

THIS FORM MUST BE COMPLETED FOR ALL CALLS RECEIVED

DATE CALL RECEIVED (DD/MM/YYYY):	
TIME CALL RECEIVED (24HR CLOCK):	
NAME OF CALLER REPORTING INCIDENT:	
NAME OF ORGANISATION/PERSON RAISING INCIDENT:	
CONTACT PHONE NUMBER FOR THE INCIDENT:	
On-Call Manager Details	
ICB On-Call manager's name:	
Full details of Incident and your Actions *Please ensure all times / Actions / Issues, are recorded on this form*	

Were there any security issues requiring police attendance?					
Yes (✓)		No (✓)		Not sure (✓)	
LOG COMPLETED BY:					
DATE:					

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Appendix 8 - Mutual Aid Request Template

MUTUAL AID REQUEST FOR AGREEMENT

This form should be completed following the requirements outlined in Section 6.10.1. of the Incident Response Plan.

Requesting Organisation. *Full name of organisation*	
Date & Time (dd/mm/yyyy / hh:mm) Date and time request is made	
Request being made to. *Full name of assisting organisation*	
Mutual Aid Requested. *This must be explicit including exact quantities, for how long, and for what purpose.*	
Costs Agreed *Any pre-agreed costs (indicative costs can be obtained from the JRLO)*	
Where the Mutual Aid is to be sent to. *Full address where Mutual Aid will be received, including postcode.*	
Transport Arrangements. *Include any details of transport requested. If transport has been arranged include details of what is being used (courier, ambulance, taxi, etc).*	
Full Name and Position/Role of Person Completing this form.	
Contact Arrangements. *Including in and out of hours contacts*	
Name of On-Call Executive. *Full name of On-Call Executive approving request.*	
Signature of Approving On-Call Executive.	

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Appendix 9 - Acronyms and Abbreviations

BCM	Business Continuity Management
BTP	British Transport Police
C3	Command, Control and Communication
Carbon Steeple	Operation Carbon Steeple: Acute trusts have plans for receiving persons who are subject to armed protection and who need emergency medical treatment and are suspected of being contaminated with CBRN materials
CBRN(e)	Chemical, Biological, Radiological and Nuclear incidents (explosives)
CCA	Civil Contingencies Act 2004
CCP	Casualty Clearing Point
CCS	Casualty Clearing Station
CHEMET	Met Office specialist weather forecast requested by the Fire & Rescue Service to aid reviewing risk posed by plumes from industrial related fires or chemical releases
COBR	Cabinet Office Briefing Room
Consort	Operation Consort: Acute trusts have plans for receiving members of the Royal Family who are subject to armed protection and who need emergency medical treatment and are not suspected of being contaminated with CBRN materials
COMAH	Control of Major Accident Hazards
CRIP	Common Recognised Information Picture
CT	Counter Terrorism
DHSC	Department of Health and Social Care
DIM	Detection, Identification and Monitoring Teams (Fire Service specialists officers who have the equipment to make an initial analysis of gases or other potentially hazardous substances)
DPH	Director of Public Health
DVI	Disaster Victim Identification
WMAS	West Midlands Ambulance Service
EOC	Emergency Operations Centre
EOD	Explosive Ordinance Disposal
EPRR	Emergency Preparedness, resilience and response.
HART	Hazardous Area Response Teams – each ambulance service has two HART teams. These are specialist paramedics trained to operate in hazardous areas
HAZMAT	Hazardous Materials
ICB	Integrated Care Board
ICS	Integrated Care System
IED	Improvised Explosive Device
IOR	Initial Operational Response (Steps to follow in the decontamination of contaminated casualties)
JDM	Joint Decision Model – from JESIP
JESIP	Joint Emergency Services Interoperability Principles

JRLO	Joint Regional Liaison Officer (military officers who liaise with civil authorities on the provision of military support to major incidents
LHRP	Local Health Resilience Partnership
Operation Menai Bridge	Central Government plan that would be implement in the event of the death of the King (similar plans are in place for the death of other senior royals). Local planning is led by the LRF. Any specific requirement on the NHS would be issued by NHSE.
LRF	Local Resilience Forum
MACA	Military Aid to Civil Authorities
METHANE	Mnemonic for briefing in incidents
MTA	Marauding Terrorist Attack – used to describe live incident where there is an active and armed terrorist
NACC	National Ambulance Coordination Centre – (Would coordinate the national provision of mutual aid to ambulance services in the event of a major incident
NARU	National Ambulance Resilience Unit – works to provide a coordinate approach to emergency panning
NCSC	National Cyber Security Centre
NHSE	NHS England
NILO	National Inter –Agency Liaison Officer. Emergency services officers that have been specially trained to support inter-agency coordination during incident response
UKHSA	UK Health Security Agency
PI IRT	Pandemic Influenza Incident Response Team
PLATO	Operation Plato is the term given to the emergency services response to a suspected marauding armed terrorist. The Police would declare Operation PLATO. In such operations, specialist Police units would seek to neutralise the terrorist threat to secure the incident scene, enabling other responders to treat any casualties.
PPE	Personal Protective Equipment
PRPS	Powered Respirator Protective Suit – All acutes hold a stock of PRPS suits to be used by trained personnel to decontaminate casualties
Resilience Direct	Secure government website for the sharing of information in the planning for and response to incidents
SAGE	Scientific Advice to Government in Emergencies (group established to advise the government during an emergency)
SBAR	Mnemonic widely used in briefing
SCG	Strategic Coordinating Group (Multi Agency Commanders)
SITREP	Situation Report
SOC	ICB System Operations Centre
SPOC	ICB Single Point of Contact
STAC	Scientific and Technical Advice Cell
TCG	Tactical Coordinating Group (Multi Agency Commanders)
USAR	Urban Search and Rescue

Appendix 10 - Equality Analysis Initial Assessment

Title of the change proposal or policy:

Incident Response Plan

Brief description of the proposal or policy:

This policy defines how STWICB will discharge its duties in responding to incidents as they arise.

Name(s) and role(s) of staff completing this assessment:

Stuart Allen, Senior EPRR Lead

Date of assessment: June 2024

Please answer the following questions in relation to the proposed change: Will it affect employees, customers, and/or the public? Please state which.

Yes, it will be applicable to all employees.

Is it a major change affecting how a service or policy is delivered or accessed?

Policy reviewed and updated with some reformatting completed.

Will it have an effect on how other organisations operate in terms of equality?

No

If you conclude that there will not be a detrimental impact on any equality group, caused by the proposed change, please state how you have reached that conclusion:

From an initial assessment of this policy and consideration of employees with protected characteristics under the Equality Act 2010 there is no anticipated detrimental impact on any equality group. There are no statements or conditions within this policy or requirements of this policy that disadvantage any particular group of people with a protected characteristic.

END OF DOCUMENT

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

NHS Shropshire, Telford & Wrekin Integrated Care Board

Business Continuity Management System

2024/25

PLEASE NOTE THIS IS A PLANNING DOCUMENT AND NOT A RESPONSE DOCUMENT, PLEASE REFER TO THE BUSINESS CONTINUITY PLAN FOR RESPONSE ARRANGEMENTS

1. Version Control

Title:	NHS Shropshire, Telford & Wrekin Integrated Care Board Business Continuity Management System
Description of Amendment(s):	Version 0.1
Financial Implications:	None
Policy Area:	Corporate
Version No:	Version 1.1
Author:	Stuart Allen, Senior EPRR Lead, NHS Shropshire, Telford and Wrekin ICB
Approved by:	Audit Committee
Effective Date:	30 August 2024
Review Date:	April 2025
List of referenced policies	Business Continuity Plan Individual Service Level Business Continuity Plans
Key Words section (metadata for search facility online)	Continuity Emergency Preparedness Resilience Response Incident
Target Audience	Business Continuity Leads Business Continuity Approvers ICB approved policies apply to all employees, contractors, volunteers, and others working with the ICB in any capacity. Compliance with ICB policy is a formal contractual requirement and failure to comply with the policy, including any arrangements which are put in place under it, will be investigated and may lead to disciplinary action being taken.

2. Table of Contents

3. Introduction

Business Continuity Management (BCM) is a legal requirement. BCM forms part of the Care Quality Commission's essential Standards of Quality and Safety, which all health providers must comply with as a condition of registration. It is also a requirement under the Civil Contingencies Act 2004 (CCA) and NHS England's Core Standards for Emergency Preparedness, Resilience and Response (EPRR). Business Continuity Management (BCM) is an integral part of EPRR.

This Business Continuity Management System (BCMS) sets out how NHS Shropshire, Telford and Wrekin (NHSSTW) Integrated Care Board (ICB) will meet the requirements of its EPRR obligations as defined in the CCA, the NHS England EPRR Framework, the Publicly Available Specification (2015) and NHS England Business Continuity Toolkit. This BCMS aligns to ISO 22301.

The BCMS incorporates the framework and methodology through which the ICB delivers a robust Business Continuity Management response and reviews its performance in this regard. This document should be read in conjunction with the ICB's Business Continuity Management Plan (BCMP) and other EPRR related guidance and plans.

ICBs are defined as Category 1 Responders under the CCA. This places them at the heart of any incident response and places them subject to the full set of civil protection duties, Further details of this can be found in the ICB's EPRR Policy and Incident Response Plan (IRP).

Where possible the BCMP's of the ICB have taken into account the interests and requirements of key Shropshire, Telford and Wrekin (STW) Integrated Care System (ICS) stakeholders and been developed in partnership with these where necessary.

4. Purpose

The BCMS indicates the process taken by the ICB to ensure effective, embedded, holistic Business Continuity (BC) processes in relation to the services that it provides, supports and commissions.

This document is for usage by the Business Continuity Lead and authorisers to ensure that local planning for Business Continuity incidents and threats are completed effectively to ensure holistic planning for threats.

This document is owned by the Accountable Emergency Officer (AEO) and will be delivered by the EPRR Team.

5. Policy Statement, Aims & Objectives

5.1. Policy Statement

The Business Continuity Management approach for NHSSTW aligns to the EPRR Policy and Incident Response Plan, NHSE BCM guidance, ISO 22301, Business Continuity Institute Good Practice Guidelines and legal requirements. NHSSTW accepts and abides by their statutory duties as a Category 1 Responder under the Civil Contingencies Act 2004 (CCA).

This Policy represent the overarching document that establishes the Business Continuity Management programme for NHSSTW, provides the strategic direction from which the programme is delivered, defines the way in which the organisation will approach business continuity, and how the programme will be structured including resources.

This policy is intended to be used in conjunction with the overarching Emergency Preparedness, Resilience and Response (EPRR) Policy. NHSSTW's Business Continuity Management System aligns with the organisation's strategy and objectives.

5.2. Aim

To provide the ICB with a framework for planning for business continuity events by the efficient delivery of a Business Continuity process, and to support the ICB in anticipating business continuity risks for the purpose of mitigating them and having robust plans in place to minimise the impact of such events on the ICB's normal service delivery.

5.3. Objectives

- Identify roles and responsibilities of individuals involved within the planning for Business Continuity Incidents (BCI) to ensure appropriate management oversight of the business continuity programme.
- Indicate the process to be followed by areas to ensure a robust process is in place for Business Continuity.
- Define the testing and exercising processes in place for the ICB in relation to business continuity planning.
- Identify and develop preventative measures to reduce the risk of a business continuity disruption occurring.
- Ensure the ICB can identify and continue delivering its critical functions during an incident ensuring that statutory requirements are maintained.
- Set standards for the development of business continuity plans.

6. Definitions

For acronyms, please refer to the UK civil protection lexicon.

6.1. Business Continuity (BC)

Business Continuity (BC) means an event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, to below acceptable predefined levels. This would require special arrangements to be put in place until services can return to an acceptable level. Examples include surge in demand requiring temporary re-deployment of resources within the organisation, breakdown of utilities, significant equipment failure or hospital acquired infections. There may also be impacts from wider issues such as supply chain disruption or provider failure.

6.2. Business Continuity Management Plan (BCMP)

Business Continuity Management Plan (BCMP) is defined as the overarching plan in relation to business continuity containing command and control principles for BC Incidents to be utilised by command staff.

6.3. Business Impact Analysis (BIA)

Business Impact Analysis (BIA) is defined as the process used to identify critical areas/functions within the ICB, available in support of this document.

6.4. Maximum Tolerable Period of Disruption (MTPD)

Maximum Tolerable Period of Disruption (MTPD) is defined as the maximum amount of time that a service or function can be unavailable or undeliverable after an event that causes disruption.

6.5. Recovery Time Objective (RTO)

Recovery Time Objective (RTO) is defined as the targeted duration of time within which a function must be restored after a disruption to avoid unacceptable consequences associated with a break in provision.

6.6. Subsidiarity

Subsidiarity is defined as decisions relating to the management of an incident should be taken at the lowest appropriate level, with co-ordination and oversight at the highest necessary level. For the ICB, this means that while the ICB Incident Director retains overall responsibility for an incident, the Provider Strategic Commanders will continue command and control of their organisations at their local level.

7. Responsibilities

For the ICB to develop effective embedded business continuity planning and awareness, it is essential that responsibilities are clear across the organisation.

7.1. Chief Executive Officer (CEO)

NHSSTW's Chief Executive Officer (CEO) has overall responsibility for the delivery of EPRR and Business Continuity across the organisation. This

responsibility is delegated to the Accountable Emergency Officer (AEO) to ensure delivery and assurance of processes being in place for Business Continuity.

7.2. Accountable Emergency Officer (AEO)

NHS England (NHSE) expect all NHS-funded organisations to have an Accountable Emergency Officer (AEO) who is a board-level Director (or equivalent in organisations without a Board) responsible for the EPRR programme delivery and for discharging the duties placed on their organisation under Section 252A(9) of The NHS Act 2006. AEO's will have executive authority and responsibility for ensuring their organisation complies with legal and policy requirements.

NHSSTW's Chief Delivery Officer (CDO) is the named Director with delegated responsibility to discharge to duties as the AEO. Specifically for BC, the AEO is responsible for ensuring NHSSTW, and any sub-contractors the ICB commissions, have robust business continuity planning arrangements in place that align to ISO22301 or subsequent guidance that may supersede this.

To support the AEO to discharge their duties, organisations are required to have appropriately qualified and experienced EPRR Practitioners in post; for NHSSTW this is the Senior EPRR Lead.

7.3. Senior EPRR Lead

The Senior EPRR Lead is responsible for oversight and sign off of Business Continuity processes for the team, must retain oversight of the associated risks from business continuity processes and ensure mitigations are implemented and local capture of risks where required in local risk registers.

They support the AEO with the planning and delivery of the business continuity programme of work for the ICB, and ensure assurance for both ICB and partners is completed to assure the wider regional partners that business continuity is aligned to ISO22301 and embedded within STW system organisations.

7.4. Directorate Business Continuity Lead (DBCL)

Each Directorate Chief Officer/Department Lead is responsible for identifying a Directorate Business Continuity Lead (DBCL). The DBCL will be responsible for overseeing all Business Continuity related activity for their respective Directorate and report into the Director/Department Lead on BC related activity and progress. They will be responsible for the operational delivery of the Business Continuity programme of work for their given directorate.

The DBCL will:

- Act as the single point of contact for to Directorate in relation to Business Continuity matters and support the team in delivering business continuity related work.
- Conduct a yearly audit of the Directorate's Business Continuity arrangements supported by the EPRR Team.
- Ensure oversight and assurance against local (ICB) plans.

- Ensure training and exercising for Directorate Business Continuity is embedded and delivered annually.
- **Ensure provision of assurance by circulation to the ICB of individual Business Continuity Plans for 3rd party contractors utilised by the Directorate and that business continuity is considered in relation to services/works provided to the ICB that are deemed critical to the delivery of ICB business. The DBCL should gain assurance of the 3rd party contractors own BC plans in this regard and that they satisfy the BC requirements the Directorate has set for its critical services.**

7.5. Information Governance Lead

In line with Information Governance (IG) Toolkit requirements, the ICB's Information Governance Lead should ensure that a business continuity strategy is in place for all critical information assets and critical processes, including those provided under service contract or agreement by third parties. Assurance should be gained of the 3rd party contractors own BC plans in this regard and that they satisfy the BC requirements delivery of any critical services.

7.6. Senior Information Risk Owner (SIRO)

The Senior Information Risk Owner (SIRO) is accountable and responsible for information risk across the organisation. The responsibilities of the SIRO aligned to Business Continuity Management will cover areas such as:

- Identifying and assigning Recovery Classes to technical assets
- Arranging off-site support and recovery
- Security of critical & vital electronic records
- Recovery of critical & vital systems, assets & infrastructure

7.7. Procurement Team

The Procurement Team must ensure that all parties providing goods and services to the ICB's critical services provide assurance to the organisation that they can continue delivery in the face of disruption in line with ISO22301.

7.8. All staff

All Departmental Managers/Service Leads are responsible for ensuring all staff in their Directorate/Department a familiarised with Business Continuity arrangements and BCMP's and all associated actions and escalations.

All NHSSTW staff are required to ensure that any risks and disruptions are immediately highlighted to their line manager in the first instance; if line managers are not available staff should continue to escalate to the next senior member of staff or directly to the On-Call Executive. Staff are required to follow any immediate or emergency instructions that are given to them in the event of an incident to maintain the safety of themselves, other staff members, visitors and any potential patients, and to minimise disruption to service delivery as much as is possible.

8. Classifications of Types of Incidents

The EPRR Framework defines three main types of incidents which may require activation of these co-ordination arrangements. **This policy is concerned with incidents that fall under the definition of a Business Continuity Incident.**

8.1. Business Continuity Incident (BCI)

An event or occurrence that disrupts or might disrupt an organisation's normal service delivery to below acceptable pre-defined levels. This would require special arrangements to be put in place until services can return to an acceptable level.

Examples include surge in demand to a point that requires temporary re-deployment of resources within the organisation, breakdown of utilities, significant equipment failure or hospital acquired infections. There may also be impacts from wider issues such as supply chain disruption or provider failure.

8.2. Critical Incident

Any localised incident where the level of disruption results in an organisation temporarily or permanently losing its ability to deliver critical services or where patients and staff may be at risk of harm. It could also be down to the environment potentially being unsafe, requiring special measures and support from other agencies, to restore normal operating functions.

A Critical Incident is principally an internal escalation response to increased system pressures/ disruption to services.

8.3. Major Incident

The Cabinet Office and the Joint Emergency Service Interoperability Principles (JESIP) define a Major Incident as an event or situation with a range of serious consequences that require special arrangements to be implemented by one or more emergency responder agency.

In the NHS this will cover any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties as to require special arrangements to be implemented.

9. NHS Incident Response Levels

The level and type of incident will determine which agency holds lead responsibility. The following table provides a reference point regarding incident levels and lead responsibility arrangements. These levels are specific to the NHS in England and are not interchangeable with other organisation's incident response levels.

As an event evolves it should be described in terms of its level as shown below. For clarity, these levels must be used by all organisations across the NHS when referring to incidents. All incidents and emergencies resulting in the activation of

central government response arrangements will be managed as a Level 4 incident. The level of incident may change as the incident evolves. Upon declaration the declaring officer will confirm the incident level being declared. The ICB can declare incidents for Levels 1 and 2 and are responsible for coordinating the response to, and recovery from, incidents are described in the table below.

Level 1	An incident that can be **responded to and managed by an NHS-funded organisation** within its respective business as usual capabilities and business continuity plans.
Level 2	An incident that requires the response of a number of NHS-funded organisations within an Integrated Care System (ICS). **NHS coordination by the Integrated Care Board (ICB)** in liaison with the relevant NHS England region.
Level 3	An incident that requires a number of NHS-funded organisations within an NHS England region to respond. **NHS England (Regional) to coordinate the NHS response in collaboration with the ICB.** Support **may** be provided by the NHS England Incident Management Team (National).
Level 4	An incident that requires NHS England national command and control to lead the NHS response. **NHS England Incident Management Team (National) to coordinate the NHS response at the strategic level.** NHS England regions to coordinate the NHS response, in collaboration with the ICB, at the tactical level.

Incidents can escalate as well as de-escalate; the incident level should be frequently reviewed and amended as appropriate.

10. NHS STW Approach

The BCMS is an ongoing process, which adapts in response to the changing nature of an organisations internal and external operating environment. NHSSTW adopts a holistic management process that identifies potential threats and the impacts of those threats to business operations.

NHSSTW ensures that the **Plan, Do, Check, Act** (PDCA) cycle is utilised within its annual business continuity planning process.

The services within the ICB will be expected follow the PDCA process by:

- undertaking a Business Impact Analysis (BIA) to identify and prioritise activities and services.
- identifying risks to delivery of prioritised activities and services and likely impact if they are affected.
- planning how to mitigate against risk to activity and improve resilience.
- developing a BCMP detailing activities, Maximum Tolerable Period of Disruption (MTPD), their Recovery Time Objective (RTO), minimum and appropriate resource required to deliver them, and order of priority in which services should be restored to normal function.

The ICB embeds an annual process to ensure Business Continuity is regularly assessed and embedded within its local processes. This is aligned to the Plan, Do Check, Act process as indicated by ISO22301.

10.1. Plan

This stage includes the duty to carry out a risk assessment of an emergency occurring within the geographical area of NHSSTW. The identified risks are then documented on the local Risk Register and fed to the Local Health Resilience Partnership (LHRP) for a review of impacts on the health system. Once these risks have been identified, the EPRR Team work to ensure that the relevant risks are also on the ICB Risk Register.

Additionally, internal risk assessments are conducted in line with the ICB Risk Policy. Each Directorate should the risks for its service areas and develop relevant

mitigating plans as part of its Directorate Business Continuity planning. Risks should be assessed and graded in line with the NHSSTW's Risk Management Policy.

10.1.1. Business Impact Analysis (BIA)

For NHSSTW to meet its overall Strategic Objectives, it depends on the uninterrupted running of all its services. Each of the services provided by the ICB is important, however during a major disruption it will be extremely difficult or almost impossible to maintain a normal level of service delivery.

The BIA is the first stage of the BCMP development process where services will be required to consider what the impact would be on both its own service, and its stakeholders if the delivery of a key function or service would be disrupted for any reason. The BIA process should be part of a yearly review cycle conducted by the DBCL and can be supported by the EPRR Team. BIA information will be collated by the EPRR Team and processed to assist in ICB wide planning and for audit purposes.

For the purposes of the BIA, the cause of the disruption is considered on the basis of loss of, People, Premises and Processes (including ICT, electronic systems etc). Where a risk identified via the local risk assessment or the local Risk Register poses a threat to People, Premises and Processes (including ICT, electronic systems etc), the Business Continuity Management Plan of the affected Directorate will be updated to reflect this.

The BIA is part of the Directorate Business Continuity template. Following the impact assessment, each of the activities, depending on their final rating, will be assigned a:

- Maximum Tolerable Period of Disruption (MTPD)
- Recovery Time Objective (RTO)
- Recovery Point Objective (RPO)

It is recommended that the following MTPD, RTO and RPO timeframe limits are applied against each activity aligned to their rating. These timeframes are indicative and serve only as a suggestion. Depending on the nature of the activity, the timeframes can be amended where deemed necessary by the Plan Owner.

Services with the shortest Maximum Tolerable Period of Disruption (MTPD) are deemed as highest priority therefore must be Resumed or Recovered as soon as possible following a disruption.

The Business Impact Assessment should draw on a range of data regarding directorate activities and be linked to the delivery of the Directorates priorities.

The outcome of the BIA provides an overview of the critical services delivered within the ICB. The information gained from the BIA will likely allow for the team to identify interlinks between services, including any dependencies that impact on the recovery time of services.

BIAs and ultimately Directorate Business Continuity Management Plans will be approved by the relevant Executive Directors. Reporting on these plans will form part of the reporting cycle to Audit Committee carried out by the AEO and Senior EPRR Lead.

10.2. Do

Developing BCMPs enables staff and managers to prepare and respond more effectively to incidents. BCMPs will be put in place at organisational level, directorate level, and where required team/service level for complex services that require specialised planning at a more granular level than their directorate's plan.

Each Directorate should have a nominated Business Continuity Lead to champion business continuity planning within their respective directorate. These individuals will also be the Plan Owners for their respective Directorates.

Plans will contain the following:

- Escalation and Activation method including management of the incident.
- Communication methods and channels
- List of services and their criticality (achieved through BIA)
- Resources required and actions to ensure that services can be maintained (achieved through BIA)
- Actions for the response to disruption to staff numbers, premises, suppliers, IT services, specialist equipment and data (where applicable)
- Specific roles required to respond.
- Internal and external interdependencies (achieved through BIA)
- Decision support checklists
- Details of meeting locations
- Links to other plans and procedures
- Version control

Where team/service level plans are developed these should make provision for staff contact details, where the team is based and line management arrangements. The DBCL should ensure annual action plans are developed where gaps in response are identified.

Plans should be updated, monitored and reviewed and tested annually, in line with the ICB's EPRR policy and updated in line with policy and guidance changes or changes in Directorate procedures or structures. Plans are also required to be reviewed following and activation of the plan to ensure any learning from an incident, as well as from testing and exercising can be reflected in the updated plans. Plan owners are responsible for their maintenance and upkeep. Historical documents will be identified and archived in the Directorate's identified location.

Any interlinked issues with other Directorates should be addressed and highlighted to the EPRR Team.

Any plan or documentation related to BC will be subject to strict version control. This includes a version number, issue date and the date of next planned review date. This will be centrally monitored by the EPRR Team.

Plans are to be held by the Plan Owner, and a copy of the plan will be shared with the EPRR Team. An electronic copy of all plans will be kept on the Emergency Preparedness, Resilience and Response repository in MS Teams. All plan versions should be stored virtually for a minimum of 10 years. A hard copy of every Business Continuity Management Plan and Organisational BIA will be held by the EPRR Team with a copy in the Incident Coordination Centre (ICC) cupboard. Once approved, the plan will be circulated to appropriate members of staff via email and will be referenced in local training.

10.2.1. Planning Assumptions

The following assumptions should be considered when developing Business Continuity Management Plans:

- In the event of a major incident, existing business premises could, potentially, be out of use for up to 5-7 days, possibly months in the event of floods or fire related incidents.
- Following recovery from the COVID-19, workplace guidance for home-based working is in place. In addition some resilience is provided via the option to use ICS partners premises for some staff
- Where a generator is not available loss of electricity supply across a region could last for up to 1-5 days.
- The mains water supplies and sewerage services may be interrupted for up to 3-5 days.
- Availability of the IT network historically runs at over 85%. In the event of a partial failure of a server the network could be unavailable for up to 12-24 hours.
- In the event of loss of IT connection during home working for 4 hrs or more, staff should make their Line Manager aware and then attend the NHSSTW office, or a partner organisation site (with agreement) to complete essential work.
- If the server were to be completely lost it could take up to 1-3 days to restore a limited desktop service (Microsoft package, e-mail and Internet access). Other software could take even longer to restore.
- A cyber-attack carries the risk of a potential of significant data loss for considerable periods of time.
- Access to the public telephone network and mobile communications could be disrupted for up to 3 days during a Major Incident.
- In a pandemic 25% - 50% of staff could be off work at any one time. This will include those who are sick, those caring for others and the ‘worried well’ who are simply too scared to come to work. On average people will be absent for 5-7 days, but some may take longer to return.
- In the event of a fuel shortage NHSSTW staff are not likely to be guaranteed to have priority access to fuel.

- In the event of flooding or other adverse weather up to 20% of staff may be affected in terms of travel or communications.
- Consider short term and long term impacts in line with climate change adaption planning.

In responding to a Business Continuity Incident. The identified lead may refer to the table below to support decision making regarding the classification and associated business continuity response:

Critical Service Categorisation		
Category	Impact	Recovery Timescale
Category A: Critical	Loss of service would immediately: • Directly endanger life. • Endanger the safety of those individuals that the ICB has legal responsibility. • Prevent the operation of another service within this category. • Seriously affect the ICB's finances or accuracy or records. • Prevent communication of vital information.	This service must continue to be provided. This group will include services/functions that usually provide a full service 7 days a week, 365 days per year.
Category B: High Priority	Loss of this service would immediately: • Present a risk to health and safety. • Prevent the ICB meeting its statutory obligations. • Prevent the operation of another service in this category. • Would seriously adversely affect the ICB's reputation.	This service must be resumed within 3 calendar days. Services included in this group are mainly those that provide a reduced service at weekends and during holiday periods.
Category C: Medium Priority	Loss of service would lead to serious knock-on effects for the operation of a Critical or High Priority Service; the ICB's reputation being adversely affected.	This service must be resumed within 7 calendar days. Services included in this group will include those that normally close during weekends and during holiday periods.
Category D: Low Priority	Loss of service would lead to potential knock-on effect in disrupting the activities and functions of other services within the ICB, but no immediate impact upon the provision of Critical or High Priority services.	This service should be resumed as soon as practicable. This includes all other service areas that are required for the ICB to go about its usual business.

10.3. Check and Act

10.3.1. Training

Training of all staff will be conducted based on the NHSSTW's Training Needs Analysis which will outline the competencies required by different groups of staff involved Business Continuity planning. This framework is set out in the ICB's EPRR Policy.

The EPRR Team is responsible for maintaining the EPRR Training Needs Analysis. Training frequency is set out in the EPRR Training and Exercise Programme to meet minimum statutory requirements and may be delivered internally, by an external party and by physical or virtual means.

Training records will be maintained by the EPRR Team.

10.3.2. Exercising

The ICB will carry out exercising of its Business Continuity Plans no less than annually. This can be done as part of an ICB wide exercise, at a departmental level or in an actual incident, as set out in the ICB's EPRR policy.

Exercises will be evaluated by the participants against the aim and objectives of the exercise; this is done at the end of the exercise in a hot debrief carried out in line with the EPRR policy debriefing arrangements.

A post exercise report will be completed. This report will include an action plan to address any concerns and preventative actions required to improve the business continuity plans and strategy issued within 4 weeks of the exercise.

All training and exercising records are maintained by the EPRR Team and include:

- List of participants, including directorates they represent.
- The exercise aim and objectives.
- The Exercise scenario and injects.
- The skills/competence tested by the exercise.
- When the exercise took place.
- The outcomes of the exercise
- Further training required.
- Actions, recommendations and learning.

10.3.3. External Suppliers and Contractors

As part of the tendering process of any new contract or agreement for the provision of goods and services in relation to ICB's critical services as identified in the organisational/ Directorate BIA, all involved parties are required to provide a statement and evidence of Business Continuity arrangements.

Plans will be reviewed as part of this process to ensure suitable arrangements are in place for the provision of the goods and services they are being contracted for.

This function will be supported by the EPRR Team as appropriate and before a contract is awarded.

A signed statement or declaration by the providers attesting their Business Continuity arrangements will be considered acceptable assurance, however a copy of the Business Continuity Management Plan would be preferred.

As a minimum, Business Continuity Management Plans/ Statements being reviewed must provide assurance to the organisation that in the event of a disruption, arrangements are in place to ensure the continuation of the delivery of the services they are contracted for, maximum tolerable period of disruption, and recovery time objectives.

External BCMPs will be maintained by the EPRR Team in an access controlled central repository.

10.3.4. Mutual Aid

During an incident response an organisation's capacity and / or capability to provide safe and effective patient care may be exceeded. Once internal business continuity arrangements have been exhausted, it may be necessary to seek support from other organisations in a formal, documented way within our ICS or wider. This formalised support is referred to as 'mutual aid'. Agreement(s) for mutual aid provision should exist between organisations in advance of the requirement. Mutual aid arrangements can exist between providers of NHS funded care and external partners e.g. public, private, or voluntary sectors. Mutual aid can vary in need from staff, equipment, supplies of laundry, advice, capacity, pharmacy, estate for relocation, mortuary etc.

NHSE will support the brokering of mutual aid requests if the health system led by the ICB is unable to resolve this and will mediate multiple provider requests and go wider than the ICS footprint when escalated by the ICB. All NHSE requests for mutual aid need to follow NHSE command and control arrangements in the NHS EPRR Framework.

ICBs are required to support NHSE in discharging its EPRR function. This includes providing leadership in the agreement and activation of mutual aid arrangements across its geography to support its population and commissioned providers.

ICBs will hold copies of the written mutual aid arrangements for any arrangements across their ICS for health and will also maintain centralised records of requests made and declines across their providers even if no financial implication is involved. ICBs will review active mutual aid arrangements in place working with partners in the LRF to identify and plan for mutual aid eventualities and look to identify impacts these may have on patient services in the responding and health supporting organisations.

To activate mutual aid the health organisation must have exhausted all internal business continuity arrangements and have formally declared a business

continuity, critical, or major incident as defined by NHS EPRR Framework in response to an incident.

The NHS Mutual Aid guide (March 2022) is available in the ICB On-Call pack which details the key information of the expectation and requirements of assisting the call for mutual aid.

The requesting of Mutual Aid should be done by completing the 'Mutual Aid Request Template' found at Appendix 9 of the NHSSTW Incident Response Plan (IRP). All requests for Mutual Aid (whether receiving or providing) must be approved by the On-Call Executive/Incident Director.

11. Business Continuity Governance and Audit

Documents associated with the Business Continuity Management System will be reviewed by the plan owners and the EPRR Team at least once a year. Directorate Plans will be approved by the relevant Executive Director and the overall Business Continuity Management Plan and Management System will be approved by the ICB's EPRR Programme Group, Audit Committee and Board.

Reviews will be managed by the DBCL with support and oversight by the Senior EPRR Lead. Reporting on Business Continuity will form part of the twice yearly report to the Audit Committee and will be reported by exception in addition to this if required.

The maintenance and review of this document is the responsibility of the Accountable Emergency Officer (AEO). Reviews will take place no less than annually but will be completed when learning has been identified which will improve the approach.

The Senior EPRR Lead will ensure that the Business Continuity arrangements are periodically audited and will liaise with the ICB's appropriately qualified internal auditors (annually) and appointed external auditors (every 3 years) for their input into this process. Audit outputs will be reported to the Audit Committee. Where auditing identifies gaps or deficiencies in arrangements the Senior EPRR Lead, linking with other key staff, will be responsible for ensuring the appropriate remedial action is taken to address those gaps or deficiencies.

All staff must comply with this ICB-wide policy and failure to do so may be considered a disciplinary matter leading to action being taken under the ICB's Disciplinary Policy. Actions which constitute breach of confidence, fraud, misuse of NHS resources or illegal activity will be treated as serious misconduct and may result in dismissal from employment and may in addition lead to other legal action against the individual/s concerned.

This Business Continuity Management System policy is a living document which is constantly being monitored, reviewed, and amended to reflect learning from incidents, exercises, audits and other sources. All DBCLs and BCMP holders are

responsible for contributing to the review process. The EPRR Team are responsible for ensuring that this process is carried out.

This Plan will be communicated via the following methods:

- **NHSSTW All Staff Huddle** – briefing on documents and information regarding the business continuity processes, introducing and directing staff to relevant Business Continuity information.
- **Intranet** – publishing of information relating to business continuity and the ICB's intent on the intranet allowing engagement with stakeholders and partners. All EPRR Policies, Plans, Guidance and tools will be available on the ICB staff intranet as well as on the On-Call Executive MS Teams platform.
- **Directly** – direct contact with those implementing the processes in this strategy via a variety of routes including email and face to face contact. This method will also be used to engage with partners and other stakeholders where required. Emergency communications will be sent out using direct contact.
- **Staff Newsletters** – promoting relevant Business Continuity information in the regular email communications to all staff.
- **New Starter Inductions** – incorporating details of Business Continuity Management Plans within the New Starter Induction Booklet and induction process, ensuring that new members of the organisation are aware of relevant procedures.

12. Equality Statement

The ICB aims to design and implement policy documents that meet the diverse needs of our services, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account current UK legislative requirements, including the Equality Act 2010 and the Human Rights Act 1998, and promotes equal opportunities for all. This document has been designed to ensure that no one receives less favourable treatment due to their protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity. Appropriate consideration has also been given to gender identity, socio-economic status, immigration status and the principles of the Human Rights Act.

Where the implementation of business continuity arrangements has the potential to create inequalities these will be balanced with the risk of not implementing business continuity arrangements and all possible options will be considered to avert this eventuality

13. Appendices

Appendix 1 – Business Continuity Data Collection Tool
Appendix 2 – Service Level Business Continuity Planning Tool

Appendix 1 - Business Continuity Data Collection Tool

Team Name:	
Directorate:	
Directorate Business Continuity Lead (DBCL) name and job title:	

1. KEY PERSONNEL			
Job Role	Name	Mobile Number	Email

2. FUNCTIONS ASSESSMENT			
	Departmental Functions	Recovery Time Objective (RTO)	Maximum Tolerable Period of Disruption (MTPD)
Activity 1			
Activity 2			
Activity 3			
Activity 4			
Activity 5			
Activity 6			
Activity 7			
Activity 8			
Activity 9			
Activity 10			

3. DEPARTMENT RISK ASSESSMENT												
Activity	Financial Risk (>5 million)			Legal/Statutory Breaches			Reputational Damage to ICB			Operational Running of ICB		
	Immediate	4hr-48hr	>48hr	Immediate	4hr-48hr	>48hr	Immediate	4hr-48hr	>48hr	Immediate	4hr-48hr	>48hr
Activity 1												
Activity 2												
Activity 3												
Activity 4												
Activity 5												
Activity 6												
Activity 7												
Activity 8												
Activity 9												
Activity 10												

4. TEAM ANALYSIS			
Please list key IT software utilised by your team, if there is specific software linked to specific activities, please detail them.	Software Namer	Function Linked To	
	•	•	
Please list key equipment used by the team, if there is specific equipment linked to specific activities, please detail them (this is to include IT hardware).	Hardware Name	Function Linked To	
	•	•	
Staff members with specific skills please indicate key staff with specialist skill sets i.e. Registered Nurse or Medic if they are linked to specific activities, please detail them.	Staff Role	Number of Staff in this Role	Function Linked To
	•	•	•
Key suppliers or 3rd party contract utilised by this team, if linked to specific functions please indicate those. *(IF YOU HAVE AN EXTERNAL PROVIDER/CONTRACTOR YOU WILL BE CONTACTED BY ERM AS FURTHER INFORMATION WILL BE REQUIRED)*	Provider	Function Linked To	BCMP Seen?
	•	•	•

5. TEAM/DEPARTMENT PROFILE	
Current Location of Services:	
Alternative Work Location (if identified):	
Current Operating Hours of the Team:	

6. WORKFORCE			
Number of staff requiring a fixed location i.e. workstation based, access to specialist equipment.	Role	Workstation or Equipment Required	Rationale
	•	•	•

Minimum number of staff required as a minimum to deliver your functions? Please include any specific skills that they may require (to see you through to the Maximum Tolerable Period of Disruption).	Function Number	Minimum Number of Staff Required	Specific Skills Required
	Function 1		
	Function 2		
	Function 3		
	Function 4		
	Function 5		
	Function 6		
	Function 7		
	Function 8		
	Function 9		
	Function 10		
Number of agile working enabled staff (laptop, MS Teams access, etc).			

7. VITAL RECORDS	
Paper copies (what and where stored)	
Electronic copies (include file pathways)	
Externally hosted systems	

8. MUTUAL AID	
Can your activities or services be carried out fully or partially by another team/department? If yes, please detail the team that could do this.	

9. IS THERE ANYTHING ADDITIONAL THAT HAS NOT BEEN COVERED THAT REQUIRES RESILIENCE CONSIDERATION WITHIN THE OPERATION OF YOUR TEAM?

10. DEPARTMENTAL PREPAREDNESS AND RESILIENCE		
Question		Response
Are all your staff aware of the actions required in a Business Continuity Incident?		
Business Continuity Management Plan (BCMP) – is the BCMP printed off and readily available within your service area?		
Staff Contact Details – have all your staff contact details been updated in the last 6 months?		
Business Continuity Testing and Exercising	Have you tested/exercised your BCMP locally?	
	Have you tested/exercised your team notification/communication cascade?	

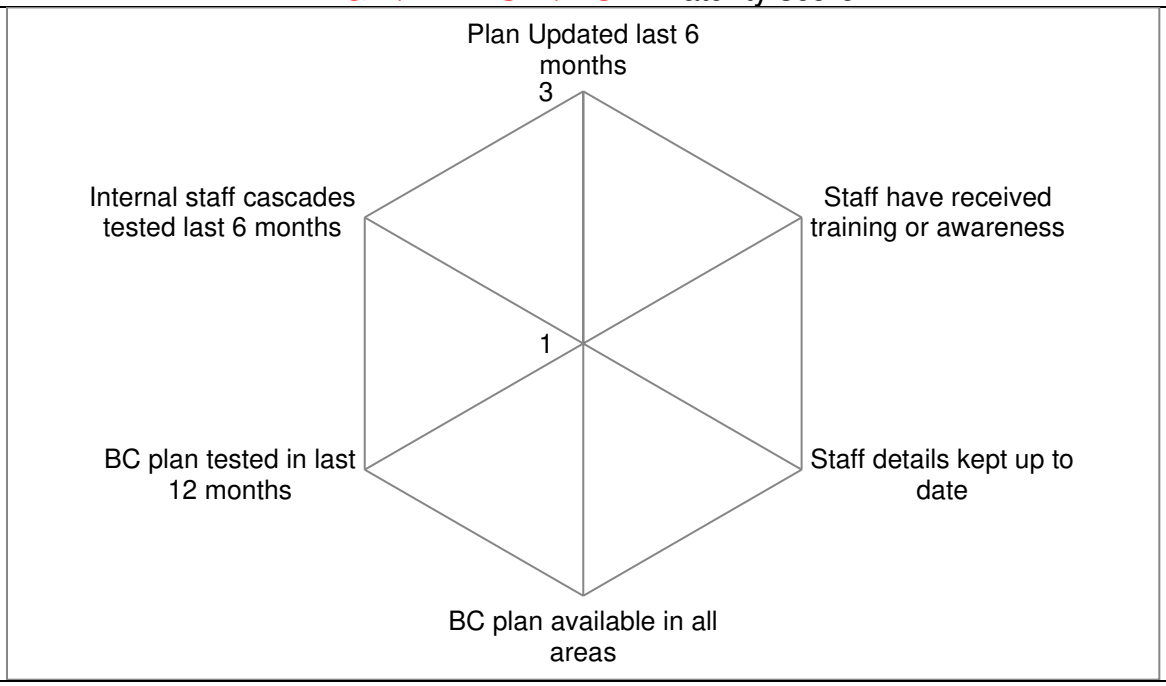
Appendix 2 - Service Level Business Continuity Planning Tool

Directorate:	
Author:	
Job Title:	
Date of Issue:	

Risks of the Loss of the Team/Department to NHSSTW	
Financial Loss over £5m	HIGH / MEDIUM/ LOW
Legal of Statutory Breaches	HIGH / MEDIUM/ LOW
Damage to NHSSTW Reputation	HIGH / MEDIUM/ LOW
Disruption to Operational Running of the ICB	HIGH / MEDIUM/ LOW

PREPAREDNESS MATURITY ASSESSMENT

Based on the indicated preparedness assessment this team/department has a HIGH / MEDIUM / LOW maturity score



TEAM/DEPARTMENT MATURITY SCORE IN DETAIL

1	BCMP updated in last 6 months.	4	BCMP is available in all service areas.
2	Staff have received training of have awareness of what is required.	5	BCMP has been tested/exercised in the last 12 months.
3	Staff details are kept up to date regularly.	6	Team notification/communications cascade has been tested/exercised in last 6 months.

NHS Shropshire, Telford and Wrekin Integrated Care Board

Business Continuity Management Plan

1. Document History

This plan is required to be reviewed at least annually, or sooner as required following activation of the plan or significant changes to the organisation's structure.

Title:	NHS STW ICB Business Continuity Management Plan
Financial Implications:	None
Policy Area:	Corporate
Version No:	Version 0.6
Author:	Stuart Allen, Senior EPRR Lead, NHS Shropshire, Telford and Wrekin ICB
Approved by:	Audit Committee
Effective Date:	30 August 2024
Review Date:	April 2025
List of referenced policies	Business Continuity Management System Individual Service Level Business Continuity Management Plans
Key Words section (metadata for search facility online)	Continuity Emergency Preparedness Resilience Response Incident
Target Audience	Business Continuity Leads Business Continuity Approvers ICB approved policies apply to all employees, contractors, volunteers, and others working with the ICB in any capacity. Compliance with ICB policy is a formal contractual requirement and failure to comply with the policy, including any arrangements which are put in place under it, will be investigated and may lead to disciplinary action being taken.

All amendments are noted below.

Date	Version Number	Changes Made	Name
01/11/21	0.1	First draft (combined STW CCG)	S Tilley
24/05/22	0.2	First draft (ICS)	A Parkes
19/08/22	0.3	Second draft (ICB version)	S Tilley
21/09/22	0.4	Final Draft – Approve by Audit Committee	S Tilley
22/06/22	0.5	Re-draft to ensure compliance with NHSE EPRR Core Standards.	S Tilley
30/08/23	0.5	Approved by Audit Committee	S Tilley
12/02/24	0.5	Location references updated following ICB office relocation	S Tilley
28/08/2024	0.6	Annual review and update. Formatting changes applied.	S. Allen.

The Senior EPRR Lead is the lead for Business Continuity for NHS Shropshire, Telford and Wrekin ICB and is responsible for ensuring that a full review of this plan is undertaken on an annual basis, or sooner as required following activation of the plan or significant changes to the organisation's structure.

This will include ensuring that contact details are reviewed quarterly. However, all members of staff have a responsibility to inform the business continuity lead, via their manager if their contact details change.

2. Related documents

Other documents that may be useful to support this plan are detailed below. Copies of existing policies are held in the dedicated On-Call MS Teams Area.

National NHS EPRR documents can be found at: http://www.england.nhs.uk/ourwork/eprr

Document	Document Location
NHSSTW Incident Response Plan	On-Call Executive MS Teams Platform Intranet
Serious Untoward Incidents	On-Call Executive MS Teams Platform
On Call Policy	On-Call Executive MS Teams Platform Intranet

3. Table of Contents

4. Introduction

Business Continuity Management (BCM) is a legal requirement. BCM forms part of the Care Quality Commission's essential Standards of Quality and Safety, which all health providers must comply with as a condition of registration. It is also a requirement under the Civil Contingencies Act 2004 (CCA) and NHS England's Core Standards for Emergency Preparedness, Resilience and Response (EPRR). Business Continuity Management (BCM) is an integral part of EPRR.

Business Continuity planning forms an important element of good business management and service provision. All business activity is subject to disruptions such as technology failure, flooding, utility disruption and terrorism. Business Continuity Management (BCM) provides the capability to adequately react to operational disruptions, while protecting welfare and safety.

BCM involves managing the recovery or continuation of business activities in the event of a business disruption, and management of the overall programme through training, exercises and review to ensure the business continuity plan stays current and up to date.

For the NHS, BCM is defined as the management process that enables an NHS organisation to:

- Identify those key services which, if interrupted for any reason, would have the greatest impact upon the community, the health economy and the organisation.
- Identify and reduce the risks and threats to the continuation of these key services.
- Develop plans which enable the organisation to recover and / or maintain core services in the shortest possible time.

This Business Continuity Management Plan (BCMP) describes how NHS Shropshire, Telford & Wrekin Integrated Care Board (NHSSTW) will discharge its functions in the event of an incident that causes serious interruption to business operations involving one or more sections/service areas. This is a corporate level BCMP which would be implemented when any incident cannot be contained and managed within a single section/directorate/service area. This plan is intrinsically linked to, and forms the core part of our Emergency Preparedness, Resilience and Response (EPRR) arrangements as a Category 1 Responder.

This Business Continuity Management Plan facilitates the rapid and efficient mobilisation of ICB services in the event of an incident disrupting normal service delivery.

This Plan is supported by a Business Continuity Management System and Directorate level Business Continuity Management Plans as associated documentation.

This plan requires ALL services in ALL divisions/areas to develop Business Continuity Management Plans (BCMPs) detailing how services perform their functions in the event of disruption by defining and prioritising its activities and services, detailing contingency arrangements during the disruption and, when the disruption has passed and how all services will be restored (recovered), this process is covered in the ICB's Business Continuity Management System (BCMS).

5. Duties for Business Continuity and Recovery

There are a number of key documents that outline and detail the need for NHS organisations to establish a Business Continuity Management System. This Plan should be read in conjunction with the following documents:

- Civil Contingencies Act 2004
- NHS England Emergency Preparedness, Resilience and Response Framework 2022
- NHS England Business Continuity Management Toolkit (2023)
- ISO 22301 Societal Security – Business Continuity Management System
- NHSE Emergency Preparedness Resilience and Response Framework (2022)
- Local Health Resilience Partnerships guidance
- NHS Operating Framework – Response to Pandemic Influenza
- STW Health Protection Strategy
- The Cold Weather Plan for England
- The Heatwave Plan for England
- Flooding Advice for the Public
- Requests for Military Aid to the Civil Authorities (MACA) from the NHS in England
- NHSSTW EPRR Policy
- NHSSTW Incident Response Plan
- NHSSTW EPRR Communications Plan

This document has been written to align to the NHS England Business Continuity Toolkit and ISO22301 requirements.

6. Purpose

This plan is to be used to assist in the continuity and recovery of NHS Shropshire, Telford & Wrekin ICB in the event of an unplanned disruption and serves as the overarching response framework for the ICB in relation to Business Continuity Incidents (BCI).

A disruption could be any event which threatens personnel, buildings or operational capacity and requires special measures to be taken to restore normal service. This could be a matter specifically relating to NHSSTW or as part of a wider incident that affects a broader range of system partners.

This plan details the roles and responsibilities required within the ICB to ensure an effective response to a Business Continuity Incident, whilst considering ongoing business as usual (BAU) activities.

This plan is designed to complement existing arrangements within Shropshire, Telford and Wrekin (STW) 'responder' agencies including the LRF as well as linking into the NHS England Regional Business Continuity Management Plan to ensure onward support for Level 3-4 Incidents.

This plan is for use by the Executive Team, Directorates and teams that comprise the ICB. The plan acts as a reference and signposting document to provide appropriate guidance in planning and response and recognises that the NHS follows the principles of subsidiarity in that an incident should be managed at the level closest to the people affected so far as is reasonably practicable.

This plan supports the incident management structure established within NHSSTW's Incident Response Plan. The response however will be scalable dependant on the severity of the Business Continuity Impact i.e. the incident may only affect the ICB leading to a response only being enacted by the ICB as an individual organisation.

This plan is supported by a wider range of EPRR plans for specific events, including the NHSSTW Incident Response Plan, the EPRR Policy and the EPRR Incident Communications Plan.

6.1. Aim & Objectives

6.1.1. Aim

To provide an ICB framework for response to a business continuity incident that has the potential to affect staff, services and/or estates, and to set out the roles, responsibilities and actions to be taken by NHSSTW to enable continuity and recovery of the key parts of the service following a significant disruption.

6.1.2. Objectives:

- Provide the response and recovery framework for business continuity incidents.
- Detail the internal Business Continuity Incident Response Team (BCIRT).
- Indicate the ICBs critical functions that must be maintained during response.
- Identify roles and responsibilities of individuals involved within the response.

7. Definitions

7.1. Business Continuity (BC)

Business Continuity (BC) means an event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, to below acceptable predefined levels. This would require special arrangements to be put in place until services can return to an acceptable level. Examples include surge in demand requiring temporary re-deployment of resources within the organisation, breakdown of utilities, significant equipment failure or hospital acquired infections. There may also be impacts from wider issues such as supply chain disruption or provider failure.

7.2. Business Continuity Management Plan (BCMP)

Business Continuity Management Plan (BCMP) is defined as the overarching plan in relation to business continuity containing command and control principles for BC Incidents to be utilised by command staff.

7.3. Business Impact Analysis (BIA)

Business Impact Analysis (BIA) is defined as the process used to identify critical areas/functions within the ICB, available in support of this document.

7.4. Maximum Tolerable Period of Disruption (MTPD)

Maximum Tolerable Period of Disruption (MTPD) is defined as the maximum amount of time that a service or function can be unavailable or undeliverable after an event that causes disruption.

7.5. Recovery Time Objective (RTO)

Recovery Time Objective (RTO) is defined as the targeted duration of time within which a function must be restored after a disruption to avoid unacceptable consequences associated with a break in provision.

7.6. Subsidiarity

Subsidiarity is defined as decisions relating to the management of an incident should be taken at the lowest appropriate level, with co-ordination and oversight at the highest necessary level. For the ICB, this means that while the ICB Incident Director retains overall responsibility for an incident, the Provider Strategic Commanders will continue command and control of their organisations at their local level.

7.7. Command

Command is defined as the exercise of vested authority that is associated with a role or rank within an organisation (the NHS), to give direction to achieve defined objectives.

7.8. Control

Control is defined as the application of authority, combined with the capability to manage resources, to achieve defined objectives.

7.9. Coordination

Coordination is defined as integration of multi-agency efforts/capabilities to achieve pre-defined objectives.

7.10. Emergency Preparedness

Emergency Preparedness is defined as the extent to which emergency planning enables the effective and efficient prevention, reduction, control, mitigation of, and response to emergencies.

7.11. Incident Coordination Centre (ICC)

The Incident Coordination Centre (ICC) is the designated point for command and control in regard to system response within STW. It is a resilient location with good communication links to assist and support the Incident Management Team (IMT) in coordinating an incident response. There are 5 key tasks that an ICC is expected to deliver and maintain these are:

1. Coordination – matching capabilities to demands.
2. Policy making – decisions pertaining to the response.
3. Operations – managing as required to directly meet the demands of the incident.
4. Information gathering – determining the nature and extent of the incident ensuring shared situational awareness.
5. Dispersing public information – informing the community, news media and partner organisations.

7.12. Business Interruption

An unwanted incident which threatens personnel, buildings, operational procedures, or the reputation of the organisation, which requires special measures to be taken to restore things back to normal.

8. About this Plan

Business Continuity is complementary to risk management frameworks which set out to understand the risks to operations or business, and the consequences of those risks. Reference should be made to the ICB's risk management strategy and risk registers which relate to strategic and operational risks and directorate risk assessments that may be considered in conjunction with this business continuity planning process.

Business Continuity is complementary to the Incident Response Plan that sets out how NHSSTW will mobilise and, where necessary, lead and co-ordinate the ICS local health NHS response in the event of a Provider/System/Community Business Continuity Incident, Critical Incident, or Major Incident.

Business Continuity is also complementary to Emergency Preparedness, Resilience and Response (EPRR). ICBs are defined as Category 1 Responders (organisations at the core of emergency response) under the Civil Contingencies Act 2004 (CCA). There are core duties set out by the Cabinet Office which all Category 1 Responders have to meet. Category 1 Responders are subject to the full set of civil protection duties and as such are required to:

- Assess the risk of emergencies occurring and use this to inform contingency planning.
- Put in place emergency plans.
- Put in place business continuity management arrangements.
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency.
- Share information with other local responders to enhance co-ordination.
- Co-operate with other local responders to enhance co-ordination and efficiency.

8.1. Responsibilities

Responsibilities for delivering a Business Continuity Incident response are set out in the ICB's Business Continuity Management System (BCMS) documentation.

8.2. Scope

The scope of this BCMP will centre on conformity with ISO22301, legislative requirements within the Civil Contingencies Act 2004 (CCA) and NHS England (NHSE) guidance, EPRR Framework, and NHS Core Standards for EPRR.

This plan applies to the functions provided by NHS Shropshire, Telford & Wrekin ICB at the following site but also acknowledges risks to infrastructure that may be relevant to home working:

Wellington Civic Offices
Larkin Way
Wellington
Shropshire
TF1 1LX

A Business Continuity disruption that impacts on multiple providers will need to be co-ordinated using the ICB's Incident Response Plan which can be found on the Intranet or in the On-Call Executive MS Teams platform.

If the NHSSTWs Wellington offices becomes unusable then a virtual option for conducting business will be utilised until such time that suitable premises are identified.

The details of the critical functions of NHS Shropshire, Telford & Wrekin ICB have been included in this Business Continuity Management Plan but are set out in detail in Directorate Business Continuity Management Plans.

9. Business Continuity Type and Impact Levels

Successful Business Continuity planning includes the ability to define the essential business services of the organisation and must be identified at all levels. These can be broken down into critical, vital, necessary and desired. Determining and categorising services in this way is the responsibility of heads of service within the organisation.

CRITICAL services must be provided immediately or the loss of life, infrastructure destruction, loss of confidence and significant loss of revenue will result. These services will require continuity within 24 hours of interruption.

VITAL services are those that must be provided within 72 hours or loss of life, infrastructure destruction, loss of confidence and significant loss of revenue or disproportionate recovery costs will result.

NECESSARY services must be resumed within two weeks or considerable loss, further destruction or disproportionate recovery costs could result.

DESIRED services could be delayed for two weeks or longer but are required in order to return to normal operating conditions and alleviate further disruption or disturbance to normal conditions.

Several eventualities can cause a Business Continuity Incident to take place, these broadly are broken down for the ICB into the below categories:

- loss of Premises
- loss of Process
- loss of People
- loss of IT/Data
- loss of Utilities
- to prepare for a potential incident i.e. planned Power Outage
- service interruption or deficiencies (including 3rd parties) impacting on the ICB
- activation of the process in support of a Major Incident response.

And as a result there is impact upon:

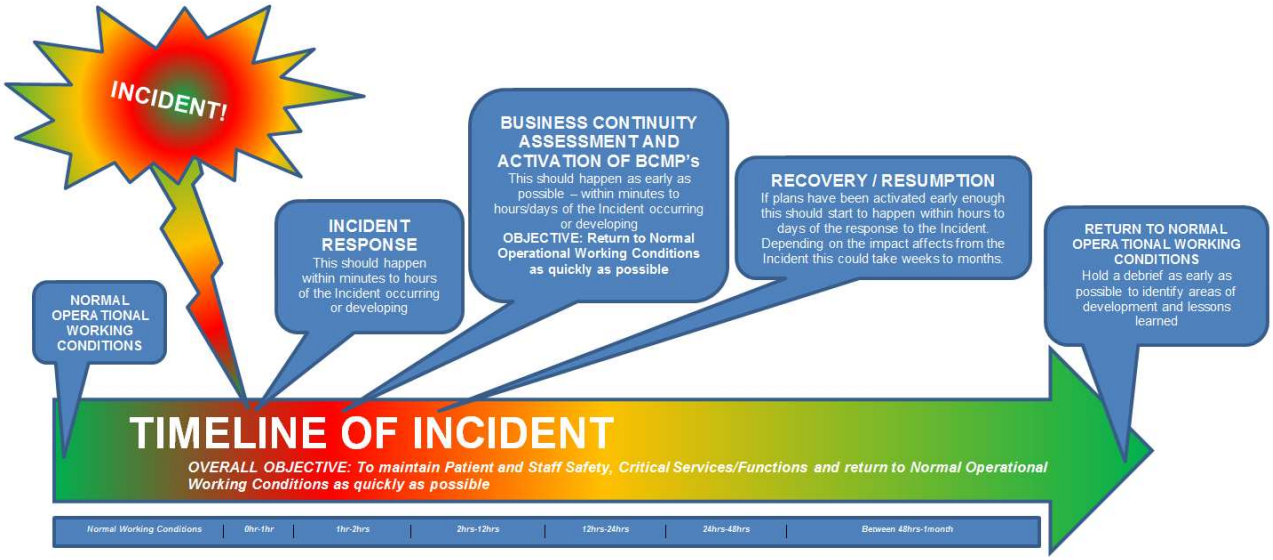
- Health and Safety
- Possibility of either adverse financial or reputational damage.
- A requirement to relocate to alternative working premises or service delivery resources.

Business Continuity Incidents vary in scale. These are indicated below alongside the level response required. These are specific to the ICB and are scalable to the response:

Category	Notional Scale of Impact	Definition	Level of Response
Category D	Business as Usual	• All ICB functions operating at normal levels including contribution to system functions. • No escalation required at Directorate level of key factors within Business Impact Assessment • Staffing levels within normal range (3% absence or less)	• None

		• All buildings fully operational	
Category C	Low-Medium Level Impacts	• ICB functions operating below normal levels. • 25% of key factors within Business Impact Assessments escalating • Staffing levels reducing (up to 25% absence) • Partial or temporary site closure	• BCIRT established
Category B	Medium-High Level Impacts	• ICB functions operating below normal levels to the extent that contribution to system functions are at risk. • 50% of key factors within Business Impact Assessments escalating • Staffing levels reducing (up to 50% absence) • Single site closure	• BCIRT established. • Local groups as necessary to ensure system aware of impacts. • Support from NHSE Regional
Level A	Catastrophic Impacts	• ICB unable to meet statutory functions. • 75% of key factors within Business Impact Assessments escalating • Staffing levels reducing (up to 75% absence) • All sites closed	

Below is an anticipated Incident timeline linked to business continuity incidents. This is scalable depending on the level of impact and the threat being faced:



10. Risk Assessment

The following table shows the key risks that have been identified to Business Continuity for the ICB, this references National and Community Risk Register processes:

Risk Scenario	Likelihood	Impact	Score
Pandemic	3	5	15
Industrial Action	5	4	20
Loss of Critical Supplier or Service	4	2	8
Malicious or Intentional Cyber Attacks	4	4	16

Period of Adverse Weather	4	3	12
Fuel Shortage (4-5 days)	3	3	9
Flooding	3	3	9
Loss of Utility – Electricity	3	4	12
Loss of Utility – Gas	4	2	8
Loss of Utility – Water and/or Sewerage	4	2	8
Loss of Workforce	3	3	9

10.1. ICB Critical Services Functions

The table below indicates the services and their functions that have been stratified in line with the key categories identified above. Commanders and staff can utilise this table as a quick directive tool in the event of an incident to ensure that incident response considers those activities that "must" be continued in the event of a Business Continuity Incident.

This process can also be used in a Major Incident or incidents requiring re-deployment of numbers of ICB staff to ensure an effective response to an ongoing threat or incident (as was seen during COVID-19). This will ensure that commanders can maintain ICB critical activities whilst ensuring a response to an ongoing incident.

Category	Activities/Services/Functions
Category D: Low Priority	•
Category C Low- Medium Priority	• SCC • Wellington Offices
Category B: High Priority or Medium Priority	• POD • RAS • TRAQS
Category A: Critical	• IT • Finance • SaTH Switchboard

11. Business Continuity Incident Response

11.1. Activating the BCP

11.1.1. Declaring a Business Continuity Incident

In the event of any threat or incident being identified with the potential to impact on the ICB Business Continuity processes it is key that appropriate activation is followed, the department is expected to notify the On-Call Executive and System Coordination Centre (SCC) and the Senior EPRR Lead of the incident and ensure the SBAR process is followed to indicate what is happening and how it is affecting the department or organisation.

The On-Call Executive (SCC in-hours) will then notify NHS England Regional First On-Call within 15 minutes of incident declaration of the incident affecting the ICB and ensure a completed SBAR is submitted within 1 hour of activation.

11.1.1.1. In hours

The department and SCC will ensure notification of the key staff below within the ICB of the incident to ensure the Business Continuity Incident Response Team (BCIRT) can be established rapidly.

- On-Call Executive
- Accountable Emergency Officer
- EPRR Team/Senior EPRR Lead
- ICB Communications and Engagement Lead
- Chief Executive Officer (or deputy)

11.1.1.2. Out of hours

The department will ensure notification to the ICB On-Call Executive of the incident to ensure the Business Continuity Incident Response Team (BCIRT) can be established rapidly.

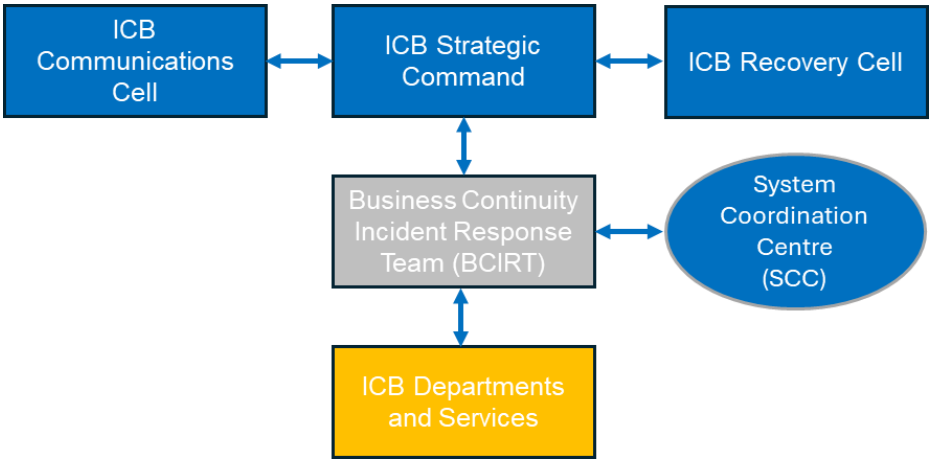
11.1.2. Decision Making

Utilising a Joint Decision Making Model (JDM) the On-Call Executive will determine the level of response required. If it is established that a Business Continuity Incident is occurring then a BCIRT will be mobilised.

All decisions will be made using the JDM and utilising processes indicated with the ICB's Incident Response Plan regarding effective decision making, record keeping etc.

11.1.3. Command and Control

Command and control principles will be the same as laid out in the ICB Incident Response Plan however the key difference is that due to the expected impacts being internal the Tactical level of response will be led by the BCIRT as indicated by the diagram below.



In the event of the activation of the BCMP, the Incident Co-ordination Centre (ICC) will be identified. As a default this would be located in meeting room 3, Wellington Civic Offices. If a virtual arrangement is to be used this will be determined at the time of activating the incident and the necessary arrangements for virtual access made.

11.1.3.1. Strategic Command

The Strategic Commander will be the On-Call Executive (supported by the AEO and Senior EPRR Lead in-hours). The incident response must remain scalable and following a Dynamic Risk Assessment; it could be determined that the incident is of a significant low level that the department can lead/coordinate themselves this will revert to the responsible Executive or Director leading the response from a strategic level. This process is indicated within the individual services Business Continuity Plans.

11.1.3.2. Business Continuity Incident Response Team (BCIRT)

Business Continuity Incident Response Team (BCIRT) will be led by the On-Call Executive (supported by the AEO and Senior EPRR Lead in-hours). The BCIRT will remain scalable and in the event of singular departments being affected the response can be led by the individual department as indicated within their own service level Business Continuity Management Plans. The Senior ICB Manager will be determined by the nature of the incident and the department affected in order that the person with the right departmental knowledge/ technical expertise assumes this role.

In addition, the BCIRT will comprise additional members of staff who bring the relevant knowledge and expertise to assist with the management of the particular incident. The Strategic Commander will determine who this should be.

Effective decision making will be enacted utilising processes within the Incident Response Plan, principles for data collection, information storage, logging must be followed as per the Incident Response Plan. There should be clear documentation of decisions and actions and the rationale for these.

11.1.4. Criteria for escalation

- Increase in geographic area or staff affected (Pandemic, flooding etc.).
- the need for additional internal/external resources.
- increased severity of the business interruption.
- increased demands from government departments, the service or commissioned service.
- Incident affecting system partners which required ICB input as a Category 1 Responder or which has the potential to impact on the ability of the ICB to deliver its services.

11.1.5. Shelter and Evacuation

Should the ICB office premises become unusable and staff require evacuation this will be carried out in accordance with the building's fire regulations. Staff will initially evacuate to designated assembly points. Should these assembly points be deemed unsafe staff will be directed to either work from home or to access alternative sites that have been agreed in individual departmental BCMP's. It is likely that this will only apply to a small number of office-based staff as the ICB utilises an agile working approach and most staff are home based. In addition, the ICB has options to utilise offices of partner ICS organisations and these options can be enacted if required.

As the ICB operates an in-hours only service it is unlikely that shelter will be required. Should this be the case the On-Call Executive will need to identify appropriate premises/locations if staff are unable to immediately make their way home.

11.2. Information Sharing

During a business continuity situation or an incident, the usual Information Governance protocols, as set out in the NHS STW Information Governance Policy should be adhered to. A copy of the policy can be found on the ICB Intranet.

The information held in relation to an ICB Business Continuity Incident is most likely to be staff information. However, the privacy of individuals should still be taken into account before sharing information, even in an emergency situation. During an emergency it is more likely than not that it will be in the interests of the individual data subjects for personal data to be

shared. When considering the issues and to help get to the right decision in an emergency it is acceptable for responders to have in mind the following set of questions:

- Is it unfair to the individual to disclose their information?
- What expectations would they have in the emergency at hand?
- Am I acting for their benefit and is it in the public interest to share this information?

Following these broad principles in an emergency will mean that the sharing of data is unlikely to be found unlawful.

11.2.1. Key Principles

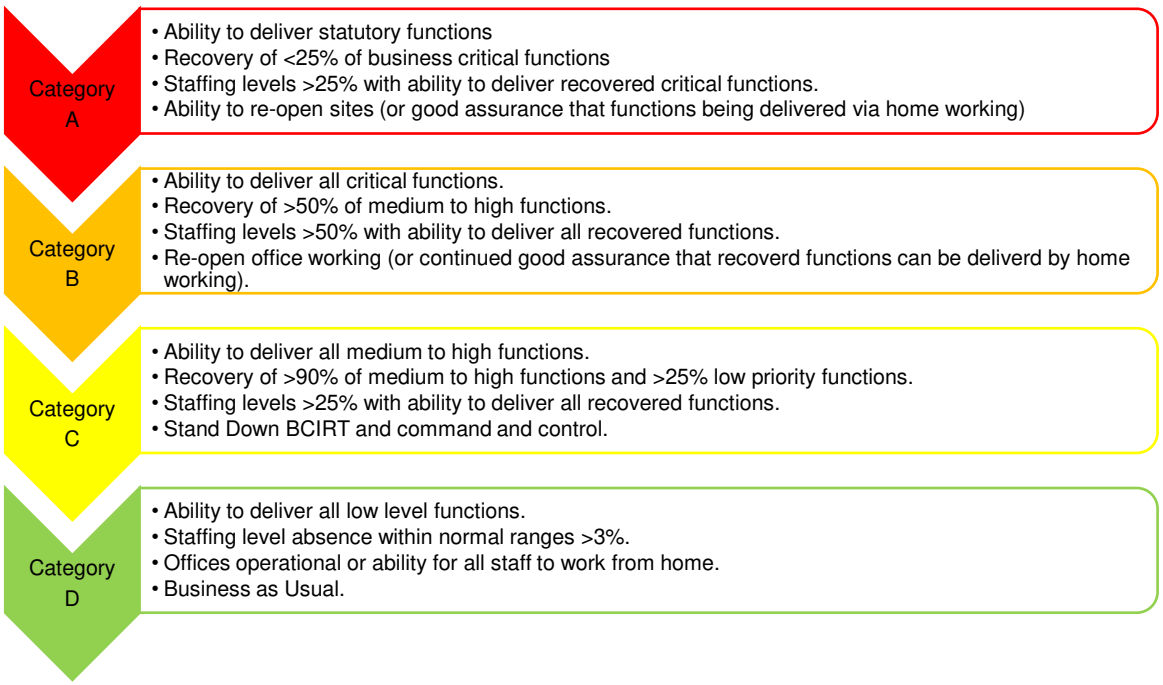
- Data protection legislation does not prohibit the collection and sharing of personal data – it provides a framework where personal data can be used with confidence that individuals' privacy rights are respected.
- Emergency responders' starting point should be to consider the risks and the potential harm that may arise if they do not share information.
- Emergency responders should balance the potential damage to the individual (and where appropriate the public interest of keeping the information confidential) against the public interest in sharing the information.
- In emergencies, the public interest consideration will generally be more significant than during day-to-day business.
- Always check whether the objective can still be achieved by passing less personal data.
- Category 1 and 2 Responders should be robust in asserting their power to share personal data lawfully in emergency planning, response and recovery situations.
- The consent of the data subject is not always a necessary pre-condition to lawful data sharing.
- You should seek advice where you are in doubt – though prepare on the basis that you will need to make a decision without formal advice during an emergency.

12. Stand Down

The member of ICB staff identified as leading the incident response will make the decision to stand down the incident in discussion with the AEO and Senior EPRR Lead. The ICB On-Call Executive (via the SCC in-hours) will be required to notify NHSE 1st On-Call of the stand down of the incident ensuring an SBAR is submitted as per the Incident Response Plan.

12.1. Stand down Triggers

The Level of response will have been determined during the response, to stand down the response the ICB must reach a defined level of business as usual, this will then allow the stand down of the BCIRT and internal command and control principles. Decisions regarding standing down and their rationale should be recorded. To meet de-escalation to the next level key metrics are indicated as a guide below:



13. Training, Exercising, Debrief and Continuous Improvement

13.1. Training

All NHS Shropshire, Telford & Wrekin ICB staff will have access to Business Continuity Information via the ICB Intranet/department SharePoint. New starters will be made aware of this plan and their potential role during a disruption as part of the ICB's new starter induction process (refer to NHS STW ICB Business Continuity Management System documentation).

Any staff with a specific role in the recovery from a disruption, or who may be asked to cover another suitable role, will be given appropriate training.

Line managers are responsible for ensuring all staff in their teams are aware of the ICB's Business Continuity Management Plan.

EPRR training will be provided to all relevant staff, but specifically On-Call staff as required.

13.2. Exercising

NHSSTW will test this Business Continuity Management Plan on a regular basis. This will be facilitated by the local EPRR team by means of a tabletop exercise and via larger scale exercises arranged by the system as a whole or our partners.

The call out / cascade arrangements, particularly the staff cascade, will be tested twice a year; with most staff now working remotely, out-of-work access/contact details are updated regularly.

13.3. Debrief and Continuous Improvement

The Business Continuity Incident Lead will be responsible for making arrangements for a debriefs. A Hot Debrief should take place within 48 hours of the incident being stood down and a Cold Debrief within 28 days of the incident being stood down. The Business Continuity Incident Lead will be responsible for ensuring that a Hot and Cold debrief report is completed. These reports, including areas for learning and improvement should be shared with the EPRR

Team who will be responsible for ensuring areas identified informs improved practice. The report will be considered at a meeting of the EPRR Programme Group and submitted to the Audit Committee and Board together with any recommendations and actions.

At the conclusion of the incident, Senior EPRR Lead will make arrangements for a cold debrief session and coordinate preparation of a report on the incident, to include issues identified by the debriefing process. Depending on the nature of the incident it may be appropriate to utilise an independent debriefer. If this is determined to be the case a request should be made via neighbouring ICB's and/or the West Mercia Local Resilience Forum (WMLRF) Secretariat at WMLRFSecretariat@westmercia.police.uk.

This Business Continuity Management Plan will be reviewed and updated at least annually (but also following an incident were learning has highlighted areas for improvement) to ensure it remains fit for purpose, accommodates learning and updates in policy and best practice.

Periodic independent assessment of the ICB's Business Continuity/EPRR processes (or specific elements of these processes) will be carried out by the ICB's Internal Auditors and reported to the Audit Committee and Board.

14. Specific Service Failures

14.1. Failure of IT Services

The ICB, like many organisations, rely upon IT systems for their day-to-day business. A disaster that prevents the organisation from accessing these systems whether caused by the failure of the systems themselves or being due to an incident such as fire or flooding will potentially have a serious impact on the continuation of the ICBs functions.

The impact of the loss of IT systems to each department should be covered in their individual departmental plans and it is expected that they can be adapted to cater for any specific incident. If there is a failure in the IT system or any stand-alone computer for important data for a prolonged period, staff will need to change to a paper back-up system where possible to capture the data so that this can be recorded on the system retrospectively.

The priority in which restoration is required will depend on the service area and is detailed in the ICB Business Impact Analysis. Lists of specific service areas and their priority/ impact and restoration times is included in the Directorate level Business Continuity Management Plans associated with this document. These can be found on the intranet and in the On-Call Executive MS Teams platform.

If there is a loss of hardware or software through theft or criminal damage, then advice should be sought from the IT provider and the incident reported (via the On-Call Executive) to the Police. All reasonable steps should be taken to preserve any evidence and maintain the forensic integrity of any identified crime scene.

The maintenance of the ICB IT systems is provided by the Midlands and Lancashire Commissioning Support Unit (MLCSU) under a Service Level Agreement (SLA). Under the terms of this SLA the MLCSU will invoke their Disaster Recovery Plan to cope with any event causing prolonged interruption of service. These plans will be subject to annual checks. In the event that there is an IT related incident an appropriate MLCSU representative will form part of the BCIRT.

14.2. Failure of Telecommunications

All On-Call staff have access to a mobile telephone alongside some staff having access the ICB's telecommunications system. The majority of ICB staff work from home or have the ability to do so. This will provide some resilience in terms of key staff needing to respond to potential incidents covered by this plan. In addition, paper copies of key incident response plans, other relevant documents and contact information is held in the ICC cupboard in Wellington office site. ICB staff also have the ability to work from a range of ICS partners' offices.

Each departmental plan identifies in more detail the actions required should the telephone systems be inactive. The priority in which restoration of phone lines are required will depend on the service area and if crucial will be detailed in individual departmental plans.

It is key to note that the ICB utilises Microsoft Teams for most of its communications and therefore reliance on phones is reducing across the ICB as the organisation moves to a remote working model. Loss of MS Teams will be managed via IT outage planning.

If electricity has failed, then consideration needs to be given to the ability to recharge mobile phone batteries.

Communications Functions	Primary Communications Systems	Secondary Communications Systems
Public Switched Telephone Network (PSTN).	• ICB mobile phones. • MS Teams.	• Analogue Lines.
Data Sharing Capability up to Official-Sensitive and Patient identifiable.	• NHS.net email to NHS.net email. • Fixed external VPN connection.	• Direct access to ICB systems/server via (and its fixed systems). • Hard copy/paper.
Internet Service.	• NHS-installed internet web browser.	• Smart phones issued to on-call staff.
Collaboration/file sharing server accessible from the internet.	• NHS-installed shared IT service areas.	• Web-based shared service-Hub. • Resilience Direct. • NHS Futures.
Monitoring of Public Service news broadcasts and social media.	• Internet-based services. • Digital Radio.	• Smart phones issued to On-Call. • Home access to TV systems.

14.3. Failure of Utilities (Electricity/Gas/Water)

The ICB uses various utility suppliers for its Wellington offices. In the event of any utility failure at the offices the local supplier should be contacted by the landlord to receive estimates of how long it will take the repair the fault. Director leads in conjunction with the Executive team will make a dynamic decision on whether to request all staff work from home and appropriate communication made.

In the event of a failure affecting an employee home and this is their location of work a decision will be made on the practicality of the employee working from an ICB premises or whether alternate arrangements are to be made i.e. utilisation of another NHS premises (if

agreements exist). As with all types of business continuity incident a dynamic risk assessment must be undertaken by the director lead on the impact to the business through loss of working time or work location and communicated to the executive team.

14.4. Loss of ICB Building(s)

If premises are unable to be used, then services may need to be suspended or relocated, the BCIRT will then work to identify alternate premises and ensure this is communicated to staff members.

Working from home is a tried and tested alternative and was used successfully during the COVID-19. Microsoft Teams ensures that effective communication can still be achieved to facilitate discussions / meetings both internally and externally.

Directorate level Business Continuity Management Plans identify specific impacts at Directorate Service level. For example, the loss of a building, the impact, mitigations and restoration times. These Directorate level plans can be found on the intranet and on the On-Call Executive MS Teams Platform.

14.5. Fuel Shortages

In the event of a fuel shortage the ability to maintain services may be affected. If it has been necessary for the invocation of the National Fuel Plan then it is likely that a Tactical Coordination Group (TCG) will be stood up via the LRF to oversee the management of the situation within the ICS. In this event the ICB would take the co-ordinating role for health agencies within the ICS. It is unlikely there will be provision of fuel for ICB staff to get to their work base and the responsibility for alternative travel arrangements is with the individual members of staff in discussion with their line manager.

14.6. Staff Shortages

The absence of staff will have a varying effect depending on their role. In some cases roles can be covered by other staff but others may be highly specialised and necessary arrangements will be detailed in departmental plans as to whether a service can continue particularly if the service depends on that person alone. Due to the low numbers of staff within the ICB and specialist roles, multiple resignations or sickness absence of key staff may affect business continuity.

Industrial Action can also impact on the ability to deliver services; however, notice is normally given by the trade unions of the action that is planned. It should be noted that action not connected with the NHS may also impact on the ability to deliver a service for example a postal dispute.

There may be a scenario when a number of staff are all incapacitated at the same time such as pandemic influenza or infectious disease. The departmental manager will be responsible for assessing the impact on the ability to continue to provide a service and what contingencies can be put in place, and whether some non-critical services can be cancelled as detailed in the individual departmental plans and Business Impact Assessments (BIA's). Mutual aid may be asked for and provided to other health partners and the wider Local Resilience Forum (LRF) if there is sufficient resilience.

Planning assumptions for Business Continuity purposes can be found in the Business Continuity Management System documentation.

14.7. Climate Change Adaption Planning

The STW ICS has an overarching Health Protection Strategy in place which sets out the systems actions/ response in relation to climate change and adverse weather. This strategy can be found on the ICB Intranet and in the On-Call Executive MS Teams platform.

The ICB has signed up to the Met Office and UK Health Security Agency (UKHSA) alerts system and as such is alerted when adverse weather is expected. These alerts are received into ICB's Single Point of Contact (SPOC) mailbox, the EPRR Team mailbox, and direct to the Senior EPRR Lead. Alerts will be routinely monitored for advance forecast of any potential adverse weather. Where there is a sudden weather event or where the forecast predicts an adverse weather event, the SPOC and/or Senior EPRR Lead will alert the appropriate staff within the ICB and the On-Call Executive and provider level SPOCs. The specifics of the alert or warning and the impact of the information, will guide any initial incident response.

The ICB will monitor any long-term climate guidance from NHS England or the UKHSA and update its plans as required. The ICB will also continue to engage with the adverse weather reporting provided to the quarterly Tactical Command Group meetings via the Met Office and to work with the WMLRF and LHRP to identify and manage adverse weather related risks.

14.7.1. Hot Weather

The UKHSA Adverse Weather Plan aims to prepare for, alert people to and prevent the major avoidable effects on health during periods of severe heat in England. The UKHSA Adverse Weather Plan was introduced in May 2023 and guidance and alerting systems are in place. The ICB is signed up to receive both UKHSA and Met office weather alerts. Weather-Health Alerts can be accessed via this link where you will find other related documents and guidance. Met Office weather warnings can be accessed via this link.

14.7.2. Cold Weather

Cold weather alerts will be issued by the Met office on the basis of the following weather events:

- Low temperature of 2◦c or less
- Heavy snow and ice

Heavy Snow – defined as snow falling at a rate of at least 2cm per hour or more, expected for at least 2 hours.

Widespread Ice – defined as when rain falls on to surfaces with temperatures at or below zero; or condensation occurs on surfaces at or below zero; or already wet surfaces fall to or below zero. Widespread indicates that icy surfaces will be found extensively over the area defined in the Met Office bulletin.

The UKHSA Adverse Weather Plan aims to prepare for, alert people to and prevent the major avoidable effects on health during periods of severe heat in England. The UKHSA Adverse Weather Plan was introduced in May 2023 and guidance and alerting systems are in place. The ICB is signed up to receive both UKHSA and Met office weather alerts. Weather-Health Alerts can be accessed via this link where you will find other related documents and guidance. Met Office weather warnings can be accessed via this link.

14.7.3. Travel Disruption from Adverse Weather

Previous adverse weather events have demonstrated that adverse weather can cause severe disruption to local transport networks and that the travel plans of staff can become compromised. In response to that event, there was a large demand for 4x4 vehicles, military assistance and emergency services support that impeded the service delivery of emergency services to deliver front line services.

Due regard must be given to offers from the general public - there may be staff (or patient) safeguarding issues utilising non vetted persons, or liability issues in the event of an accident. If using staff's own vehicles, it is important to ensure they have business use insurance, and are familiar with driving in adverse conditions.

There is no legal obligation for employers to transport staff to and from work, however it is an important consideration as a lack of available staff may have a severe impact on the ICB and partner agency's ability to deliver services.

The ICB will assess the situation in relation to its own business continuity plans and enact mitigations as per these plans. In addition, it will provide a co-ordination role across the STW ICS and LRF as required in line with the requirements set out in this plan.

The ICB On-Call Executive is likely to become aware of an adverse weather related incident via the LRF. The ICB On-Call Executive (and Senior EPRR Lead in-hours) will engage with any associated weather related TCGs/SCGs that may be called and will co-ordinate both health related information to feed into the TCG/SCG and co-ordinate the health response should it be required. As such the incident response arrangements set out in the EPRR Policy and IRP will be applied.

In the event of adverse weather the ICB via the Communications Team will issue advise to staff regarding working in extreme heat and cold and will ensure appropriate steps are taken to support staff. The ICB has access to pre-prepared messaging regarding working in adverse temperatures and these will be utilised and adapted in conjunction with advice from local Directors of Public Health as necessary.

15. Equality Statement

The ICB aims to design and implement policy documents that meet the diverse needs of our services, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account current UK legislative requirements, including the Equality Act 2010 and the Human Rights Act 1998, and promotes equal opportunities for all. This document has been designed to ensure that no one receives less favourable treatment due to their protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity. Appropriate consideration has also been given to gender identity, socio-economic status, immigration status and the principles of the Human Rights Act.

16. APPENDICES

Appendix 1 - Initial Response Checklist

Task	Completed by (date / time)
Start a log of actions and expenses incurred	
Identify which critical functions have been disrupted	
Consult with the On-Call Executive (or Senior EPRR Lead in-hours) about activating Business Continuity Management Plan.	
Seek authorisation decision from the On-Call Executive (or member of the Executive Management Team) to suspend non-critical functions.	
Convene Executive Management Team meeting. • Evaluate impact of situation • Decide on contingency actions to be taken. • Identify staff, resources, equipment required. • Assign responsibility and timescales	
Inform staff.	
Inform relevant stakeholders.	
Daily tasks during the recovery process	
Convene Executive Management Team as necessary to monitor progress made, obstacles encountered and decide on continuing recovery process.	
Provide updated information to staff and stakeholders.	
Maintain a log of actions and expenses.	

Integrated Care System
Shropshire, Telford and Wrekin

Appendix 2 - M/ETHANE Report

RESTRICTED ONCE COMPLETE

Time		Date	
Organisation			
Name of Caller		Tel No	

M	Major incident	Has a Major Incident been declared? YES / NO	
E	Exact Location	What is the exact location or geographical area of incident	
T	Type of Incident	What kind of incident is it?	
H	Hazards	What hazards or potential hazards can be identified?	
A	Access	What are the best routes for access and egress?	
N	Number of casualties	How many casualties are there and what condition are they in?	
E	Emergency Services	Which and how many emergency responder assets/ personnel are required or are already on-scene?	

Name:	
Role/Jobe Title:	
Signature:	

Appendix 3 - Actions and Expenses Log

Date / time	Decision / action taken	By whom	Cost incurred

Integrated Care System
Shropshire, Telford and Wrekin

Appendix 4 - Business Continuity Planning Team Agenda

MEETING OF BUSINESS CONTINUITY (PLANNING) TEAM
FIRST MEETING AGENDA

Date (dd/mm/yyyy):		Time (24hr):	
Place/Platform: (meeting room/MS Teams)		Chair:	
Attendees:			

No	Item	Action	Action By Who	Action By When
1	**Analysis of Impact** • Review Service Impact Analysis Sheets • Brief team on nature, severity and impact of disruption. • Identify information gaps. • Agree immediate action necessary. • Adjourn to take immediate action as needed. • Agree time to reconvene			
2	**Confirm Roles** • Agree roles and responsibilities of staff during the disruption. • If required revise roles and determine if additional staff/deputies are required. • Identify additional team members that may be required. • Stand down members not required			
3	**Confirm Key Contacts at Scene of Disruption** • Main points of contact for ongoing information updates			
4	**Logs** • Ensure personal logs in place. (Written record of significant events and all communications)			
5	**Recovery Management** • Review recovery priorities • Determination of support requirements.			
6	**Welfare Issues** • Have members of staff, visitors or third parties been affected? • What is their location? • What immediate support and assistance is required? • What ongoing support and assistance might be required?			
7	**Communications** • Who should we inform? • Are Communications managers required / present? • Professional Public Relations/Media advisors required? • Determine which, if any external regulatory bodies should be notified. • Determine any internal communications that need to take place (other sites, affected services etc.			
8	**Media Strategy** • Determine the media strategy to be implemented. • What is the story? What is the deadline?			
9	**Legal Perspective** • Determine what legal action or advice is required.			
10	**Insurance Position** • Determine whether insurance cover is available and if so, how best to use the support it may provide.			
11	**Next meeting** • Date, time, place and attendees of next meeting			

Appendix 5 - Debrief Template

Debrief Template Post Incident

Incident Details							
Declared				Stood Down			
Date: (dd/mm/yyyy)		Time: (24hr)		Date: (dd/mm/yyyy)		Time: (24hr)	
Outline of Incident:							

This debrief template provides the framework for undertaking a structured debrief and will assist in the development of the post incident Report which will cover:

- What was supposed to happen?
- What actually happened?
- Why were there differences?
- What lessons were identified?

Issues	Response
How prepared were we?	
What went well?	
What did not go well?	
What can we do better in the future?	
Is there a need to modify the plan / training?	
Other Issues	
Communications:	
Equipment:	
Human Resources:	
Planning and Briefing:	
Other issues:	

Completed by: (name and role)		Date: (dd/mm/yyyy)	

Appendix 6 - Business Continuity Action Plan

How to complete the action plan:

To ensure that the ICB has a workable Business Continuity Strategy, it is recommended that time is allotted to complete the sections and that there is an active dialogue with all staff to ensure feedback on the planning process.

Consider the list of possible disruptions to services and add others you may believe relevant; this process is completed by working through the business impact analysis tool and remembering to focus on the questions below:

1. How would that particular disruption impact on the individual service area?

2. Plot each disruption against the three 'Ss':
    a. **STAFF** (needed to provide critical activities)
    b. **SPACE** (workplace)
    c. **SUPPLIES** (consumables required to complete the critical activities, etc.)

3. Once plotted, actions to resolve issue:
    a. **STAFF** - Call in other staff, arrange cover etc. Consider such issues as contact lists for staff, the time to attend and method of travel to work.
    b. **SPACE** - What possible alternative locations would be available as space for essential staff to use on a temporary basis?
    c. **SUPPLIES** - IT, telephones, electricity, gas, water, road fuel, essential office supplies etc. How would the loss or shortage be resolved in the short term?

4. State what gaps or vulnerabilities are exposed by the process, how they can be addressed and any resourcing implications.

NHS
Shropshire, Telford and Wrekin

Appendix 7 - Key Business Continuity Risks and Mitigation Reference Cards

Type of Disruption/Event	1. Access denial to work area (any reason including fuel shortage) or utility failure (electricity, heating, water) or flooding.
IMPACT ON NHSSTW BY THE DISRUPTION/EVENT	NHSSTW would be unable to provide its critical functions as listed within this Business Continuity Management Plan and would also need to suspend non-critical functions until normal services could be resumed or alternative premises or access to premises was established.
RISK RATING OF THIS EVENT	MEDIUM/LOW
CONTINGENCIES AVAILABLE REGARDING THIS DISRUPTION/EVENT	NHSSTW staff are mainly based at home however, some staff work from the following location: Wellington Civic Offices Larkin Way Wellington Shropshire TF1 1LX **Critical Functions** NHSSTW staff that provide critical functions are able to work at the location listed above or remotely at home. Some staff may be able to work from other locations across Shropshire and Telford. With the approval of their line managers, office based staff may be able to work remotely from home **Non-Critical Functions** In short term incidents, if the interruption is due to utilities failure, lack of access to the building or damage to the building or work area and an alternative arrangement cannot be found, then staff covering non-critical functions may be given time off at the discretion of their line managers. However, staff covering non-critical roles could be asked to take annual leave or flexi time whilst they are unable to attend their designated place of work or an alternative site; if reasonable efforts have not been made to attend work; or if the interruption is caused by lack of access to fuel or severe weather. This will be aligned to the ICB's policy annual leave, flexible working and special leave policies subject to negotiation.
INITIAL ACTIONS DURING EVENT	If there is an issue with your place of work: • Verify the information and identify the anticipated timescale of the interruption. • Discuss and agree access to alternative locations to relocate staff on a temporary basis as above if required. • Notify the AEO or nominate deputy who will inform staff via the NHSSTW communication cascade by email and text message (for relevant staff) if incident occurs in hours or by text message only if out of hours. • Contact Midlands and Lancashire Commissioning Support Unit (MLCSU) to arrange IT/telecoms for the alternative sites for staff. If fuel shortage or severe weather (e.g. snow): • Confirm continuation of critical functions.

	• Implement flexible working arrangements for staff. • Communicate decisions to staff via appropriate medium.	
COMMUNICATIONS & MANAGEMENT CONTACTS **For Wellington Civic Offices:** Business Watch Out of Hours contact number: 01952 582092 **For NHS Property services contact:** In-Hours: 01785 221333 Out-of-Hours: 01785 257888	Cordon established:	Building has to be evacuated – notify staff of evacuation if in hours via email / text message to relevant staff group. If out of hours and cordon is to remain in hours, then notify staff by text message.
	Damage or flooding to buildings:	Notify relevant staff via cascade of closure of building and alternative site to be used via email / text message in hours and via text message only out of hours.
	Utilities failure:	Notify staff who work at the affected location of alternative working arrangements and timescale of interruption and when normal arrangements are proposed. Provide number for staff to call to provide an update on progress or advise staff to check on the ICB website for information.
	Severe Weather:	Activate cascade to all staff as above. Provide flexible working arrangements to all staff ensuring critical functions are maintained. This will be aligned to the ICB's policy annual leave, flexible working and special leave policies subject to negotiation
	Fuel Shortage:	Activate cascade to all staff as above. Provide flexible working arrangements to all staff ensuring critical functions are maintained.
ACTIONS IN RELATION TO STAFF	Activate staff communications cascade - via On-Call Executive/AEO *NOTE: Senior Managers are required to have access to this information for the staff in their respective sections.*	
ACTIONS IN RELATION TO SPACE	Limited accommodation for staff providing critical functions will be provided at Wellington Civic Offices or where office based arrangements will be made to facilitate home working. Hot desk facilities will be provided for staff but this may mean sharing facilities. Space will be identified in alternative sites to allow for meetings with visitors to proceed.	
ACTIONS IN RELATION TO SUPPLIES & SERVICES	Contact MLCSU regarding the access to IT/Telecoms at alternative sites and where remote working is established. Suppliers will be notified by staff responsible for ordering essential supplies of any alternative location arrangements for deliveries. If utility services fail within specific sites it will be the responsibility of NHS Property Services to liaise with the utility provider on progress and timescales for restoration of services.	
PLANNING VULNERABILITIES & GAPS	If the incident affects patient facing services as well as commissioning functions, priority will be given to services which provide these services in terms of alternative sites and support from MLCSU in relation to IT/Telecoms issues.	
PROPOSED REMEDIAL ACTIONS	None	
OTHER ACTIONS/COMMENTS	Ensure that the communications cascade is updated at least every six months and tested once completed to validate functionality. Ensure all NHSSTW staff are aware of this plan and what is expected of them during incidents.	

Type of Disruption/Event	2. Loss of established systems (IT, specialised software, email and telecommunications)	
IMPACT ON NHSSTW BY THE DISRUPTION/EVENT	NHSSTW would be unable to provide its critical functions as listed within this Business Continuity Management Plan and would also need to suspend non-critical functions until normal services could be resumed.	
RISK RATING OF THIS EVENT	MEDIUM/LOW	
CONTINGENCIES AVAILABLE REGARDING THIS DISRUPTION/EVENT	**Critical Functions** For critical functions and where loss of IT functionality is expected to be more than 24 hours and up to one week – alternative premises to relocate these staff in the short term are to be identified through partnership discussions with local STW ICS partners. Midlands and Lancashire Commissioning Support Unit (MLCSU) would need to arrange access to IT/Telecoms systems at these locations. With the approval of their line managers, office based staff are able to work remotely from home via if this functionality is available and not affected by the interruption. MLCSU would be mobilised to assess the issue and implement remedial action to both address the IT failure and implement interim solutions if required. **Non-Critical Functions** NHSSTW staff providing non-critical functions that rely on IT functionality and who are unable to be relocated and are not able to work remotely from home via VPN, then they may be given time off at the discretion of their line manager. All other staff that do not depend on IT functionality could operate manual paperwork systems until normal IT services are re-provided by the MLCSU.	
INITIAL ACTIONS DURING EVENT	If IT functionality is disrupted and critical functions are required: • Establish likely timescale of loss of functionality. • Discuss workstation availability at alternative sites for staff that provide critical functions. Alternatively agree staff working from home. • Contact Commissioning Support Unit to arrange software installation and remote connections where necessary. • Where possible notify staff in person if incident occurs in hours or by text message if incident occurs out of hours	
COMMUNICATIONS & MANAGEMENT CONTACTS	At sudden onset of IT failure which has been verified with MLCSU. Including likely timescale of interruption	Implement the communications cascade to staff at affected sites via text message (assuming no email available).

	At sudden onset of Telecoms failure which has been verified with MLCSU. Including the likely timescale of interruption	Implement the communications cascade to staff at affected sites via text message (assuming no email available). As and when the telecoms functionality at sites are affected this normally affects telecoms also as the system is Voice Over Internet Provider (VOIP). Use of media may be required to get message to staff and visitors and MLCSU will be required to support this.
ACTIONS IN RELATION TO STAFF	Activate staff communications cascade – via On-Call Executive/ AEO *NOTE: Senior Managers are required to have access to this information for the staff in their respective sections.*	
ACTIONS IN RELATION TO SPACE	Staff will obtain IT as detailed above. Visitors will be advised on change of any locations.	
ACTIONS IN RELATION TO SUPPLIES & SERVICES	Contact MLCSU and maintain contact with them regarding progress on re-establishment of service. MLCSU will contact all ICBs of IT/Telecoms issues which attract an Amber or Red rating via their IT Systems Incident Plan. Notify all relevant stakeholders of the interruption to Telecoms – via mobile phones.	
PLANNING VULNERABILITIES & GAPS	MLCSU may establish service to other services prior to NHSSTW and therefore the interruption may be extended due to prioritisation.	
OTHER ACTIONS/COMMENTS	Ensure that the communications cascade is updated at least every six months and tested once completed to validate functionality. Ensure all NHSSTW staff are aware of this plan and what is expected of them during incidents.	

Type of Disruption/Event	3. Restricted staffing levels for any reason (including Pandemic Influenza and travelling difficulties due to adverse weather).	
IMPACT ON NHSSTW BY THE DISRUPTION/EVENT	NHSSTW would be unable to provide its critical functions as listed within this Business Continuity Management Plan and would also need to suspend non-critical functions until normal services could be resumed or where sufficient staff are available to cover these functions. All ICB staff are encouraged to have the annual influenza and Covid19 vaccinations where eligible and appropriate.	
RISK RATING OF THIS EVENT	MEDIUM/HIGH	
CONTINGENCIES AVAILABLE REGARDING THIS DISRUPTION/EVENT	Using staff redeployment, all critical functions are required to be maintained in this situation. In the first instance, staff available who cover non-critical roles and with suitable skills within NHSSTW would be made available to cover the identified critical functions. If necessary, additional resources from other partners would be sought to support the critical functions. (Staffing MOU in place to support re-deployment) In adverse weather situations, flexible working arrangements will be implemented including working from alternative bases for up to one week or working from home remotely. This will be aligned to the ICB's policy annual leave, flexible working and special leave policies subject to negotiation	
COMMUNICATIONS & MANAGEMENT CONTACTS	Pandemic is announced and staffing numbers are affected. Daily reporting of staff situation indicates an impact on services provided.	Cascade to staff that BCP arrangements are being implemented, including suspension of non-critical functions where appropriate, redeployment of staff to cover the critical and essential workload and support of the pandemic flu response. Cascade information to staff via email contact lists and text message.
	Extreme weather warnings received.	Cascade to staff via email.
	Extreme weather happens/ schools/ nurseries close/ road networks affected/ public transport affected.	Cascade to staff via email and text message (text message only if incident commences out of hours). Implement flexible working arrangements for staff, working from alternative sites, working from home. Staff unable to access an alternative location to work or unable to access work remotely will be asked to take annual leave. This will be aligned to the ICB's policy for annual leave, flexible working and special leave policies subject to negotiation. Staff needing to look after very young children due to nursery closures will be required to take annual leave if alternative carer arrangements cannot be found. This will be aligned to the ICB's policy annual leave, flexible working and special leave policies subject to negotiation

ACTIONS IN RELATION TO STAFF	Activate staff communications cascade – via On-Call Executive/ AEO *NOTE: Senior Managers are required to have access to this information for the staff in their respective sections.*
ACTIONS IN RELATION TO SPACE	Under flexible working arrangements for severe weather situations, staff should already have notified their line manager of the nearest base they can attend or whether flexible working arrangements have been agreed.
ACTIONS IN RELATION TO SUPPLIES & SERVICES	The ICB's Medicines Management Team will be critical in maintaining appropriate access to antivirals during a pandemic.
PLANNING VULNERABILITIES & GAPS	If these situations arise during key staff holiday times, then the impact on staffing levels would be experienced earlier than in the times when staff would normally be at work (e.g. summer holiday periods, Easter and Christmas).
PROPOSED REMEDIAL ACTIONS	None
OTHER ACTIONS/COMMENTS	Ensure that the communications cascade is updated at least every six months and tested once completed to validate functionality. Ensure all NHSSTW staff are aware of this plan and what is expected of them during incidents.

END OF DOCUMENT

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Incident Communications Plan

July 2024

Document Reference Information

Version No.:	**Version 4**
Author(s) (name and post):	**Alison Smith** Chief Business Officer **Harriet Hopkins** Communications and Engagement Lead
Directorate responsible:	**Communications and Engagement**
Directorate lead:	**Chief Business Officer**
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Target audience:	All permanent and temporary employees of the NHS Shropshire, Telford and Wrekin (ICB), Board members, contractors and agency staff and health partners.

Version Control Record

Version	**Description of changes**	Reasons for Change	Author	Date
V1	**ICB process and change to Cat 1 provider**	ICB EPRR responsibilities	EB/HH	21 July 2022
V2	**NHS EPRR Framework and CCA 2024**	NHS EPRR Framework publication and ICB EPRR responsibilities	EB	Sept 2022
V3	**NHS EPRR Framework and CCA 2024**	NHS EPRR Framework publication and ICB EPRR responsibilities. Annual review of plan.	HH/EB	July 2023
V4	**NHS EPRR Framework and CCA 2024**	Annual assessment against the NHSE EPRR Core Standards outlined in NHSE EPRR Framework.	HH	July 2024

Table of Contents

This plan sets out the arrangements for both preparing in advance and managing communication systems during an emergency (major incident) situation, including pandemic influenza, to ensure that the right people receive the right information at the right time.

It forms part of the NHS Shropshire, Telford and Wrekin Integrated Care Board's (ICB) overall communications and engagement approach and supports the organisation's warning and informing responsibilities as a Category 1 responder.

1. Introduction

Effective communication is an essential element of a response to any emergency, critical or major incident or disruptive event.

The key communications objective must be to deliver accurate, clear, well informed and timely information so that the public are aware of what is going on, know what they need to do and that they feel confident and safe. It is also important that communications planning and activity during an incident/event aligns to organisational/system-wide Emergency Preparedness, Resilience and Response (EPRR) planning.

Communicating with patients, members of the public and partner agencies is also a requirement outlined in the Civil Contingencies Act (2004) which places a duty on Category 1 responders to warn and inform members of staff and the public.

This plan details the communications response for NHS Shropshire, Telford and Wrekin (NHS STW) before, during and after an emergency, critical or major incident or disruptive event has happened. Please also refer to the ICB Business Continuity Plan, EPRR Policy and Incident Response Plan (IRP) for further guidance.

Communications during a regional or national emergency/major incident will follow the regional or national communications protocols. NHS STW will undertake health system lead role for communications.

NHS England EPRR Framework core principles of communication

Communication specialists in the ICB ensure they can deliver the six core principles as documented in the NHS England EPRR Framework (July 2022):

1. Joined up communication. Manage and coordinate communication and media response across responding NHS bodies and aligned to the multi-agency response via NHS England regional and National teams.
2. Accurate and timely statements to staff and media. NHS England should provide regular statements where appropriate to the both the public and staff. These should include situation updates and reliable useable information about accessing services, facilities and other aspects of the incident response.
3. Sharing key information to warn and inform the public. The NHS has a duty to

review timely information, warning and inform the public, in coordination with partner organisations, if an emergency has occurred or is likely to occur.

4. Ensure websites and other digital channels are kept up to date. The public, media and will use digital media to find out about an incident and the response to it. Websites and other NHS digital media must be regularly updated to give clear, accurate, consistent and reliable information about the situation. This should include ensuring that any press statements are put on the relevant organisation websites and disseminated more widely using social media sites such as X and Facebook.
5. Support designated spokespeople. The modern media landscape means there is around the clock demand for information during an incident. Responder organisations will need trained and informed spokespeople to take part as required.
6. Support any regional led communication response and coordination to incident management and nationally led communications strategy in response to a level 4 incident, or similar declare will be advised by national NHS England Communications.
7. To work with West Mercia Local Resilience Forum (WMLRF) Communications response teams at Tactical Coordinating Group (TCG) and Strategic Coordinating Group (SCG) level as required.

2. Aim

The aim of this plan is to outline the ICB procedures for providing a coordinated and controlled response to the media following the declaration of a business continuity, critical or major incident. This plan aligns with the NHS England EPRR Framework (July 2022) and aims to maintain public and staff ***confidence*** by establishing an effective communication ***capability*** with our staff, the public, and other stakeholders in the event of a significant disruptive event or major incident requiring a response from NHS STW.

3. Objectives

- To communicate with patients, members of the public, staff, partner agencies, other organisations and the media before, during and after an emergency / major incident, ensuring joined up communication aligned to multi agency response.
- To communicate accurately, clearly, and timely so all stakeholders, staff and patients feel safe and well informed.
- To identify key roles and responsibilities.
- Ensure response and communication plans are joined and coordinated by the ICB as lead for health system.
- To ensure an effective, coordinated approach to communications before, during and after incidents or emergency situations
- To ensure agreement is reached between partner organisations prior to the publication of any information to the media.
- To ensure a robust process of sign off by Incident Leads, as well as NHS England where appropriate.

- To ensure all partner organisations take responsibility to communicate promptly with their internal stakeholders involved in the incident.
- To identify clear channels of communication between partner organisations who are involved in the incident.

To test activation of communication cascade messages to staff, both in and out of hours in accordance with **NHS STW ICB EPRR Policy**.

4. Defining a major incident

An emergency/major incident is an event or situation that requires the implementation of special arrangements by one, or all the Category 1 responders for:

- the initial treatment, rescue, and transport of many casualties
- the involvement either directly or indirectly of large numbers of people
- the handling of many enquiries, likely to be generated both from the public and the news media, usually to the police
- the need for the large-scale combined resources of two or more of the emergency services
- the mobilisation and organisation of the emergency services and supporting organisations, e.g., local authority, to cater for the threat of death, serious injury or homelessness to many people.

For the NHS, a major incident is any occurrence which presents a serious threat to the health of the community, disruption to the service, or causes (or is likely to cause) such numbers or types of casualties as to require special arrangements to be implemented by hospitals, ambulance services or health authorities.

If it is considered that any one of the criteria outlined in the major incident definition given above has been satisfied, then a major incident may be declared by:

- an officer from one of the emergency services
- a Local Authority Chief Executive Officer, or their nominated deputy
- a Health Service Chief Executive Officer, or their nominated deputy.

Not all incidents will be regarded as a major incident to all organisations. Indeed, only one organisation may declare it as such without the others doing so. Equally, there may be occasions where this plan is activated without an emergency being declared as a 'major incident' as the plan is scalable and adaptable for business continuity and critical incidents.

5. Stakeholders

NHS STW has many stakeholders that it will need to communicate with if a major incident occurs. These are identified as:

- Staff, including those from shared services and partnership working
- Patients, families, and carers, at the scene of an incident, in the community and at specific settings such as an acute trust
- Members of the public, even if they are not in direct receipt of services at the time
- Associated organisations / services such as:
    - Provider Trusts
    - Local Authorities
    - Voluntary Sector Community
    - Public Health teams
    - Social Care Services
    - Shropshire Fire and Rescue Service
    - West Mercia Police
    - West Midlands Ambulance Service University NHS Foundation Trust
    - NHS England
    - UK Health Security Agency
    - Local Healthwatch organisations.

- Associated groups / boards such as:
    - MPs / local Councillors
    - Service user support groups
    - Carer support groups
    - Advocacy groups
    - Health Overview and Scrutiny Committee
    - Health and Wellbeing Board

6. Activation

The term ‘emergency/major incident’ must not be used until it is designated as such.

When an emergency/major incident is declared, the initial stages are often chaotic, and depending upon the location and the time of day, it is likely that the media will hear of the incident at the same time as those agencies responding to it.

The overarching decision to activate this plan will be taken by either the Chief Executive Officer, The Accountable Emergency Officer, the Director on call, or the Chief Business Officer.

The Communications Team will collaborate closely with the WMLRF Communications Cell, ICB EPRR Lead, relevant Executive, or the Chief Executive Officer.

The ICB communications lead will ensure that all key stakeholders are identified and will coordinate with the appropriate NHS organisation to manage and lead the health response for the system working. This may involve establishing a health communications cell. The ICB will work in partnership with stakeholders, the Local Resilience Forum (LRF), and NHS England, ensuring alignment with the LRF and recognizing that the ICB may not always be the most appropriate NHS organisation to lead health communications in every situation.

When appropriate an initial holding statement will be issued as soon as possible following the incident being declared. If a stand-up phase is implemented the Communications Team will be activated by the Incident Director as documented in the Incident Response Plan.

The exact content of the holding statement will be determined by the nature of the emergency / major incident but will include, as far as possible, the following:

1. What has happened?
2. What type and level of incident has been declared?
3. What is the exact location of the incident?
4. What time did this occur?
5. What level of emergency response has been initiated?
6. What are the immediate hazards present or suspected?
7. What are the number, type and severity of casualties?
8. What access is there to the location?
9. What are the urgent warning or advice messages needed?
10. Who do these messages need to reach and where?
11. Has any information already be published by an agency and if so, what?
12. Where is the SCG & TCG sitting and command for the incident response location?
13. Who are the key appointed leads as named individuals?
14. Where should public enquiries be directed in relation to this incident?
15. Where should initial media enquiries for this incident be directed?
16. Where is going to be the location of an initial and appropriate media rendezvous point?
17. Who is going to be the lead spokesperson for the response to this incident?

On-call officers from each organisation are responsible for contacting their senior communications lead in line with their own internal procedures.

Triggers for the WMLRF Communications Cell include:
Any one of the following will trigger the WMLRF Communication Cell to stand up;

- Declaration of a Major Incident and/or
- Stand up at request of a Tactical Coordinating Group (TCG) or Strategic Coordinating Group (SCG)
- A national or local release of an Emergency Alert

When a trigger is met the below actions should be taken by the initial communications lead for the immediate responding agency at the earliest opportunity

1. Use WMLRF Lead Responder Protocol to identify Lead Agency for incident to Chair Communications Cell.
2. Alert communications representatives from agencies. Outline initial details of the incident raising awareness of the situation / initial detail known. This can be done via email or using the WMLRF General Activation procedure. Further details and standard messaging can be found in the WMLRF Warning & Informing Framework

3. Set up virtual MS Teams meeting invite to multi-agency comms leads (if required)
4. Use Agenda template and Resilience Direct actions as outlined in WMLRF Multi-Agency Operational Cells Guidance (Appendix C for template agenda)

Out of hours (evenings, weekends, and Bank Holidays).
In the event of an incident occurring out of hours that may require the implementation of the EPRR plan, the out-of-hours team will contact the NHS STW Director on call in the first instance who will contact the on call Tactical Commanders or on call Strategic Incident Commander to support and establish a systematic process for tracking information flows which will inform the Media Briefing Centre (see below) and any additional cells alongside NHSE either regionally or nationally in consultation as required.

7. Plan maintenance and review

The NHS STW Communications Team will take responsibility for reviewing this plan and ensuring it is kept up to date with the correct information.

The plan will be reviewed half yearly, or earlier if a change in circumstances or procedures takes place.

Review dates, along with the dates of revisions are listed on the front page.

This plan should be read in conjunction with the NHS STW EPPR Policy, EPRR Incident Response Plan, NHS STW Business Continuity Plan.

8. Roles and responsibilities

This section sets out the roles and responsibilities once the plan has been activated.

8.1 Strategic Incident Lead

Role:

The NHS STW Accountable Emergency Officer or EPRR Lead (or director on-call) will be responsible for the NHS STW response to any business continuity, critical or major incident and will direct the overall strategy.

Responsibilities:

- Activate NHS STW's incident response
- Maintain an overview of the incident to determine the strategic response and allocate responsibilities to services via the Incident Control Centre
- Strategic liaison with NHS England, where required, and with partner agencies
- Work with the Communications and Engagement Lead to set and agree the communication strategy

- Perform the role of media spokesperson with support from the Communications and Engagement Lead
- Horizon scan and identify the likely service disruptions
- Risk assesses decisions and response strategies and identify alternative options
- Identify staff to participate in the recovery working group where requested.
- Report to NHS England, according to incident level as required, on the conduct, planning and resolution of the major incident
- Assess requests for financial assistance from commissioned providers where expenditure is above contract
- Ensure a facility to track expenditure is established
- Log all actions and decisions for inclusion in the final incident report.

8.2 Chief Business Officer / Communications and Engagement Lead

Role:

To liaise with incident room and ensure that their communications needs are effectively addressed.

Responsibilities:

- To provide a communications professional (Band 8A or above) for the Incident Control Centre. While this role will usually fall to the Communications and Engagement Lead, it is important to consider the feasibility of this, especially if the incident occurs out of hours or requires 24-hour coverage. In such cases, an appropriate resource would be identified to ensure continuous support. To develop and implement the communications strategy
- To ensure close liaison/coordination/briefing with communications professionals from NHS England and other partner agencies
- To link with communication cells which may be stood up as part of the Local Resilience Forum/ Strategic Coordinating Group (LRF/SCG) or Tactical Coordinating Group (TCG)
- To support the establishment of a media briefing centre (virtual if possible) if requested by the Local Resilience Forum (LRF).To assist the Media Briefing Officer in issuing media briefings, coordinating closely with health partners as the ICB system health lead, if tasked by the LRF. To develop key media lines and stakeholder communications, ensuring all are signed off by the strategic incident lead before release, and by NHS England if appropriate, but only under the direction of the LRF. To advise the incident management team on communications related matters
- To establish a regular briefing schedule for the executive leadership team at NHS STW and lead those briefings – to be delivered virtually via Microsoft Teams. The schedule for these incidents will vary depending on the incident.
- To prepare, support and brief the media spokesperson.

8.3 Communications Officer

Role:
To undertake call handling, media, and social media monitoring working closely with the wider communications team.

Responsibilities:

- Take and log all media enquiries regarding the incident
- Provide regular media and social media monitoring reports.
- To feed into the tactical coordination process by alerting the Communications and Engagement Lead and/or Critical Information Officer to significant emerging issues or risks as they happen.
- Update all digital channels (corporate website and social media) to warn, inform and reassure staff, the public and other stakeholders.

9. Media Strategy

There will inevitably be newspaper, radio and/or television interest in an emergency where there are casualties, or which could be described as a human-interest story. Additionally, you need to consider the impact that local blogs, resident journalists, and social media will have on the flow of information. It is crucial to address the information and misinformation that will inevitably circulate, particularly on platform X, as well as on social media in general. To ensure factual messages are disseminated through the media (and social media), the Communications Team will follow an approval process, all communications will be signed off by incident leads, as well as NHSE (if appropriate). This means that all messages relating to the incident should be approved by the NHS STW Director with overall responsibility for the response, and by the Chief Business Officer. However, given the potential complexity of the process, especially with the need to coordinate with LRF partners, it's essential to ensure that this approval process is streamlined and responsive to allow for timely communication.

The Communications and Engagement Lead will identify media spokespeople within the organisations involved in the major incident to coordinate the identification of appropriate media spokespeople. While director-level professionals may be considered, frontline staff might be more suitable depending on the nature of the incident. It is recommended that key spokespeople receive media training to support their ability to respond effectively, although availability and suitability may vary, and flexibility in choosing spokespeople is important. Key individuals include:

- Chief Medical Officer,
- Deputy Chief Medical Officer
- Chief Nursing Officer
- Deputy Chief Nursing Officer
- Chief Executive Officer
- EPRR Lead

- All On-Call Director level staff

Depending upon the location and the size of the incident, the Communications Team may set up a Media Briefing Centre, work with the Incident Command Centre (ICC) or establish regular live media briefings.

The Communications Team will ensure the timely and effective dissemination of key messages to the media and all organisations involved.

Assistance in staffing the central press office may be required depending upon the level of incident. This support may need to come from other organisations involved.

Consideration will need to be given to ensure there are sufficient resources to cater for the following:

- Incoming media enquiries
- Dissemination of media statements
- Regular contact with control centres of the emergency services, local authorities, and other organisations involved.

9.1 Media Briefing Centre

A Media Briefing Centre should be established to manage the communications response to a major incident. The location of this ideally should be close to the incident site but not where it will hinder rescue or jeopardise safety.

In the event of the need for a media briefing centre, the key criteria will include:

- Space to accommodate journalists
- Easy access to key road networks
- Suitable parking facilities
- Good power and wifi connections
- Access to toilets

It is unlikely that NHS STW would have any incident which did not involve other agencies, so consideration should be given to whether any briefing centre should be shared.

The COVID-19 pandemic has taught us that media briefing is possible remotely and consideration should be given to whether a regular media live Microsoft Teams session would be the best approach.

The media briefing centre will be managed by the Communications and Engagement Lead will take the main burden of dealing with the media. The centre will provide a regular flow of information to alleviate media speculation.

Once the centre has been established, the Communications and Engagement Lead will ensure notification is given to the media officers of other organisations involved. Other media officers may be asked to attend the centre.

The media briefing centre will require the following areas:

- An area for media representatives to prepare their reports and receive information from media briefing centre staff
- Briefing area for formal press updates and / or conferences
- Room for internal staff

9.2 Liaison with Central Government

A major incident will result in requests for ministerial briefing and statements. The Communications Team will be responsible for handling any ministerial briefings through the usual channels with NHS England.

9.3 Media debriefing

It will be important to review what went well and what could have been handled differently in terms of managing media interest in the major incident.

To do this, all communications representatives involved in the incident will meet after the incident has been stood down (within 4 weeks) to discuss how the media was managed and to identify any lessons to be learned.

All incidents will involve a range of debriefs including the potential of a Hot Debrief very soon after the incident or in between phases of a live incident, a whole incident debrief within 4 weeks after the incident and a multi-agency debrief up to 6 weeks after the incident. Where appropriate communications representatives will participate in this process.

10.0 Information management

10.1 Communicating with staff and stakeholders

It is important that staff and stakeholders are updated as soon as possible, using the most appropriate method, including out of hours communications. More than one method may be used, but it is important that the message remains consistent. The communication methods include:

- E-bulletin to NHS STW employees
- E-bulletin to Primary Care
- Limited email to a number of staff e.g. NHS STW Board Members and Executive Team using a distribution list
- Face-to-face or virtual live briefing from a member of the Executive Team
- Email to STW ICS leaders
- Email to neighbouring NHS/LA organisations via system communications colleagues
- Make use of existing WhatsApp groups – including:
    - NHS STW comms team group

    - NHS STW directors group
    - NHS ICS comms group
- Establish an incident-specific WhatsApp Group to include all key personnel involved in the Communications response – Communication and Engagement Lead for NHS STW will be responsible for establishing this group.

The ICB holds an electronic 'In Case of Emergency' (ICE) pack with links to the following:

- Key communications contacts – NHSE comms contacts/ Directors / System Comms colleagues / LRF contacts
- Key login details to NHS STW comms channels
- Local, regional and national press contacts
- A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc)
- A developed list of key local stakeholders who are key to service delivery (such as local elected officials, LRF contacts, neighbouring NHS organisations etc)
- Key ICS spokespeople

The ICB Communications Team also holds a detailed database with key local stakeholders for Shropshire, Telford and Wrekin including local elected officials, media, communications leads, CEOs and execs etc. Depending upon the nature of the major incident, some methods of communication will be preferable than others.

To avoid the risk of misinforming staff with incorrect information, all communication to staff must be approved by the Incident Director or Chief Business Officer or the on call out of hours duty Strategic Incident or /Tactical Commanders.

In line with our workforce guide to using social media, we will re-emphasise the rules of engagement to all NHS STW staff, in particular highlighting guidance to senior staff on effective usage whilst the organisation is in incident response. All staff are required to adhere to the ICB Social Media Policy (see Appendix 1) at all times, even during an incident.

Social media monitoring will be enhanced as part our communications handling to identify and track information relating to incidents.

10.2 Communicating with the media

The Communications Team holds a list of local and regional contacts for issuing information and press releases as appropriate.

Any media statements will be sent out by the Communications and Engagement Lead responsible for media once they have been approved. If appropriate, they will also be added to the NHS STW website and shared via social media.

After the initial holding statement has been issued confirming the major incident, there will be numerous press enquiries asking for further information such as number of casualties.

The following information should only be released to the media after full consultation between all organisations involved in the major incident; numbers of casualties and deceased should only be released once approved by NHSE to ensure the Department of Health and Social Care (DHSC) is briefed before the media:

- Casualties – number and types of injuries, with confirmation primarily from the ambulance service for those at the scene, and coordinated overall numbers from hospitals, including specialized units such as burns or major trauma centres.
- Deceased – numbers should only be confirmed by the police, and causes of death should be withheld unless cleared by the appropriate authorities. Incident cause
- Persons involved – may have criminal / security implications
- Specific advice to public
- Specialist assistance / personnel
- Security issues.

The media will welcome any factual statements, particularly from eye-witnesses – it is essential that all staff from all organisations involved are aware of their individual media protocols when dealing with journalists.

There will be great pressure from journalists to obtain interviews with staff involved with the incident and perhaps survivors/relatives. All interviews should be managed through the media briefing centre and interviewees should be supported and advised on how to prepare a statement.

It is important to develop good relationships with media personnel and set out how they will be updated from the outset of any major incident.

All media enquiries will be recorded by the media briefing centre.

All statements released must be recorded with date/time/issued to, so the Communications Team can monitor what has been issued. A specific issues log will be set up to keep this record, following the template of the generic Issues log already kept by the NHS STW Communications Team. Additionally, all team members should maintain their own personal logs, detailing their actions, timing, and rationale, to ensure comprehensive documentation throughout the incident.

10.3 Websites

The NHS STW Communications Team will post any information on the NHS STW website, providing regular updates about the major incident. Any press releases and additional information given to the media will also be updated on the website.

Any press releases and information updates will need to be shared with partner organisations. Where appropriate partners will be encouraged to reshare social media and uploaded press releases and/or information to their websites to maximise the flow of information being provided to the public. The ICB Communications Team will share updates

with staff and post any information to the Staff Hub providing regular updates on major incidents

10.4 Social media

The NHS STW Communications Team will post any information onto the NHS STW social media accounts providing regular updates about the major incident (to warn and inform). Any press releases and additional information given to the media will also be updated on to these channels.

10.5 Communicating with wider partners

The NHS STW Communications Team will produce toolkits of information for partners across the STW Integrated Care System, depending on the nature and duration of the incident. These toolkits will be especially important for amplifying messages in an incident requiring a longer-term public response. They will be used to communicate with patients who have appointments booked, inpatients, their families, and carers, and may also include toolkits for GP member practices. The production of these toolkits will be adjusted based on time pressures and the specific needs of the situation.

10.6 Local Resilience Forum (LRF)

NHS STW Communications Team will produce toolkits of information including example messages for switchboard and telephony systems for partners across the STW Integrated Care System to update as necessary.

11. Other resources

- NHS STW Incident Response Plan
- NHS STW Business Continuity Plan
- NHS STW EPRR Policy
- NHS STW On Call Policy
- NHS STW Risk Management Policy
- NHS England EPRR Framework 2022
- West Mercia Local Resilience Forum

12.0 Appendices

- Appendix 1 – Incident communication roles and responsibilities
- Appendix 2 – Social media policy
- Appendix 3 – Media training record
- Appendix 4 - Attendance at WMLRF communication forums

Appendix 1 – Incident communication roles and responsibilities

ACTION CARD 1	CHIEF BUSINESS OFFICER / COMMUNICATIONS & ENGAGEMENT LEAD	
Accountable to	**Incident Director**	
Responsible for: Providing communication co-ordination, advice and support to the Incident Director		
Number	**Action**	**Time Completed**
1.	Set up communications log and media monitoring service	
2.	Attend the initial Incident Management Team (IMT) meeting and commence personal log. Assign a communications professional for the Incident Control Centre.	
3.	Contact the provider (Incident Levels 1 & 2) communications lead and agree, with NHS STW Incident Director, who will be leading on media communications on the incident. For incident levels 3 & 4 liaise with NHS England Communications Team	
4.	Invoke **NHS STW Emergency Communications Plan** and, with Incident Director approval, issue a holding statement or pre-arranged public health/safety messages in conjunction with Health Security Agency, if appropriate, as above, ensuring all are sign off with the Strategic Incident Lead before release, as well as NHS England and Improvement if appropriate.	
5.	Organise regular briefings for the NHS STW leadership team – agreeing the schedule with the Incident Director.	
6.	If leading on the incident media communications assume responsibility for managing all public information and media communications. If provider or NHS England is agreed as communications lead then liaise and respond according, continually updating IMT. *If a Strategic Co-ordinating Group (SCG) is established, and it is likely that a media cell will be established to lead on media and communication, then act as the conduit for IMT and SCG	
7.	If leading, rapidly formulate and implement an integrated media handling strategy on behalf of the local NHS response and agree approach with IMT.	
8.	Deal with all media enquiries/draft statements/organise press conferences and interviews as agreed, with Incident Director, in media handling strategy. Identify and brief any “talking heads” and advise media (and stakeholders) on the regularity and timing of future media updates	

9.	Identify communications officer/ cell (based on incident requirements) to log media calls, monitor media and social media, update IMT, develop rolling question and answer brief, develop comms for staff and undertake on-going liaison with responding NHS comms leads and partners.	
10.	On stand down, ensure that all original documentation (including notes, flip charts, e-mails etc.) are kept. Close personal log.	
11.	Attend debriefs and share learning	
12.	Manage any on-going media interest in the NHS response, including social media.	

ACTION CARD 2	**Incident Media Briefing Officer**	
Accountable to	**CHIEF BUSINESS OFFICER**	
Responsible for: Representing NHS STW in the multi-agency media briefing centre		
Number	**Action**	**Time Completed**
1.	Liaise with Chief Business Officer and communications professional within the Incident Control Centre to obtain a briefing of the incident and immediate communication actions	
2.	Facilitate the development and flow of information to the media, public, and stakeholders.	
3.	Maintain a personal log of all calls/conversations/actions/events and decisions taken. All entries in the log book must be dated.	

ACTION CARD 3	**Incident Communications Officer**	
Accountable to	**CHIEF BUSINESS OFFICER**	
Responsible for: Undertaking call handling, media and social media monitoring and working closely with the wider communications team to respond to the incident		
Number	**Action**	**Time Completed**
1	Following loggist principles, open a communications log and report on it all decisions and actions taken by the team to respond.	
2.	Ensure all media enquiries, calls/events and decisions are logged.	
3.	Ensure owned social media channels are being utilised to share key messages.	
4.	Provide regular (daily) media and social media monitoring reports to the Chief Business Officer, Communications and Engagement	

	Lead and nominated Media Briefing Officer and alert the leads to any significant emerging issues and risks as they happen.	
5.	Support the circulation of communications to stakeholder to warn, inform and reassure.	

Appendix 2 – Social media policy

Social Media and Digital Content Policy – updated August 2022

Appendix 3 – ICB Media training

Name	Title	Organisation	Date last received media training
Simon Whitehouse	CEO	ICB	5th Dec 2023
Claire Skidmore	Chief Finance Officer	ICB	4th Dec 2023
Nick White	Chief Medical Officer	ICB	4th Dec 2023
Dr Ian Chan	Interim Chief Medical Officer & GP	ICB	5th Dec 2023
Vanessa Whatley	Chief Nursing Officer	ICB	4th Dec 2023
Gemma Smith	Director of Strategic Commissioning	ICB	5th Dec 2023
Gareth Robinson	Director of Transformation and Delivery	ICB	5th Dec 2023
Alison Smith	Chief Business Officer	ICB	10th Sept 2024
Angela Szabo	Director of Finance	ICB	10th Sept 2024
Julie Garside	Director of Planning, Performance, BI and analytics	ICB	10th Sept 2024
Angie Parkes	Deputy Director of Planning	ICB	10th Sept 2024
Sam Tilley	Director of Collaboration	ICB	10th Sept 2024
Tracey Jones	Head of Inequalities	ICB	10th Sept 2024
Liz Walker	Head of Primary Care	ICB	10th Sept 2024
Claire Parker	Director of Strategy and Development	ICB	10th Sept 2024
Gareth Wright	Head of Clinical Operations & EPRR	ICB	10th Sept 2024
Stuart Allen	Senior EPRR Lead	ICB	10th Sept 2024
Helen Onions	Deputy Director of Public Health	Telford & Wrekin Council	4th Dec 2023
Dr Laurence Ginder	Associate Medical Director and Consultant Radiology	SaTH	5th Dec 2023
Dr Finola Lynch	GP & Clinical Director SW Shropshire PCN	STW Clinical Commissioning Group (CCG)	Mar-22
Dr Mike Innes	GP	STW CCG	Mar-22
Anne-marie Lawrence	Director of Midwifery	The Shrewsbury and Telford Hospital NHS Trust	Mar-22
Zena Young	Executive Director of Nursing & Quality	STW CCG	Mar-22
Dr Priya George	GP, STW ICB Clinical Lead	STW CCG/ICB	Mar-22
Dr Ruth Longfellow	Chief Medical Officer	Robert Jones & Agnes Hunt NHS Foundation Trust	Mar-22

Dr Chandan Aladakatti	Consultant Psychiatrist and Medical Professional Lead	Midlands Partnership NHS Foundation Trust	Mar-22
Clair Hobbs	Director of Nursing & Allied Health Professionals	Shropshire Community Health NHS Trust	Mar-22
Dr Ed Rysdale	Clinical Director, Emergency Care	The Shrewsbury and Telford Hospital NHS Trust	Mar-22

Appendix 4 – Attendance at WMLRF communication forums

Meeting	Who attended	Date	Notes
WMLRF Communication Study Day	Harriet Hopkins	18/11/2024	in-person
Exercise REDSTREAK (warning and informing campaign)	Kate Manning	09/04/2024	(due to Harriet being off sick)
Exercise REDSTREAK (warning and informing campaign)	Harriet Hopkins	08/04/2024	
WMLRF Comms Working Group	Harriet Hopkins	19/Mar/2024	Fed back on the comms cell protocol
WMLRF Comms Cell	Harriet Hopkins	12-Jan-24	Fed back on the comms cell protocol
WMLRF Comms Working Group	Harriet Hopkins	07/11/2023	

Agenda Item

ICB 27-11.086

System Integrated Improvement Plan

Appendix 1 - Summary of NHS STW Transition Criteria and Key Deliverables

Appendix 2 - NHS STW SIIP

(Please click on link to access Appendix 2)

Appendix 3 - Risk Summary Nov 24 v2

Appendix 1. Summary of NHS STW Transition Criteria and Key Deliverables

Transition Criteria	Deliverables
Finance: Develop and deliver a single Recovery Plan ("the Recovery Plan"), to be agreed with NHS England, that brings together the ICB, provider and additional system wide recovery initiatives, that has clear demonstrable improvement in financial performance for 2024/25 including supporting metrics such as increased efficiency delivery (cost reduction), adherence to agency rules and workforce numbers. This is to have Board agreement from all STW organisations and is signed off Regionally and Nationally. Have an agreed Capital Plan that is clearly aligned to system strategic priorities, supporting the financial recovery plan with realistically agreed funding sources.	The system has an agreed medium term 3–5-year financial plan (MTFP) in place that has been signed off by the Board and agreed with the ICS and NHS England (capital and revenue) Triangulation exercise - financial plan to workforce, activity and performance plans; with evidence of testing and review against the HTP model. To be included with the MTFP for sign off. A further +5-year high level summary plan is required to align with HTP timescales and underlying financial balance for the system. MTFP to include a summary of efficiencies linked to benchmarking opportunities
	24/25 and 25/26 financial plans (revenue) agreed and signed off by all component organisations and NHS England Plans to include a fully developed Financial Improvement Plan (i.e. CIPs) with supporting PIDs linked to the benchmarking opportunities
	Capital plans for 24/25 and 25/26 signed off by all component organisations and NHS England
	Independent review of 'grip & control' - identifying gaps (I&I phase 1 work) resulting in a plan to address the gaps Follow up re-assessment review of- 'grip & control'
Workforce: Develop and deliver a workforce improvement plan, that has Board agreement from all STW organisations and is signed off Regionally and Nationally, that is clearly aligned to system strategic priorities and financially sustainable	Workforce delivery plans for 24/25 and 25/26 signed off by all component organisations and NHS England
	Refreshed People and OD strategy
UEC: Develop and deliver a comprehensive, system-wide Urgent and Emergency Care Improvement plan ("the Improvement Plan") which demonstrates the appropriate system actions and controls in place for improving U&EC access, quality and performance across the whole U&EC pathway, including an outline of how the ICB demonstrates it has robust escalation procedures in place (both in and out of hours) for addressing system capacity, utilisation and the management of risk.	System UEC Improvement Plans 24/25 and 25/26 25/26 plan to be finalised when national guidance for 25/26 is published
	Workstream 1: 4hr performance
	Workstream 2: Accident & Emergency Medicine, Medical and Internal Professional Standards
	Workstream 3: Alternatives to ED and Care coordination
	Workstream 4: System Frailty (to be led by the ICB)
	Workstream 5: System Discharge
	Effective governance and oversight of the delivery of the plan
Governance: Implement sufficient programme management and governance arrangements across system providers to enable delivery and reporting of improvement, with immediate focus being on Finance and U&EC.	System governance structure at Level 2 of the ICB/System, Governance structure for Finance, UEC and Workforce re-designed, implemented and functioning (balancing finance, quality & safety, performance and workforce)
	System performance & accountability framework designed, implemented and functioning
	An agreed provider wide risk management approach (including consistent policies and risk assessment tools) that is then adopted as the system and ICB approach that is implemented and functioning.
	System PMO designed, implemented and functioning
Leadership: Demonstrate collaborative decision-making at both system and organisational levels, based on the principle of delivering the best, most sustainable and most equitable solutions for the whole population served by the system	Functioning Provider Collaborative (aligned to the priorities within the Strategic Commissioning Plan approved by Board) where open and honest conversations are brokered.
	Development and implementation of two Place committees to enable increased autonomy and delegation of local decision-making.
	Demonstrate collaborative decision-making through the co-development and co-delivery of an Integrated System Improvement Plan that supports delivery of all the RSP exit criteria at both system and organisational levels, based on the principle of delivering the best, most sustainable and most equitable solutions for the whole population served by the system.
	Clear culture and leadership improvement programme and evidence of a positive shift in staff experience through pulse survey/NHS staff survey.

Integrated Care System
Shropshire, Telford and Wrekin

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Shropshire, Telford and Wrekin

Appendix 3
System Integrated Improvement Plan

Risks to Delivery

November 2024

Key risks to delivery (1/4)

Transition Criteria	Risk	Mitigation / Ask for support from the National Executive	RAG Rating
Finance	Data Warehousing Data Reporting, Data Quality Issue - Elective data reported below planned levels due to Data Quality issues. Risk to System ERF Income delivery.	Weekly operational meeting in place across SaTH/ICB - focused action plan based on identified issues, with weekly cycle of issue resolution, tests and sign off by BI and Finance. Expert additional resource brought in to deliver plan with oversight by NHSE, interim solution identified. Longer term solution also under development. Adding staff capacity to increase capacity and activity. National payment variation requested to allow implementation of interim solution, additional capacity to accelerate (NHSE scoping).	
Finance	Risk to delivery of the Financial Improvement Programme - Resource constraints to support the full identification and delivery of the 2024/25 Financial Improvement Programme and development of the multi-year FIP programme	○ Financial improvement plans are now fully identified for 24/25, PIDs developed and required mitigations identified against the initial plans. ○ Phase 1 I&I complete, Phase 2 I&I supporting delivery in UEC, Workforce and System PMO alongside additional PMO support agreed for CHC. ○ Further system mitigations and unpalatable decisions under discussion.	
Finance	Risk to the delivery of the 2024/25 Financial Plan - 2024/25 Financial Risks are: Efficiency Delivery Risk £19.8m Month 6 (100% High Risk plus 25% of Medium risk, reduced from £28.5m Month 5) Cost Risk £39m Month 6 (Reduced from £59.4m in Month 5 - HCA re-banding risk increased) Income Risk £29.7m Month 6 (Reduced from £30.4m Month 5)	○ Efficiency - System PMO and FIP Governance in place to address £14.9m high risk schemes, including weekly action plans to de-risk delivery with oversight from Executive leads supported by PWC through the Phase 2 I&I. ○ Cost - Workforce Controls/Non-Pay Controls in place and System Governance for reporting and oversight. ○ Income - NHSE decisions awaited on spec comm ERF RJAH, SaTH Endoscopy and junior doctors funding and national payment variation requested in relation to SaTH Data Reporting issue.	
Workforce	Reduction of WTE not achieved in full in 2024/25 taking into account the impact on WTE of additional £6m stretch	Process implemented at System Vacancy Panel to track dis-established posts. All roles reviewed are compared to plan and minimum staffing levels at service level. Establishment reviews underway, refined vacancy panel criteria via Phase 2 I&I.	
Workforce	Pay pressures for bank and agency staff.	System approach to negotiation on rates with agency providers – also to be progressed at regional level. Roll out of NHSP bank across system. Improved e-rostering. Focus on price cap overrides. WM Cluster medical rates. Strengthening of approval processes for bank shifts. Increased focus on workforce unavailability. Enhanced bank rates ceased.	

Key risks to delivery (2/4)

Transition Criteria	Risk	Mitigation / Ask for support from the National Executive	RAG Rating
Workforce	Increased escalation costs.	Escalation plan is reviewed and challenged at UEC Board and FIP. I&I PwC Phase 2 support, focused on driving improvement and impact.	
Workforce	Impact of cessation of RJAH LLP contract on finance, activity and waiting lists.	Mitigation plan in place inc. alternative staffing through NHS locum appointments, and HTE framework, SLAs with other local trusts, review job plans and rostering practices to optimise substantive staffing	
Workforce	Reduced workforce planning capacity and expertise impacts ability to develop plan for 25/26.	Review of people team structure underway, will develop proposed structure – looking to share resources across SaTH / SCHT / ICB, which will help but more resource to support workforce planning is required. Action: Seek support from NHSE for workforce planning resource across system.	
Workforce	The level of workforce unavailability (absences via sickness, parental leave etc) remain high impacting need for temporary workforce or creating unfilled gaps across services	Introduced programme to support all aspects of unavailability management (including, strengthened absence management policy, improved rostering etc) Actions: Review unavailability mitigation being undertaken at SaTH and assess relevance and applicability at SCHT by December 24	
UEC	Resource constraints in programme management, BI, clinical leadership and improvement capability.	Detailed resource plan identifies need. External support provided by national teams (ECIST Tier 1 GIRFT). External support in place to develop a system Programme Management Office by Nov 24.	
UEC	Clinical workforce already stretched. However, they are key to delivering the additional aims of A-tED, IPS and Frailty models.	To be addressed through detailed implementation planning and support of national teams.	
UEC	Commissioning & Contracting implications on some projects relating to care coordination will delay final operating model.	Commissioning approach signed off by NHS STW w.c. 6th May. Commissioning plan now being implemented with stakeholder engagement in progress.	
UEC	Inability to fund proposed changes and commissioning requirements after successful A-tED tests of change.	Clear evidence of benefits related to any investment. Non recurrent funding has been sourced Longer term commissioning intentions will ensure integrated care model defined and will align with local care & HTP	
UEC	Unable to align workforce to meet ED demand or staff capacity to drive change	SaTH recruited to full ED consultant establishment. Workforce review required to align workforce to demand.	

Key risks to delivery (3/4)

Transition Criteria	Risk	Mitigation / Ask for support from the National Executive	RAG Rating
UEC	System care records are not integrated between providers to share Rockwood score appropriately	Digital enabling will be required across multiple providers in the meantime, an interim solution will be implemented	
UEC	Availability of workforce and funding to deliver enhanced 7-day model	Providers reviewing how they can use existing capacity to provide better coverage across 7 days	
UEC	System-wide Discharge workstream: Patients are at risk of deconditioning due to length of acute stay.	plans to reduce long ambulance handover delays, optimising short stay capacity for frail/elderly cohort and SDEC. Actions to reduce LoS + SaTH deconditioning programme	
Leadership & Governance	Providers don't agree, buy into and comply with the new framework , undermining its effectiveness.	Inclusive design process: Involve key stakeholders (e.g., clinicians, finance teams, operations leaders, etc.) in the development of the framework to ensure their perspectives are considered and incorporated. Clear communication of benefits: Communicate the value of the framework to stakeholders, such as improved performance, enhanced patient outcomes, and better alignment of system goals. Leadership endorsement: Secure strong backing from senior leadership to promote the importance of the framework and foster organisational and system commitment to its success.	
Leadership & Governance	Inadequate resource may limit the long-term viability of the PMO	PWC to support the identification of suitability qualified resource across the system, provide training, upskilling, and on-the-job learning.	
Leadership & Governance	Complexity arising from potential PMO duplication across the system PMO teams	PWC to support System and composite PMO's through a process of standardisation, integration, and alignment prior to departure.	
Leadership & Governance	Developing an effective governance structure for the provider collaborative can be challenging. Each Trust has different governance models, and integrating these into a single decision-making framework could lead to delays or inefficiencies.	Collaborative governance model: Design of a governance structure that ensures equitable representation from all four NHS Trusts. Clear roles and responsibilities: Establish clear roles, responsibilities, and decision-making processes within the collaborative governance structure to avoid confusion and duplication of efforts. Escalation pathways: Develop clear escalation procedures for resolving governance-related conflicts, ensuring that issues are addressed promptly and fairly.	

Key risks to delivery (4/4)

Transition Criteria	Risk	Mitigation / Ask for support from the National Executive	RAG Rating
Leadership & Governance	Changes in senior leadership across the ICB and SATH may risk pace of programme delivery while individuals embed into roles.	Regular system CEO networking embedded in system governance structure to support the development of positive and constructive relationships. Supportive handover processes in place for all leaders using existing governance and improvement plans to maximise delivery and opportunity.	
Leadership & Governance	There is a risk around the capacity of the MPUFT OD team to deliver the OD programme.	Scoping exercise taking place with MPUFT as to how funding can be used to support with capacity and delivery of the programme.	
Leadership & Governance	Risk to collaborative system decision-making if there is no unified direction, to align on goals, improve productivity, and drive cohesive strategies.	System organisational development programme developed and being implemented, funded from RSP. The OD programme aims not only to build trusting partner relationships to support collaborative decision-making but also develop a unified system direction and alignment of goals which will improve productivity and drive cohesion of our organisational and system strategies.	

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Integrated Performance Report

November 2024

Operational Performance

The changeover of the Electronic Patient Record (EPR) at SaTH has had an impact on the systems ability to report our activity. This is turn has made it difficult to complete triangulation between activity, workforce and finance information. Work is ongoing to address these issues and minimise impact on future reporting.

The validated activity data month for the purposes of this report is September 2024 however, where possible more current unvalidated data from providers has been included. Some Mental Health Indicators may lag behind the September data month.

This month, charts show performance against national targets using the Making Data Count (MDC) methodology: this uses Statistical Process Control (SPC) to better illustrate variation in performance over time and enable the identification of Special Cause Variation in performance data. SPC is far more useful at identifying significant changes than, for example, comparing year-on-year or month-on-month performance. Charts produced in this manner feature the following key:

Variation				Assurance		
						
The default grey line is for common cause variation, with no significant change.	Variation points highlighted in orange: special cause of concerning nature or higher pressure due to values being H – higher or L – lower.	Variation points highlighted in blue: special cause of improving nature or lower pressure due to values being H - higher or L – lower.	Purple arrows represent special cause variation; neither a concern nor an improvement	A question mark indicates inconsistent performance, with indicator passing and failing target.	Charts with a blue P are those in which metrics consistently achieve target. Such charts will not normally feature in this report unless a significant risk is foreseen.	Where indicated with an orange F the target is consistently missed, and no assurance can be given based on past performance.

The charts feature a black line to represent the mean, and a red line to indicate relevant targets.

Performance against the operational metrics using the MDC principles is summarised below in a matrix of assurance against current performance:

SPC Matrix		Assurance			Movement in Month
		Consistently Failing the Target	Inconsistently Achieving the Target/ No Target	Consistently Achieving the Target	
Variation	Concerning Variation	◆ Diagnostics: Diagnostic waits of 13+ weeks - STW ◆ LDA: Adults with LDA in a MH Inpatient Unit (per million) - STW ◆ LDA: CYP with LDA in a MH Inpatient Unit (per million) - STW ◆ Community: Community Waits of 52 or more weeks for CYP services - SCHT ◆ Community: Community Waits of 52 or more weeks for adult services - SCHT ◆ Diagnostics: All Diagnostics - < 6ww against target - STW		◆ Mental Health: Patients accessing perinatal mental health - STW	Metric Performance deteriorated from improving to normal variation or from normal to concerning variation
	Normal Variation	◆ Planned Care: Incomplete RTT pathways of 65+ weeks - STW ◆ Cancer: Referral to treatment < 62 days % - STW ◆ Cancer: Diagnosis to First Treatment< 31 days - STW ◆ Primary Care: No. of GP appointments attended within 2 weeks - STW ◆ Mental Health: OAP - Active inappropriate out of area adult placements - STW ◆ Mental Health: Adult CMH - number of people who receive 2+ contacts - STW ◆ Mental Health: Proportion of Adult SMI having Physical Health Checks - STW ◆ UEC: A&E 4 hour performance achievement (Type 1&3) - SaTH ◆ UEC: A&E 12 hour breaches - SaTH	◆ Planned Care: Incomplete RTT pathways of 78+ weeks - STW ◆ Cancer: 28 Day Faster Diagnosis Standard - STW ◆ Primary Care: No. of GP appointments attended same or next day - STW ◆ Mental Health: Talking Therapies reliable recovery after 2+ contacts - STW ◆ Community: 2hr Urgent Community Response - SCHT ◆ Primary Care: Total Primary care appointments - STW ◆ Primary Care: Appointments Booked/Cancelled Online - STW ◆ Primary Care: Practice with high quality online workflow tools - STW ◆ UEC: Number of Super Stranded Patients - SaTH ◆ UEC: Total A&E attendances against plan - SaTH		Metric Performance improved from concerning to normal variation or from normal to improving variation
	Improving Variation	◆ Mental Health: Dementia diagnosis rate - STW ◆ LDA: % Annual Health checks per LD register aged 14 or over - STW ◆ Mental Health: CYP - persons U18 supported with at least 1 contact - STW	◆ Mental Health: Talking Therapies patients reliably improved after 2+ contacts - STW ◆ UEC: Cat 2 Response Mean time - WMAS ◆ Primary Care: GPs in Post (FTE) - STW ◆ Primary Care: Direct Patient Care in Post (FTE) - STW ◆ Primary Care: Patients enabled to manage appointments on-line - STW ◆ Primary Care: Practices with digital telephony - STW ◆ Mental Health: OAP - Number of inappropriate bed days - STW	◆ Planned Care: VWA - STW	New metric for this report
Insufficient data					

1. Primary Care

Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Assur.	Mean
Total Primary care appointments	Primary Care	STW	Sep 2024		252,224			247,769
No. of GP appointments attended within 2 weeks	Primary Care	STW	Sep 2024	88%	82.0%			83.2%
No. of GP appointments attended same or next day	Primary Care	STW	Sep 2024	54%	51.0%			52.5%
GPs in Post (FTE)	Primary Care	STW	Sep 2024		306			303
Direct Patient Care in Post (FTE)	Primary Care	STW	Sep 2024		167			156
Appointments Booked/Cancelled Online	Primary Care	STW	Aug 2024		3,643			3,575
Patients enabled to manage appointments on-line	Primary Care	STW	Aug 2024		44.3%			43.3%
Practices with digital telephony	Primary Care	STW	Oct 2024		100%			98.4%
Practice with high quality online workflow tools	Primary Care	STW	Oct 2024		100%			100%

1.1 GP collective action is ongoing, and practices are each making decisions about which of the actions they are taking. Most practices are choosing not to use standard referral proformas and we are monitoring this through RAS and TRAQS and feedback from secondary care. The local system group is currently meeting weekly and the Regional Group weekly although daily operation sitreps continue every morning. We are monitoring activity in ED, UC and 111 to detect any increases. There have been none so far. It is noted that following a ballot by the National Pharmacy Association, Community Pharmacies in England may also join GPs in taking collective action over their funding and the financial impact of the recent budget. Action could begin in January 2025.

1.2 Practice visits continue with ten of the 12 scheduled visits in 24/25 now complete. Practices were chosen using local intelligence including lowest appointments per 1,000 patients and patient survey results. Three of our nine PCNs have now given assurance that their practices have implemented the 24/25 Capacity Access Payment requirements of better digital telephony, simpler online requests and faster care navigation, assessment and response.

1.3 The pharmacy workstreams within PCARP continue to be delivered well. Based upon draft ICS level contributions to the national PCARP ambition, STW is delivering above expected trajectories for Clinical Pathways and Blood Pressure Checks and is matching trajectories for the Oral Contraception Service.

1.4 There is no significant variation for the metrics shown, with appointments same/next day, online workflow tools and GPs in post all perform within normal variation.

1.5 The total primary care appointments metric does not have a national target but is 3.1% below plan for September 2024.

2. Urgent Emergency Care

Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Assur.	Mean
Cat 2 Response Mean time	UEC	WMAS	Oct 2024	30	00:40			42.3
A&E 4 hour performance achievement (Type 1&3)	UEC	SaTH	Oct 2024	70.3%	52.2%			52.0%
A&E 12 hour breaches	UEC	SaTH	Oct 2024	0	2,494			2,344
Number of Super Stranded Patients	UEC	SaTH	Oct 2024		91			103
Total A&E attendances against plan	UEC	SaTH	Oct 2024		13,067			12,900
2hr Urgent Community Response	Community	SCHT	Oct 2024	70%	70%			82.5%

2.1 STW 4 hour ED performance remains in normal variation but does not achieve the national target. SaTH performance is off plan by 11.1%. SaTH are focusing on achieving minors performance by improving overnight performance, staffing and correcting a coding issue in trauma and orthopaedics. This is expected to improve minors performance back to plan by March 25.

2.2 A&E 12 hour breaches remains high but is in normal variation. A review of 12 hour ED waits is being undertaken to identify patients who may have benefited from an alternative pathway or where community in reach could have reduced the time spent in ED to aid learning.

2.3 "The Perfect Week" was initiated at the end of October and improvements identified are being implemented permanently including a second triage area, protecting the second triage nurse, moving some non-critical tests to 'Fit to sit' and protecting this area. This has significantly reduced the average time to be assessed.

2.4 The number of super stranded patients have further reduced below plan during October.

3. Planned Care

Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Assur.	Mean
Incomplete RTT pathways of 78+ weeks	Planned Care	STW	Sep 2024	0	58			26.8
Incomplete RTT pathways of 65+ weeks	Planned Care	STW	Sep 2024	0	744			854
VWA	Planned Care	STW	Mar 2024	100%	105%			103%
Community Waits of 52 or more weeks for CYP services	Community	SCHT	Sep 2024	0	71			45.3
Community Waits of 52 or more weeks for adult services	Community	SCHT	Sep 2024	0	1,606			573
All Diagnostics - < 6ww against target	Diagnostics	STW	Sep 2024	85%	62.2%			69.9%
Diagnostic waits of 13+ weeks	Diagnostics	STW	Sep 2024	0	2,676			1,399
28 Day Faster Diagnosis Standard	Cancer	STW	Sep 2024	77%	68.3%			69.9%
Referral to treatment < 62 days %	Cancer	STW	Sep 2024	85%	50.6%			53.2%
Diagnosis to First Treatment< 31 days	Cancer	STW	Sep 2024	96%	85.2%			84.6%

3.1 Long waits remain a concern with 24 over 78 week waits and 777 over 65 week waits at the end of October. Our providers are forecasting 43>78wks and 661 >65wks at the end of November. The system remains under Tier 1. NHSE are supporting the system to access as much appropriate insourcing, outsourcing and mutual aid as is available. Community waits remain a concern while CYP decreased by 4 in September adult services have increased by 442 to 1,606.

Improvement plans and associated trajectories for these waits are being managed via the monthly contract review meetings with SCHT.

3.2 Diagnostic standards for 6 week and 13 week waits are failing their targets and are a cause for concern. Recovery plans are due to be submitted to the ICB by 22 November. Modalities of concern are MRI, NOUS, Cardiorespiratory and Endoscopy. In addition to the actions to reduce the access times a detailed action plan is now in place at SaTH to improve the reporting waiting times, especially in MRI, CT and NOUS where excessive waiting times are currently being seen. This is an absolute priority due to the impact on cancer pathways and associated outcomes for patients.

3.3 The cancer Faster Diagnosis Standard (FDS) is showing normal variation and remains below target but is slightly ahead of its recovery trajectory and FIT performance continues to meet national standard. The backlog of patients waiting over 62 days has decreased to 309 in October. The challenged tumour sites are Head & Neck, Colorectal, Urology and Gynae. Key actions taken to increase capacity are:

- OFMU: Royal Wolverhampton consultants providing 30 additional OPA in November.
- Gynae- Kits procurement and OPN confirmed to support once funding is approved.
- Urology - Additional Cystoscopy clinics in place due to increase haematuria referrals.
- Colorectal to increase Cancer Nurse Specialist capacity from week commencing the 25th November.

SaTH have recently started their new Triomic study as part of the colorectal pathway, which aims to reduce the referral to diagnostic test time from ~27days down to 13. SaTH are a test site for this and have been asked by NHSE to share their learning across the region.

3.4 Oncology remains an issue due to workforce and despite reaching out to other providers across the West Midlands there is no additional support available due to staffing challenges regionally and nationally.

4.0 Mental Health, Learning Disabilities and Autism

Metric Name	Workstream	Metric Type	Latest Date	Target	Value	Var.	Assur.	Mean
Talking Therapies reliable recovery after 2+ contacts	Mental Health	STW	Sep 2024	48%	49%			46.8%
Talking Therapies patients reliably improved after 2+ contacts	Mental Health	STW	Sep 2024	67%	72%			69.9%
OAP – Number of inappropriate bed days	Mental Health	STW	Sep 2024		160			346
OAP – Active inappropriate out of area adult placements	Mental Health	STW	Mar 2024	0	5			5
Dementia diagnosis rate	Mental Health	STW	Sep 2024	66.7%	61.4%			60.4%
Patients accessing perinatal mental health	Mental Health	STW	Sep 2024	501	680			764
CYP – persons U18 supported with at least 1 contact	Mental Health	STW	Sep 2024	8341	6,250			5,719
Adult CMH – number of people who receive 2+ contacts	Mental Health	STW	Sep 2024	4984	4,310			4,235
Proportion of Adult SMI having Physical Health Checks	Mental Health	STW	Oct 2024	75%	51.3%			54.0%
Adults with LDA in a MH Inpatient Unit (per million)	LDA	STW	Oct 2024	30	55.9			48.0
CYP with LDA in a MH Inpatient Unit (per million)	LDA	STW	Oct 2024	10	30.1			28.5
% Annual Health checks per LD register aged 14 or over	LDA	STW	Sep 2024	75%	24.5%			8.88%

4.1 Talking Therapies performance is exceeding target for both Reliable Improvement and Reliable Recovery. The number of completed treatments in September and year to date are marginally below plan but annual target is expected to be met in full. Waiting times for referral to commencing treatment in 18 weeks are showing continued improvement.

4.2 Dementia Diagnosis rate shows improving variation but is still significantly below target. A detailed System Improvement Plan is in place and was approved at the Commissioning Working Group in November and progress will continue to be monitored by the MH and LDA Delivery Group to ensure it is having the expected impact.

4.3 Adults with SMI annual health checks performance deteriorated in October to 51.3% against the national target of 60% by March 25 (local target of 67% in place). National reporting moved to GPES (GP extractions service) from April 2024 which resulted in small differences in national reporting with lower compliance across all systems.

4.4 CYP access shows improved variation but remains below target. A delivery plan is in place to increase access with additional investment by recruiting to posts. Assurance that recruitment is on track will be sourced from the provider. Demand is increasing especially across autism and other Neurodevelopmental pathways.

4.5 LD inpatients for adults and children are showing concerning variation. Some of the adults have a length of stay exceeding 5 years which increases the challenges around appropriate discharge. The Assurance and Oversight Panel (ICS) and Mental Health, LD&A Delivery Group provide oversight of the challenges.

4.6 LD annual health checks shows improving variation, exceeds the local plan and is expected to achieve the annual target by year end.

5 Quality

A summary of quality indicators is provided at Appendix B.

5.1 UEC oversight remains a priority following the CQC inspection and the more recent Channel 4 Dispatches programme and there is an action plan and quality oversight dashboard to monitor and ensure improvements. Both ED sites have been visited.

5.2 Cancer remains an area of focus due to a deterioration on Cancer Waiting Times performance and the backlog of patients waiting over 62 days on a cancer pathway, the Trust continues to remain in Tier 1 NHSE management.

5.3 Diabetes remains a focus with a drive to improve outcomes and experience across the System. There are now clear steps to take the diabetes transformation approach forward.

5.4 Discharge Policy for Advanced Care Practitioners has been approved which should help with flow and discharges.

5.5 Quality audits for September, demonstrate concern that dementia audit results have dipped to their lowest in the last 12 months due in part to changes in monitoring. The dementia lead is meeting with the quality lead to review this training. This is also evident in ED where scores are consistently poor. Fluid balance monitoring in ED is poor particularly at PRH. Other areas of concern are nutrition and Pressure area care. Both of which will be considered during insight visits.

5.6 Due to issues with the water supply in Endoscopy at RSH, six of the seven washers which reprocess the scopes were taken out of action. Disposable scopes were introduced as an immediate short-term solution. This will have a financial impact which has been recognised by the Capital Planning Group.

5.7 Due to ventilation issues on Ward 5, the elective arthroplasty program at PRH remains on hold, posing a significant risk of 65-week breaches. A Communication Alert has been posted on the SATH website advising patients of potential delay to their treatment. Series of meetings were held with the chief exec during the month of September to consider reopening of ward with mitigation in situ. Due to wait list management orthopaedics number of theatres has been reduced. Resumption of full theatre capacity has not yet been achieved due to staffing.

5.8 Maxillo-facial (Max Fax) service remains closed for bone reconstruction. Discussions ongoing. Max Fax Cancer – risk assessment has been carried out and scored as extreme with the recommendation to consider temporarily closing to new Maxfax cancer referrals. 1 Consultant on phased return following extended sickness. 1 Consultant leaving mid-November who currently supports skin cancer.

5.9 Impact of HTP work on the Eye Department and Copthorne Building with significant changes taking place outside the Copthorne Building increased incidents of patients falling and being witnessed struggling to navigate – this is exacerbated due to impaired vision and demographic of patients attending Department. Mitigation measures are being reviewed.

5.10 Maternity metrics show an improving picture, there is monthly oversight of maternity quality data by the ICB Quality Lead at Maternity Safety Champions and LMNS (Local Maternity & Neonatal System) Programme Board/Perinatal Quality Surveillance Group meeting – post-partum haemorrhage rates show a slight improvement and there is quality improvement work including audit currently being undertaken to identify areas for learning and improvement. Smoking at Time of Delivery rates are showing improvement with the Lead reviewing quarterly Saving Babies Lives submissions and therefore having oversight of SATOD. Stillbirths reported are below the national average; however, the neonatal death rate remains above the national average. An external review was commissioned by SaTH and undertaken in November 23 this report is now shaping the improvement work as part of the whilst the final report is awaited there are system workshops aimed at understanding key actions and work is ongoing.

5.11 Infection Prevention and Control

5.11.1 QOC November papers recognise there is a lack of isolation rooms within the current ED footprint. C.Diff improvement programme in place. Clostridium *difficile* remains over the expected trajectory and MRSA bacteraemia remains a challenge. Collaborative *Clostridium difficile* Action Plan and System IPC Strategic Plan in development to include prevention of HCAIs. SaTH has an action plan in place following a review of practice against national guidance. This has been developed with NHSE support. Trust-wide gram-negative prevention working group has been established at RJAH.

5.11.2 Promotion of measles and whooping cough immunisations has been increased with both national and local campaigns. Current MMR and RSV immunisation rates are above national and regional averages.

5.11.3 System group rapid response meetings held to ensure pathways are developed and in place for possible Mpox cases within ST&W.

5.11.4 Cases of Influenza A have been reported locally.

6. Finance - Month 7 Financial Position

Revenue:

6.1 The ICS is reporting a £27.6m actual YTD System deficit, £11.7m adverse to plan YTD at M7. NHS STW ICS submitted a 24/25 deficit plan of £89.9m, however in Month 6 the deficit plan was funded therefore the expected end of year position is now breakeven.

6.2 Of note, the System is £0.8m above the agency plan month 7 YTD which is £3.9m below the agency cap value (£22.2m cap YTD).

6.3 ICB – Has a year-to-date favourable variance of £0.3m which is due to efficiency being delivered ahead of plan offset by additional MH CHC spend, NCA performance in Acute, Community and Mental Health services (NCA overspend is planned to be recovered in year).

6.4 SaTH – Are reporting a year-to-date adverse variance of £10.9m, £1.7m due to industrial action lost income, £0.7m endoscopy, £3.6m agency and £1.2m additional escalation costs and £2.7m pay award shortfall to M7.

6.5 RJAH – Report a year-to-date adverse variance of £1.6m, £0.9m impact of reduced theatres following the end of LLP arrangements, £0.4m spec comm erf baseline issue awaiting NHSE resolution, Industrial Action impact of £0.3m assumed to be offset by NHSE support, £0.3m inflationary non-pay pressures, offset by favourable efficiency delivery and agency savings.

6.6 SCHT – Have a year-to-date favourable variance of £0.4m. Pay underspends are partially offset by pressures across non-pay including support to community hospitals, sub-acute, rapid response units and within the Prison healthcare service.

6.7 The System cannot currently fully mitigate the financial risks that are flagged, with the risk adjusted System deficit noted as £29.2m as reported at month 7. Key areas of unmitigated risk are: RJAH/SCHT HCA rebanding £2.6m (SaTH issue for 25/26), SaTH Non-Recurrent Endoscopy income, Activity/income risk - SaTH Data Warehouse and RJAH following

end of LLP contract. All partners are working to de-risk their forecast assumptions and also seek further mitigations where risks might not be avoided.

Capital:

6.8 Year to date system operational capital spend is £8.4m behind plan at month 7 due to slippage with SaTH modular wards, although the full capital plan is expected to be delivered by the end of the financial year with schemes coming online in later months.

6.9 The total system capital plan including IFRS16, HTP and CRL is £27m behind plan at month 7, predominantly due to the phasing of the HTP plan as there was a delay in signing the contract.

6.10 Key Capital risks have been added to the ICB/System risk register:

- IFRS16 actual charges are circa £3.25m above the current funding envelope, of this the impact of Black Country leases within SCHT is £1.65m.
- SCHT Frontline Digitisation. Funding of £0.7m has not yet been approved by NHSE.
- RJAH Forecast Risk - overspend forecast on EPR programme £1m due to implementation slippage.

7. Workforce

7.1 Our monthly ICS workforce dashboard enables us to track our trajectory of planned staff in post (WTE) and planned cost of that workforce against actual staff in post and actual cost, in addition to key workforce KPIs. Data is taken from the Provider Workforce Returns and Provider Financial Returns to NHSE. This report provides data for M6 of 2024/25.

The workforce dashboard does not contain Whole Time Equivalent (WTE) plan data for MPFT, and so it is therefore not possible to include MPFT in the actual vs plan part of the analysis.

7.2 **System WTE:**

The operational plan contains assumptions about activity, turnover and vacancy rates. Workforce WTE and Cost variances from plan are influenced by several factors, including workforce unavailability, activity demands and workforce supply (recruitment and training).

- **Substantive WTE:** at the end of September 2024, RJAH, SaTH and SCHT are below plan for substantive workforce by just 1 WTE following an increase of 85 WTE since August.

- **Bank WTE**: at the end of September 2024, RJAH, SaTH and SCHT are above plan for bank workforce at +39wte with higher than planned bank usage due to industrial action, vacancy cover, escalation, enhanced medical/locum rates and nursing bank rates. Mitigations for bank overspend include removal of enhanced bank rates from October, standardisation of rates through WM cluster alliance and focus on unavailability and a recruitment pipeline to reduce reliance on bank staff.

- **Agency WTE**: at the end of September 2024, RJAH, SaTH and SCHT are below plan for agency workforce by -62wte agency staff, with a corresponding underspend of £95k against plan. overachieving against the planned agency workforce reductions of –158wte (Apr-Sept24).

7.3 System Workforce Costs:

- At M6, overall system pay expenditure YTD is adverse to plan by £3.4m predominantly due to bank overspend (Industrial Action, escalation and unavailability). WTE slightly under plan except bank usage.

- Based on M6 outturn, FY run rate is currently £13.4m over plan mitigated by plans to reduce workforce spend during M7 - M12 including an additional £6m stretch across SaTH.

- Workforce efficiency schemes in place with total value of £40.3m of which £28m is planned for delivery from M7 onwards. Schemes include further agency reduction (£2.4m still to deliver), reduction in unavailability (£3.4m), elimination of enhanced bank rates and reduction in temporary staffing premium medical (£2.8m), WTE reduction (£3.5m) and impact of off-framework elimination (£0.8m).

- Of the total £40.3m schemes in place, £8.7m rated as high risk with £5.8m of that associated with escalation – work continues to de-risk via the UEC Board.

7.4 Vacancy Position

At M6, the vacancy rate for the system overall is 8.8% - a slight reduction on M5. This is reflective of the operational workforce plan which planned to grow vacancies by 105wte as well as the subsequent application of a ‘stretch’ efficiency target to the STW workforce requiring additional WTE reductions.

A system approach to vacancy controls is in place resulting in a significant proportion of vacancies not approved to proceed to recruitment. During September, 33% (169) roles were rejected at provider level. A process is now in place to track the number of disestablished posts. PWC support has identified further areas of control.

7.5 Sickness and Turnover Position

Considering sickness and turnover (in-month, not 12-month average), all NHS employers are performing well. Each employer set targets in their operational plan and the average of these is our system target. For sickness absence, our system average target for Sept 24 is 5.3% and for turnover is 11.9%. At M6, system sickness is on target at 5.3% and turnover is at 10.2% and therefore has exceeded target.

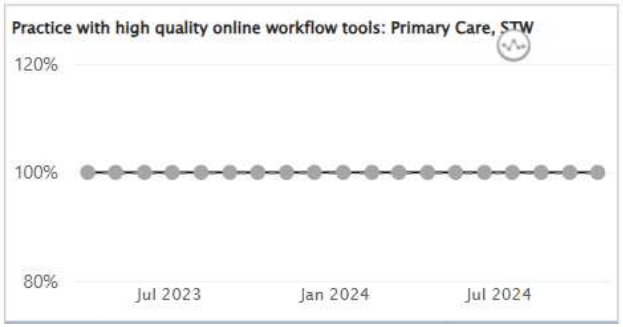
7.6 Next Steps

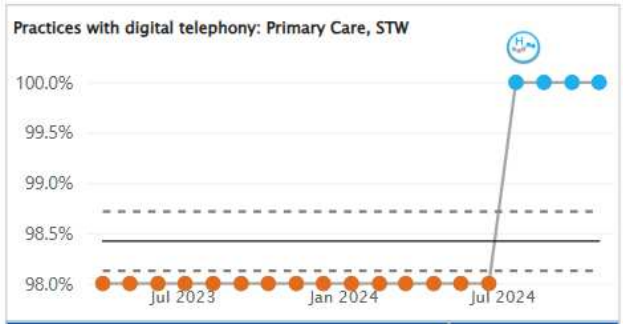
Workforce efficiency schemes in progress include:

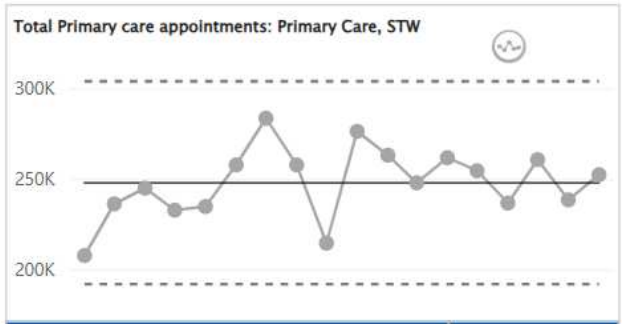
- A review to better understand the drivers of workforce unavailability and develop an improvement plan to mitigate against increased bank and agency usage.
- Cessation of enhanced bank rates from October
- WM Cluster Alliance and NHSP National Bank
- Engagement with NHSE regional temporary staffing team on standardised temporary staffing rates for nursing as Phase 1, with medical to follow in Spring 2025 as Phase 2.
- RRU outsourced medical model.

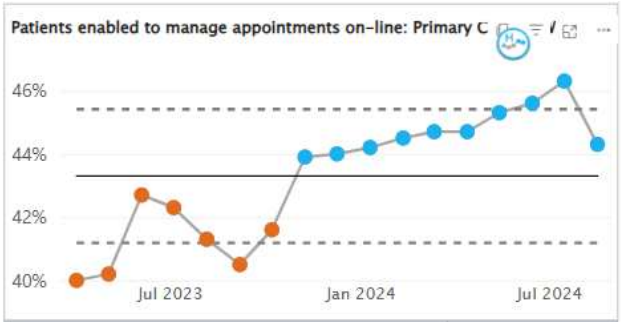
Appendix A – Operational Metrics

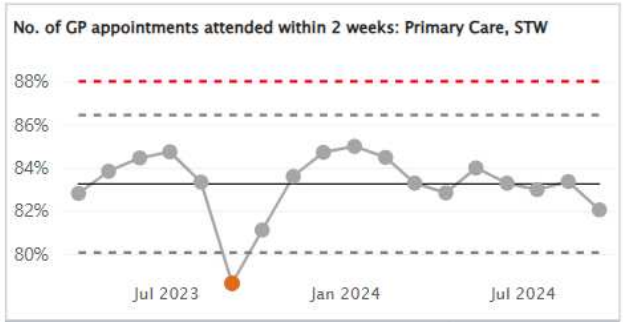
Primary Care

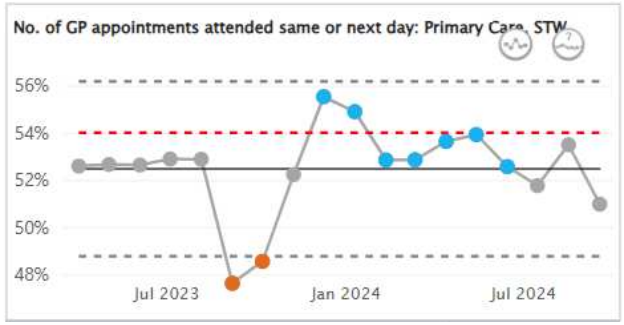


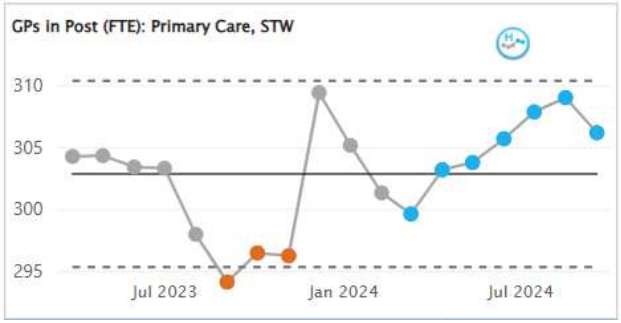


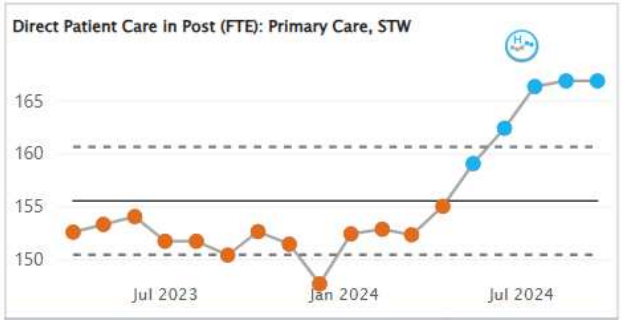


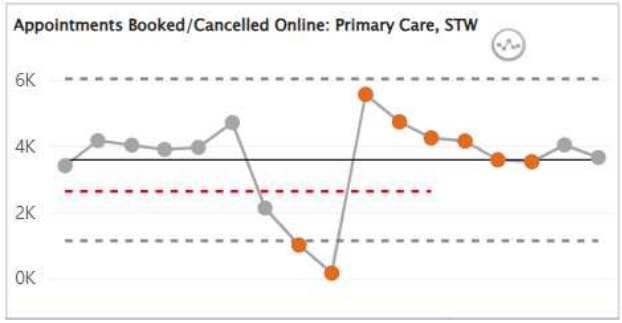




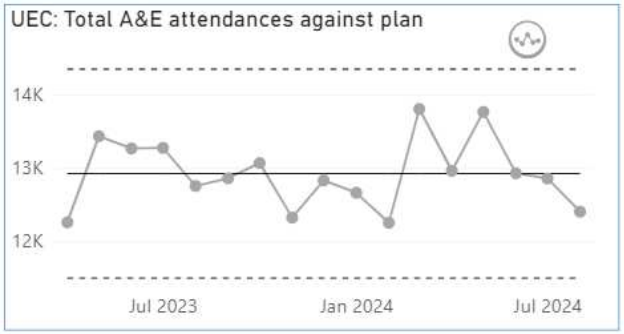


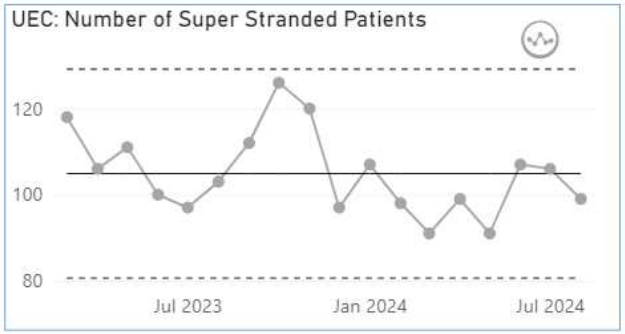

GPs in Post (FTE): Primary Care, STW
310
305
300
295
Jul 2023
Jan 2024
Jul 2024

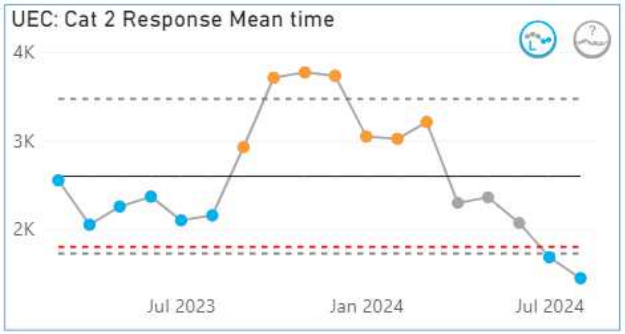

Direct Patient Care in Post (FTE): Primary Care, STW
165
160
155
150
Jul 2023
Jan 2024
Jul 2024

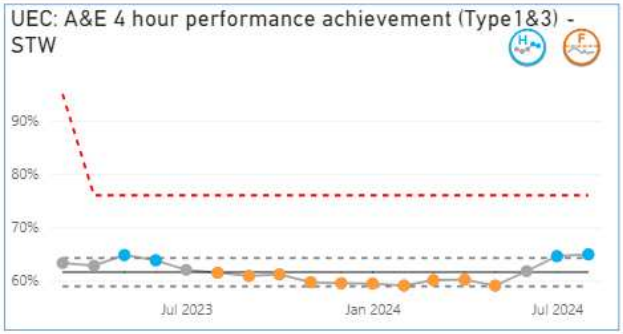

Appointments Booked/Cancelled Online: Primary Care, STW
6K
4K
2K
0K

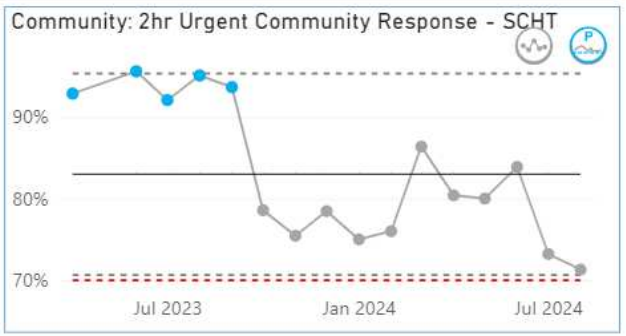
Urgent & Emergency Care



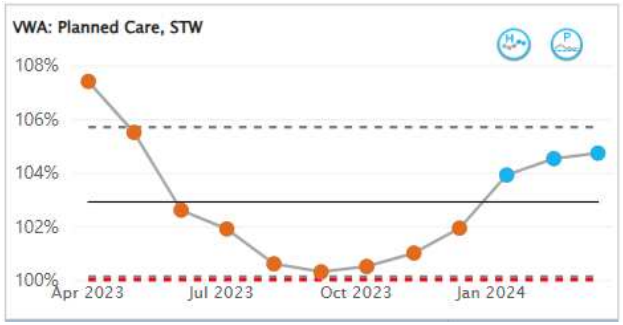


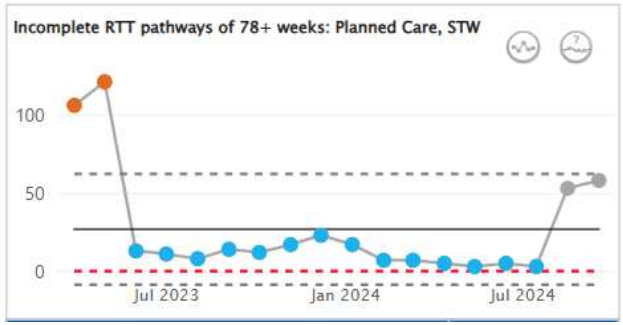


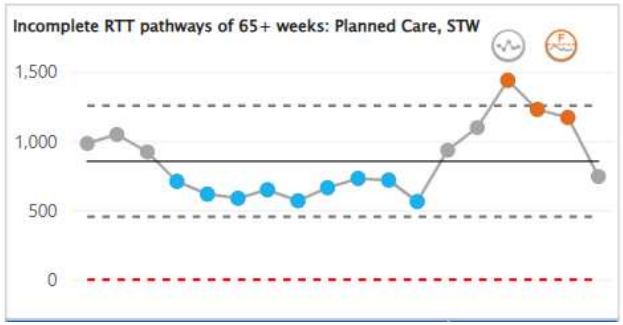


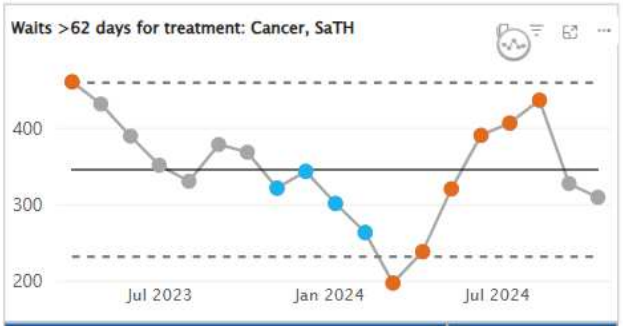


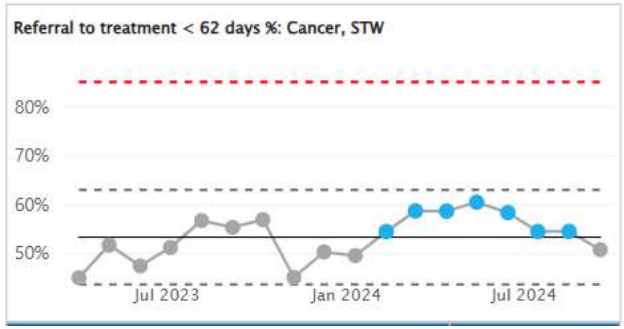
Planned Care – Elective

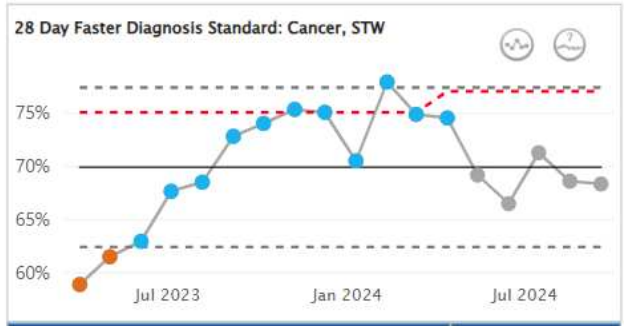


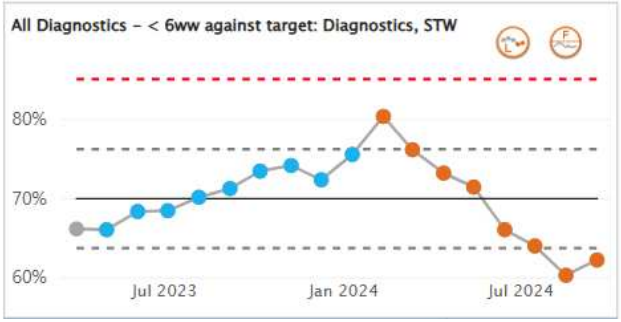


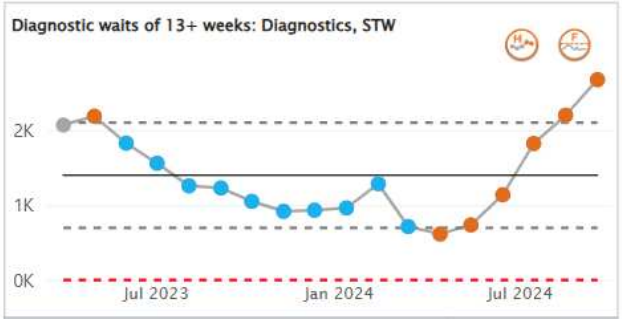


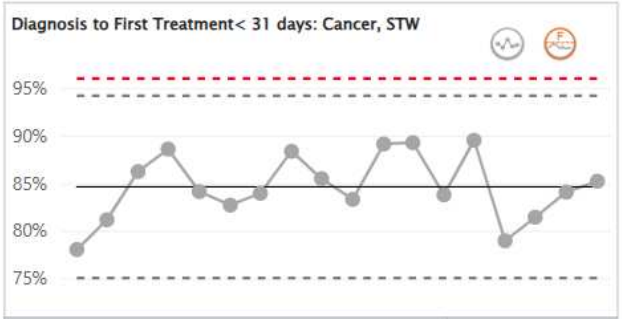




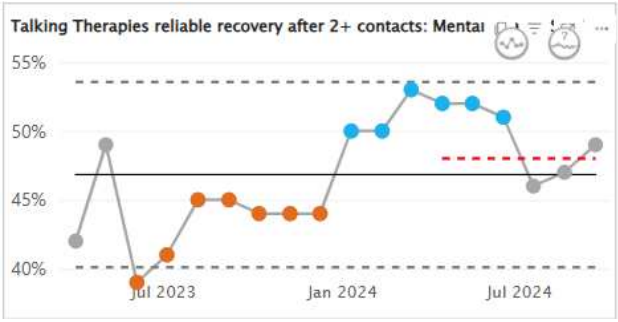


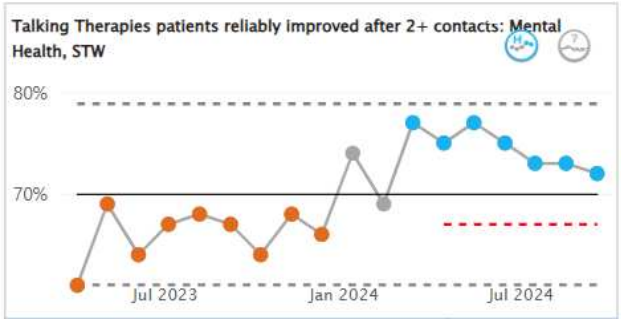

All Diagnostics – < 6ww against target: Diagnostics, STW
80%
70%
60%
Jul 2023
Jan 2024
Jul 2024

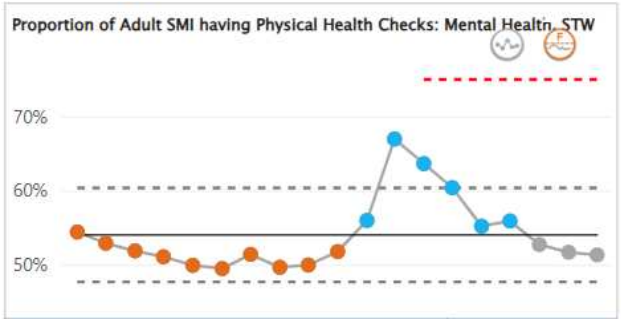

Diagnostic waits of 13+ weeks: Diagnostics, STW
2K
1K
0K
Jul 2023
Jan 2024
Jul 2024

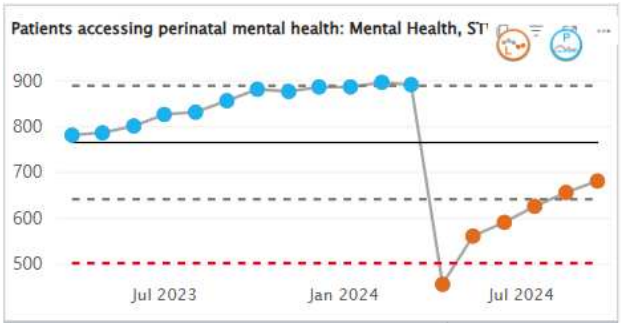

Diagnosis to First Treatment< 31 days: Cancer, STW
95%
90%
85%
80%
75%

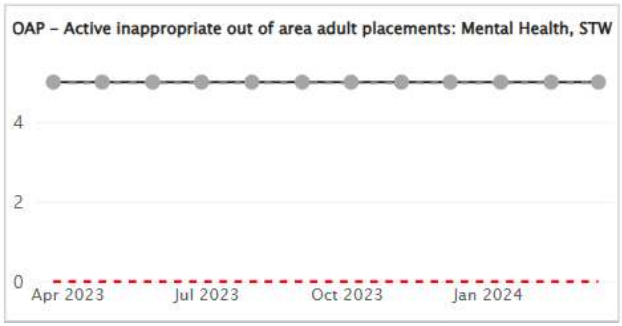
Mental Health, Learning Disabilities & Autism

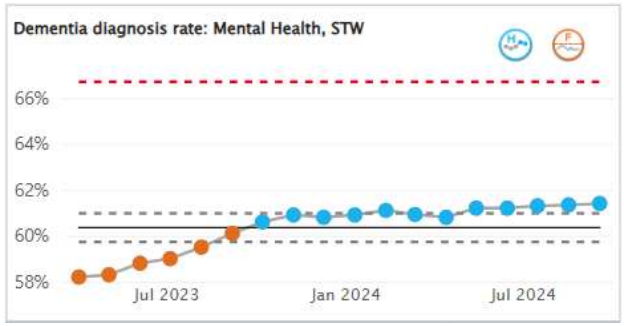


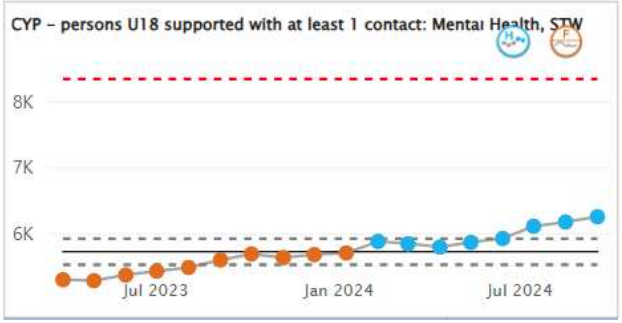


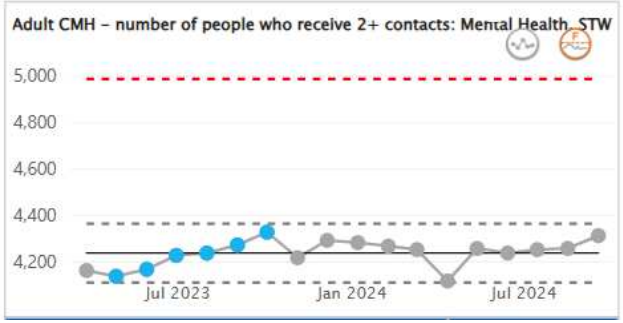


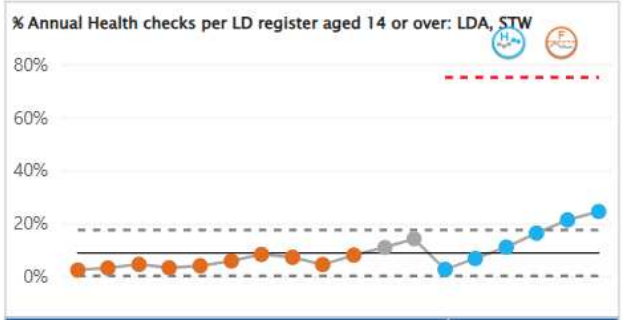


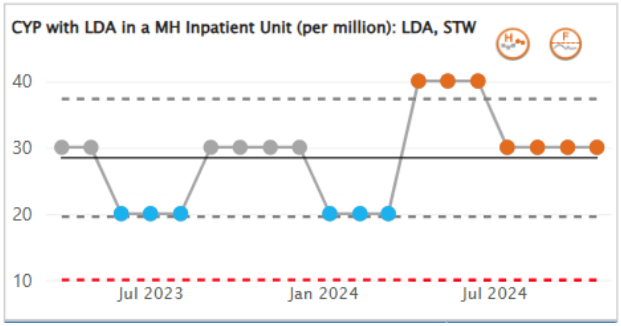


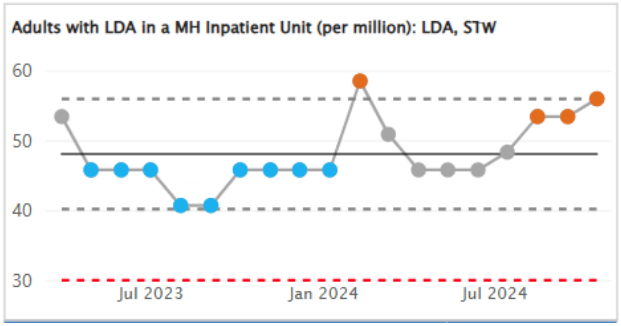


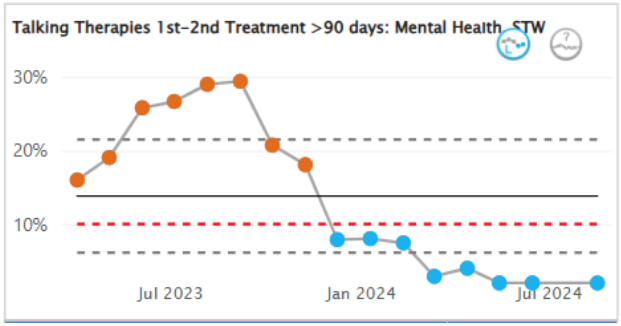

CYP – persons U18 supported with at least 1 contact: Mental Health, STW
8K
7K
6K
Jul 2023
Jan 2024
Jul 2024


Adult CMH – number of people who receive 2+ contacts: Mental Health, STW
5,000
4,800
4,600
4,400
4,200
Jul 2023
Jan 2024
Jul 2024


% Annual Health checks per LD register aged 14 or over: LDA, STW
80%
60%
40%
20%
0%


CYP with LDA in a MH Inpatient Unit (per million): LDA, STW
40
30
20
10
Jul 2023
Jan 2024
Jul 2024


Adults with LDA in a MH Inpatient Unit (per million): LDA, STW
60
50
40
30
Jul 2023
Jan 2024
Jul 2024


Talking Therapies 1st–2nd Treatment >90 days: Mental Health, STW
30%
20%
10%
Jul 2023
Jan 2024
Jul 2024

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

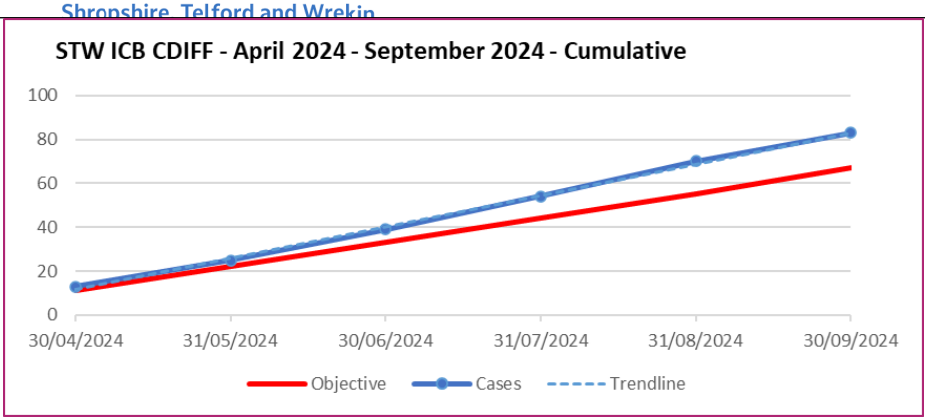
Appendix B – Quality Metrics

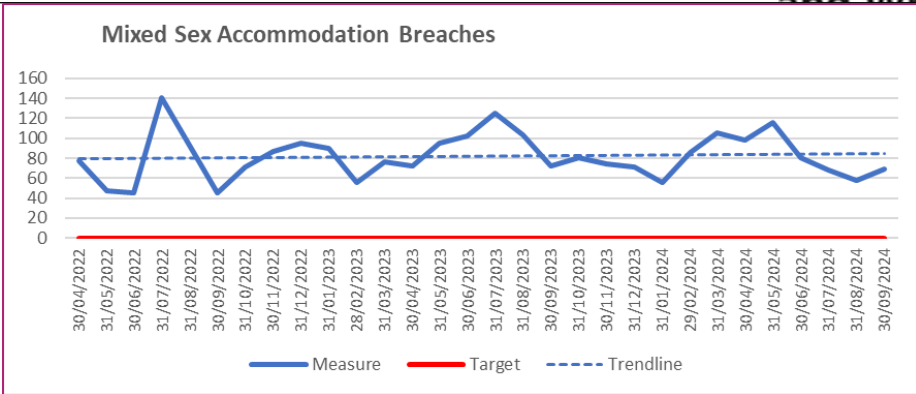
Area	Indicator *Please Note Indicators affected by changes to Occupied Bed Data For Detail See Reference Sheet	STW CCG - M2L0M	STW ICB - M2L0M				SaTH			RJAH			MPFT			SCHT		
							Large acute trust			Acute specialist trust (including children)			Mental Health provider to STW only			Shropshire Community		
		Value	Objective	Value	Reporting Period	Standard / England rate	Value	No of reponses	Trend	Value	No of reponses	Trend	Value	No of reponses	Trend	Value	No of reponses	Trend
IPC	C.difficile		67	83	Cumulative Apr 24 - Sep-24	SATH Objective = 48 RJAH Objective = 1	48			1								
IPC	E.coli Bacteraemia		210	245	Cumulative Apr 24 - Sep-24	SATH Objective = 72 RJAH Objective = 6	84			5								
IPC	Pseudonmonas aeruginosa Bacteraemia		13	20	Cumulative Apr 24 - Sep-24	SATH Objective = 10 RJAH Objective = 0	8			0								
IPC	Klebsiella spp Bacteraemia		48	46	Cumulative Apr 24 - Sep-24	SATH Objective = 18 RJAH Objective = 3	16			0								
IPC	MRSA Bacteraemia		0	6	Cumulative Apr 24 - Sep-24	SATH Objective = 0 RJAH Objective = 0	3			0								
IPC	MSSA Bacteraemia		0	70	Cumulative Apr 24 - Sep-24	No trajectory set	28			0								
Maternity	Stillbirths per 1,000 total births	3.3			2018 - 20	England = 3.9												
Maternity	Neonatal deaths per 1,000 total live births	3.2			2018 - 20	England = 2.8												

Area	Indicator *Please Note Indicators affected by changes to Occupied Bed Data For Detail See Reference Sheet	STW CCG - M2L0M	STW ICB - M2L0M				SaTH			RJAH			MPFT			SCHT		
							Large acute trust			Acute specialist trust (including children)			Mental Health provider to STW only			Shropshire Community		
		Value	Objective	Value	Reporting Period	Standard / England rate	Value	No of reponses	Trend	Value	No of reponses	Trend	Value	No of reponses	Trend	Value	No of reponses	Trend
CHC	% Referrals completed within 28 days			92.7%	2024/25 Qtr 2	England = 72.4%												
	Incomplete Referrals delayed >12 weeks			0	2024/25 Qtr 2													
Incidents	Number of Never Events				Cumulative Apr 24 - Aug-24	0	1			1								
	Number/Trend Serious Incidents				Monthly Apr 23 - Jun-23		1452			133			1557			45		
Friends & Family Test	Friends & Family Test - Inpatient				Sep-24 Public	Not applicable Higher is better	98.9%	1503		99.3%	269							
	Friends & Family Test - Maternity (Birth)				Sep-24 Public	Not applicable Higher is better	100.0%	5										
	Friends & Family Test - A&E				Sep-24 Public	Not applicable Higher is better	53.1%	32										
	Friends & Family Test - Mental Health				Sep-24 Public	Not applicable Higher is better							96.09%	256				
MSA	Mixed Sex Accommodation Breaches				Sep-24	Zero Lower is better	69											

Clostridioides difficile continues to be above trajectory for SaTH and while RJAH is above annual objective they have regained monthly trajectory. Actions include review of antibiotic usage and deep clean as bed capacity allows. Gram negative and MRSA bacteraemia cases also remain higher than plan. Improvements to screening and Infection prevention and control practices are the areas of action.	Stillbirths are below the national average; however, the neonatal death rate is above the national average. An external review was commissioned by SaTH and undertaken in November 23 whilst the final report is awaited there are system workshops aimed at understanding key actions and work is ongoing. West Midlands Neonatal deaths are higher than the national average as a region.

Information from the Serious Incidents website (NRLS) - We have currently paused the publishing of this data while we consider future publications in line with the introduction of the Patient Safety Incident Response Framework (PSIRF) and the Learning from Patient Safety Event platform (LFPSE).





Overview:

- The Mixed sex accommodation breaches at SaTH have reduced to 72 in September from 103 in August. These remain high and the trust is taking action to reduce these further as part of an ongoing action. Incidents of Clostridioides difficile (C diff) infection remain above the monthly trajectory for the system and all partner NHS organisations have breached their annual trajectories. A system action plan is in place and is reviewed monthly at the System IPC and Antimicrobial Resistance Group.

- There are 3 new never events to report in this period.

- Due to the implementation of the Patient Safety Incident Response Framework as part of the Patient Safety Strategy Serious Incidents have been replaced by Patient Safety Incident Investigations (PSII's). NHS STW ICS has transitioned to the new framework and partners are committed to embedding the changes outlined in the PSIRF Policy and Plan – future reporting to follow.

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Appendix C – Finance M7

System Financial Position Month 7

Financial Performance	MONTH			YTD			FULL YEAR			PRIOR YEAR	Prior Month FOT	Movement
Organisation	Plan Surplus/ (Deficit) £000	Actual Surplus/ (Deficit) £000	Variance to Plan £000	Plan Surplus/ (Deficit) £000	Actual Surplus/ (Deficit) £000	Variance to Plan £000	Plan Surplus/ (Deficit) £000	Forecast Surplus/ (Deficit) £000	Variance to Plan £000	Actual £000	Actual £000	£000
Commissioners												
NHS Shropshire, Telford and Wrekin	2,482	2,315	(167)	(18,511)	(18,192)	319	(4,677)	(4,677)	0	(16,249)	(4,677)	0
Total Commissioners	**2,482**	**2,315**	**(167)**	**(18,511)**	**(18,192)**	**319**	**(4,677)**	**(4,677)**	**0**	**(16,249)**	**(4,677)**	**0**
Providers												
The Shrewsbury and Telford Hospital NHS Trust	0	(5,242)	(5,242)	0	(10,863)	(10,863)	0	0	0	(54,582)	0	0
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT	321	234	(87)	1,951	360	(1,591)	2,909	2,909	0	(1,867)	2,909	0
Shropshire Community Healthcare NHS Trust	99	399	300	663	1,112	449	1,768	1,768	0	224	1,768	0
Total Providers	**420**	**(4,609)**	**(5,029)**	**2,614**	**(9,391)**	**(12,005)**	**4,677**	**4,677**	**0**	**(56,225)**	**4,677**	**0**
TOTAL SYSTEM Performance Financial Position Surplus/(Deficit)	**2,902**	**(2,294)**	**(5,196)**	**(15,897)**	**(27,583)**	**(11,686)**	**0**	**0**	**0**	**(72,474)**	**0**	**0**

Key Data

- £27.6m actual YTD System deficit, £11.7m adverse to plan YTD at M7. NHS STW ICS submitted a 24/25 deficit plan of £89.9m. An allocation to fund the planned deficit was transacted in M6 resulting in a revised breakeven plan for the System. The allocation has been distributed between organisations previously planning a deficit (SaTH and ICB), with the remaining ICB deficit offsetting the surpluses being reported in other System Providers.
- £0.8m above the agency expenditure plan at M7 and £3.9m below the agency cap value (£22.2m cap YTD) for the system.
- ICB - Year to date favourable variance of £0.3m is due to efficiency being delivered ahead of plan offset by additional MH CHC and NCA performance in Acute, Community and Mental Health services (NCA overspend to be recovered in year). Additional costs associated with WMAS have been recognised in Month 7.
- SaTH - Year to date adverse variance of £10.9m - key drivers: £1.7m due to industrial action, £0.7m endoscopy, £3.6m agency, £1.2m additional escalation costs and £2.7m pay award shortfall.
- RJAH - Year to date adverse variance of £1.6m - key drivers: £0.9m net impact of reduced theatre capacity (LLP) after mitigations, £0.4m adverse impact NHSE ERF baseline error escalated to regionaland national specialised commissioning teams for resolution, £0.3m adverse non pay inflation pressures above planning assumption
- SCHT - Year to date favourable variance of £449. Pay underspends are partially offset by pressures across non-pay including support to community hospitals, sub-acute wards and within the Prison healthcare service.

Financial Risk

System Risk	24/25 Gross Risk £'000	Mitigation £'000	Un-Mitigated Risk £'000	Prior Month Un-Mitigated Risk £'000	Movement from Prior Month £'000
NHS Shropshire, Telford & Wrekin ICB	20,014	(20,014)	0	0	0
Robert Jones & Agnes Hunt Hospital	15,173	(11,473)	3,700	6,336	2,636
Shrewsbury & Telford Hospitals	38,200	(14,550)	23,650	25,550	1,900
Shropshire Community Hospital Trust	4,723	(2,922)	1,801	3,538	1,737
Grand Total	**78,110**	**(48,959)**	**29,151**	**35,424**	**6,273**

Risk is monitored closely. Work is ongoing to identify further mitigations across this system supported by the investigation and intervention Phase 2 work. More detail is provided on the next slide and under each individual organisation's section of this report.

Movements in month relate to RJAH income/activity risk following the loss of LLP, SaTH medical award backpay and SCHT reduction in HCA banding challenge risk.

If all unmitigated risks were to materialise, the risk adjusted System deficit would be £29.2m.

Key areas of unmitigated risk are:

- All providers HCA rebanding £2.6m - discussions underway to ascertain approaches taken in other systems to reduce the risk, will only be included if all key conditions for a provision are met - SaTH £14m removed from unmitigated risk at Month 6;
- SaTH pay award related risks - £4.7m – mitigations to be identified (post submission of the M7 position this has reduced to £3.1m)
- SaTH Non-Recurrent £5.0m Endoscopy income risk matched to insourcing costs - discussions underway with NHSE/WMCA
- Activity/income risk - £1.7m Industrial Action and £5.5m SaTH Data Warehouse- National Payment Variation Requested
- Escalation activity - £5.8m at SaTH - mitigations under discussion through UEC Phase 2 I&I scope.
- Income risk - £2.5m at RJAH – alternative capacity to be identified following cessation of LLP contract

The ICB has included anticipated mitigations for expected Dental underspends of £3m as reported although further mitigations post submission of the report now exclude the Dental underspend. Specialised commissioning reserves (£2.1m) are included within the forecast outturn position.

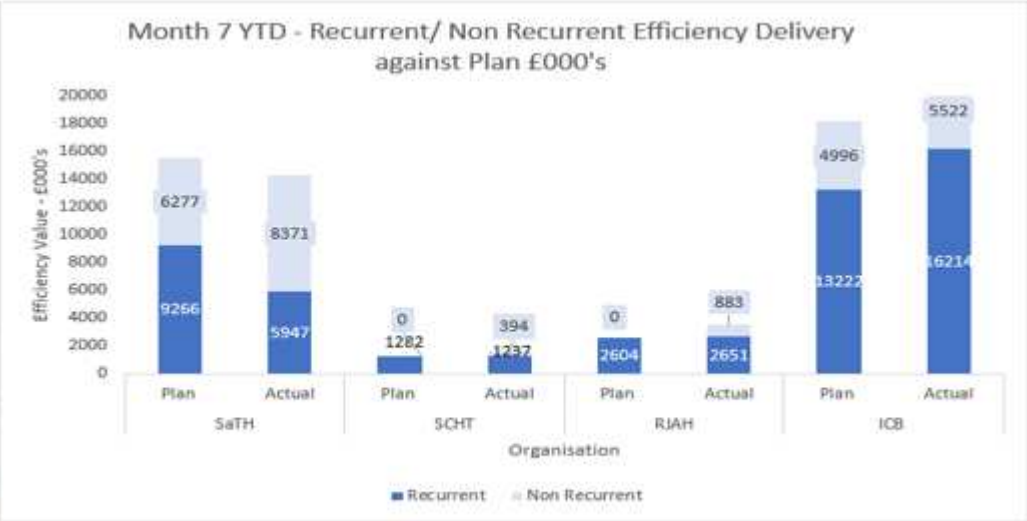
Integrated Care System
Shropshire, Telford and Wrekin

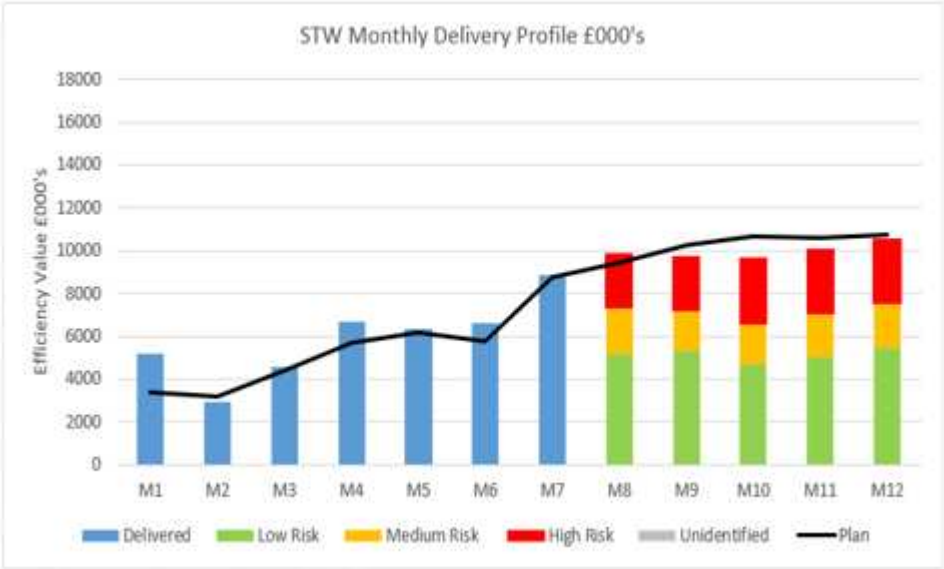
NHS
Shropshire, Telford and Wrekin

Efficiency Delivery Month 7 Year to Date

STW	2024/25 Plan	Month 7 YTD Plan	M7 YTD Actual	M7 YTD Variance	Forecast	Low Risk	Medium risk	High Risk
SaTH	44701	15545	14317	-1228	44701	25965	6878	11858
SCHT	3588	1282	1633	351	3588	2365	840	383
RJAH	5589	2604	3534	930	6896	6053	399	444
ICB	35787	18218	21736	3518	35787	31234	3009	1544
Total	89665	37649	41220	3571	90972	65617	11126	14229
Previous Month						55967	19400	14946
Movement from M6						9650	-8274	-717

- Efficiency delivery is showing a positive variance of £3.5m compared to the M6 year-to-date efficiency plan, though performance varies across organisations
- The majority of high-risk schemes are reported by SaTH, and are linked to system escalation (£6m), Workforce Unavailability (£2m) and WTE Reduction plan (£2m).
- Phase 2 I&I via PWC are providing support to mitigate the remaining high-risk schemes, and targeted interventions are in place to support Escalation. Additional oversight and governance has been established through fortnightly FIP and one to one Executive meetings.
- Further detail on scheme delivery and risk mitigation is available through the Month 7 Efficiency report.





Capital Summary

CAPITAL PROGRAMME	MONTH			YTD			FULL YEAR			PRIOR YEAR	Prior Month FOT	Movement
Organisation	Plan £000	Actual £000	Variance to Plan £000	Plan £000	Actual £000	Variance to Plan £000	Plan £000	Forecast £000	Variance to Plan £000	Actual £000	Actual £000	Actual £000
Total Charge against Capital Allocation (before impact of IFRS16)												
NHS Shropshire, Telford and Wrekin	51	207	156	51	207	156	883	883	0	801	883	0
The Shrewsbury and Telford Hospital NHS Trust	1,749	(99)	(1,848)	8,871	2,111	(6,760)	16,768	16,768	0	18,485	16,768	0
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT	813	456	(357)	5,551	4,555	(996)	6,385	6,379	(6)	5,677	6,379	0
Shropshire Community Healthcare NHS Trust	277	37	(240)	1,132	301	(831)	2,250	2,250	0	2,396	2,250	0
TOTAL SYSTEM	**2,890**	**601**	**(2,289)**	**15,605**	**7,174**	**(8,431)**	**26,286**	**26,280**	**(6)**	**27,359**	**26,280**	**0**
Total Charge against CRL including IFRS impact												
NHS Shropshire, Telford and Wrekin	0	0	0	0	0	0	0	0	0	1,872	0	0
The Shrewsbury and Telford Hospital NHS Trust	8,880	3,656	(5,224)	37,416	12,013	(25,403)	92,483	92,983	500	78,668	92,483	500
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT	813	461	(352)	6,606	5,565	(1,041)	7,585	7,579	(6)	12,504	7,579	0
Shropshire Community Healthcare NHS Trust	277	229	(48)	4,660	4,084	(576)	7,385	7,385	0	5,833	7,385	0
TOTAL SYSTEM	**9,970**	**4,346**	**(5,624)**	**48,682**	**21,662**	**(27,020)**	**107,453**	**107,947**	**494**	**98,877**	**107,447**	**500**

- The System Capital Prioritisation and Oversight Group role is to ensure the management of system operational capital within CDEL inclusive of management of overspends where required, this is especially challenging with the 10% reduction as per the financial framework. The systems ability to consume IFRS16 lease additional costs in addition to the 10% reduction is limited and is being compounded by lack of sufficient frontline digital funding.
- YTD system operational capital spend is behind plan by £8.4m at month 7 predominantly relating to the delays with the modular wards at SaTH, the ICB schemes are slightly ahead of plan, RJAH slippage relates to the Theatres scheme and SCHT due to delays in starting the capital programme whilst the prioritization exercise was completed, although the full capital plan is expected to be delivered by the end of the financial year with schemes coming online in later months.
- The total system capital spend including IFRS16, HTP and CRL is £27m behind plan at month 7, predominantly as a result of the phasing of the HTP plan due to the delay in signing the contract.

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Shropshire, Telford and Wrekin

Appendix D - Workforce

System Overview – WTE and Availability

11,314	8.8%	10.2%	5.3%	81%	87%	92%
WTE	Vacancy	Turnover	Sickness	AfC Appraisals	Medical Appr.	Mand. Training

Reduced by 17 wte since last month

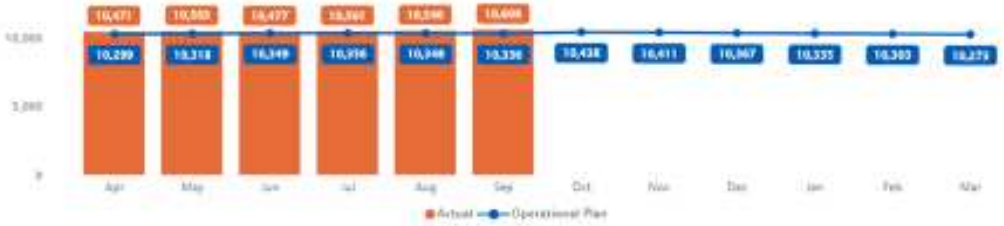
Reduced by 0.3% since last month and at same level as M1

Slightly below System plan of 11.9%

On plan although further work on unavailability required to deliver additional stretch efficiency target

Substantive WTE Actual vs Plan

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Operational Plan	10,299	10,318	10,349	10,356	10,348	10,336	10,438	10,411	10,367	10,335	10,303	10,273
Actual	10,471	10,503	10,477	10,501	10,546	10,608						
Variance	172	185	129	145	198	273						



Metric	Staff Group	Data Period	MPFT Value	MPFT Variation	RJAH Value	RJAH Variation	SaTH Value	SaTH Variation	SCHT Value	SCHT Variation	SYSTEM Value	SYSTEM Variation
Sickness %	Total	Sep 2024	5.11%		5.11%		5.32%		5.34%		5.27%	
Turnover %	Total	Sep 2024	10.1%		8.21%		10.5%		10.9%		10.2%	
Vacancy %	Total	Sep 2024	14.4%		5.12%		9.05%		11.5%		9.59%	

KPI	Plan	Performance
Delivery of 2024/25 Workforce Plan: WTE	WTE 10,867 exc 220 'stretch'	Overall WTE on track (below plan by 24 wte)
Delivery of 2024/26 Workforce Plan: Expenditure across all staff types	£609.5m	YTD adverse variance £3.45m
Refreshed People & OD Strategy	March 2025	On track
2025/26 Workforce Delivery Plan signed off	March 2025	On track
Vacancy rate	7.25%	8.8%*
Turnover	11.9%	10.2%
Sickness	5.3%	5.3%**
% Agency Price Cap Compliance	60% (national target)	69%
% Agency Framework Compliance	100%	100%
Agency as % Total Pay	4.2%	5.1%

* System Vacancy Panel in place to ensure robust controls applied to vacant posts – if roles are held or paused but not disestablished, this will impact the vacancy rate

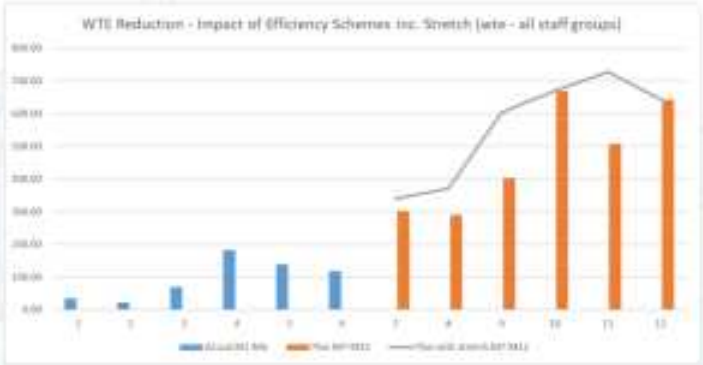
** Sickness on track for workforce plan but revision to efficiency target resulting in lower target for sickness as part of 'stretch' plans

NHS

System Overview - Spend

Expenditure (£000s)	YTD Plan M6	YTD Actual M6	YTD Variance M6	Current FY Plan 2024/25	Current FY Forecast 2024/25	Current FY Variance Plan vs Forecast 2024/25	FY Run Rate 2024/25 (at M6)	FY Variance Plan vs Run Rate 2024/25
Substantive	265601	265779	-178	536674	534377	2297	531558	5116
Bank	26348	29715	-3367	48336	50932	-2596	59430	-11094
Agency	16055	15960	95	24466	23015	1451	31920	-7454
TOTAL	308004	311454	-3450	609476	608324	1152	622908	-13432

- Overall adverse cost variance at M6 at just under £3.5m – based on run rate the FY adverse variance has reduced from £19.4m at M5 to £13.4m at M6.
- Overspend related primarily to industrial action, unavailability, escalation and enhanced bank rates.
- Mitigations included in workforce efficiency schemes with a total value of £40.3m in 2024/25 of which £28m is phased for delivery from M7 onwards.
- Schemes include further agency reduction (£2.4m still to deliver), reduction in unavailability (£3.4m), elimination of enhanced bank rates and reduction in temporary staffing premium medical (£2.8m), WTE reduction (£3.5m) and impact of off-framework elimination (£0.8m).
- Of the total £40.3m workforce schemes underway, £19.6m considered medium/high risk and £20.68m considered low risk.
- Work is underway with PWC to de-risk high value schemes and £2.78m has moved from medium/high to low risk during September. £5.8m rated as high risk is associated with escalation – work continues to de-risk via the UEC Board.
- Engagement with regional initiative on standardised temporary staffing rates for nursing – STW continues with systemwide initiative to introduce harmonised rate cards for medical temporary staffing.
- Enhanced bank rates ceased beginning October.



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SATH - Availability, WTE and Spend

Workforce trends by staff group SATH

Metric	Staff Group	Data Period	SaTH Value	SaTH Variation
Sickness %	Total	Sep 2024	5.32%	
Turnover %	Total	Sep 2024	10.5%	
Vacancy %	Total	Sep 2024	9.05%	
	Nursing, midwifery and health visiting	Sep 2024	6.09%	
	Infrastructure and Administration	Sep 2024	4.28%	
	HCSW	Sep 2024	11.3%	
	CP, Medical and dental	Sep 2024	5.14%	
	Allied Health Professionals	Sep 2024	21.1%	
Vacancy WTE	Total	Sep 2024	711	
	Nursing, midwifery and health visiting	Sep 2024	134	
	Infrastructure and Administration	Sep 2024	78.8	
	HCSW	Sep 2024	127	
	CP, Medical and dental	Sep 2024	48.7	
	Allied Health Professionals	Sep 2024	106	

Spend Actual vs Plan

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Operational Plan	34,827	34,864	41,625	36,251	35,905	35,631	35,052	34,945	34,631	34,229	34,100	33,926
Actual	37,529	74,564	-51	37,223	37,339	36,830						
Variance	2,702	39,700	-41,676	972	1,434	1,199						

Staff Costs Actual vs Plan – (£000)

WTE Actual vs Plan

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Operational Plan	8,122	8,118	8,117	8,050	7,973	7,904	7,940	7,852	7,759	7,665	7,572	7,478
Actual	7,994	7,998	7,943	7,922	7,918	7,921						
Variance	-128	-120	-175	-128	-55	17						

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

RJAH - Availability, WTE and Spend

Workforce trends by staff group RJAH

Metric	Staff Group	Data Period	RJAH Value	RJAH Variation
Sickness %	Total	Sep 2024	5.11%	
Turnover %	Total	Sep 2024	8.21%	
Vacancy %	Total	Sep 2024	5.12%	
	Nursing, midwifery and health visiting	Sep 2024	4.38%	
	Infrastructure and Administration	Sep 2024	5.85%	
	HCSW	Sep 2024	10.7%	
	CP, Medical and dental	Sep 2024	2.01%	
	Allied Health Professionals	Sep 2024	4.03%	
Vacancy WTE	Total	Sep 2024	85.2	
	Nursing, midwifery and health visiting	Sep 2024	14.4	
	Infrastructure and Administration	Sep 2024	35.5	
	HCSW	Sep 2024	23.7	
	CP, Medical and dental	Sep 2024	3.67	
	Allied Health Professionals	Sep 2024	7.62	

Spend Actual vs Plan

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Operational Plan	7,715	7,690	7,730	7,733	7,712	7,665	8,074	7,890	7,857	7,822	7,822	7,627
Actual	8,054	7,831	8,107	7,888	7,701	7,777						
Variance	339	135	377	155	-11	-88						

Staff Costs Actual vs Plan - (£000)

WTE Actual vs Plan

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Operational Plan	1,690	1,695	1,702	1,689	1,688	1,681	1,672	1,670	1,651	1,640	1,638	1,639
Actual	1,646	1,632	1,645	1,695	1,695	1,676						
Variance	-44	-63	-57	6	7	-6						

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Shropshire, Telford and Wrekin

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SCHT - Availability, WTE and Spend

Workforce trends by staff group SCHT

Metric	Staff Group	Data Period	SCHT Value	SCHT Variation
Sickness %	Total	Sep 2024	5.34%	
Turnover %	Total	Sep 2024	10.9%	
Vacancy %	Total	Sep 2024	11.5%	
	Nursing, midwifery and health visiting	Sep 2024	6.54%	
	Infrastructure and Administration	Sep 2024	14.9%	
	HCSW	Sep 2024	11.9%	
	CP, Medical and dental	Sep 2024	27.0%	
	Allied Health Professionals	Sep 2024	11.2%	
Vacancy WTE	Total	Sep 2024	207	
	Nursing, midwifery and health visiting	Sep 2024	44.9	
	Infrastructure and Administration	Sep 2024	66.8	
	HCSW	Sep 2024	22.8	
	CP, Medical and dental	Sep 2024	7.41	
	Allied Health Professionals	Sep 2024	24.6	

Spend Actual vs Plan

WTE Actual vs Plan

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Operational Plan	1,755	1,755	1,755	1,750	1,750	1,750	1,750	1,750	1,750	1,750	1,750	1,750
Actual	1,696	1,688	1,708	1,714	1,715	1,717						
Variance	-60	-67	-47	-36	-35	-33						

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

MPFT – Availability and WTE

Workforce trends by staff group MPFT

Metric	Staff Group	Data Period	MPFT Value	MPFT Variation
Sickness %	Total	Sep 2024	5.11%	
Turnover %	Total	Sep 2024	10.1%	
Vacancy %	Total	Sep 2024	14.4%	
	Nursing, midwifery and health visiting	Sep 2024	16.0%	
	Infrastructure and Administration	Sep 2024	10.8%	
	HCSW	Sep 2024	11.4%	
	CP, Medical and dental	Sep 2024	29.2%	
	Allied Health Professionals	Sep 2024	38.6%	
Vacancy WTE	Total	Sep 2024	248	
	Nursing, midwifery and health visiting	Sep 2024	76.1	
	Infrastructure and Administration	Sep 2024	41.9	
	HCSW	Sep 2024	21.1	
	CP, Medical and dental	Sep 2024	21.1	
	Allied Health Professionals	Sep 2024	47.8	

Spend Actual vs Plan

* MPFT spend not available

WTE Actual vs Plan

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Operational Plan	1,056	1,073	1,073	1,073	1,073	1,073	1,087	1,087	1,087	1,087	1,087	1,087
Actual	1,560	1,577	1,584	1,594	1,596	1,608						
Variance	504	504	512	521	523	535						

Agenda Item

ICB 27-11.087

Integrated Care System Performance Appendix 1 - Integrated Performance Report Nov 24 Final

Agenda Item

ICB 27-11.089

Maternity and Neonatal Annual Position Statement

Appendix 1 - SaTH 154.24-External-Neonatal-Review-Report-Final

The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 14 November 2024

Agenda item	154/24				
Report Title	Invited Review: The Shrewsbury and Telford Hospital NHS Trust Neonatology Service Review				
Executive Lead	Dr John Jones, Executive Medical Director				
Report Author	Mike Wright, Programme Director Maternity Assurance				
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**	
Safe	√	Our patients and community	√	BAF1, BAF2, BAF 3, BAF 4 and BAF 8	
Effective	√	Our people	√		
Caring	√	Our service delivery	√	**Trust Risk Register id:**	
Responsive	√	Our governance	√	684, 700, 859, 871, 903, 1091	
Well Led	√	Our partners	√		
Consultation Communication	Quality & Safety Assurance Committee 29/10/2024				
Executive summary:	1. This paper presents the findings of the invited Royal College of Physicians' review of neonatal mortality from 2021 to 2022 including review of SaTH's use of the perinatal mortality review tool (PMRT). The review was commissioned by the Trust to understand the above average mortality noted in successive MBRRACE reports 2. The review commented that, "neonatal mortality at SATH cannot be considered in isolation to neonatal mortality across the region. The West Midlands has the highest infant mortality in England (with 5.6 deaths per 1,000 live births), and this has been the picture since 2000." The review suggests the need to investigate the drivers underpinning these data, including social determinants, and poverty and ethnicity factors. 3. The review team did not identify evidence to indicate that the quality of care provided to babies by the neonatal service was substandard or directly contributing to the unit's outlier status in terms of perinatal mortality. However, there were findings of poor care, or very poor care in one instance. 4. Work is underway to communicate with the 18 families affected by the review, and the Trust is working with colleagues and system partners to implement the recommendations. 5. As family meetings progress, details of individual care have been redacted from the review to minimise risk of harm caused by hearing, without consent, very detailed care being discussed in public even though anonymised. Only if consent has clearly been obtained should such detail be included.				
Recommendations for the Board:	The Board of Directors is requested to: • Receive this report for noting and assurance • Decide if any further information and/or assurance are required.				
Appendices:	Appendix 1: The Royal College of Physicians (RCP) – Invited Service Review Report (with redactions)				

1.0 Introduction

1.1 Following initial discussions with the Royal College of Paediatric & Child Health in February 2022, in April 2022, the Executive Medical Director commissioned the Royal College of Physicians (RCP), supported by other royal colleges, to undertake an independent review of the neonatology service at the Trust. This was to try and ascertain if any aspects of care provided at the Trust influenced its higher than average perinatal mortality rate, specifically neonatal deaths[1].

1.2 The review provided initial feedback and recommendations in December 2023, and the final report was received on 6 September 2024. This paper describes the background to this work, the findings of this review, and the actions being taken to address its recommendations. Work is underway already to address the recommendations.

1.3 The review team did not identify evidence to indicate that the quality of care provided to babies by the neonatal services was substandard or directly contributing to the unit's outlier status in terms of perinatal mortality.

1.4 Whilst identifying aspects of good care, the review also found examples of poor care, or very poor care in one case. In some cases external independent review of care had already taken place as part of statutory reporting to the healthcare safety investigation branch (HSIB). The Trust is in contact with the families concerned and apologises unreservedly to them for care that was not provided to the required standard.

2.0 Background and context

2.1 The Board of Directors is aware of the findings of the Independent Review of Maternity Services at the Trust (IMR), chaired by Donna Ockenden, which was published in March 2022. This review included a profile of neonatal care provided at the Trust between 2000-2019, and described changes to the levels of service provided during this time as a consequence of the establishment of neonatal networks in England from 2004. This included several years of transition from the Trust providing Level 3 (full) Neonatal Intensive Care to its current designation as a Local Neonatal Unit (LNU) providing Level 2 care (special care, high dependency care and short term intensive care only, with transfer to Level 3 units required for more complex or ongoing intensive care). During this time there were challenges and complexities both within and external to the Trust and the network, as the newly reconfigured unit designations, procedures, policies, and arrangements became established.

2.2 The IMR provided actions for the Trust's neonatal service to implement, and these centred on ensuring early communication with tertiary NICU's (Level 3 units) and neonatal staffing matters.

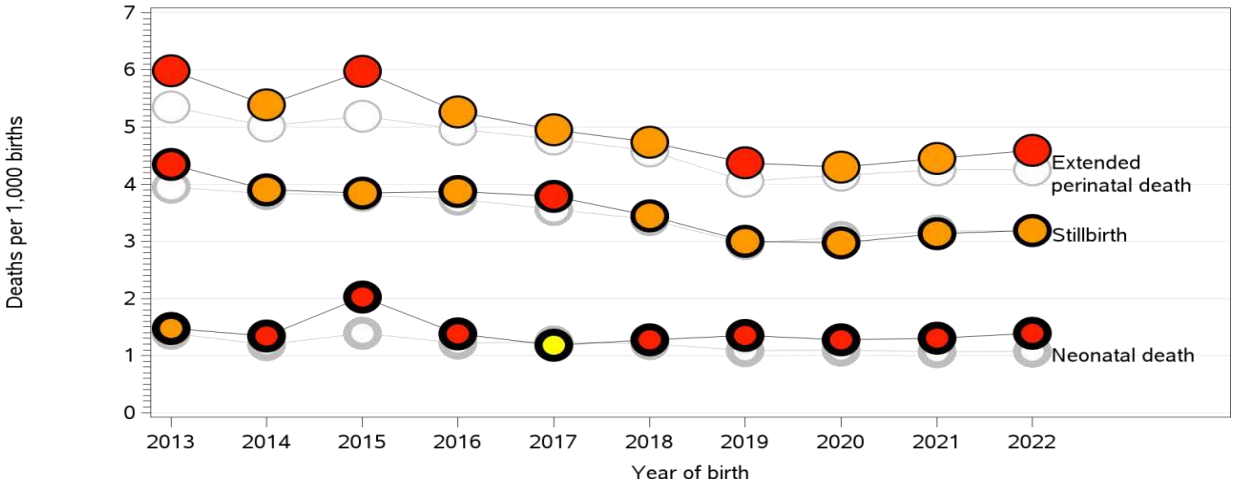
2.2 Alongside this, since 2013, all NHS providers of maternity and neonatal services have been required to report to MMBRACE-UK[2] all late fetal losses (babies born between 22 and 23 completed weeks' gestation showing no signs of life), all stillbirths, and all neonatal deaths. Compliance with MBRRACE submissions forms part of the Saving

[1] (Extended) Perinatal Mortality means the sum of stillbirths and neonatal deaths. The term stillbirth is applied when a baby is delivered at or after 24 weeks gestation but shows no signs of life. A neonatal death is term given when a baby is born alive from 20 weeks completed gestation but dies within 28 days of birth.
[2] The perinatal programme of MMBRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) is led by the Infant Mortality and Morbidity study group (TIMMS) at University of Leicester. Hyperlink: Perinatal programme of work | MBRRACE-UK | NPEU (ox.ac.uk)

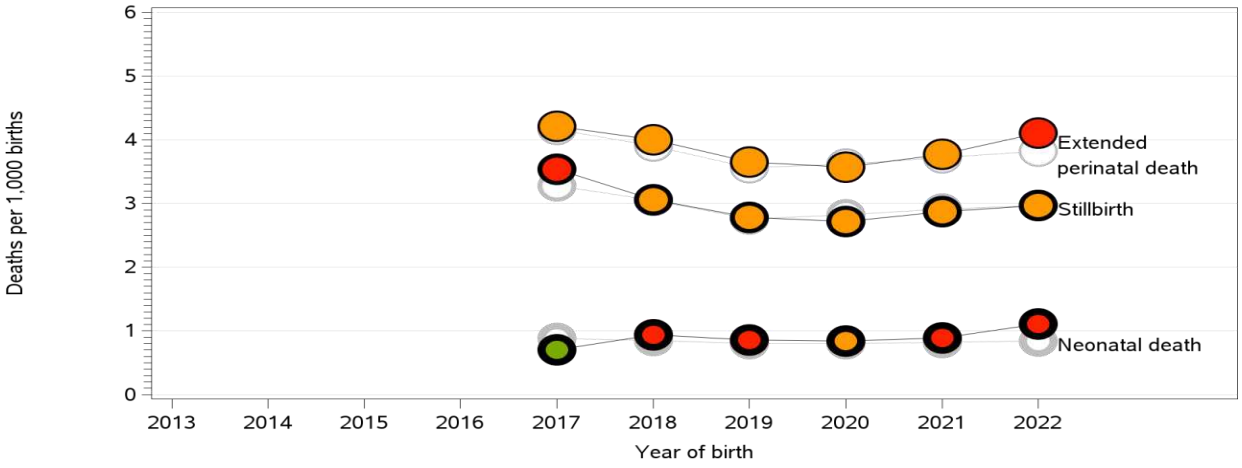
Babies Lives Care Bundle requirements, also. From these data, annual reports are produced for individual trusts along with national reports, which provide crude mortality and risk adjusted data, and benchmark comparisons.

2.3 Since 2017, MBRRACE calculates stabilised and adjusted mortality rates**,** which provides a more reliable estimate of the underlying mortality rate, and takes account of factors such as the mother's age, socio-economic and deprivation factors, the baby's sex and ethnicity, multiplicity, and (for neonatal deaths only) gestational age at birth. MBRRACE advises that while it is not possible to adjust for all potential risk factors, these measures do provide an important insight into perinatal mortality. Trust results are then benchmarked against trusts offering similar level services which, for this Trust, is those that provide *'4,000 or more births per annum at 22 weeks or later*.'

2.4 The latest published MBRRACE data for this Trust[3] covers the calendar year 2022, and was published in March 2024. The following table shows the stabilised and adjusted mortality rates for babies born at 24 weeks gestational age or later by year of birth (all deaths from 2013-2022):



2.5 The following chart shows the stabilised and adjusted mortality rates for babies born at 24 weeks gestational age or later by year of birth – excluding deaths due to congenital anomalies:



** Note 2022 includes a reporting error on one Neonatal Death (see below)

[3] The Shrewsbury and Telford Hospital NHS Trust MBRRACE-UK Perinatal Mortality Report, March 2024 *(MB249) v1.0*

The stabilised & adjusted neonatal mortality rate excluding deaths due to congenital anomalies is reported as 1.11 per 1,000 live births. This is more than 5% higher than the average for similar trusts and Health Boards. However, these data include a reporting error (1 out of 8 babies incorrectly recorded in MBRRACE data 2022 as not having a congenital anomaly recorded as cause of death). Therefore, this neonatal mortality rate is likely to be lower than reported. The reporting error was escalated to MBRRACE in May 2024 but, unfortunately, the report cannot be retrospectively amended.

2.6 In response to this, MBBRACE advises trusts to review the data submitted to ensure accuracy and completeness, and to ensure that a review of each death has been undertaken using the Perinatal Mortality Review Tool (PMRT) to assess care, and identify and implement service improvements to prevent similar deaths.

2.7 This Trust undertakes the PMRT process for each death; however, the reasons for the Trust's outlier status have not been explained through this.

2.8 In line with this and in anticipation of the publication of the final Independent Maternity Review Report, in February 2022, the former Chief Executive, Medical Director and Programme Director for Maternity Assurance met with members of NHS England Midlands Region and the West Midlands Neonatal Operational Delivery Network (WMNODN). This was to discuss the Trust's MBBRACE data, to understand their perspectives, and agree a way forward. Several meetings took place to discuss this.

2.9 We recognised there were similar trends across the region. Whilst continuing to work with the network and system partners, to try and understand these data more fully from an organisational perspective the Trust commissioned its own independent external review. Invited reviews are in line with best practice and demonstrate the Trust's desire to maintain transparency and to learn and to improve.

3.0 The Royal College of Physicians (RCP) – Invited Service Review Report Findings

3.1 The RCP review considered membership and advice from other royal colleges, and the review team included three consultant neonatologists, two consultant obstetricians, a consultant midwife, and two advanced neonatal practitioners. The review focused on the two most recent consecutive years (2021 and 2022), and looked at 18 cases of neonatal deaths over that period. Their methodology included case note and other documentary reviews, alongside site visits, and meetings/interviews with key staff, which took place during October and November 2023.

4.0 Review Findings

4.1 The review team described their overall impression as being of a maternity service that had taken huge strides over the past 18 months to two years (following publication of the first Ockenden Report in December 2020) to rebuild the service, staff teams, processes, and culture. However, it recognised that the neonatal service, having not had the same level of external scrutiny, and with some staffing and other challenges, as being in a different place.

4.2 Specifically and importantly, *"the review team did not identify evidence to indicate that the quality of care provided to babies by the neonatal service was substandard or directly contributing to the unit's outlier status in terms of perinatal mortality."*

4.3 Notwithstanding this, the review found that the unit sometimes managed very pre-term babies who were not delivered in the right location (adjacent to a level 3 Unit). Recommendations include the Trust working with the WMNODN to address these matters.

4.4 Alongside opportunities identified to strengthen care, the review team identified some examples of excellent care, both in maternity and neonatal services. Other review findings identified aspects and components of care that were either poor or, in one case, very poor care with significant room for improvement.

4.5 The review commented that, *"neonatal mortality at SATH cannot be considered in isolation to neonatal mortality across the region. The West Midlands has the highest infant mortality in England (with 5.6 deaths per 1,000 live births), and this has been the picture since 2000."* The review suggests the need to investigate the drivers underpinning these data, including social determinants, and poverty and ethnicity factors.

4.6 The review team also raised concerns *"regarding paediatric mortality, with the system within which SATH sits reported to have been flagged as one of the highest areas for paediatric mortality in national datasets."* While the review team acknowledge this was not within the terms of their review, it pointed to the need for work to take place across the system and the region, to understand how child and infant deaths can be reduced.

4.7 Work has commenced already to address the recommendations from the report with the maternity, neonatal, and transformation support teams.

5.0 Communication with Families

5.1 The RCP report is anonymised, and no family identifiable details are provided with in it. Nonetheless, the review provides specific instances where care was not of the required standards and where improvements can be made against individual cases, with unique reference numbers. As such, these are likely identifiable to each family concerned.

5.2 It was important to determine if there were any care concerns or related matters to address before contacting families and causing any unnecessary anxiety or trauma for them. Now that the final report has been received, the executive medical director has written individually to each family to advise them of the review and to invite each family to meet with senior clinical members of the Trust to discuss the report findings and their own individual care findings. These meetings have begun taking place and as well as addressing and apologising for any poor or very poor care, these meetings are to listen to the families.

6.0 Next Steps

6.1 As mentioned already, work has started to address the recommendations. Progress against these will be reported to the Quality and Safety Assurance Committee (QSAC) and the Board of Directors accordingly.

6.2 Discussions with the WMNODN, ICB, Local Maternity and Neonatal System (LMNS) and NHSE Midlands Region are ongoing to provide a joined up response to the findings of this review.

7.0 Action required of the Board of Directors

7.1 The Board of Directors is requested to:

7.2 Receive this report for noting and assurance

7.3 Decide if any further information and/or assurance are required.

John Jones
Executive Medical Director
November 2024

Appendix One

Invited Review: The Royal College of Physicians (RCP) – Invited Service Review (redacted)

APPENDIX 1

Shrewsbury and Telford Hospital NHS Trust on 12–13 October, 16–17 November 2023

Contents

This report has been prepared by the Royal College of Physicians (RCP) under the RCP Invited Review (IR) mechanism for submission to the healthcare organisation that commissioned the invited review. It is an advisory document, and it is for the healthcare organisation concerned to consider any conclusions and recommendations reached and to determine subsequent action.

It is the responsibility of the healthcare organisation to review the content of this report and take any action that is considered appropriate to protect patient safety. The healthcare organisation should ensure that patients have received communication in line with the responsibilities set out in the Health and Social Care Act 2008 (Regulated activities) Regulations 2014, Regulation 20.[1]

1 Executive summary

The executive medical director of Shrewsbury and Telford Hospital NHS Trust (SaTH) commissioned the Royal College of Physicians (RCP) to undertake an invited review (IR) of the trust's neonatal service and specifically, perinatal mortality. The review was led by the RCP, using IR processes that are well established[2] and ordinarily applied within the 30 different physician specialties. The scope of this review involved medical specialties outside the specialist expertise of the RCP; therefore, the RCP worked with other colleges and specialty associations to ensure that appropriate and relevant specialist expertise was obtained. Specialist input was provided via the Royal College of Paediatrics and Child Health (RCPCH), the Royal College of Obstetrics and Gynaecology (RCOG), and the Royal College of Midwives (RCM). The British Association of Perinatal Medicine (BAPM) also provided assistance to the RCP in identifying specialist reviewers.

These organisations supported the RCP in building a review team to cover the breadth of expertise needed. This included: three consultant neonatologists (two with experience of a local neonatal unit (LNU) and the third from a neonatal intensive care unit (NICU)); two consultant obstetricians, one of whom was also a consultant in fetal medicine; a consultant midwife; and two advanced neonatal nurse practitioners. The review manager had previously served as a lay reviewer for the RCPCH on seven reviews, including of neonatal services.

The main objective of this IR was to provide an independent and expert review of perinatal mortalities, focusing on two consecutive years, 2021 and 2022. SaTH, which operates an LNU, had been an outlier on MBRRACE-UK[3] (UK perinatal deaths) since 2020. The trust was keen to understand any changes necessary to reduce neonatal mortality.

Context

The quality and safety of maternity and neonatal services has been under intense scrutiny with the publication of several independent investigations into maternity and neonatal services at specific NHS trusts. SaTH has been one of four trusts focused upon in recent years.[a] The final report of the independent review of maternity services at SaTH ('the Ockenden review') was published in March 2022.[4] The review found repeated failures in the quality of care and governance at the trust and hundreds of cases where the trust failed to undertake serious incident investigations, with some cases of death not being examined appropriately.[5] The trust has apologised for the pain and distress caused and taken full responsibility for its failings.[6]

While recognising the traumatic experiences of the women and families covered by the review, the process has also taken its toll on trust staff, who have had to cope with unpleasant comments made in the social media and the press. A police investigation into maternity services at the trust (Operation Lincoln) remains ongoing.[7] It is against this backdrop that interviews with trust staff took place under this invited review.

Maternity services were not the core focus of this review. However, all parties recognised that neonatal mortality could not be fully understood without considering the obstetric journey, and whether the risks associated with perinatal mortality had been identified and managed appropriately. This review therefore involved interviews with staff from obstetric and midwifery services, as well as from the neonatal service.

[a] The other three being Morecambe Bay, East Kent and Nottingham University Hospitals

Key messages

The overall impression was of a maternity service that had taken huge strides over the past 18 months to 2 years (following publication of the first Ockenden report in December 2020[8]) to rebuild the service, staff teams, processes, and culture.

The neonatal service, which had not received the same level of external scrutiny, was in a different place: more fragile and mending after nursing leadership challenges, which had severely impacted morale. The review team did not identify evidence to indicate that the quality of care provided to babies by the neonatal service was substandard or directly contributing to the unit's outlier status in terms of perinatal mortality. However, the review team observed that the unit sometimes managed very preterm babies who were not delivered in the right location (ie adjacent to a NICU), which created pressure on staff to stabilise and manage very vulnerable babies until they could be transferred out. This review raised some questions over the extent to which the West Midlands Neonatal Operational Delivery Network (WMNODN) was achieving its objective of 'high quality care for the right mother and right baby in the right place as close as possible to home'.[9] Princess Royal Hospital, SaTH's centre for inpatient women and children's services, is shown at number 2 on the map below. Number 1 is Royal Stoke University Hospital, described as SaTH's link NICU. Good working relationships were also reported with New Cross Hospital NICU, number 3.

Source: https://www.wmnodn.org.uk/app/maps/SWMNNMap202011.pdf

It was clear that neonatal mortality at SaTH cannot be considered in isolation to neonatal mortality[b] across the region. The West Midlands has the highest infant[c] mortality in England (with 5.6 deaths per 1,000 live births[10]), and this has been the picture since at least 2000.[11] There is a need to investigate the drivers underpinning the regional mortality and to give attention to pathways across the region. The ultimate solution to addressing neonatal mortality rests at population level and a public health approach will be necessary, taking into consideration multiple factors, such as social determinants, poverty and ethnicity.

[b] A neonatal death is the death of an infant aged under 28 days
[c] An infant death is the death of an infant under 1 year

During the review concerns were also raised regarding paediatric mortality, with the system within which SaTH sits reported to have been flagged as one of the highest areas for paediatric mortality in national datasets (see 6.2.2). These issues are broader than deaths captured by perinatal mortality review tools but point to a need for work to take place across the system, and the region, to understand how child and infant deaths can be reduced.

The review team identified several opportunities to improve certain aspects of neonatal care within SaTH's LNU. A letter providing immediate feedback was issued to the trust medical director on 4 December 2023. This report provides the full conclusions of the review team, relevant to each of the terms of reference (section 2). The recommendations arising from these conclusions can be found at section 3.

Alongside opportunities to strengthen care, the review team identified some examples of excellent care: specifically, three of the 18 cases examined by the review team were graded excellent care for the obstetric journey (section 6.1.2) and one case also demonstrated excellent end of life care (section 6.1.7). Other highlights of the review included the positive evolution in organisational culture evident in the maternity service, which was described by one interviewee as 'a good culture of professional challenge' (section 6.2.3). Another highlight was stronger family engagement arising from learning from incidents. The bereavement midwives were said to receive 'exceptional feedback' from parents and had been working with bereaved fathers, who can often be overlooked in terms of engagement (section 6.3.3). Finally, one interviewee described teamworking amongst the multidisciplinary neonatal team as 'amongst the best in the West Midlands' (section 6.3.4), which provides a firm foundation for the neonatal unit to build upon.

2 Conclusions

TOR 1: Clinical record review

Before undertaking staff interviews, the review team undertook a clinical record review of 18 perinatal mortalities that occurred in 2021 and 2022. These were deaths that were reportable to MBRRACE and subject to the national Perinatal Mortality Review Tool (PMRT), which is integrated into the MBRRACE-UK programme of work. Of the 18 cases that were subject to structured judgement review:

- five were graded 'good practice'
- eight were graded 'room for improvement' for clinical reasons
- two were graded 'room for improvement' for both clinical and organisational reasons
- two were graded 'unsatisfactory'
- there was insufficient information to assess the quality of care in one case (see 6.1.1).

Obstetric journey: More than half the cases were graded adequate, good or excellent in terms of antenatal risk assessment and care provided in the antenatal, intrapartum and postnatal period. Opportunities for improvement were identified with respect to:

> planning for babies with identified fetal anomalies, where the absence of referral to a tertiary centre denied the mother the opportunity for wraparound care and a clear plan in terms of outcome options for the baby
> clinical decision making in the intrapartum period, including delays observed in delivering some babies with sufficient urgency and decision making over task delegation in preterm births.

No systemic issues were identified regarding obstetric anaesthesia.

Care of the baby at delivery by the multidisciplinary team: Most cases were graded good or adequate care under this heading, reflecting responsive care of the baby at delivery, with appropriate staff present. Often in cases graded good care, a neonatal consultant was present and strong leadership was evident. Opportunities for improvement were identified with respect to the following:

> delayed cord clamping
> deviation from Newborn Life Support (NLS) guidelines[12]
> use of the resuscitation proforma
> intubation (in several cases, multiple attempts were made at intubation, and at times this gave rise to a sense of panic during resuscitation and indicated learning needs in this area)
> senior leadership (in some cases, the review team believed that consultant presence could have resulted in more coherent care of the baby at delivery)
> documentation issues.

Neonatal resuscitation followed the NLS algorithm in most cases but not infrequently there was tendency by junior staff to rapidly progress through the airway management without adequately checking or documenting chest movements. This meant there were early and multiple unsuccessful attempts at intubation by junior doctors, in some cases even with a consultant present. Senior oversight and measured decision making appeared to be lacking in these instances.

Extreme preterm infants born in an LNU often need intubation for transfer reasons; however, in one case [redacted]

[redacted]. In many of the cases reviewed, the babies were born out of hours and therefore the first responding team comprised doctors in training or advanced neonatal nurse practitioners (ANNPs), which could have contributed to an overly invasive approach to preterm stabilisation. BAPM's new neonatal airway safety standard document[13] sets out expectations regarding intubation of babies. For those staff who do not have the skills to intubate competently and confidently, the focus for safe airway management should be on using skills and simulated sessions on maintenance of the airway using non-invasive ventilation techniques. Supporting training materials for the BAPM neonatal airway safety standard include airway skills training and assessment tools; tips for videolaryngoscopy; and a guide on the use of waveform capnography.

Care following admission to the SaTH neonatal unit: For three of the 18 babies, no care was provided on the neonatal unit (the baby was admitted to the Children's Assessment Unit or died on the delivery unit, or deteriorated in the community and was taken to another hospital).

The review team recognised the challenges for the unit in caring for very premature babies; in two cases, the infants were 25+3 weeks and 26 weeks. Opportunities for improvement were identified with respect to the following:

- golden hour timings (particularly for giving surfactants and antibiotics) – see 6.1.4
- antibiotic regimens
- baby handling during the golden hour
- temperature maintenance
- ventilation
- clinical decision making
- equipment issues (for one case, scales in the neonatal unit were broken and no accurate weight was available for this baby until after they had died)
- senior leadership
- communication and escalation to transport service and a NICU.

Multidisciplinary team working and communication between colleagues: Most cases were graded good or adequate care under this heading, reflecting evidence of expected standards around teamworking and communication between colleagues. There were some good examples of neonatal consultants seeking the additional input of colleagues with subspecialty expertise (eg in metabolic disorders). Some issues were identified with respect to senior leadership, specifically: the difference it may have made had the consultant on call in one case attended the unit at night for a very preterm infant; and the delegation of tasks during resuscitation in another case, which could have been improved by more decisive decision making and stronger senior leadership.

Interactions with parents, family members and family integrated care: Most cases were graded good or adequate care under this heading, reflecting clearly documented information sharing with the parents and involvement of the parents in the baby's care where possible. In some cases, discussions with parents were not documented as well as they might have been or were not as timely as expected. Sometimes there was delay in offering parents the opportunity to see or touch their baby on the neonatal unit.

End-of-life care and support offered before and after a perinatal death: In nine of the 18 cases, the infant was transferred from SaTH to a NICU. End-of-life care and support offered before and following the death of the infant took place at the NICU and gradings could not be reached on this element of care in these nine cases. In the remaining nine cases, where end-of-life care was provided at SaTH, one case stood out for providing excellent care under this heading. Other cases were graded good or adequate.

Clinical record keeping: Clinical record keeping was mostly graded adequate care. ANNP documentation was observed as being to a high standard.

TOR 2: The internal application by SaTH staff of the PMRT in the perinatal mortalities that occurred in 2021 and 2022

The review team identified several themes from consideration of the PMRT reports for 16 of the 18 babies. The PMRTs often involved large panels, with good representation from the LNU and the NICU. However, most panels lacked neonatal externality in terms of a neonatal consultant from another hospital who could bring an independent perspective to events, particularly where issues relating to leadership needed to be explored. While two consultant obstetricians from another trust were job planned to provide externality in PMRTs, the review team was not clear whether they covered fetal medicine and high-risk pregnancy/ preterm birth. The PMRTs were highly process-focused with limited exploration of leadership issues. At times, the neonatal consultant involved in the delivery of care was present on the panel, which may limit the exploration of areas for learning in relation to leadership and decision making. Plans were said to be underway to develop neonatal externality, with neonatologists rotating to contribute to PMRTs across different units.

The PMRTs often missed some relevant learning at the LNU, with a tendency to focus more heavily on the transfer of care to another centre and on the care provided at the NICU. There was a tendency for the review to be process-focused with respect to LNU care – for example, on use of the resuscitation proforma, temperature before transfer to the neonatal unit, documentation of transfer, and monitoring in the neonatal unit. Some actions were to address identified issues via one-to-one discussions with staff, which risked feeling punitive and undermining departmental learning. The review team concluded that some cases raised questions about the functioning of the neonatal network and the escalation of care, with the LNU at times left in a vulnerable position, caring for extremely sick premature babies. It was not evident that the PMRTs fully explored network issues that may have undermined the ability of the unit to provide high-quality care.

Participants in the PMRTs need a mechanism for flagging learning that sits outside the unit or units concerned, such as improved pathways for high-risk patients. Without this, it is difficult to see how quality improvement arising from PMRTs can ever be more than piecemeal. There would appear to be a role for the network in drawing together and acting upon network-wide learning.

Documentation issues were said to be a recurring theme from the PMRTs and the trust should expedite a business case to achieve its aspirations for a full electronic patient record system, which was expected to address some of these issues. The use of locums was another issue said to have surfaced during some PMRTs and pointed to a need for additional safeguards to be put in place to support locum neonatologists, particularly out of hours.

Feedback from PMRTs to the neonatal teams was disseminated via monthly neonatal governance meetings, which had been made more robust in the latter half of 2023. However, there were opportunities to strengthen feedback from PMRTs and specifically to make it timelier and to ensure that the entire team benefits. Staffing challenges were preventing neonatal nurse input into PMRTs, which undermined the dissemination of learning to nursing teams, who appeared isolated from PMRT learning. The neonatal nurse lead for PMRTs must have protected time to participate in PMRTs, mirroring the job-planned time given to consultants for this activity. The planned appointment of a governance lead neonatal nurse will support knowledge dissemination to all those working clinically on the unit. The unit may wish to draw on the approach taken in midwifery where shift coordinators disseminate learning in ‘real time’ during handovers at the beginning of each shift.

TOR 3: Pathway documentation, including escalation policies

The review team graded most of the 18 cases adequate in terms of compliance with network, national and Trust guidelines and recognised best practice. However, some non-adherence to guidelines was observed with respect to airway management; NLS algorithm; recognition and prompt treatment of low blood glucose levels; surfactant administration; and first dose of antibiotics within 1 hour of admission. There was variation in how care was delivered in the first hour depending on team configuration and leadership. There was reluctance to administer surfactant in the delivery suite and staff interviews indicated that this was local practice to avoid a perceived risk of inadvertent single lung surfactant administration due to suboptimal endotracheal tube position.

Of the 16 guidelines shared with the review team, just two guidelines had been adopted from the network, with the rest locally authored. The two that had been adopted from WMNODN were: Golden hour preterm babies <28 weeks' gestation and guidelines on transport and retrieval. The review team was informed that the unit started the clock for golden hour timings after admission to the neonatal unit, not the first hour of life. The WMNODN guidelines (2019–21) emphasise that the aim of the golden hour is 'to stabilise baby and perform all procedures required within the first hour **after birth'** (emphasis as shown on page 126 of the guidelines). The unit must be prepared to demonstrate (for example, via audits) that the decision not to comply with this aspect of network guidelines is not to the detriment of babies cared for on the unit.

The doses of antibiotics given were consistent across the cases and differed from network guidance, leading to the conclusion that the unit followed its own guidelines with respect to antibiotics. Several interviewees believed that antibiotics were administered within the golden hour, but no audits had been conducted in recent times to confirm this and some of the 18 cases reviewed demonstrated that this was not always achieved. Interviewees frequently expressed confidence that care was being provided in compliance with guidelines but were unable to provide evidence from audits to demonstrate this.

A key challenge related to this was the pressure on neonatal nursing staff, due to staffing shortfalls. Issues associated with the nursing leadership had led to nurses on the unit feeling demoralised and unwilling to step forward to take on additional responsibilities until human resources processes had concluded. This, together with difficulties in recruiting to some nursing roles (including a unit manager and band 6 nurses) and a lack of workforce planning, had resulted in staff being pulled away from non-clinical activities to focus on clinical tasks. The unit lacked specialist quality roles and qualified in specialty (QIS) nurses, with agency staff drafted in to fill these roles. Ambitions for the unit to 'grow its own' are unlikely to be achieved without a concerted focus on nurse training and education, which was said to be poor and ad hoc. Attention was needed to investing in the existing nursing workforce and succession planning. This issue was also of relevance to the ANNP team and the unit has fallen behind in terms of succession planning and progression from tier 1 to tier 2. Again, ANNPs needed protected time to undertake non-clinical and leadership roles to meet the four pillars of advanced practice.

The unit boasted a new cadre of allied health professionals. These staff are vital for good neonatal care and outcomes, and should be embedded into the unit and supported to develop in line with their specialist national standards.

The review team heard only positive feedback regarding the new divisional leaders and the executive leadership team. This new level of stability has replaced considerable turmoil and high management turnover, which limited the ability of the unit to progress and implement quality improvements. The entire division has been through enormous change and there was a pervading sense of optimism and determination relating to maternity services, which was only just beginning to filter through to the neonatal service. If equivalent dynamism of the leadership witnessed in maternity services could also lift

the neonatal nursing workforce (eg driving cultural change by empowering individuals), it could have benefits for the neonatal unit in terms of continuous quality improvement. All the outstanding actions for the neonatal unit from the Ockenden review related to staffing, mostly nursing and ANNPs.

The neonatal unit is but one part of a network; it relies on effective relationships with others within the network, supported by responsive pathways, to enable babies and their families to access the right level of care as near to home as possible. The review team observed that the SaTH unit sometimes treated extremely premature babies with complex needs for longer than it ought to, which may reflect a network that is not functioning as well as it might. Many LNUs would have difficulties caring for such babies without error. The review team heard about the challenges obstetric staff frequently faced in trying to transfer out a mother antenatally to avoid a high risk, preterm delivery within the unit. Issues were described in identifying both a bed for the mother and a neonatal cot, with the result that some babies were not delivered in the location best suited to meet their needs. There seemed to be a clear case for having a robust 24/7 cot locator service for antenatal and acute postnatal transfers. Across the network, intensive care capacity needs to be reviewed to ensure that provision can meet demand. Changes in fetal medicine consultant capacity were forcing new models of care and should result in new pathways for high-risk mothers and their babies.

Finally, the focus of this review was on neonatal mortality and the review team wished to commend the two specialist bereavement midwives who were the first point of professional support for most families where a poor outcome was anticipated, or when there was the unexpected death of a baby. There are opportunities to strengthen the bereavement pathway by appointing neonatal bereavement quality roles, to mirror those on the delivery suite. This is particularly important out of hours and also in light of the scope of work undertaken by the two specialist bereavement midwives.

Linked to this, the neonatal unit needs to develop its Family Integrated Care strategy to ensure that the voices of local families inform everything it does, including the response to this invited review.

3 Recommendations

Key for timelines for implementing recommendations:

> **Immediate (0–3 months)** – action should be completed within 3 months of receipt of the initial invited review feedback letter.

> **Short term (0–6 months)** – action should be completed within 6 months of receipt of the invited review report.

> **Medium term (6–12 months)** – action should be completed within 12 months of receipt of the invited review report. Planning for actions resulting from these recommendations should start as soon as possible.

> **Long term (12–24 months)** – action should be completed within 24 months of receipt of the invited review report. Planning for actions resulting from these recommendations should start as soon as possible.

Immediate recommendations	
Recommendation	**Timelines**
1. The service, an LNU, has retained equipment to provide nitric oxide even though changes have been made nationally to focus the provision of nitric oxide within NICUs.[14] The equipment was rarely used and yet associated with anxiety among nursing staff, many of whom were said to lack experience or training in its use. It is therefore recommended that the nitric oxide equipment should be removed from the unit.	**Immediate (0–3 months)**
2. The unit should develop a first hour (golden hour) checklist to facilitate delivery and documentation of time critical interventions within the first hour from birth for all infants admitted for intensive care.	**Immediate (0–3 months)**
3. There are several areas where the unit should undertake audits to better understand its current care provision. These include the following: a. The unit should collaborate with the ODN to review the number of intensive care days (HRG1) within the unit. The review team observed that for a birth denominator of 4,100, intensive care days appeared to be high, potentially indicating an interventionist approach to neonatal care. b. The unit should undertake quarterly audit of all neonatal resuscitations that extend beyond initial inflation breaths, against UK Resuscitation Council Newborn Life Support guidance, with specific focus on timeliness and sequence of interventions, escalations for additional senior help, response, and documentation on advanced resuscitation proforma. c. The unit should undertake a gap analysis of how its Family Integrated Care provision aligns with national guidelines. d. The unit should review National Neonatal Audit Programme (NNAP) quality outcome trends, particularly bronchopulmonary dysplasia, brain injury, non-invasive ventilation rates, and create quality improvement projects to address any issues identified.	**Immediate (0–3 months)**

Staffing and training	
Recommendation	**Timelines**
4. The unit should develop a training programme on approaches to ventilation that reflect expectations in BAPM's Neonatal Airway Safety Standard,[13] drawing on supporting training materials (for example, including for videolaryngoscopy).	Short term (0–6 months)
5. All neonatal nursing staff should be given protected time to attend mandatory training, equipment training and simulation sessions as a minimum. Simulation sessions should be regularly timetabled. To avoid nurses being pulled away from clinical duties, the trust could consider allocating one to two days over the year to complete mandatory training and attend multidisciplinary simulation training (like the approach taken in maternity services).	Short term (0–6 months)
6. Nursing quality roles must be allocated, with a particular focus on education, governance and Family Integrated Care, and staff given protected time to fulfil these roles.	Short term (0–6 months)
7. There should be protected time for bereavement quality roles in the neonatal service to work alongside the bereavement midwives.	Short term (0–6 months)
8. ANNPs should receive 20% protected time to ensure they complete all four pillars of advanced practice and must be able to access their allocated time to update their skills on a NICU.	Short term (0–6 months)
9. Team building should be undertaken to reflect on this review and enable the multidisciplinary team to identify actions. This should provide the following opportunities: a. For more junior nursing staff to develop effective working relationships with senior doctors on the unit and collaborate in projects to take the unit forward. b. To ensure debriefs, learning events, meetings, teaching and education aim for a multidisciplinary and multiprofessional theme to reflect the work environment and how care is delivered. c. To encourage psychological safety in ways of working, events, education and training, to ensure a safe space for colleagues to flag any concerns and worries.	Medium term (6–12 months)

Leadership	
Recommendation	**Timelines**
10. Neonatal nursing leaders (eg senior sisters) should be given protected time to undertake management and leadership responsibilities.	Short term (0–6 months)
11. This review highlights the benefits realised with excellence in clinical leadership. The trust should build on this with specific leadership development investment for medical and nursing leaders within the neonatal unit (eg Neonatal Clinical Lead, Clinical Director, Neonatal Matron). This could be executive coaching or specific leadership development programmes to include topics such as embedding psychological safety in teams, leadership succession planning etc.	Medium term (6–12 months)
12. The maternity service has had a new level of stability, following patterns of high turnover across all senior management roles, which has boosted recruitment (section 6.3.4). Trust leaders should facilitate learning from what has worked well in maternity and how this can be translated to	Medium term (6–12 months)

neonatal consultant and nursing leadership development on an ongoing basis.	

Perinatal mortality review	
Recommendation	**Timelines**
13. The PMRT process needs further development to become a useful mechanism for learning, including securing neonatal consultant as well as fetal medicine externality, protected time for neonatal nurse participation, and a clear mechanism for sharing learning with respect to the network. A network-wide approach may be needed to make best use of available resources and expertise, given the tension between a neonatal unit functioning with significant workforce gaps alongside a need of more from this same workforce in terms of PMRT attendance.	Short term (0–6 months)
14. Learning and actions from PMRT and incidents must be clearly documented and there must be a robust mechanism for feedback to the multidisciplinary team.	Short term (0–6 months)

Pathways, practice and escalation	
Recommendation	**Timelines**
15. The service should ensure compliance with the medical and nursing standards as listed in BAPM Service and Quality Standards for Provision of Neonatal Care in the UK, November 2022.[15]	Short term (0–6 months)
16. The neonatal service should review its 'golden hour' care practices for preterm infants and sick term infants born within the service, with a focus on implementing evidence-based care practices around resuscitation, stabilisation, surfactant administration and other supportive measures in the first few hours after birth.	Short term (0–6 months)
17. The trust should expedite consideration of the business case for an electronic patient record to enhance the accurate recording of the clinical journey for babies admitted to the neonatal unit.	Medium term (6–12 months)
18. The trust should engage the network in discussions over having a robust 24/7 cot locator service for antenatal and acute postnatal transfers, and for a review to take place into NICU capacity. Consideration could be given to a digital solution that also incorporates maternal bed availability and to learn from exemplar networks with well-developed cot locator services.	Medium term (6–12 months)
19. The trust should engage the neonatal network in the findings of this review, and specifically: a. Questions raised by the review team over the functioning of the network, with the LNU at times left caring for extremely sick premature babies for longer than it ought to. b. The impact of instances when the NICU appeared reluctant to accept patients for transfer from the LNU (section 6.1.4) on the likelihood or readiness for staff at the LNU to make a referral, and on timely transfer. c. Questions raised during interviews over whether escalation to NICUs happened sufficiently early and 'assertively enough' (section 6.2.2).	

Governance and learning	
Recommendation	**Timelines**
20. The neonatal team should review the feedback provided on the 18 cases reviewed as an opportunity to consider learning for the whole MDT.	Short term (0–6 months)
21. The unit should develop a clear programme of quality improvement and audit linked to clinical incidents and PMRT. Audits may include: airway management, golden hour timings, stabilisation, prescribing, documentation. It may be advisable to ask comparable units within a different ODN to share details of their audit programmes and examples of audit proformas, in addition to linking with audits taking place across the ODN.	Short term (0–6 months)
22. The trust should consider sharing the conclusions of this review with families (in particular the parents of the babies whose cases were reviewed), and other service users.	Short term (0–6 months)
23. The service must implement Family Integrated Care and regularly seek out family feedback and involvement in service improvements and redesign. This could be done by using network parent advisory groups, for example.	Medium term (6–12 months)
24. This report should be shared with the trust board, which should have oversight of any action plan developed to address the recommendations.	Medium term (6–12 months)

4 Introduction

Dr John Jones, executive medical director of SaTH, approached the RCPCH's IR service in February 2022, regarding SaTH's neonatal service. At the time, the RCPCH IR service was paused, therefore the RCP IR service was approached to undertake this review, with expertise drawn from RCPCH and other organisations. Dr Jones discussed the review with Dr Adam de Belder, RCP medical director for IRs at the RCP on 28 March 2022 and it was agreed that an invited review of the neonatal service at SaTH would be undertaken in October and November 2023.

4.1 Terms of reference for this invited review

The terms of reference for this review are as follows:

1. To assess the clinical management and quality of care provided by SaTH staff to the cohort of patients identified, including consideration of appropriate transfer of mother and babies. Consideration will be given to:
   - the obstetric journey, and specifically whether the risks associated with stillbirth, problems during delivery, and/or perinatal mortality were identified and managed appropriately (antenatal, intrapartum, postnatal, obstetric anaesthesia)
   - compliance with network guidelines in place at the time
   - adherence to trust guidelines in place at the time and the extent to which these guidelines aligned with network guidelines, national guidelines and recognised best practice
   - care of the baby at delivery by the multidisciplinary team (eg midwives, obstetricians, anaesthetists, nursing staff and healthcare assistants, neonatologists, neonatal nurses)
   - neonatal unit admission (as relevant)
   - multidisciplinary team working and communication between colleagues
   - communication and interactions with the parents, including demonstration of Family Integrated Care, as relevant, and support offered before and following a perinatal death
   - clinical record keeping.

2. To consider the internal application by SaTH staff of the national perinatal mortality review tool (PMRT) in the perinatal mortalities that occurred in 2021 and 2022. This will include:
   - the effective application of the PMRT within SaTH to support high-quality standardised perinatal reviews, and subsequent reporting
   - how learning is identified and disseminated by the perinatal mortality review group
   - the effectiveness of actions implemented to improve patient care.

3. To review pathway documentation, including escalation policies during and post-delivery.

The review team will prepare a report that highlights areas of good practice identified by the review as well as any concerns and any lessons to be learnt and recommend appropriate actions, as relevant. The RCP will recommend that the review report is shared with the trust board and that an appropriate action plan is developed to address any recommendations. The trust board should also consider sharing the report with relevant clinical teams and, where appropriate, patients and/or their relatives.

4.2 Approach to this review

This review was led by the RCP, with specialist input provided by the RCPCH, RCOG and RCM. A review team was convened, as set out in section 4.4.

In advance of the review, the specialist review team received 18 clinical records (review methodology described in section 4.3). In addition, documentation provided by the healthcare organisation was examined for the insights it offered in respect of the terms of reference (see appendix 3). The review team held face to face interviews with staff using videoconferencing software on 16–17 November 2023. Details of those interviewed can be found in appendix 4.

The findings contained in this report are outlined in section 6 and represent a summary of the information gathered by the review team from the clinical record review, the interviews and the documentation submitted. The findings are organised under the agreed terms of reference. The findings reflect the viewpoints of those individuals being interviewed and will not necessarily reflect the views of the healthcare organisation, the RCP or its reviewers. The views of the review team are provided in the conclusions and the recommendations.

4.3 Clinical record review methodology

The RCP was provided with clinical records for 18 neonatal deaths, as detailed in the terms of reference (section 4.1). Each of the 18 cases was considered independently by two specialist clinical reviewers – see section 4.4 for details of the review team. Each reviewer used a structured form adapted from the RCP National Mortality Case Record Review (NMCRR) Programme[16] to independently examine phases of care that the patient received. These were graded by the reviewers as **1 = very poor care; 2 = poor care; 3 = adequate care; 4 = good care, or 5 = excellent care**. The review team also utilised a grading system[17] developed by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD)[18] to give an overall perspective on the quality of care provided. This considers both clinical and organisational care. The overall gradings were as follows: **good practice, room for improvement – clinical, room for improvement – organisational, room for improvement – clinical and organisational, unsatisfactory, insufficient information.**

Having independently reviewed the cases, the review team presented them at a meeting held using video conferencing software on 12 and 13 October 2023, with a further meeting focusing on the obstetric journey only, held on 2 November 2023. The meeting was chaired by the medical director for IRs and supported by an RCP review manager. Each case was considered in turn, the specialist review team presented their views, followed by a 'confirm and challenge' discussion to agree the grading of phases of care and the overall care. In making judgements about the overall care provided to the patient, the review team considered national good practice and guidelines.

4.4 Invited review team

Role
Medical director and chair of invited reviews
Consultant neonatologists (LNU) x 2
Consultant neonatologist (NICU)
Consultant in feto-maternal medicine and obstetrics
Consultant obstetrician and gynaecologist

Role
Consultant midwife
Advanced neonatal nurse practitioners (ANNPs) x 2
Lay reviewer and review manager

5 Description of the service

The trust was the main provider of district general hospital services for nearly half a million people in Shropshire, Telford and Wrekin, and mid Wales.[19] There were two hospital sites providing a wide range of acute hospital services, including accident and emergency, outpatients, diagnostics, inpatient medical care and critical care:

> Royal Shrewsbury Hospital
> Princess Royal Hospital (Telford)

Between the two hospitals, there were just over 800 beds and assessment and treatment trolleys. The trust was reported to employ approximately 5,800 staff (whole-time equivalent).[19] The Princess Royal Hospital became the main centre for inpatient women and children's services following the opening of the Shropshire women and children's centre in September 2014.

The most recent Care Quality Commission (CQC) inspection took place in July and August 2021 and was published in November 2021[20] (further inspection took place in November 2023, coinciding with this review). The services inspected were urgent and emergency care, medical care and end-of-life care services at both acute hospitals; and maternity services at the Princess Royal Hospital. The overall rating for the trust was 'inadequate'. The ratings were broken down as follows:

- safe – inadequate
- effective – requires improvement
- caring – requires improvement
- responsive – inadequate
- well-led – requires improvement
- use of resources – requires improvement.

The CQC reported that the trust had experienced significant challenges during the COVID-19 pandemic, with staff redeployed to care for the most acutely ill patients and to support staff in critical areas, and services were redesigned at short notice. At the time of the inspection, the trust was part of an improvement alliance with an NHS trust based in Birmingham, which had commenced in 2020. The alliance involved the sharing of resources, staff, expertise and learning to facilitate improvement across the trust.

Among the inspection findings were that:

- the trust had made improvements since the last inspection but further work was needed to improve the rating
- staff did not always assess and respond to patient risk. Records were not always of good quality, stored safely or easily available to staff to ensure that they could provide safe nursing care
- vacancies within nursing, medical and allied health professional staffing were still impacting on the safety and quality of patient care
- staff did not always treat patients with compassion and kindness but it was acknowledged their ability to do so was impacted by other challenges the trust faced
- individual needs were not always met. People could not always access the service when they needed it and did not receive the right care promptly
- leadership at trust level and across core services had improved but there was further work to do, which included management of risk and performance, culture and governance.

The CQC identified outstanding practice as follows: 'Midwifery staff showed immense levels of resilience as they were able to continue to provide high levels of care to women and babies and maintained a positive and caring attitude during extremely challenging circumstances. The maternity department was under considerable scrutiny following the publication of the first Ockenden review (independent review of

maternity services) and during the COVID-19 pandemic. This was in addition to the maternity service's ongoing challenges with the stability of the senior maternity leadership team which further impacted on staff.'

SaTH's neonatal department

The neonatal service served a catchment population of half a million, with approximately 4,800 births per year. The service was designated as an LNU (previously described as level 2). It was supported by NICUs (level 3) within the West Midlands Neonatal Network. SaTH's designated partner unit was at the University Hospital North Midlands.[21]

The unit was staffed and equipped to provide:

- conventional and synchronised ventilation
- volume targeted ventilation
- short-term high frequency oscillation
- inhaled nitric oxide therapy as well as active therapeutic hypothermia pending transfer to a NICU
- cranial sonography and echocardiography services
- retinopathy screening.

The unit stated it provided care for babies from 27 weeks of gestation and over 800 grams based on network pathways.

The unit was described as 'an entirely new, modern-day high-specification facility.'[21] It was located on the first floor, adjacent to the labour suite and maternity theatres and obstetric wards. The postnatal ward including transitional care, children's ward, assessment unit and outpatient facility were sited immediately below on the ground level. There was a seminar/education facility within the unit, and a comprehensive education and simulation suite immediately below on the ground floor.

There were 22 cots: three intensive care, three high dependency and 16 special care cots. In 2020, the unit delivered approximately 500 intensive care days, 1,120 high dependency days, 3,700 special care and 1,700 transitional care days. There was an active neonatal outreach service provided by three senior neonatal nurses, who looked after babies discharged home on oxygen or who met other criteria.

6 Findings

6.1 Terms of reference 1 – Clinical case record review

To assess the clinical management and quality of care provided by SaTH staff to the cohort of patients identified, including consideration of appropriate transfer of mother and babies.

The findings below are based solely upon review of the clinical case records by the specialist reviewers, who reached judgements based on the information shared with them by the trust. There was no discussion with members of staff at this stage of the review, which may have shed further light on certain aspects of the patient pathway. Equally, interviews with the families involved, which were not part of the scope of this review, may have provided a differently nuanced interpretation of the clinical records.

6.1.1 Overall rating for quality of care

The review team's overall ratings for the quality of care provided across the 18 cases were as follows:

- Five cases were graded 'good practice' (RC[redacted], RC[redacted], RC[redacted], RC[redacted], RC[redacted])
- Eight cases were graded 'room for improvement' for clinical reasons (RC[redacted], RC[redacted], RC[redacted], RC[redacted], RC[redacted], RC[redacted], RC[redacted], RC[redacted])
- Two cases were graded 'room for improvement' for both clinical and organisational reasons (RC[redacted], RC[redacted])
- No cases were graded 'room for improvement' for organisational reasons alone
- Two cases were graded 'unsatisfactory' (RC[redacted], RC[redacted])

A full breakdown of gradings by phase of care and overall can be found in appendix 5. The gradings for review of PMRTs associated with the 18 cases can be found at section 6.2.1. The gradings relating to compliance with network, national and trust guidelines across the 18 cases can be found at section 6.3.1.

There was insufficient information to reach a grade of the overall quality of care for RC[redacted].

Ten of the cases were graded room for improvement, mostly for clinical reasons. This reflected issues with clinical decision making at different stages of the pathway (as outlined in the gradings associated with different phases of care). Organisational issues were identified in two cases:

- In case **RC**[redacted]
- In **RC**[redacted]

Two cases were graded 'unsatisfactory':

> For [redacted]

> The grading of unsatisfactory for case [redacted]

6.1.2 Obstetric journey: risks associated with stillbirth; problems during delivery and/or perinatal mortality

The specialist reviewers were asked to consider evidence relating to the obstetric journey in each of the 18 cases.

Three cases were rated excellent care ([redacted], [redacted], [redacted]). For example:

> Case [redacted]

Five cases were rated good care ([redacted], [redacted], [redacted], [redacted], [redacted]). For example:

> In case [redacted]

[d] According to NICE guidance NG192, category 1 caesarean birth is when there is immediate threat to the life of the woman or fetus, and category 2 caesarean birth is when there is maternal or fetal compromise that is not immediately life-threatening. Category 1 caesarean births should be performed as soon as possible, and in most situations within 30 minutes of making the decision. Category 2 caesarean births should be performed as soon as possible, and in most situations within 75 minutes of making the decision. www.nice.org.uk/guidance/ng192/chapter/recommendations

Three cases were rated adequate care ([redacted]). In these cases, opportunities for improvement were identified around the timeliness of decision making. For example:

- In case [redacted].

Seven cases were rated poor care for the obstetric journey ([redacted]). Two of these cases highlighted issues around planning with respect to babies with fetal medicine conditions:

- Case [redacted].
- Case [redacted]

[redacted]

Two cases highlighted issues around clinical decision making in the intrapartum period:

- Case [redacted]

[redacted]

[redacted]

> Case [redacted]

For the other cases graded poor care, this grading reflected delays in delivering the baby with sufficient urgency and clinical decision making around delivery:

> Case [redacted]

- Case [redacted]

- Case [redacted].

6.1.3 Care of the baby at delivery by the multidisciplinary team

Most cases were graded good or adequate care under this heading. Eight cases were graded good care ([redacted]), reflecting responsive care of the baby at delivery, with appropriate staff present. Often in cases graded good care a neonatal consultant was present and strong leadership was evident. In case [redacted].

Six cases were graded adequate care ([redacted]). Across these cases a range of issues were identified that stopped short of good care of the baby at delivery.

- **Delayed cord clamping** – one case stood out for delaying cord clamping ([redacted]); more often there was no delayed (or optimal) cord clamping[22] (eg [redacted]).
- **Deviation from Newborn Life Support (NLS) algorithm** – in several cases, chest compressions were started before chest wall movement had been detected (eg [redacted]).
- **Resuscitation proforma** – it was not evident that the resuscitation proforma was used in some cases (eg [redacted]).

- **Issues with intubation** – in several cases, there were multiple attempts made at intubation ([redacted], [redacted], [redacted]) and, at times, this gave rise to a sense of panic during resuscitation and indicated learning needs in this area. In case [redacted], there were six attempts at intubation, which took place in the neonatal unit.

- **Senior leadership** – in some cases, the review team believed that consultant neonatologist presence could have resulted in more coherent care of the baby at delivery (eg [redacted], [redacted]). In case [redacted], the review team observed the benefits of the consultant staying on the telephone to advise the team while driving to the hospital.

- **Documentation issues** – in case [redacted], there was no documentation of thermal management of the baby; in case [redacted], there were discrepancies in the descriptions of attempts at intubation and of Apgar scores (a test given to newborns to checks heart rate and other indicators).

Two cases were graded poor care under this heading ([redacted]).

- The obstetric journey for case [redacted].

- The obstetric journey for case [redacted].

In some cases, high pressures were given appropriately to preterm babies ([redacted] and [redacted]). However, the review team questioned whether the decision to increase inflation pressures to 30 cm H20 was too high, too early in cases [redacted] and [redacted]. This was thought to be influenced by the conclusions of the Ockenden review, as follows:

> *"Neonatal practitioners must ensure that, once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cm H2O in term babies, or above 25cm H2O in preterm babies may be required. The Resuscitation Council UK's Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm."*[23]

A further theme around the care of the baby at delivery related to timing of the administration of surfactant, used to reduce the risk of bronchopulmonary dysplasia and pneumothorax in preterm infants.[24] The network guidelines placed emphasis on the early administration of surfactants,[25] although no

timeframe was given (and the UK national consensus is for early administration of surfactant[26]). The review team concluded that administration of surfactant across the cases was not sufficiently early, ranging as follows:

- 50 minutes ( ) or 56 minutes ( ) of age
- an hour after admission following delivery at home ( )
- 82 minutes ( ) or 90 minutes ( )
- two hours (of age.

In case

In case .

6.1.4 Care following admission to the SaTH neonatal unit

For three of the 18 cases, no care was provided on the neonatal unit:

- In case , the baby was admitted to (and care in that setting has been graded)
- In case , the baby died on the (not graded)
- In case (not graded)

The gradings for this phase of care were as follows:

- Good care – five cases (, , , ,)
- Adequate care – three cases (, ,)
- Poor care – seven cases (, , , , , ,)
- Very poor care – one case ( )

Cases graded adequate care stopped short of being good care usually due to delays, for example, in administering surfactant (,) and vitamin K ( ) and reflecting the amount of handling of the baby during the golden hour[f] ( ). However, the review team recognised the challenges for the unit in caring for very premature babies. In cases and , the babies were 25+3 weeks and 26 weeks, respectively.

- In case).

Of the seven cases graded poor care, a number of issues were identified:

[f] 'The care preterm babies receive within the first few hours and days has a significant impact on their long-term outcomes. The CESDI 27–28 study highlighted the importance of good early care for preterm babies with particular reference to effective resuscitation'. The aim of the golden hour is 'To stabilise baby and perform all procedures required within the first hour after birth'. *Neonatal guidelines 2022-24. The Bedside Clinical Guidelines Partnership in association with the West Midlands Neonatal Operational Delivery Network*, p136.

- **Golden hour timings** – in some cases, some or all the procedures to be completed within the golden hour to stabilise the baby were not met ([redacted], [redacted]). Several delays were observed in giving surfactant (as detailed previously), which appeared in part to reflect a local policy not to administer this on the delivery suite. In case [redacted], none of the golden hour timings were met, surfactant and antibiotics were delayed and there was delay in getting inotropes up and running (requested [redacted] and running at [redacted]).

- **Antibiotic regimens** – antibiotic dosage regimens did not reflect network or NICE guidelines, with 30 mg (benzylpenicillin) used across all babies (eg [redacted], [redacted]). Delay in administering antibiotics was also observed in several cases ([redacted], [redacted], [redacted], [redacted], [redacted]), including where infection was suspected.

- **Baby handling** – in some cases there was a great deal of handling of the baby in the first few hours, including having multiple X-rays ([redacted], [redacted], [redacted]). In case [redacted], the baby was brought straight to the neonatal unit by ambulance and there [redacted] on the unit. The network guidelines stipulate: '*Once baby set up – minimise handling. Hands off – eyes on.*'

- **Temperature maintenance** – in some cases, the review team observed that the baby's temperature cooled after admission to the neonatal unit ([redacted], [redacted]). On one occasion, [redacted]). In case [redacted].

- **Ventilation** – the review team was sometimes critical of an apparent failure by the neonatal team to consider a change in ventilation mode or recognise that more ventilator support was needed ([redacted]). Issues with respiratory management were also identified in [redacted], and the review team questioned whether there was a lack of understanding of volume guarantee ventilation (a volume targeted ventilation strategy).

- **Clinical decision making** – in case [redacted]. In case [redacted]. In case [redacted], [redacted]. In case [redacted]

- **Equipment issues** – in case [redacted]. In case [redacted], no umbilical packs were available.

- **Senior leadership** – across the cases graded poor care there was often an absence of clear senior leadership and care seemed to be poorly coordinated ([redacted], [redacted], [redacted]). At times, it seemed a locum consultant was managing the patient and then another, presumably more senior consultant, would become involved in the baby's care.

- **Delays in transfer to NICU** – the timing of calls to tertiary centres sometimes seemed to lack urgency and coincided with staff handover times (eg [redacted]), even when it could have been predicted that the baby would require transfer ([redacted]). The tertiary units sometimes gave advice over the phone and instructed to call back later (eg [redacted]), and seemed reluctant to take the baby

([redacted]), when more responsive timely transfer was needed. Consequently, the local team was left to manage a baby with complex needs for longer than they should have been.

The case graded very poor care reflected the care provided to the baby not on the neonatal unit, but on the children's assessment ward:

> Case [redacted].

6.1.5 Multidisciplinary team working / communication between colleagues

Most cases were graded good or adequate care under this heading. Eight cases were graded good care ([redacted]), reflecting evidence of expected standards around teamworking and communication between colleagues.

Six cases were graded adequate care ([redacted]). In these cases, multidisciplinary team working seemed to have been reasonable but stopped short of being good care. For example:

> In case [redacted].

> In case [redacted].

> In case [redacted].

Three cases were graded poor care under this heading ([redacted]):

- In case [redacted].
- In case [redacted].
- In case [redacted].

[redacted].

6.1.6 Interactions with parents / family, including demonstration of Family Integrated Care

Most cases were graded good or adequate care under this heading. Eight cases were graded good care ([redacted]), reflecting clearly documented information sharing with the parents and involvement of the parents in the baby's care where possible (eg [redacted]).

Eight cases were graded adequate care ([redacted]). In these cases, discussions with parents were not documented as well as they might have been or were not as timely as expected. Sometimes there was delay in offering parents the opportunity to see or touch their baby on the neonatal unit (eg [redacted]). For example:

- In case [redacted].

One case was graded poor care:

- Case [redacted].

[redacted].

[redacted].

6.1.7 End-of-life care and support offered before and following a perinatal death

In nine of the 18 cases, the baby was transferred from SaTH to a NICU. End-of-life care and support offered before and following the death of the baby took place at the NICU and gradings could not be reached on this element of care in these nine cases ([redacted]).

In the remaining nine cases, where end-of-life care was provided at SaTH, one case stood out for providing excellent care under this heading, as follows:

- Case [redacted] This was graded excellent care.

Three cases were graded good care under this heading ([redacted]). For example:

- In case [redacted]
- For case [redacted]

The remaining cases were graded adequate care ([redacted]). This reflected that there were opportunities to have gone further to support parents around the time of the baby's death. For example:

[8] The infant was taken from the community to another hospital; assumed to be a NICU or paediatric intensive care.

> In case [redacted]

> In case [redacted]

> [redacted]

6.1.8 Clinical record keeping

Clinical record keeping was graded adequate care in 11 cases ([redacted]). There was insufficient information to grade [redacted] (the baby was not under the care of the neonatal team).

Two cases were graded good care under this heading ([redacted]). For example:

> In case [redacted].

Four cases were graded poor care under this heading ([redacted]). For example:

> In case [redacted]

> In case [redacted]

> In case [redacted]

[redacted]

6.2 Terms of reference 2 – Perinatal mortality review tool

To consider the internal application by SaTH staff of the national perinatal mortality review tool (PMRT)[5] in the perinatal mortalities that occurred in 2021 and 2022. This will include:

- The effective application of the PMRT within SaTH to support high-quality standardised perinatal reviews, and subsequent reporting
- How learning is identified and disseminated by the perinatal mortality review group
- The effectiveness of actions implemented to improve patient care.

6.2.1 Review of PMRTs associated with the 18 cases

Redactions within the PMRTs shared with the review team made a few difficult to read (eg [redacted], [redacted]). The review team observed that the PMRT panels graded most of the care issues identified as they 'would have made no difference to the outcome', ie grade B, (see table below for explanation) – this applied to the following cases: [redacted]. Some care issues were identified that may have made a difference to the outcome (ie grade C) in three of the PMRTs: [redacted]. The review team discussed whether some of the care issues identified in the PMRT for case [redacted] could have been graded D (see 6.1.3 care of the baby at delivery).

Box 1.5: Categories used to grade the different aspects of care for each death

A. No issues with care identified
B. Care issues that would have made no difference to the outcome
C. Care issues which may have made a different to the outcome
D. Care issues which were likely to have made a difference to the outcome

Learning from standardised reviews when babies die National Perinatal Mortality Review Tool first annual report (2019)[29]

There were several recurring themes across the PMRTs:

> First, the PMRTs often involved large panels, with good representation from the LNU and the NICU. However, some panels lacked externality in terms of an external neonatal consultant who could bring an independent perspective to events (eg [redacted]), particularly where issues relating to leadership needed to be explored.

> Second, the PMRTs were highly process-focused with limited exploration of leadership issues. Relevant learning at the LNU was often missed, with a tendency to focus more heavily on the transfer of care to a NICU and on the care provided at that tertiary unit (eg [redacted]).

> Third, some actions were to address identified issues via one-to-one discussions with staff, which risked feeling punitive and undermining departmental learning (eg [redacted]).

> Fourth, the review team concluded that some cases raised questions about the functioning of the neonatal network and the escalation of care, with the LNU at times left in a vulnerable position, caring for extremely sick premature babies. It was not clear that the PMRTs fully explored network issues that may have undermined the ability of the unit to provide high-quality care.

Across the 18 cases, 15 PMRTs were graded as adequate ([redacted]).

One PMRT was graded poor care:

> Case [redacted].

No grading was reached for two cases:

> In case [redacted]

> There was a PMRT for case [redacted]

6.2.2 The PMRT process

6.2.2.1 Documentation review

The MBRRACE-UK perinatal mortality report concerned stillbirths and neonatal deaths among the 4,322 babies born within SaTH in 2021, excluding births before 24 weeks gestational age and all terminations of pregnancy. The stabilised and adjusted stillbirth rate (all deaths) was 3.13 per 1,000 total births, which was around average for similar trusts and health boards. The stabilised and adjusted neonatal mortality (all deaths) was 1.30 per 1,000 live births, which was more than 5% higher than the average for similar trusts and health boards. It had been more than 5% higher for the previous 3 years. The stabilised and adjusted perinatal mortality (all deaths) was 4.45 per 1,000 total births, which was around average for similar trusts and health boards. The MBRRACE-UK report recommended that as neonatal mortality had been highlighted, the trust should: a) review the data entered locally about the trust to ensure it was accurate and complete; and b) ensure that a review using the PMRT had been carried out for all deaths in the report to assess care, and identify and implement service improvements to prevent similar deaths.

The documentation shared with the review team also included the following:

- Neonatal mortality standard operating procedure (SOP), to identify the actions needed after a baby dies and who is responsible for undertaking them (review date January 2027)
- Child death process SOP – neonates (draft)
- An example of review of a case, prepared by the clinical lead for obstetrics and the neonatal mortality lead (September 2023)
- A case presented to a perinatal mortality meeting (April 2023)
- A presentation on the MBRRACE 2021 data by the clinical lead for obstetrics and the neonatal mortality lead (September 2023)

- The minutes of a neonatal governance meeting at which the MBRRACE 2021 data was discussed (July 2023)
- PMRT 2021 table detailing, amongst other things, the cause of death, PMRT grading, level of investigation, whether there was a PMRT feedback meeting, and neonatal actions/lessons to be learned
- Triggers for Datix 1 reporting on the neonatal unit (review date [redacted])

The documentation provided evidence of good processes for neonatal mortality review and frameworks for neonatal governance. However, the review team raised questions over the implementation of some of these processes. For example, the trigger for Datix reporting was hypoglycaemia <1; however, it was not evident that these triggers were followed in cases of hypoglycaemia (eg [redacted] and [redacted]). There did not appear to be any plan for externality for PMRT in the child death process SOP, and the case presented to a perinatal mortality meeting in [redacted] lacked SMART[h] actions.

6.2.2.2 Comments from interviewees

Senior leaders were keen to understand why the trust had above average neonatal mortality, which was also commented upon by the Ockenden review. Numbers remained small however, and one interviewee stated that one fewer death per year would make the unit a positive outlier rather than a negative one.

The review team heard that when a baby died a Datix report would be triggered automatically. A rapid review would then take place, which ordinarily identified a range of issues. Any deaths reportable to MBRRACE would then be subject to a PMRT.

There was awareness that the West Midlands had the highest neonatal mortality of any region in England. One interviewee remarked that the network had never investigated the reasons underpinning the region's poor performance in this regard, although it was reported that discussions had been initiated at regional level. In the meantime, the driver for this invited review was on understanding what changes might be needed to reduce neonatal mortality for the population served by the trust. Questions were raised by senior leaders over whether clinical teams were escalating care at the right point to the right people, as well as whether escalation to NICUs happened early enough and, as one said, 'assertively enough'. Ultimately, the PMRT process was not providing the trust with 'the answers in terms of things we can modify'.

Another contextual factor highlighted to the review team was paediatric mortality. The system within which SaTH sits was reported to have been flagged as one of the highest areas for paediatric mortality in national datasets and some concerns were raised specific to the trust. The issue was broader than deaths captured by MBRRACE and subject to the PMRT. Child death overview panels (CDOPs) are responsible for receiving child death notifications, including any live-born baby where a death certificate has been issued (it does not include stillbirths, late fetal loss, or terminations of pregnancy carried out within the law).[30] The review team was informed of particular concern over sepsis and the deteriorating child, which was captured as an extreme risk on the risk register of the Integrated Care Board (ICB). Other themes were communication with parents, access to medical support, and consistency with how the trust uses critical outreach support. The main concern was paediatric care, although some concerns were said to extend to neonatal services, specifically relating to infection. The trust was reported to have a transformation programme in place and there had been involvement by the regional network around critically ill children. There was a sense that the huge focus given to maternity services now needed to shift to paediatric care.

[h] Specific, Measurable, Achievable, Relevant and Time-bound

PMRT review meetings

One account was that staff were very self-critical during the PMRT process and would err on the side of saying that care could have been delivered better. PMRTs were said by this interviewee to be 'forensic' in approach and anything identified during the PMRT was tracked to ensure that the action had been completed.

Another account was that the PMRT process failed to 'always pick up the relevant things' as it was 'very task focused.' Ongoing challenges were highlighted in terms of 'the right babies being delivered in the right centre', and pathway issues that required attention across the entire West Midlands region. Approximately half of the neonatal mortalities associated with SaTH were said to relate to babies who died at other centres. One interviewee remarked: 'We need full pathway review; piecemeal doesn't help.' The review team was told that joint PMRTs were undertaken, but the proportion of the meeting devoted to discussing care provided at SaTH versus wider pathway issues was often not appropriate. The sharing of notes was reported to be a challenge, with good, reciprocal arrangements for note-sharing with Royal Stoke University Hospital, but less in evidence with other centres.

Challenges were also highlighted in terms of getting the relevant staff from different hospitals to participate. 'The team involved in the child's care should be involved at the meeting, but in West Mids it can be very variable', said one interviewee. Not having the people involved in providing care to the baby impacted on the learning derived from the PMRT process. Attempts had been made to get reviewers together first and then invite the team involved in the baby's care to the second part of the meeting to ask them questions. No concerns were raised regarding the ability of attendees to ask questions and challenge decisions; however, the right staff (the clinical decision-makers) were not always present to answer.

The review team was informed that all the consultant neonatologists and obstetricians had PMRTs covered in their job plans, and this was said to have provided for more robust support for PMRTS (each involved two consultants not involved in the care of the baby). The network was funding a nurse lead for governance, which was out for recruitment at the time of the review. Two consultant obstetricians from another trust were job planned to provide externality in PMRTs; it was not known to the review team whether this covered fetal medicine and high risk pregnancy/preterm birth. A lack of neonatal externality in the PMRT process was raised as an issue and there was said to be no process for obtaining external reviewers. The network had reportedly approached all trusts within the region to emphasise the importance of releasing external reviewers for PMRTs. It was also reported to be developing neonatal externality and considering plans for units to review care in a circular model, providing input in rotation across units.

Nursing management activities, including participation in PMRTs, had been impacted by nursing shortages in the neonatal unit. One of the neonatal nurses was nursing lead for the PMRTs but was unable to attend PMRT meetings due to staffing pressures.

6.2.3 Learning and feedback

6.2.3.1 Documentation review

The documentation shared with the review team included the following:

- Details of clinical governance assurance systems at trust level and service level:
  - Divisional governance committee
  - Quality governance framework
  - Terms of reference for neonates' governance (August 2022)
  - Minutes from directorate and clinical governance meetings held during 2021 and 2022 at which the neonatal service has been discussed
  - Agenda and minutes of perinatal mortality meetings held in June, July and October 2022

    - Governance report for divisional committee meetings in 2021 and 2022
    - Details of all recent audits undertaken
- Local maternity and neonatal system (LMNS) Programme Board and Perinatal Quality Surveillance Group (PNQSG) agenda for meeting held on 17 July 2023
- Maternity Governance meeting, Perinatal Mortality Review Tool (PMRT) Quarterly Report Q1, July 2023
- Details of clinical governance assurance systems in place (at service level):
    - Monthly neonatal governance meetings – the reports from these fed into divisional committee and LMNS meetings.
- Clinical audit meeting arrangements: Audit meetings were arranged as required to present audits.
- Morbidity and mortality (M&M) meetings: All neonatal deaths were reviewed via PMRT meetings within the specified time frames. Term admissions were reviewed at fortnightly ATAIN meetings. All cases of significant concern (morbidity or mortality) had a multidisciplinary rapid review involving neonates and maternity representation. Cases were then escalated for consideration of Serious Incident status if appropriate.

The documentation demonstrated that the right processes and frameworks were in place, together with senior oversight of governance processes.

6.2.3.2 Comments from interviewees

Interviewees explained the governance structures and the flows of assurance from service and divisional level, through to the executive team and trust board. The divisional governance team had been restructured shortly before this review as it had been very maternity focused (reflecting Ockenden). Dedicated neonatal and paediatric divisional governance support had been created. There was a quality governance lead (a midwife) across the entire division – maternity, neonates, women's and children's – who provided an 'umbrella view over the whole service' and was working to align processes across the different departments. Within the neonatology team, there had been an expansion in terms of governance leadership. There was a mortality lead consultant (0.6 programmed activities (PAs) per week) and a governance lead (1PA); previously governance had fallen under the remit of the clinical director.

Steps were also reported to make the monthly divisional governance meeting more robust. The review team heard that improvements had been evident in the previous 3 or so months; meetings were no longer cancelled (as had happened previously), and there was good staff engagement. The review team heard that a significant number of neonatal guidelines were out of date and there were overdue Datix reports. The newly formed divisional governance team was part of efforts to introduce more rigour to governance.

One impact of the changes was thought to be a newfound willingness among the neonatology team to give voice to concerns. 'It has taken time for them [neonatal consultants] to knock on doors to raise issues,' said one interviewee.

The trust achieved the maternity incentive scheme in 2022 and was reported to be close to achieving it for year five (in 2023).[31] The maternity incentive scheme supports the delivery of safer maternity care through an incentive element to trust contributions to the clinical negligence scheme for trusts (CNST)[32]. The scheme rewards trusts that meet 10 safety actions designed to improve the delivery of best practice in maternity and neonatal services.

PMRT feedback

Feedback from PMRTs was disseminated via monthly neonatal governance meetings, maternity governance and quarterly divisional meetings. If there was specific learning the neonatal governance lead would coordinate a learning review document. One interviewee remarked that feedback to the governance

meeting needed to be stronger, more focused on learning and timeliness (it often took three months for feedback to be given). Suggestions included having a 'message of the week', using learning to drive guideline change and to incorporate learning into training.

There had been monthly meetings between neonatal and obstetric services to share learning; these had been moved to quarterly meetings. Discussions included learning around babies born at the margin of viability and about caring for baby's receiving palliative care.

The absence of neonatal nursing representation at PMRTs profoundly impacted the ability to bring feedback to the nursing team. At the time of the review only neonatal consultants were attending PMRT meetings, leaving nursing staff isolated from learning. The situation was compounded by an inability to leave the clinical floor to undertake Datix investigations; while band 7 staff should be able to have an hour away from the clinical floor to undertake these investigations, in practice this was not achievable. There was no formal mechanism for feeding back learning from mortality reviews to nursing staff. Sometimes consultant neonatologists would provide feedback via informal chats.

In the maternity service, there was a push for learning from PMRTs to be fed back to clinical staff through safety messages. The delivery suite used twice daily handovers to cascade learning and interlink Datix numbers. This approach to disseminating feedback meant that a large proportion of the workforce could be covered within 1 week. Formal processes for disseminating learning comprised weekly incident meetings, open to all maternity staff (including community), either in person or via Microsoft Teams. Good engagement was described. The meetings involved going through the incident timeline and learning together, capturing different perspectives through discussion. One interviewee described having observed 'a good culture of professional challenge'.

Themes from PMRTS

The overriding recurring theme arising from PMRTs related to documentation. This included: documentation around resuscitation; with respect to the transfer from delivery suite to the neonatal unit; documentation of blood pressure; and thermal care. A neonatal resuscitation proforma had been developed to enable a minute-by-minute record of events around resuscitation but this was not completed consistently, so work was underway to identify improvements. The unit was said to have an audit to show that thermal care was very good, but thermal care often came up as an action from PMRT because it was not documented. There were aspirations to have BadgerNet electronic patient system, which would address some of the issues in terms of documentation, and a business case had been created for an electronic patient record.

The use of locums was also said to have surfaced from the PMRT process. There had been a consistent gap in the consultant medical workforce since March 2022, which had created issues in populating the 1 in 6 rota and so a long-term locum had been recruited. To meet the 7-day service standard, the neonatal unit had moved to a 1 in 7 rota in April 2023. A long-term locum was moving on and a consultant due to start in the summer of 2023 withdrew, leaving two consultant gaps.

6.2.4 Incident management

6.2.4.1 Documentation review

The documentation shared with the review team included the following:

- Details of the trust's clinical incident process flow
- Datix web reporting neonatal active risks. Six active risks featured, as follows:
    - Babies on the delivery suite and neonatal unit not tagged – risk of abduction. Current risk level: high.

- Compliance of qualified in specialty (QIS) nurses not meeting BAPM requirements. Current risk level: high.
- Full BadgerNet EPR not yet implemented in neonates – financial and clinical risk. Current risk level: high.
- Risk of not maintaining guidelines reviews, updates and benchmarking against national guidance. Current risk level: extreme.
- Single paediatric specialist registrar on night shifts across paediatrics and neonates. Current risk level: high.
- Inability to recruit to ward manager role for neonatal unit. Current risk level: high.

The documentation provided evidence of a reasonable understanding and articulation of risks, with appropriate risk scoring and escalation.

6.2.4.2 Comments from interviewees

An assistant director of nursing was responsible for quality governance and oversaw the patient safety team, Datix and incident teams. This role involved ensuring there were standardised processes for patient safety and incident management; the PMRT process and departmental governance was outside the scope of this role.

Following the Ockenden review, there had been new leadership and a huge maternity transformation programme. Most of the previous governance team had left and it was only in the weeks leading up to this invited review that staff had settled into new structures.

The neonatal unit was thought to be reporting incidents effectively, reflecting new leadership within the unit, including a neonatologist governance lead and separate mortality lead. There was a weekly rapid MDT review of incidents, chaired by the assistant director of nursing and covering all divisions. Any moderate harm or above came through that meeting, without exception. The review team heard that close attention had been given to perinatal mortality.

Following rapid review, cases might be escalated to the review action and learning from incident group (RALEG), chaired by the medical director, to decide whether the death should be reported as a serious incident. Separately, cases were considered under PMRT or CDOP. Actions were uploaded on to the Datix system and the division was reported as being much more responsive than previously in terms of ensuring actions were completed. The biggest area of learning that had led to changes was family engagement, and the women's and children's division had shared this learning with other parts of the trust, including the emergency department and medicine.

Reporting to the trust board had increased from quarterly to bi-monthly. A board risk committee monitored every risk over 50 and staff from women's and children's participated in that review. The ICB was represented on the trust's quality committee and quality group and received details of all serious incidents. A non-executive director and director of the trust attended the ICB's quality committee. The review team heard that the system had yet to take charge of neonatal mortality, with CDOP and MBRRACE creating silos. There were aims to bring this mortality review together on a quarterly basis within the ICB, with public health involvement to give attention to prevention and health inequalities (the first of these meetings was due to take place in December 2023).

Plans were underway to move to the new patient safety incident response framework (PSIRF) system in December 2023.[33] This was expected to shift the focus away from serious harm to also learning from near misses.

There were also aspirations to give attention to governance across the wider system. One interviewee said: 'We have to stop looking inwards and start looking outwards.' SaTH was the only acute service within the integrated care system, making benchmarking difficult within the system. Benchmarking could be achieved with other systems across the region.

6.2.5 Listening to parents

6.2.5.1 Documentation review

No relevant documentation identified.

6.2.5.2 Comments from interviewees

Staff were mindful of the criticisms laid out in the Ockenden review with respect to failures in listening to pregnant women and their families and had taken steps to make improvements. The neonatal unit received feedback from parents via the NHS Friends and Family Test (FFT). The response rate to the FFT had been boosted by incorporating it into the discharge checklist and by developing a QR code displayed on lockers and other places across the unit. The review team heard that FFT feedback was generally 'extremely positive'. Parents or family members raising concerns were directed to PALS or the complaints team.

The maternity neonatal voices partnership framework (MNVP) asked about experiences of neonatal care, although feedback to the neonatal unit was described by one interviewee as 'still hit and miss'. Efforts were underway to integrate MNVP voices into quality meetings.

There was no nursing lead on Family Integrated Care (FIC) at the time of the review. A consultant lead and an ANNP lead had been identified as needed as part of the Ockenden business case, but there was no FIC nursing champion. An occupational therapist (part of the allied health professionals' team) had been promoting FIC; however, one interviewee described this individual as 'trying to bash through a wall of resistance by herself.' The neonatal team was reported to demonstrate FIC during ward rounds by inviting parents to share any concerns about their babies, as part of an emphasis on valuing every opinion. The consultant neonatologist team were described as 'family-focused'. Parent passports were newly introduced and offered a mechanism for parents to share their feelings.

There was a Baby Friendly Initiative (BFI) lead, although the protected time allocated to this individual was said to be limited. A recurring theme was that the unit was short on specialist quality roles. Previously a Bliss champion attended the unit; there was uncertainty over whether a replacement was being arranged. The unit also received support from a local children's hospice called Hope House; a member of staff from the hospice attended the unit to counsel parents of babies with long-term health issues.

Following the Ockenden review, maternity services had undertaken a great deal of activity around listening to mothers as part of the maternity transformation programme. This included birth preferences cards encouraging communication around birthing choices and fetal monitoring, which were sent out via BadgerNet as well as displayed in every room so that families could circle their choices. The unit had been nominated for an award for these cards. The maternity governance team was working closely with MNVP and there was a dedicated Facebook page. Action was also reported to strengthen communication with families involved in maternity-related incidents and to explore parents' differing needs for information and support. An open event was held in June 2023 for prospective and expectant parents to engage with SaTH maternity services and twice weekly unit tours had resumed. Aspirations were articulated among maternity staff to incorporate the parent perspective into the PMRT process.

6.3 Terms of reference 3 – Pathway documentation

To review pathway documentation, including escalation policies during and post-delivery.

6.3.1 Compliance with guidelines (network, national and trust)

6.3.1.1 Documentation review

The documentation shared with the review team relevant to guidelines included the following:

- Neonatal guidelines 2022–24: The bedside clinical guidelines partnership in association with the West Midlands Neonatal Operational Delivery Network
- Neonatal guidelines 2019–21: The bedside clinical guidelines partnership in association with the West Midlands Neonatal Operational Delivery Network
- West Midlands Neonatal Operational Delivery Network neonatal care pathways 2020
- SaTH guidelines:
    - Ex utero exception reporting (review date April 2026) – *local authors*
    - Fungal infections in neonates (review date August 2024) – *local authors*
    - Golden hour preterm babies <28 weeks' gestation (April 2023–April 2025) – *adopted from WMNODN*
    - Management of herpes simplex infection in neonates (review date March 2026) – *local author*
    - LISA (less invasive surfactant administration) with sedation (review date July 2024) – *local author*
    - LISA checklist
    - Triggers for Datix reporting on the neonatal unit (review date November 2024) – *local author*
    - Neonatal infection (including Group B Streptococcus infection) (review date November 2024) – *local authors*
    - Neonatal mortality standard operating procedure (review date January 2027) – *local author*
    - Preparing for ex-utero transfer from the NNU standard operating procedure (review date November 2025) – *local author*
    - Resuscitation of the newborn on delivery suite, neonatal unit and alongside midwifery-led unit (review date December 2024) – *local authors*
    - Transport and retrieval (review date September 2025) – *adopted from WMNODN*
    - When should the consultant neonatologist be informed? (review date August 2024) – *local author*
    - When to summon assistance on delivery suite and alongside MLU [midwife led unit] for neonatal resuscitation (review December 2026) – *local authors*
    - Surfactant replacement therapy (under review)
    - Transport arrangements for the movement of a sick newborn into hospital from home or a midwife-led unit (under review)

- Getting It Right First Time (GIRFT) neonatology review, unit level report, March 2021. This said that unit adherence to network pathways was good.

6.3.1.2 Clinical record review

Across the 18 cases reviewed, 11 were graded adequate under this heading ([redacted]). There was insufficient information to grade [redacted]

[redacted]

Three cases were graded good care under this heading ([redacted], [redacted], [redacted]). For example:

- For [redacted]
- For [redacted]

Three cases were graded poor care in terms of compliance with recognised guidelines and best practice ([redacted], [redacted], [redacted]).

- Case [redacted].
- Case [redacted].
- Case [redacted]

[redacted]

6.3.1.3 Comments from interviewees

Guidelines

The unit had a history of having its own guidelines and many of the WMODN guidelines were said to have been adopted from SaTH. Interviewees remarked that some rationalisation of guidelines had been needed and all hospitals within the network were being encouraged to adopt the network guidelines. Work was underway in SaTH to convert to using network guidelines; one account was that most guidelines were based on network guidelines 'with a few small tweaks. There were some guidelines in use that the network did not have, and some guidelines that had not yet been converted to network ones.

Golden hour

The unit had been working to achieve the golden hour standards from within 1 hour of admission to the neonatal unit (instead of from one hour from birth). Interviewees said they were aware of the golden hour guidelines and most felt these were being achieved most of the time, and that the unit performed well in stabilising babies as quickly as possible. One account was that care sometimes fell outside of the golden hour out of hours, when tier 2 (middle grade, registrar) cover could take longer to arrive in the unit or due to nursing shortages. Some cases were reported in 2022, involving locum consultants, where the golden hour was not achieved.

The unit was thought to perform well on thermoregulation, with the baby's temperature documented in the delivery suite before being transferred to the neonatal unit and checked again once on the unit. Previously, there were separate weighing scales, which meant a baby had to be taken off respiratory support. Babies can now be weighed in the incubator, using incubator scales, which was said to make the stabilisation process safer.

Opportunities for improvement were identified in terms of documentation. For example, blood pressure was one area that was not always documented. Observation charts needed to be revamped but no one had been given dedicated time to do that. If a nursing staff member was 'spare', they would scribe while another nurse provided care. There were aspirations to have BadgerNet electronic patient records to enhance recording.

Surfactant provision

The unit had a policy of delivering surfactant on the neonatal unit. This was said to reflect previous incidents in surfactant delivery on the delivery suite. One interviewee stated that surfactant could be delivered in the delivery suite but this was not the norm. Some interviewees defended the practice on the grounds that babies were transferred to the neonatal unit fairly promptly.

One interviewee reported that the unit had been cautious in its introduction of less invasive surfactant administration (LISA).

Antibiotics

The review team heard that the aim was to administer antibiotics 'asap' and that audit indicated antibiotics were administered within the golden hour; however, delays were said to arise when there were issues in gaining intravenous access. An issue was also reported around awareness of the time taken by nursing staff to draw up the drugs and work had been undertaken to improve this. The antibiotic dosage was said to reflect network agreements and a neonatal formulary was used.

Nitric oxide

The neonatal unit had retained two machines to provide nitric oxide since changes made nationally to focus the provision of nitric oxide within NICUs. The equipment was rarely used. There was said to be apprehension among the nursing team about still having the machines, as a substantial number had never administered nitric oxide. Staff were said to get the equipment out at night and simulate using it. There were said to be guides on how to use it, although one interviewee relied on pictures on their mobile phone as a reminder. There was anxiety about being the senior nurse and feeling under pressure to use the equipment while waiting for the transport team to arrive.

Maternity guidelines

Work had taken place in conjunction with the clinical audit team to proactively identify any out-of-date maternity guidelines, which was said to have resulted in a decrease from more than 20 out-of-date guidelines to just two. Activity had also been underway to share templates across all four services within

the division to support consistent processes. Some issues were raised around securing medical input into guideline development, which had been exacerbated by medical staffing strikes.

There had been a rise in women choosing to birth outside guidance and the trust had been in the spotlight regarding this. The consultant midwife had undertaken training to support midwives anxious about the implications of birthing outside of guidelines, and to increase understanding of personalised care. The consultant midwife also conducted monthly care planning meetings with midwives and obstetricians for women who choose to birth outside of guidelines. A session on personalised care was also provided for obstetricians as part of day 5 mandatory training. There were plans for solicitors to provide a training session on documentation issues relating to care outside guidance to support midwives to feel more at ease.

Reduced fetal movements

Women received advice on reduced fetal movements and when to contact the unit in a Tommy's leaflet that was pushed out automatically by BadgerNet. Some women chose not to use BadgerNet and so paper copies of leaflets on reduced fetal movements were made available. This advice was said to be reiterated at every contact with community midwives. Information was also shared on the SaTH MVNP page.

The advice was to attend the unit if there were any change in fetal movements and the standard was to be triaged within 15 minutes of arrival. Previously, the process was to attend an external local midwifery unit, but that had stopped and been replaced by what one interviewee described as 'a very robust reduced fetal movement process'.

Any doctors or midwives working in the intrapartum setting or involved in interpreting CTGs must be up to date with CTG training; compliance was presented at monthly performance meetings and any staff not up to date with training were redeployed to other areas. Midwives and doctors attended a full day of fetal monitoring training, incorporating CTG interpretation, and must score 90% or above at an assessment at the end of the day. They were required to attend two CTG online case sessions, plus a peer review session on the ward. The training package for CTG was locally developed, focused on physiological interpretation rather than pattern recognition, and supported multidisciplinary learning. The training was led by a consultant obstetrician and team of fetal monitoring midwives.

If there were issues with CTG interpretation, a second opinion would be sought. All CTGs in labour received hourly "fresh eyes" (whether readings were normal or otherwise). The input of a consultant obstetrician was sought in the event of concerns and obstetricians routinely reviewed CTGs on ward rounds.

6.3.2 Neonatal network

6.3.2.1 Documentation review

The documentation shared with the review team included the following:

- Getting It Right First Time (GIRFT) neonatology review, unit level report, March 2021. This stated that the unit's clinical engagement in the network was excellent.
- West Midlands Neonatal Operational Delivery Network Neonatal Care Pathways 2020 (marked final June 2021 V1.2). This was the first pathway document since the merger of Staffordshire and Shropshire and Black Country, and Southern West Midlands operational delivery networks. Subspecialty services were provided by Birmingham Children's Hospital, Alder Hey Children's Hospital and Robert Jones and Agnes Hunt Hospital.
- Statement from lead neonatal consultant for KIDS NTS, the regional neonatal and paediatric transfer service, based at Birmingham Children's Hospital. This statement commended the level of care provided by the SaTH neonatal team and described referrals to KIDS NTS as 'timely and appropriate'. The SaTH team were also described as 'proficient at providing neonatal care –

including stabilisation', 'receptive to supporting other units in the region who are over capacity' and 'receptive to feedback'.

- Statement from the senior network manager, West Midlands perinatal network (neonatal). This welcomed the review of neonatal deaths and expressed a desire to support learning across the network, given the regional mortality. During the periods the deaths occurred the network was said not to be providing 'any enhanced mortality review activities due to repurposing of the network team in light of the pandemic'. The network's mortality review work was being 'refreshed' following organisational change and there were aspirations for 'meaningful, specialist externality within trust PMRT reviews'. The statement indicated that consideration should be given to missed opportunities for *in utero* transfers for any babies under the gestational age threshold of an LNU who may have died at SaTH.

6.3.2.2 Comments from interviewees

One interviewee remarked that approximately half of babies whose mortality was linked to SaTH (reflecting their place of birth) died at a different unit. 'If you don't look at the whole journey, you're not looking at all the opportunities to reduce mortality,' they said. This highlighted a need to look at mortality across the West Midlands.

Right place for delivery

Emphasis was placed on having, as one said, the 'right babies being delivered in the right centre'. Instances were reported when there was not a place for mother and baby on a NICU. However, the issue was thought to relate to bed capacity for mothers instead of NICU cots. Within the trust, the women's and children's team had been brought into site safety meetings, which were held four times a day, and this was said to have enhanced understanding of the issues facing the division.

Another account was that one of the major challenges to neonatal mortality was neonatal capacity within the region. If a woman presented at 24 weeks and it looked like she may deliver, the unit would actively try to move her out. This was said to require obstetricians and midwives spending hours on the telephone trying to identify a unit with both delivery and neonatal capacity. The review team heard that staff could spend 5 hours making telephone calls across the West Midlands, East Midlands and ultimately the whole country, in a bid to find an alternative unit for women presenting in threatened preterm labour. One interviewee described this as 'a huge waste of resource and means we potentially lose the window to transfer that lady out to deliver elsewhere'. The network was said to have agreed to add this issue to its risk register.

There was a cot locator service, however it was said this did not operate in the way of other cot locator services and was thought to exacerbate missed opportunities to transfer out women.

Transferring babies

Where a baby was born in the unit and needing level 3 care, the NICUs were said to try hard to exchange babies where possible and good working relationships were described. The network did not usually get involved in conversations over where to transfer a baby, even where this was proving difficult. The unit received a daily email regarding the OPEL[i] status of each NICU. The network was said to be aware that capacity for intensive care cots was not where it should be. Geographical challenges were also highlighted, with the nearest NICU an hour away and parents said to be reluctant or unable to travel such distances.

Relationships with the KIDS neonatal transport service (NTS) were also described positively. KIDS NTS was a combined neonatal and paediatric critical care advice and transport service within the West Midlands

[i] Operational pressures escalation levels framework

region, based at Birmingham Women's and Children's NHS Foundation Trust.[37] Feedback provided to the Trust by KIDS NTS was said to be good.

Network escalation

The unit worked closely with the NICU team at Royal Stoke University Hospital (part of University Hospitals of North Midlands NHS Trust), described as its 'link NICU'.

Events leading up to the Ockenden review marked, as one interviewee said, 'a quite significant breakdown in relationships' between the unit and this NICU team; however, these relationships were described as much improved. The NICU at Royal Stoke University Hospital was said to have had problems recently with consultant staffing, which caused it to close to outside referrals, and this was not communicated until several weeks after it happened.

Good working relationships were reported with the NICU at New Cross Hospital (part of the Royal Wolverhampton NHS Trust).

One interviewee remarked: 'Most of the time we get the help we need'. This interviewee highlighted a need to improve pathways for some high-risk patients managed in the community, with a defined pathway for obstetric care attached to a NICU. For some of these patients, their care could be transferred back to the LNU, as appropriate. The network was due to be meeting to discuss pathways. This interviewee said: 'It's about flow. It sometimes feels like one-way traffic and NICUs can't cope. It's about right place, right birth.'

Fetal medicine

Until July 2023, two subspecialty-trained fetal medicine consultants and a third consultant with a diploma in fetal medicine ran SaTH's fetal medicine service. The service carried out many invasive diagnostic tests and would refer to the fetal medicine department at Birmingham Women's Hospital as necessary. Between October 2022 and July 2023 all three consultants either left or no longer provided fetal medicine services and SaTH was forced to give notice on the fetal medicine service. Emergency procedures were put in place and all patients were referred out across the region. New Cross Hospital was highlighted as having been particularly supportive during this period.

In mid-October 2023, one of the fetal medicine consultants came back from retirement for 1 day a week. A locum fetal medicine consultant was due to start around the time the review was conducted. A job plan had been approved for a substantive post.

The network was said to be creating a business case to appoint fetal medicine consultants who would be employed by the tertiary unit in Birmingham and rotate across units (ie a hub and spoke model). This was thought to be a more sustainable model in the long term and would have helpful consequences in terms of standardised guidance and pathways across the region.

There was a monthly fetal medicine meeting involving discussion and planning for high-risk pregnancies. There was involvement of bereavement midwives, a fetal medicine consultant, a lead neonatal consultant, and sometimes a genetic counsellor from Birmingham would join the discussion.

6.3.3 End-of-life and bereavement pathway

6.3.3.1 Documentation review

The documentation shared with the review team included the following:

- Child death process standard operating procedure (draft)
- Neonatal mortality standard operating procedure (review date January 2027)

6.3.3.2 Comments from interviewees

The bereavement team comprised two, full-time specialist bereavement midwives (band 7) and a dedicated bereavement lead obstetric consultant. The team offered care and support for women and their families following a pregnancy loss and the death of a baby due to identification of fetal anomalies, pregnancy loss after 16 weeks gestation, stillbirth and babies who died shortly after birth. Prior to 16 weeks' gestation, women were supported by the Early Pregnancy Assessment Service.[38]

Bereavement midwives

The bereavement midwives had both been in post for over a year (having been appointed in 2022). The bereavement service was available from 09.00 to 17.00 on weekdays. The midwifery team were said to be able to work through the bereavement process 'very easily' and the pathway had been designed to be accessible to the wider team.

Antenatally, the bereavement midwives were involved in the Rainbow Clinic, which began in September 2022 to support women and their families in subsequent pregnancies after a baby died, in conjunction with a lead midwife for Lighthouse – a service to support people with moderate-severe or complex mental health difficulties associated with loss, grief and trauma directly arising from or related to the maternity experience. Support through the pregnancy included arranging early scans and attending scans, as needed, and seeing the mother and baby on the postnatal ward. The bereavement midwives would 'link in' with parents of babies requiring palliative care and liaise with neonatologists surrounding the plans for end-of-life care. If a poor outcome was expected around the time of birth, the bereavement midwives would become involved and multidisciplinary discussion would take place. If care was being withdrawn from a neonate, the bereavement midwives would meet with the family and, together with a consultant neonatologist, agree a plan for palliative care. They worked closely with Hope House Children's Hospice.

For an unexpected death, contact with the bereavement service was as soon as a loss was identified; 'almost certainly within 24 hours,' said one interviewee. The bereavement midwives worked clinically on the delivery suite and provided resources to bereaved families, including information about registration, funerals, post-mortem examination and placental investigations. Other support included with memory making (including photographs and memory boxes), providing baby clothes, and liaising with the hospital's chaplaincy team. An important aspect of the role of the bereavement midwives was to support neonatal nurses with checklists for different types of loss.

Emphasis was placed on parental interactions and the bereavement midwives were said to receive 'exceptional feedback' from parents. The bereavement midwives worked with MNVP, including two bereaved fathers who were MNVP champions and had provided a training session for staff on a father's point of view.

Families were cared for privately within the neonatal unit or moved to a dedicated bereavement room located on the delivery suite. Improvements were planned to make this room soundproofed. The unit had three cold cots, which enabled mothers to spend time with their deceased babies.

Once home, the bereavement midwives would undertake home visits and postnatal visits, as required. There was no time limit on the support provided to bereaved families, with emphasis given to personalised support.

The bereavement midwives were said to have strong relationships with the mortuary team, and supported families with funeral arrangements.

Postmortems were reported to be a challenge across the region – previously babies were sent to Birmingham Women's Hospital where there were four pathologists; there was only one at the time of the review and Alder Hey Children's Hospital was providing temporary support with postmortems which had been extended to March 2024. The bereavement midwives had received training in taking consent for postmortems and took consent for these most of the time.

The bereavement midwives shared office space with the professional midwifery advocate (PMA), which enabled them to be supported in role. A staff psychology hub offered counselling, as needed.

Bereavement champions

Out-of-hours support was provided by bereavement champions who worked on the delivery suite and were said to have good knowledge of the bereavement processes. Monthly meetings were held between the bereavement midwives and bereavement champions to share information. All staff were expected to complete an e-learning for health module and the day five personalised care study day at least once.

The bereavement midwives had started work on a package for neonatal nurses and were keen to develop bereavement champions within the neonatal unit.

Palliative care

There was a consultant lead for palliative care who worked with bereavement midwives on creating a robust palliative care plan. Hope House Children's Hospice also became involved in palliative care planning and would offer memory making and support with plans for after a baby's death.

Other bereavement support

The hospital chaplains were said to provide good support and were available 24/7 for blessings or pastoral support. Hope House and Cruise bereavement, a local charity, both offered a counselling service. The Lighthouse maternal mental health service also offered ongoing support, although it was said to have a lengthy waiting list. The bereavement midwives were able to signpost to a range of charities able to offer support.

6.3.4 Neonatal staffing, teamworking and leadership

6.3.4.1 Documentation review

The documentation shared with the review team included the following:

- Ockenden Report Assurance Committee (ORAC) slides dated June 2023. These detailed that neonatal staffing was the biggest challenge to completing the remaining Ockenden actions. All four of the actions not yet delivered relating to staffing. The unit's plans to meet the outstanding Ockenden actions were as follows:
    - Separation of the tier 2 rota
    - Rotation of ANNPs
    - Rotation of nurses
    - Achievement of qualified in specialty (QIS) numbers.
- Details of simulation training, as follows:
    - Accidental extubating in a neonate

  - Can't intubate can ventilate glidescope training
  - Difficult neonatal airway in a DGH [district general hospital]
  - Delivery of an extremely preterm baby in a DGH
  - Preterm intubation in the delivery suite
  - Thermal care of the preterm neonate (22–32 weeks)
  - Neonatal simulation attendance and feedback
- The neonatal unit ward management structure
- Details of the teaching programme for doctors in training for 2023
- GMC doctors in training survey results, which showed the unit was a negative (red) outlier in 2021 (the most recent year provided) in the following aspects of paediatric training: overall satisfaction; supportive environment; adequate experience; local teaching.
- Regular consultant and business meetings:
  - Fortnightly senior team meetings (consultants, matron and ward manager)
  - Monthly Shropshire consultants' meetings
  - Monthly business meeting
  - Monthly triumvirate meeting
  - Monthly divisional committee
  - Monthly senior management team meetings
  - Neonatal Quality Improvement meetings, 2–3 times per year
  - Quarterly Family Integrated Care and baby friendly initiative meetings

The documentation provided details of simulation training, but not who attended and what feedback had been received following these sessions.

6.3.4.2 Comments from interviewees

The neonatal service was supported by the following:

- seven consultants (with six currently in post)
- Tier 2 ANNPs (3 WTE)
- Tier 2 registrars allocated by the deanery (numbers varied) and non-deanery
- Tier 1 doctors in training allocated by the deanery (numbers varied)
- Tier 1 ANNPs (7 in total; 5 WTE)
- neonatal nurses, neonatal outreach nurses, allied health professionals

Neonatal nursing staffing

Many interviewees highlighted challenges in terms of nursing staffing. One described neonatal nursing shortages as one of the main challenges relating to neonatal mortality, with the unit hampered by recruitment issues despite being funded to be BAPM compliant.

Several issues were highlighted. First, [redacted] This was a key role and the absence of a substantive postholder had impacted the unit. It had created challenges in driving through quality improvement projects and relationships within the nursing team had deteriorated, [redacted]. One interviewee said team cohesiveness suffered during this time and had not yet been regained. They said: 'We are starting to find our feet and to work as a team again.'

A recruitment process was underway for a replacement unit manager; this role had proved difficult to recruit to and had been advertised several times. [redacted]

[redacted]. Attempts to recruit an interim matron had been unsuccessful and so the [redacted] had assumed the role as an interim. Nursing staff were said to have responded positively to this individual. One interviewee said: 'She's been excellent and really moved things forward, has the confidence of the nursing team and we have seen improvements with her at the helm.'

The unit tried to ensure that there was a supernumerary coordinator for each shift, but this depended on staffing levels and patient acuity. 'If there are three babies in intensive care, you just have to muck in and get on with it,' said one. A recurring theme was of nursing staff pulled away from other roles (such as quality roles) to undertake clinical tasks due to staffing shortages.

The second staffing issue related to recruitment. There had been challenges in recruiting to some nursing roles, particularly band 6, and workforce planning had been non-existent. There had been challenges in having sufficient staff to release nurses from clinical duties to undertake quality roles. Existing nursing staff were said to be eager to take on quality roles (such as Family Integrated Care, baby friendly lead, and safeguarding); 'they're chomping at the bit,' said one interviewee.

Continued use of agency staffing had been necessary because the unit lacked sufficient qualified in specialty (QIS) staff. National standards expect 70% of neonatal nursing staff will be qualified in specialty.[39] Some interviewees spoke of the challenges in working with agency staff who were unfamiliar with the unit and whose competencies were unknown. Examples of gaps included a neonatal quality improvement nurse able to attend PMRTs on a regular basis, a neonatal bereavement nurse, and specialty nurses leading on breastfeeding or nutrition.

Plans were articulated to 'grow our own' qualified and QIS nurses; however, the third issue highlighted by interviewees was training, with a recurring theme being a lack of dedicated training for neonatal nurses in recent years. Interviewees remarked that many of the new nurses appointed lacked experience and yet 'education for nurses on the unit tends to be quite poor,' said one. Simulation training was beginning to take place with greater frequency, on an ad hoc basis when a particular consultant neonatologist was consultant of the week. Senior staff worried about being away from the clinical floor, particularly when newly qualified nurses were working. There were concerns that more junior nursing staff were not sufficiently supported. There was frustration that neonatal staff had to complete mandatory training within the trust of no relevance to the unit, such as dementia in adults training. Such training had to be sandwiched alongside existing commitments, and some interviewees would rather there was more focus on neonatal resuscitation and how to stabilise babies before they were transferred to a NICU. 'The adult world just don't understand,' said one. Many study days were said to have been cancelled under the previous matron. One interviewee said: 'We have 70 staff to train and cannot cover that in one day a year.'

Due to the turnover of staff the unit had introduced a rolling plan of training three QIS staff each year. There was an ambition to achieve parity with midwives who, after a period of induction, tend to be uplifted from band 5 to band 6 relatively quickly. This would mean giving neonatal nurses similar opportunities once they were qualified in specialty.

Morale within the nursing team had been a problem and was said to have dampened enthusiasm. However, the new management structure, including having the deputy director of nursing covering the matron role, and three new band 7s in post, had initiated a cultural shift within the neonatal unit and nurses were beginning to demonstrate a renewed appetite to undertake training to become QIS and get more involved in the unit.

Allied health professionals

The unit was almost fully recruited with a new team of allied health professionals, having previously been reliant on community support. There was a trust 'psychology hub' and a psychologist was undertaking a piece of work in neonates and paediatrics. Senior nurses, doctors and ANNPs had undergone a session led by the psychologist, with more planned, as well as plans for psychology support for parents. An occupational therapist had been in post since June 2023 and was leading work on family integrated care. The unit had been supported by speech and language therapists since June 2023. In July 2023, a dietitian joined the unit and a physiotherapist started in September 2023.

ANNPs

There was positive feedback relating to the ANNP team, however, there was recognition that the unit had fallen behind in terms of succession planning for ANNPs. At the time of the review, two staff had been undertaking ANNP training and were about to undertake the master's element of their training. The unit was beginning to work towards having a regular ANNP training programme, with an ANNP trained every 1–2 years. This was thought to increase the likelihood of attracting tier 2 ANNPs from other centres.

The ANNP rota had been split into tier 1 and tier 2, reflecting the Ockenden recommendations. Thought was being given to mechanisms for progression from tier 1 to tier 2 as part of the neonatal strategy (at the time of the review, progression was only possible when a tier 2 post became available). Tier 2 ANNPs were expected to undertake some non-clinical and leadership roles, although this had been challenged by rota gaps. Tier 2 ANNPs received protected administrative time once a week; this had not been established for those on the tier 1 rota but was thought to be in the pipeline. Progress in achieving the four pillars of advanced practice was said to be mixed among the ANNPs, which again reflected pressures around covering rotas and a lack of protected non-clinical time.

ANNPs carried the bleeps when doctors in training had teaching sessions. They also ran simulation and skills drills on the unit for both nurses and doctors. Tier 2 ANNPs were expected to spend 2 weeks a year observing NICUs beginning January 2024; for tier 1 ANNPs, such observation was expected to start from April 2024. This had been in the pipeline for 3 years according to one account.

The department had had a lead mortality ANNP since 2022.

Consultant neonatology team

The unit was described as 'reasonably well recruited to in terms of consultant paediatricians'. Only one consultant undertook both neonatal and paediatric work; all the rest were specialist neonatologists. The on-call rota had been fully separated for consultants since 2014, which meant only neonatal consultants were on call for neonates. There were six neonatal consultants; a seventh post was out for advert (and interviews were to be held in December 2023), reflecting a recent move to a 1 in 7 rota. The post advertised was for a neonatal paediatrician; most of their work would be with neonates but would also involve some paediatric work. In the meantime, a long-term locum was providing cover, with the on calls for the vacant role covered by external locums (five consultants from NICUs were regular locums at the unit).

The neonatal consultants had operated a consultant of the week system since 1996. In 2001, the unit moved to meet the 7-day service standards and Facing the Future standards, providing resident cover from 08.30–19.30 on weekdays and between 10.00–13.00 and 20.00-21.00 on weekends. The number of NOW (neonatologist of the week) weeks per consultant varied between six and nine, dependent on other commitments. The NOW was resident Monday to Friday 08.30–17.30. The on-call consultant was resident 17.00–19.30, then non-resident overnight. For weekends and bank holidays, the on-call consultant was resident 10.00–13.00 and 19.30–20.30 and non-resident the remainder of the time. If a consultant was up all night, a colleague would provide cover to enable them to get some rest. This was an ad hoc arrangement of support and was reported to be needed no more than three times a year. One said: 'I never

have any qualms about asking for help, or a second opinion, knowing my colleagues would facilitate that.' The consultant team were said to work well together, although, as for any small team, there were 'strengths and challenges'. COVID-19, the Ockenden review, and several consultants and senior leaders leaving at the same time, had taken a toll and one described morale amongst the neonatal team as 'low', although there was a sense that the team was coming through it.

There were seven ward rounds per week and consultants were reported to participate in handovers at 08.30 and 16.00.

The consultant team were described by one interviewee as 'an incredibly polite group of doctors', who had lacked strong leadership support – 'it has been a proper Cinderella service from a leadership perspective'.

Tier 1 and tier 2 neonatal rotas

In September 2023, the tier 2 paediatric and neonatal rota was separated, and an 8-person tier 2 rota dedicated to neonates was created. There had been a separate tier 1 neonatal rota since before 2014.

The tier 2 rota comprised three neonatal registrars (deanery and some community registrars), tier 2 ANNPs and a clinical fellow. Difficulties were reported in recruiting a tier 2 specialty doctor and discussions had taken place over converting the position to a tier 2 ANNP instead to provide greater stability.

Neonatal nursing staff were said to feel better supported at night following the tier 2 rota split, with registrars no longer covering paediatric A&E as well as neonates.

There were said to be clear expectations regarding mandatory training in neonates. Deanery trainees received some of their mandatory training from the deanery and some was incorporated into induction, including simulation. Non-paediatric trainees (there was one foundation year 2 doctor at the time of the review) were supernumerary for the first 2 months and only joined the tier 1 rota when all agreed that the individual was ready.

Neonatal teamworking

A neonatal MDT meeting was held on the ward every Tuesday (with plans to move to Wednesday), attended by most consultants, doctors in training, allied health professionals, nursing staff, microbiologists and hospice staff. The medical team lead the clinical discussion of patients, which would expand to cover social issues and family support; it was described as a good environment for broad-ranging discussion. The meeting lasted approximately 1 hour. If the unit was full, discussion would prioritise sick babies and exclude the 'feeders and growers'. Senior nurses were said to feel comfortable expressing their opinions during these meetings; more junior staff could find it more difficult to get their voices heard. Senior nurses would feel comfortable escalating concerns to a consultant where necessary. ANNPs were described as a good source of support for nurses and were thought to escalate concerns to consultants faster than doctors in training. One interviewee described teamworking and ANNP leadership at SaTH as 'amongst the best in the West Midlands'.

There were also neonatal senior team meetings, attended by consultants and senior nurses, every 2 weeks. The time had been changed to improve in-person attendance and administrative support had been secured for the first time.

Consultants were allocated time in their job plans to attend MDT meetings 32 times a year.

Divisional leadership

The divisional team was new. The divisional medical director, a gynaecologist, was on leave at the time of the review; this individual was said to be 'extremely approachable'. The review team met with the

divisional director of operations and director of nursing, who reported that the divisional leadership team had 'formed and stormed and normed really quickly as a senior team'.

The divisional team were said to have close working relationships with the executive team, and the executive team were said to have a sound grasp of the issues facing the division as they had covered divisional roles for some time. The executive team was also reported to be heavily involved in governance following the Ockenden review. The support provided by the executive team marked an improvement from previous arrangements – some interviewees reported that previously there seemed to be little drive or representation of the women's and children's division at trust board level or within the executive leadership team. The level of support, for example in developing new business cases and projects, was described as much improved. The ICB was also reported to have observed a significant strengthening in leadership, with the trust medical director and nursing director demonstrating clear leadership for women's and children's services until new divisional leaders and a clinical director for neonates were appointed.

The divisional team held a weekly meeting with the clinical directors across women's and children's services. Good interactions were reported with the clinical director for neonates, who met with the divisional team every month to discuss pieces of work specific to neonates. The divisional team was described as 'supportive' and 'very responsive to any concerns'.

A new director of maternity was said to have initiated 'dramatic change' across the division. A new head of midwifery was also a conduit for learning from maternity with relevance to neonates (such as around transitional care).

One interviewee described morale across the division as 'the best it has been for some time'. They added: 'It feels like we've drawn a line in the sand and while we have to keep one eye on the past, this is a new time and we are focused on the work we are doing to improve things.'

Maternity services

Relationships between obstetricians and midwives post Ockenden were reported to be 'excellent'. The department had evolved considerably over the preceding 5 years. A great deal of work had been undertaken to address cultural issues and improve working relationships in response to the Ockenden review. The last 18 to 24 months had marked a new level of stability, following patterns of high turnover across all senior management roles. One interviewee said: 'There is a completely different, and differently minded, leadership team within maternity – and it's one reason why we are one of the best recruited to midwifery departments.' The improvement methodology used to enact change was said to have been driven by MDT group working. Interviewees described how they broke down the 210 recommendations made by Ockenden by complexity and put them into workstreams. This MDT approach to improvement was credited with having 'driven good relationships. The department also received external help from interim directors of midwifery. 'Very strong leadership' was described, and staff were said to feel comfortable to speak up.

Recruitment in midwifery was described as outstanding (the department was fully recruited to midwifery), and recruitment was strong in obstetrics. The review team met with several maternity staff who described their draw to work in the department and to be part of its journey. One described being welcomed into 'a very friendly unit that was happy to have new people, new ideas, new blood. Nobody stood in the way of change. Some people were just very exhausted and hurt.'

Consultants were resident 24/7, providing immediate access to senior support during the day and at night. The obstetric and gynaecology consultants in the department supported three different 1 in 8 rotas (one of which was for gynaecology).

A strong training culture was reported, and training was multidisciplinary in its delivery.

The impact of Ockenden in terms of prioritising communication and getting everyone in the team involved early on was thought to have had a knock-on effect for neonates, with an open dialogue reported between delivery staff and the neonatal unit. Antenatal counselling where there were concerns regarding a baby was an example where maternity and neonatal staff worked closely together, with ANNPs, consultants and midwives working together to support mothers.

6.3.5 Audit and quality improvement

6.3.5.1 Documentation review

The documentation shared with the review team included details of recent audits undertaken, as follows:

- National Neonatal Audit Programme 2019 (annual report on 2018 data)
- Newborn heart murmur follow up
- Management and outcome of neonatal hypoglycaemia using BAPM framework
- Admission temperatures in babies being admitted to the neonatal unit
- National neonatal audit programme (NNAP) – neonatal care 2020 (2019 data)
- Case note audit: joint case note entry neonatal unit Ockenden action 4.97a
- Case note audit: joint case note entry neonatal unit Ockenden action 4.97b
- CLABSI (central line associated bloodstream infection) in babies
- Joint case note entries on the neonatal unit – re-audit
- Monthly exception reporting forms to neonatal network by neonatal clinical director
- NIC-TECH
- Case note audit – neonatal 2023 (neonatal daily care entries)
- Are the yellow communication sheets within the babies [sic] notes being filled in appropriately?
- Outcome data:
    - Babies receiving oxygen at 36 weeks corrected gestation 2022
    - Cranial ultrasounds
    - Intubated at birth
    - Network ventilated episodes

The documentation also included a business case associated with the final Ockenden report, dated March 2023. The stated purpose of this document was to confirm recurrent funding to ensure that achieved improvements were sustained; and to itemise recurrent funding to deliver and sustain the actions of the final Ockenden report and the trust's maternity transformation objectives. This paper demonstrated the significant financial investment associated with quality improvement following the Ockenden review.

The review team was provided with Ockenden Report Assurance Committee (ORAC) slides, dated June 2023. These indicated that Ockenden actions linked to the first report had all been evidenced and assured, except for the following, which were 'not yet delivered':

- 'There was some evidence of outdated neonatal practice at SaTH. Consultant neonatologists and ANNPs must have the opportunity of regular observational attachments at another NICU.'
- 'Neonatal operational delivery networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example, senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.'

- 'Neonatal practitioners must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.'
- 'As the trust has benefited from the presence of ANNPs, the trust must have a strategy for continuing recruitment, retention and training of ANNPs.'

Two actions were reported to be 'delivered, not yet evidenced':

- 'Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.'
- 'The number of neonatal nurses at the trust who are "qualified in specialty" must be increased to the recommended level, by ensuring funding and access to appropriate training courses. Progress must be subject to annual review.'

These slides highlighted the following outcomes linked to Ockenden:

> That the unit had two trainee ANNPs
> It had hosted an ANNP away afternoon
> The time that consultants were resident to deliver 7-day working had been extended
> Consultant neonatologists were continuing to rotate to other NICUs to help maintain their competencies
> Tier 2 ANNPs were due to start rotating in September 2023 to visit NICUs to strengthen training (it was not evident from interviews that this had happened).

Other improvements reported on the neonatal unit were as follows:

> Pulse oximetry screening
> PERIprem initiative (a perinatal optimisation pathway), including a life start trolley, probiotics, and being 'a positive outlier for optimal cord clamping'
> Allied health professionals – occupational therapists, psychologists, dietitians, speech and language therapists, physiotherapists.

6.3.5.2 Comments from interviewees

Interviewees stated that the unit was, for most parameters, at or exceeding the national average and had been a positive outlier for delayed cord clamping in 2021. Bronchopulmonary dysplasia (BPD) rates were reported to be slightly higher than the national average in 2020 but had since reduced. Screening for retinopathy was reported to have been just above national average.

One of the neonatal consultants had undertaken work into data quality to support the National Neonatal Audit Programme (NNAP). The unit was not paperless and there was an ambition to have the full capacity of BadgerNet, with an electronic paper record (EPR) – a business case had been prepared for BadgerNet EPR – however, priority was being given to replacing the trust's main patient administration system (PAS). Until then, examination of trends remained labour intensive.

Opportunities for nurses to become involved in quality improvement work were reported. For example, there were leads for different areas, such as having a nurse baby friendly lead, a PERIprem lead and a simulation lead. Neonatal nursing staff inputted to quality meetings. Neonatal voices champions also participated in meetings where quality improvements were discussed.

When asked by the review team to provide an example of quality improvement and learning, some interviewees highlighted infection prevention. This followed a serratia (bacterial) infection outbreak, involving the death of one neonate.

The unit was said to meet most of the components of PERIprem perinatal optimisation and had implemented a neonatal passport and invested in new trolleys. There had been team discussion of using hydrocortisone in neonates, but the team had decided against its use. There was a PERIprem neonatal lead but not an obstetric or nurse lead for this.

6.3.6 Neonatal strategy

6.3.6.1 Documentation review

The documentation shared with the review team included the following:

- SaTH neonatal services vision. This document set out the unit's neonatal strategy for 2023/24 under seven headings:
    - Excellence in patient care – including achieving accurate clinical and activity recording on BadgerNet and implementing recommendations from mortality review at local and regional level
    - Leadership – including developing nursing roles for Family Integrated Care and infant feeding leads
    - Team recognition – recruiting to funded posts for allied health professionals and developing band 7 coordinator cover for all shifts
    - Wellbeing – psychological support for parents and improving support for governance processes
    - Professional development – including rotational attachments across teams for ANNPs and nurses at NICUs and reviewing ringfenced training time and study budget for ANNPs
    - Shared decision making – including enhanced rates of breast feeding, Family Integrated Care, re-establishing a parent support group, and expanding use of Parent Diary
    - The workforce of the future – developing the tier 2 (ANNP) model and tier 2 overnight rota, working towards BAPM standards for numbers of qualified in specialty nurses, and implement workforce plan for rolling training of ANNPs.

6.3.6.2 Comments from interviewees

One interviewee highlighted three priority issues. First, to improve documentation of conversations with parents on ward rounds (the unit had begun to conduct monthly audits of parent communication sheets). Issues around documentation were also highlighted as a nursing issue, with clinical pressures said to sometimes prevent nurses from completing documentation during their shift. Second, to increase the numbers of qualified in specialty (QIS) nurses, as insufficient numbers were said to have an impact on the unit's ability to deliver some types of care in the first few hours. Third, to improve breastfeeding rates, which had slipped after being better than the national average.

Other priorities voiced by interviewees were to have a cot locator service, for there to be an expansion of neonatal bed capacity across the West Midlands, and to have BadgerNet electronic patient records.

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8 Appendices

8.1 Appendix 1: Glossary

Clinical term	Explanation
Antenatal care	The care provided during pregnancy.
Antepartum haemorrhage	Antepartum haemorrhage is defined as bleeding from or in to the genital tract, occurring from 24+0 weeks of pregnancy and prior to the birth of the baby. https://www.rcog.org.uk/media/pwdi1tef/gtg_63.pdf
Anhydramnios	Anhydramnios refers to a condition where there is insufficient amniotic fluid around the fetus.
Apgar score	A standardised method of evaluating the condition of a baby immediately after birth.
ATAIN	Avoiding Term Admissions into Neonatal Units.
BadgerNet	SaTH's maternity service used BadgerNet Maternity Notes – an electronic system aimed at giving mothers more access to and control of their pregnancy records and care notes. www.sath.nhs.uk/wards-services/az-services/maternity/badgernet
Bliss	Bliss exists to give every baby born premature or sick in the UK the best chance of survival and quality of life. www.bliss.org.uk
BFI	This refers to the UNICEF Baby Friendly Initiative (BFI) neonatal standards. www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2022/03/UNICEF-UK-Baby-Friendly-Initiative-Guide-to-the-Neonatal-Standards.pdf
Breech	This is where the baby is in a bottom first or feet first position. www.nhs.uk/pregnancy/labour-and-birth/what-happens/if-your-baby-is-breech
Bronchopulmonary dysplasia (BPD)	BPD is a type of chronic lung disease that can affect babies born prematurely. www.asthmaandlung.org.uk/conditions/bronchopulmonary-dysplasia-bpd-children
Cardiotocography (CTG)	Cardiotocography – CTG – is an electronic fetal monitoring machine used to monitor a baby's heart rate and a mother's contractions during labour.
Chorionic villus sampling (CVS)	Chorionic villus sampling (CVS) is a test offered during pregnancy to check if a baby has a genetic or chromosomal condition, such as Down's syndrome. www.nhs.uk/conditions/chorionic-villus-sampling-cvs
Cold cot	A cold cot is a refrigerated cot that allows parents to spend more time with their deceased baby than would otherwise be possible. www.abigailsfootsteps.co.uk/professionals/cold-cots-for-hospitals
Cystic hygromas	A cystic hygroma is a collection of fluid-filled sacs known as cysts that result from a malformation in the lymphatic system. www.gosh.nhs.uk/conditions-and-treatments/conditions-we-treat/cystic-hygroma
Datix	Datix is an online risk management system for staff to report incidents and errors.
Extubation	Extubation refers to removal of an artificial airway.
Family Integrated Care	Family Integrated Care is a model of neonatal care which promotes a culture of partnership between families and staff. This enables parents to become confident, knowledgeable and independent primary caregivers. www.bapm.org/resources/ficare-framework-for-practice

Clinical term	Explanation
	www.bliss.org.uk/health-professionals/bliss-baby-charter
Fetal ascites	Fetal ascites refers to fluid in the fetal abdomen.
Group B streptococcus (GBS) infection	GBS is a bacteria that can be present on the body and usually does not cause any harm. Many babies come into contact with GBS around the time of birth. www.nhs.uk/common-health-questions/pregnancy/what-are-the-risks-of-group-b-streptococcus-infection-during-pregnancy
Inotropes	Drugs to stimulate blood pressure.
Intermittent auscultation	Intermittent auscultation is fetal heart rate monitoring during labour via a handheld doppler or a Pinard stethoscope.
Intrapartum care	The care provided during labour and immediately after birth.
Local neonatal unit (LNU)	An LNU is for babies who need a higher level of medical and nursing support than a special care baby unit can provide. Babies born between 27 and 31 weeks' gestation may be transferred to an LNU. www.bliss.org.uk/parents/in-hospital/about-neonatal-care/how-does-neonatal-care-work
MBRRACE	MBRRACE-UK stands for Mothers and Babies Reducing Risk through Audits and Confidential Enquiries across the UK. MBRRACE-UK is the collaboration appointed by the Healthcare Quality Improvement Partnership (HQIP) to run the national Maternal, Newborn and Infant Clinical Outcome Review Programme (MNI-CORP), which continues the national programme of work conducting surveillance and investigating the causes of maternal deaths, stillbirths and infant deaths. www.npeu.ox.ac.uk/mbrrace-uk
Maternity neonatal voices partnership framework (MNVP)	An MNVP listens to the experiences of women and families, and brings together service users, staff and other stakeholders to plan, review and improve maternity and neonatal care. https://nationalmaternityvoices.org.uk/
National Neonatal Audit Programme (NNAP)	NNAP assesses whether babies admitted to neonatal units in England, Scotland and Wales receive consistent high-quality care, and identifies areas for quality improvement. www.rcpch.ac.uk/work-we-do/clinical-audits/nnap
Needle aspiration	Needle aspiration is a method of removing a small amount of fluid or tissue by passing a needle through the skin.
Neonatal intensive care unit (NICU)	A NICU is for babies with the highest need for support lasting more than 48 hours. Often these babies will have been born before 28 weeks' gestation. www.bliss.org.uk/parents/in-hospital/about-neonatal-care/how-does-neonatal-care-work
NHS Friends and Family Test (FFT)	The FFT was created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed. www.nhs.uk/using-the-nhs/about-the-nhs/friends-and-family-test-fft
PALS	The Patient Advice and Liaison Service (PALS) offers confidential advice, support and information on health-related matters. www.nhs.uk/nhs-services/hospitals/what-is-pals-patient-advice-and-liaison-service

Clinical term	Explanation
Perinatal mortality	MBRRACE-UK focuses on the surveillance of perinatal deaths from 22 weeks gestational age, including late fetal losses, stillbirths, and neonatal deaths. www.npeu.ox.ac.uk/mbrrace-uk/reports/perinatal-mortality-surveillance
Perinatal optimisation	Perinatal optimisation refers to the process of reliably delivering evidence-based interventions in the antenatal, intrapartum and neonatal period to improve preterm outcomes. PERIprem is an example of a perinatal optimisation pathway. www.bapm.org/pages/perinatal-optimisation-pathway
Placental abruption	Placental abruption is a serious condition in which the placenta starts to come away from the inside of the womb wall. https://www.nhs.uk/pregnancy/labour-and-birth/what-happens/placenta-complications/
PMRT	The National Perinatal Mortality Review Tool (PMRT) is wholly integrated within the MBRRACE-UK programme of work. It is designed to support systematic, multidisciplinary, high-quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care. www.npeu.ox.ac.uk/pmrt/programme
Pneumothoraces	A pneumothorax is when air becomes trapped in the space between the lungs and the chest wall. https://www.nhslanarkshire.scot.nhs.uk/patient-information-leaflets/emergency-department/pil-pnethx-05357-h/
Postnatal care	The care provided during the first six to eight weeks after birth.
Prenatal exome (R21) sequencing	Rapid prenatal exome sequencing (R21) may be undertaken in at-risk pregnancies to check for genetic conditions. www.genomicseducation.hee.nhs.uk/genotes/knowledge-hub/r21-rapid-prenatal-exome-sequencing
Qualified in specialty (QIS)	The qualification in specialty model was developed to enable nurses to develop along the training pathway for their specialist area. There are specific neonatal QIS programmes.
Sands	Sands supports people affected by the death of a baby. www.sands.org.uk
SCBU	Special care baby unit.
Systemic lupus erythematosus (SLE or lupus)	Lupus (systemic lupus erythematosus) is a long-term condition that causes joint pain, skin rashes and tiredness. www.nhs.uk/conditions/lupus
Tokophobia	Fear of childbirth www.nct.org.uk/pregnancy/how-you-might-be-feeling/fear-childbirth-and-tokophobia

8.2 Appendix 2: Structured judgement review (SJR) form

RCP Number:	
Initials & Hospital reference no:	
Case description:	
Initials of reviewer:	

Background/summary of the relevant history *[Please give a brief clinical history of the mother and baby e.g. gender/age/relevant co-morbidities/presenting condition/operation/outcome/any other relevant factual information from the notes. Make a note of key dates (bullet point if helpful)]*
Click here to enter text.

The obstetric journey, and specifically whether the risks associated with stillbirth, problems during delivery, and/or perinatal mortality were identified and managed appropriately (antenatal, intrapartum, postnatal, obstetric anaesthesia)	
Click here to enter text.	**Please grade this phase of care (mark with an 'x'):** ☐ 1 = very poor care ☐ 2 = poor care ☐ 3 = adequate care ☐ 4 = good care ☐ 5 = excellent care

Management of the baby at delivery by the multidisciplinary team (e.g., midwives, obstetricians, anaesthetists, nursing staff and healthcare assistants, neonatologists, neonatal nurses)	
Click here to enter text.	**Please grade this phase of care (mark with an 'x'):** ☐ 1 = very poor care ☐ 2 = poor care ☐ 3 = adequate care ☐ 4 = good care ☐ 5 = excellent care

Care following admission to the Neonatal Unit	
Click here to enter text.	**Please grade this phase of care (mark with an 'x'):** ☐ 1 = very poor care ☐ 2 = poor care ☐ 3 = adequate care ☐ 4 = good care ☐ 5 = excellent care

Multidisciplinary team working and communication between colleagues	
Click here to enter text.	**Please grade this phase of care (mark with an 'x'):** ☐ 1 = very poor care ☐ 2 = poor care ☐ 3 = adequate care ☐ 4 = good care ☐ 5 = excellent care

Interactions with parents and their family (sharing of information, discussion and agreement on management plans etc), including demonstration of Family Integrated Care	
Click here to enter text.	**Please grade this phase of care (mark with an 'x'):** ☐ 1 = very poor care ☐ 2 = poor care ☐ 3 = adequate care ☐ 4 = good care ☐ 5 = excellent care

End of Life Care, as relevant, and support offered before and following a perinatal death	
Click here to enter text.	**Please grade this phase of care (mark with an 'x'):** ☐ 1 = very poor care ☐ 2 = poor care ☐ 3 = adequate care ☐ 4 = good care ☐ 5 = excellent care

Review of care after a perinatal death	
Click here to enter text.	**Please grade this phase of care (mark with an 'x'):** ☐ 1 = very poor care ☐ 2 = poor care ☐ 3 = adequate care ☐ 4 = good care ☐ 5 = excellent care

Clinical record keeping	
Click here to enter text.	**Please grade this phase of care (mark with an 'x'):** ☐ 1 = very poor care ☐ 2 = poor care ☐ 3 = adequate care ☐ 4 = good care ☐ 5 = excellent care

Compliance with network guidelines in place at the time Adherence to Trust guidelines in place at the time and the extent to which these guidelines aligned with network guidelines, national guidelines and recognised best practice	
Click here to enter text.	**Please grade this phase of care (mark with an 'x'):** ☐ 1 = very poor care ☐ 2 = poor care ☐ 3 = adequate care ☐ 4 = good care ☐ 5 = excellent care

Any other issues identified from clinical record review	
Click here to enter text.	**Please grade this phase of care (mark with an 'x'):** ☐ 1 = very poor care ☐ 2 = poor care ☐ 3 = adequate care ☐ 4 = good care ☐ 5 = excellent care

Reviewers' comments on the overall standard of care *We are interested in comments about the quality of care the patient received at each phase of care, and whether it was in accordance with current good practise (for eg, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.*
Click here to enter text.

Clinical Reviewer's overall perspective on quality of care (please mark x in the relevant box)	
☐	**Good practice:** A standard you would accept from yourself, your trainees and your institution.
☐	**Room for improvement:** aspects of clinical care that could have been better.
☐	**Room for improvement:** aspects of organisational care that could have been better.
☐	**Room for improvement:** aspects of both clinical and organisational care that could have been better.
☐	**Unsatisfactory:** several aspects of clinical and/or organisational care that were well below that you would accept from yourself, your trainees and your institution.
☐	**Insufficient information available** to make an assessment of quality of care.

Recommendations (if you scored room for improvement/unsatisfactory – in a few words please suggest what could have been done better)
Click here to enter text.

8.3 Appendix 3: Documents received and reviewed

18 index cases

Service review documentation
1. Organisational-level information
Block NK – women's and children's unit – level 2 A1 layout
ENC – neonatal quality report 2021
Ockenden report – final (findings, conclusions and essential actions), March 2022
GIRFT report 2021
2023 Ockenden Report Assurance Committee (ORAC) slides, June 2023
Neonatal strategy 2023/24
Ockenden report December 2020
Who's-Who-Website July 2023
2. Service-specific information
Specialty overview
Activity (first attendance and did not attend) from 2018 to 31/07/2023
Admissions data from 01/01/2018 to 31/07/2023
SaTH activity data neonatal unit 2018 to 31/07/2023 – care days by level and average length of stay
West Midlands Neonatal Operational Delivery Network, Neonatal care pathways 2020
3. Clinical team
No documentation
4. Clinical governance
LMNS Programme Board and Perinatal Quality Surveillance Group (PNQSG), Agenda for meeting held on 17 July 2023
Maternity Governance meeting, Perinatal Mortality Review Tool (PMRT) Quarterly Report Q1, July 2023
Merged documents for neonates review
Neonatal guidelines 2022-24
Neonatal guidelines 2019-21
5. Doctors in training
Teaching programme: February 2023, May 2023, June 2023
GMC survey results SaTH 2021

	Neonatal Teaching Programme March 2023-Sept 2023
6.	**Statements**
	Alex Philpott, lead neonatal consultant, KIDSNTS (regional neonatal and paediatric transfer service, based at Birmingham Childrens Hospital)
	Lynsey Clarke, senior network manager, West Midlands perinatal network (neonatal)
	Email from Nei-See Hon, 17/11/2023 – adding to information provided in interview
7.	**Additional documentation**
0.1	List of additional items
1a	Accidental extubation
1b	Can't intubate can ventilate
1c	Difficult neonatal airway in the DGH
1d	Extremely preterm birth in a DGH
1e	Preterm intubation in the delivery suite
1f	Neonatal teaching programme Sept 2022–2023
1g	Neonatal simulation attendance log
1h	Neonatal simulation attendance log
1I	Simulation feedback 6 October 2023
1J	Feedback neonates simulation 25 October 2023
1K	Neonatal simulation feedback
1L	Neonatal simulation SaTH certificate of attendance
1M	Thermal care of the premature neonate
2	Business case Ockenden final report
3	MBRRACE SaTH 2021 report
4a	Babies receiving oxygen at 36 weeks corrected gestation 2022
4b	Cranial ultrasounds
4c	Intubated at birth
4d	Network ventilated episodes 03.11.2023
6a	Child death process draft (v2)
6b	Analysis of specific case
6c	Governance structure and local processes Nov 2023
6d	Perinatal mortality meeting of specific case
6e	MBRRACE 29 Sept 2023

6f	MBRRACE 2021 Neonatal mortality SaTH – neonatal governance 2023
6g	PMRT 2021
7	Datix web report neo risks 30.10.2023
8a	Ex utero exception policy
8b	Fungal infection guideline
8c	Golden hour guideline
8d	Herpes simplex infection in neonates guideline
8e	LISA checklist appendix 1
8f	LISA guideline
8g	Neonatal Datix triggers on neonatal unit guideline
8h	Neonatal infection guideline
8I	Neonatal mortality SOP
8J	Preparing for ex utero transfer SOP
8K	Resuscitation guideline
8L	Surfactant guideline (under review)
8M	Transfer in from home or outside hospital guideline (under review)
8N	Transport and retrieval guideline
8O	When should the neonatal consultant be informed guideline
8P	When to summon assistance SOP
10	NNU ward management structure
11	SaTH neonatal critical care peer review visit report
12	NNU consultant meetings agenda and minutes 2021: agendas 03.03.21, 31.03.21, 05.05.21, 26.05.21, 09.06.21, 23.06.21. NNU consultant meetings: 17.02.21, 03.03.21, 31.03.21, 05.05.21, 26.05.21, 09.06.21, 23.06.21, 13.10.21, 10.11.21
12	NNU consultant meetings agenda and minutes 2022: agendas 16.02.22, 16.03.22, 30.03.22, 11.05.22, 20.07.22, 14.09.22, 12.10.22, 09.11.22, 07.12.22. NNU consultant meetings: 16.02.22, 16.03.22, 30.03.22, 11.05.22, 20.07.22, 14.09.22, 09.11.22, 12.10.22, 07.12.22

8.4 Appendix 4: Interviews

16 November 2023 (day 1)	
08.30–09.00	Invited review team meet privately
09.00–09.45	Inese Robotham, deputy chief executive officer Dr John Jones, executive medical director Hayley Flavell, director of nursing Helen Toalen, director of finance Sara Biffen, acting chief operating officer
09.45–10.00	Invited review team discussion
10.00–10.45	Carol McInness, director of operations, women's and children Julie Plant, director of nursing, women's and children
11.00–11.45	Patria Cowley, neonatologist and clinical director [redacted] centre manager
11.50–12.35	[redacted], director of quality and safety and deputy chief nursing officer, Integrated Care Board
13.15–14.00	Patria Cowley, neonatologist and clinical director
14.05–14.50	[redacted] head of midwifery [redacted] qualified midwife and women's and children's governance lead
13.35–16.10	[redacted], consultant neonatologist and lead consultant for mortality
16.10–16.40	[redacted], clinical director for obstetrics
16.45–17.30	Invited review team discussion

17 November 2023 (day 2)	
08.30–09.00	Invited review team meet privately
09.00–09.45	[redacted], sister, neonates [redacted], sister, neonates
09.50–10.35	[redacted], neonatal consultant
10.55–11.40	Slot for neonatal doctors (non-consultant)
11.45–12.30	[redacted], consultant midwife
13.05–13.50	[redacted], band 7 nurse [redacted], advanced neonatal nurse practitioner
13.55–14.40	[redacted], bereavement midwife
14.45–15.30	[redacted], assistant director of nursing, quality governance
17.00–17.30	Inese Robotham, deputy chief executive officer Dr John Jones, executive medical director Sara Biffen, acting chief operating officer Helen Toalen, director of finance Carol McInness, director of operations, women's and children Julie Plant, director of nursing, women's and children Patria Cowley, neonatologist and clinical director

8.5 Appendix 5: Summary of clinical record review gradings

8.5.1 Gradings by phase of care

	Very poor care (1)	Poor care (2)	Adequate care (3)	Good care (4)	Excellent care (5)	Not applicable to grade
Obstetric journey: risks associated with stillbirth; problems during delivery and/or perinatal mortality		RCP1 RCP2 RCP4 RCP5 RCP6 RCP7 RCP16	RCP9 RCP13 RCP17	RCP3 RCP8 RCP10 RCP11 RCP15	RCP12 RCP14 RCP18	
Care of the baby at delivery by the multidisciplinary team		RCP6 RCP9	RCP1 RCP3 RCP7 RCP8 RCP12 RCP16 RCP17	RCP2 RCP4 RCP5 RCP10 RCP11 RCP14 RCP15 RCP18		RCP13 [redacted]
Care following admission to the SaTH neonatal unit	RCP10 [redacted]	RCP1 RCP3 RCP4 RCP6 RCP13 RCP16 RCP17	RCP9 RCP11 RCP18	RCP2 RCP5 RCP7 RCP8 RCP14		RCP12 [redacted] RCP15 [redacted]
Multidisciplinary team working / communication between colleagues		RCP1 RCP6 RCP10	RCP4 RCP9 RCP12 RCP13 RCP16 RCP17	RCP2 RCP3 RCP5 RCP7 RCP8 RCP11 RCP14 RCP18		RCP15
Interactions with parents / family, including demonstration of Family Integrated Care		RCP16	RCP1 RCP4 RCP6 RCP9 RCP10 RCP12 RCP13 RCP17	RCP2 RCP3 RCP5 RCP7 RCP8 RCP11 RCP14 RCP18		RCP15
End-of-life care and support offered before and following a perinatal death			RCP1 RCP2 RCP3 RCP12 RCP13	RCP7 RCP9 RCP14	RCP18	RCP4 RCP5 RCP6 RCP8 RCP10 RCP11 RCP15 RCP16 RCP17 [redacted]
Review of care after a perinatal death		RCP6	RCP1 RCP2 RCP3 RCP4 RCP5 RCP7			RCP10 [redacted]

	Very poor care (1)	Poor care (2)	Adequate care (3)	Good care (4)	Excellent care (5)	Not applicable to grade
			RCP8 RCP9 RCP11 RCP12 RCP13 RCP14 RCP16 RCP17 RCP18			RCP15
Clinical record keeping		RCP3 RCP4 RCP13 RCP16	RCP1 RCP5 RCP6 RCP7 RCP9 RCP10 RCP11 RCP12 RCP14 RCP17 RCP18	RCP2 RCP8		RCP15
Compliance with network, national and trust guidelines and recognised best practice		RCP6 RCP10 RCP16	RCP1 RCP3 RCP4 RCP8 RCP9 RCP11 RCP12 RCP13 RCP14 RCP17 RCP18	RCP2 RCP5 RCP7		RCP15

[redacted] There was insufficient information available to reach a grade of the overall quality of care for this case, [redacted]

8.5.2 Overall perspective on quality of care

Clinical reviewer's overall perspective on quality of care	
Good practice: a standard you would accept from yourself, your trainees and your institution.	RCP2 RCP5 RCP8 RCP14 RCP18
Room for improvement: aspects of clinical care that could have been better.	RCP1 RCP3 RCP7 RCP9 RCP11 RCP12 RCP13 RCP16
Room for improvement: aspects of organisational care that could have been better.	
Room for improvement: aspects of both clinical and organisational care that could have been better.	RCP4 RCP17
Unsatisfactory: Several aspects of clinical and/or organisational care that were well below that you would accept from yourself, your trainees and your institution.	RCP6 RCP10
Insufficient information available to make an assessment of quality of care.	RCP15

Agenda Item

ICB 27-11.090

Quality and Performance Committee Chairs Reports

Appendix 1 - QPC - Minutes 25th July 2024

Appendix 2 - QPC - Minutes 26th September 2024

NHS Shropshire Telford and Wrekin
ICS Quality & Performance Committee Meeting

Thursday, 25th July

Via Microsoft Teams

Committee Members Present:

Meredith Vivian	Chair & Non-Executive Director, NHS STW
Vanessa Whatley	CNO NHS STW
Julie Garside	Director of Planning & Performance NHS STW
Mahadeva Ganesh	Interim CMO NHS STW & Medical Director SCHT
Anne Maclachlan	Clinical and Care Director, Shropshire Care Group, MPFT (Part only)
Jill Barker	Non-Executive Director Shropshire Community Health Trust
Rosie Edwards	Non-Executive Director SaTH
Helen Onions	Interim Director of Public Health, Telford & Wrekin Council.

Attendees Representing Committee Members:

Sara Bailey	Deputy Director of Nursing- SaTH (representing Hayley Flavell)
Sara Reeve	Deputy Director of Quality, MPFT (representing Liz Lockett)
Sara Ellis-Anderson	Deputy Director of Nursing (representing Clair Hobbs) Shropshire Community Trust
Kirsty Foskett	Assistant Chief Nurse & Patient Safety Officer, RJAH (Representing Paul Kavanagh-Fields)

Presenters in Attendance:

Sue Bull	Local Maternity and Neonatal Systems Programme Manager NHS STW
Helen Rowney	Senior delivery and assurance lead for Adult Mental Health, NHS STW
Vicki Jones	Head of Transformation and commissioning: CYP, LD&A
Angie Parkes	Deputy Director of Planning NHS STW
Lisa Rowley	PA to CNO and minute taker

1.0 Minute No. QPC-24-07.94 - Welcome/Apologies by: Meredith Vivian

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

2.0 Minute No. QPC-24.07.95 Apologies:

Apologies were received from:
Hayley Flavell - SaTH
Sharon Fletcher – NHS STW
Simon Fogell – Healthwatch Telford and Wrekin
Lynn Cawley – Healthwatch Shropshire
Tracey Slater – NHS STW

3.0 QPC-24-07.96 - Members' Declarations of Interests

3.1 No new declarations of interest were noted.

4.0 Minute No. QPC-24-07.97 - Minutes of Meeting held on 25th July 2024

4.1 The minutes of the meeting held on 25th July 2024 were reviewed and accepted as an accurate record of the meeting.

5.0 Minute No. QPC-24-07.98 - Matters Arising and Action Log

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

6.0 Minute No QPC-24-07.99 – Performance/Quality Exception Report:-

The report was taken as read, a discussion with committee members ensued and Julie Garside highlighted the following key points:

Performance :-

6.1 Julie Garside opened the discussion by advising the Committee that this is first time the Performance Report includes Quality Metrics thus bringing performance and quality together with focus on the main programmes UEC; Elective & Cancer; Mental health/LDA and Maternity. There are two sections that did not align directly to programmes IPC and Friends & Family Tests, these have been put into separate sections. During the following months work will be carried out on the system performance framework to streamline the performance reporting and define the relationship between the programme delivery groups and QPC.

6.2 GP survey results have now been published, the findings of this survey will be included with the Primary Care Deep Dive report scheduled to be presented to QPC in September together with access recovery visits being carried out with practices.

6.3 Helen Onions commented the Telford & Wrekin Healthwatch GP survey report now is out in draft and discussions are taking place with partners. Helen advised that she is working collaboratively with Nicola Williams at NHS STW regarding next steps and alignment with the recovery plan.

Action: Julie Garside to pick up with Nicola Williams

6.4 UEC – There has been a small but sustainable improvement in the 4-hour performance and a reduction in the number of patients waiting over 12 hours.

6.5 The delivery plans for mental health and LDA were due by 26th July however, MPFT have requested a one-week extension to this deadline due to annual leave. These delivery plans are expected by the end of July which will allow colleagues within the ICB to provide more assurance to QPC in terms of delivering mental health and LDA objectives for 2024/25. A letter has been received from NHSE to close off the planning process and they have also specifically asked for an updated dementia diagnosis rate improvement plan; a draft plan will be available by the end of July which will then be taken forward by a task and finish group.

6.6 Anne Maclachlan referred to the dementia diagnosis rate improvement plan and said she would be happy to meet and discuss this with Julie outside of the meeting as there are several issues which could affect the delivery of the plan such as staff sickness and the loss of a locum consultant who has secured a substantive post. Anne added that the support of Primary Care is needed.

Action: Julie Garside & Anne Maclachlan to meet to discuss Primary Cares involvement in the Dementia Diagnosis Rate recovery Plan

6.7 There has been an improvement in ambulance handovers in conjunction with the additional resource that WMAS have put in place contributing to the improvement in category 2. It is not at the national 30 minutes however is better than the local plan which is achieving around 34 minutes.

6.8 Elective and cancer – Both SaTH and RJAH could be put back into tier one for elective and cancer with the elective long wait position for over 65 weeks deterioration some of which is linked to the validation and data quality issues for SaTH associated with their EPR change and data warehouse issues.

6.9 Robert Jones have an impact from July associated with the loss of their Limited Liability Partnership (LLP) capacity and are working hard to mitigate this.

6.10 A revised Cancer action plan has been received from SaTH which will be presented to the tier one call with NHS England and if signed off and the revised recovery trajectories are accepted, reporting will be adjusted from September to reflect this. The 62-day backlog has continued to increase, and the Trust has gone off track with their faster diagnosis standard mainly due to the temporary loss insourcing capacity at the end of last financial year.

6.11 There has been a strong recovery in CHC with the backlog being cleared however a direct consequence of this is the increase in appeals. The Induvial Commissioning Team should be acknowledged for their hard work in this achievement.

Quality – Vanessa Whatley

6.12 From a Quality perspective there is focus on ED harm reviews and this data is showing that frailty is a specific concern around the care of older frail people, this is a work stream in the UEC Tier 1 programme. There is an improvement methodology around frailty that involves people across the system, including Community Trust and Primary Care colleagues.

6.13 The cancer harm review processes continue with the oversight for Cancer from colleagues in STW cancer team.

6.14 CHC - the 28-day target for referrals being processed is reaping rewards with a drop in complaints together with having a good team in place and the quality of care being delivered. There is a plan in place to for the increased volume of appeals.

6.15 The deep clean programme is an area of outstanding action within SaTH, a revised action plan has been put in place to get more engagement and ownership across the Directorate.

6.16 Sara Bailey referred to frailty and commented that Sath is expecting to see improvements with the frailty assessment units being opened on both PRH and RSH. A deep dive into frailty was carried out at the Trust following which their frailty action plan has been refreshed and enhanced; and relevant work streams have been put in place.

6.17 Meredith Vivian asked if there was confidence in the process for assessing harm in cases where there is an emotional effect or psychological effect of long waits where there might not be a physical effect?

6.18 Ann Maclachlan responded that there is no national guidance around mental health harm. For mental health patients MPFT have done a piece of work around harm and clinical prioritisation and how waits are managed.

6.19 Sara Reeve added that MPFT have carried out a lot of work systematically around all their services, looking at the impact of waits with bespoke tools based on what clinicians deem as harm. regarding triangulation, PALS data is looked at to see the contact from people using the services which is triangulated in terms of impact and harm.

6.20 Sara Ellis Anderson added that the patient safety strategy has physical and psychological harm definitions for patient safety incidents and that an innovation prompt could be taken to the System Quality Group for further discussion.

The Committee:

- Noted the content of the new performance and quality integrated report regarding performance of key metrics and quality against national standards and local targets where performance/quality falls short of national standards and locally agreed targets,
- Noted the actions being taken and that risks are being appropriately mitigated

7.0 Minute No QPC-24-07.100 - System Risk Register – Vanessa Whatley

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

7.1 Vanessa Whatley explained that most Risks remain the same scoring with actions against each risk progressing; with the following exceptions.

7.2 The CYP mental health risk is having a thorough review as this is being handed over between risk owners due to the management of change. This risk is rated as Amber and it is being looked at to de-escalate, work is progressing well around reducing children's waiting lists.

7.3 UEC – this risk has not been updated post the Dispatches programme, there is a significant piece of work to do around assurance.

7.4 ADHD risk is a particular challenge and meetings are taking place on a regular basis to address various aspects of the risk, specifically those where there are mental heath co-morbidities and also to address the significant waiting list.

7.5 TB risk has not yet been added to the register. A draft specification is ready for this service to go into the commissioning working group.

The Committee:

- Provided assurance to the Committee for the risks that fall within the Committee's remit, that the principal risks of the ICS not achieving the strategic and operational priorities have been accurately identified and actions taken to manage them.
- Provided updates that the System risk relating to lack of adequate TB control is in development.

8.0 Minute No QPC-24-07.101- System Quality Metrics

The paper was taken as read.

The Committee:

Noted that Quality Metrics are now included within the Performance Reports and discussed under Minute No. QPC-24-07.99.

9.0 Minute No QPC-24-07.102 - System Quality Exception Report Chairs Report

The paper was taken as read and Vanessa Whatley highlighted the following points:

9.1 A quarterly WMAS update was received at SQG in July where it was noted many safeguarding referrals were made in quarter three - 796 adult referrals and 240 Children referrals; in quarter four there were 830 adult referrals and 229 children. Quality improvement work needs to be done with WMAS colleagues as these numbers are not upheld by the local authority. WMAS have received a drop in their ratings from CQC however, their safe, effective, responsive and well led are still good, but no longer outstanding. Particular emphasis was around ambulance waiting times and culture within the organisation that requires improvement. The ICB continues to work with the lead ICB to monitor quality and the actions arising from the report.

9.2 There are high levels of vacancies in in the Community Trust which was 15.8% in May 2024, mitigations are in place.

9.3 The experience of care group has published its priority for 2024/25 which was to improve the experience of carers. A Sustainability Plan is currently being developed for the group.

9.4 A LeDeR deep dive report was presented to SQG with emphasis on the LeDeR reviews to increase awareness.

9.5 Meredith Vivian referred to the vacancy rate at SCHT and asked whether this was an ongoing issue or if it had suddenly emerged?

9.6 Vanessa Whatley confirmed that it was an ongoing issue which had been reported on previously, the trust were mitigating some of the vacancies but this is an area of priority for the People Committee.

9.7 Jill Barker added this is closely monitored at SCHT's Quality and Safety Committee and SCHTare doing a joint piece of work with the ICB in terms of looking at what the role of Community nursing is and how this works with primary care.

The Committee:-
Accepted the report

10.0 Minute No QPC-24-07.103 – Deep Dive Mental Health LD & A – Helen Rowney &Vicki Jones
The report was taken as read, and the following key points were highlighted: -

Update on Adult Mental Health – Helen Rowney

10.1 The implementation of the system dementia vision is a large system programme of work in its final year and roles have been embedded across the organisation and different system partners. The first dementia multidisciplinary team meeting will be going ahead in August working with one of the PCNs.

10.2 The dementia diagnosis rate is below target, an action plan is in place and a specific task & finish group is going to be setup, led by the performance team, this will be a targeted approach with system partners across primary care and MPFT to drive that target going forward.

10.3 Talking Therapies – There has been a big transformation piece of work with MPFT bringing the two services together across NHS STW, this work has now been completed with a fully integrated service with a single point of access and key new national metrics for Talking Therapies introduced- Reliable recovery and Reliable improvement. Both targets are currently being exceeded at 52% and 72% respectively.

10.4 SMI (Severe Mental Illness) There continues to be improvement following the changes to the model, improved data recording, development of the outreach model to reach more hard-to-reach groups which are all contributing to the improved performance. As at the end of May 2024, 60.4% of patients on GP SMI registers have received a full physical health check over the last 12 months. This translates to 2,235 patients against a total register size of 3,702.

10.5 NHS111 - A task and finish group is overseeing the implementation of the NHSE requirement to deliver an NHS 111 mental health option which will include the crisis text service.

10.6 Adult Community Mental Health - The workstreams under the adult community mental health transformation are now completed. MPFT and STW ICB have been working collaboratively for the delivery of a 3-phase approach to a local rehabilitation service development. Phase 3 is the most complex phase to deliver. Both the commissioner and provider of mental health services are committed to the delivery of this phase and are working collaboratively to scope this development.

10.7 Bed Review – The aim of this work is to deliver high quality care closer to home to reduce reliance on Out of Area Bed placements; inpatient stays therapeutic and discharge planned into sustainable community care. As part of the Inpatient Quality Transformation Programme (IQTP), the ICB are required to publish their Adult Mental Health Inpatient Transformation Strategy 2024 – 2027 by 31 July 2024.

10.8 Rosi Edwards asked about the quality of the places people were sent to in crisis and whether there was criteria for assessing their effectiveness.

10.9 Anne Maclachlan informed the Committee of two quality visits that MPFT have undertaken T one was Cheadle Royal and a psychiatric intensive care unit in Worcester The unit in Worcester are keen to have an agreement with MPFT . Ann highlighted that they were very impressed with the visit and the service offered and which aligned with their value base at MPFT .

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10.10 Helen Rowney commented that bed rate base review is carried out as it is recognised that as a system, there is not that enough local capacity because there are a number of patients that go out of area and it is key to bring them back into area making sure local provision is offered. Once the outcome of the bed base review is known, gaps can be identified so that demand can be met going forward. This piece of work is currently being undertaken in order to inform that wider strategy.

Action: The chair requested a further update on initiatives being carried out in relation to MH crisis management. Julie Garside advised that these will be picked up through the deep dive programme.

Learning disability and autism – Vicky Jones

10.10 LD&A as a system is being monitored by NHSE monthly who have acknowledged that big improvements have been made and have assurance that clear plans are in place to meet those challenges; these meetings have now been stepped down to quarterly reviews.

10.11 In February 2024 partners and stakeholders across the system held a face-to-face event to review the Road Map and develop strategic priorities for 2024 onwards. The document was finalised in June 2024. The finished document “ICS Learning Disability and Autism Strategic Priorities (formerly known as LDA Road Map)” will inform work over the coming years.

11.0 Minute No. QPC-24-07.104 -Insight Report

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

11.1 The Chair highlighted that the Insight Report referred to quarter three and quarter one and that no reference was made to quarter four.

Action: Vanessa Whatley said that she would get this remedied and recirculated.

11.2 Healthwatch Telford & Wrekin annual Programme of worker have a project looking at the quality of discharge to care homes.

11.3 SaTH continue to receive the largest proportion of concerns with 59 NHS 2 NHS concerns (N2N) in quarter, of these 17 N2Ns of relate to Discharge related issues and 42 N2Ns relate to other issues, including clinical care, transfer related issues and medication related concerns, including controlled drug management

11.4 SaTH, SCHT and MPFT have all implemented the PSIRF framework, which replaces Serious incidents with Patient Safety Incident Investigation (PSII).

11.5 Sara Bailey commented that PSIRF priorities are part of the Trusts quality priorities for the current financial year with particularly focus on issues around prescriptions, doses of prescriptions and preparation for discharge and as part of that due diligence of governance is that they have a incidents, concerns and complaints and feedback. The Trust have monthly meetings with matrons, ward managers and divisional nurses to understand from a clinical perspective to see what is happening, supporting each other to see what can be done differently.

11.6 The Trust have mechanisms in place and have refreshed how they do the nursing metrics. Sara Bailey said she would be happy to report back to QPC in the Autumn regarding the impact of the good work of sharing and learning.

11.7 Meredith Vivian asked if the update could include illustrations and scenarios to see the nature of changes and not just the numbers of change.

Action: Sara Bailey to provide an update Report to QPC in the Autumn regarding sharing and learning.

11.8 Sara Reeve said that she was not sure about the flows into MPFT of the information. And asked if she could have a conversation offline about that and how it all works, as she is unclear of the cohort and to get an understanding of how we can make use of the information in the most meaningful way.

Action: Vanessa Whatley said she would ask Sharon Fletcher to lead this request and to ensure that both Healthwatch teams are informed.

The Committee:-
Received the report for information and discussion.

12.0 Minute No. QPC-24-07.105 – LMNS Programme Board & Perinatal Update – Sue Bull

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

12.1 Maternity services have been presented as good overall by CQC.

12.2 It has been previously noted that the neonatal data reported through LMNS programme board was correct and valid and the maternity team were happy with the data presented however, at the July LMNS Programme Board Meeting it was announced that SaTH were no longer confident in that data. Sue Bull advised that she has spoken with the regional perinatal network team, who have offered to help work with the trust to look at this and share best practice from other trusts to see how they are getting their data and how they are validating the data as there are no trusts that have a full electronic system where they are able to pull data for neonatal activity and quality data.

12.3 Interviews took place for the role of Neonatal, Independent Senior advocate, but the ICB were not able to recruit. NHS England have agreed that the ICB can remain in the pilot and funding has been agreed until March 26th therefore this longer time period will help the ICB to attract more people for this role. Approval for Recruitment will be going to panel in August 2024.

12.4 The smoking rate at delivery has shown a decrease in May to 6.6% compared to April which was 7.4%. This remains above the target rate of 6% there is ongoing improvement work between the ICB, Trust and public health teams.

12.5 Healthy Pregnancy Support Service continue to work closely with families. Saving Babies Lives Document implementation stipulates the provision of Nicotine Replacement Therapy, the rationale being to reduce smoking rates during pregnancy. This is discussed at the health pregnancy, healthy families workstream

12.6 Two areas of focus have been agreed (1) long term sickness and (2) staff that are leaving the trust, this will be looked at system wide to garner an understanding and deep diving into the reasons why people are off on long term sick and what support can be given to get them back into work, this will be linked into the overarching improvement plan.

12.7 A deep dive will be carried out looking at the training that is offered to staff and the quality of that and the placements that are offered.

12.8 Julie Garside suggested Sue connects with Craig Kynaston regarding data quality issues around maternity so that it forms part of the overarching data strategy.

12.9 Sue Bull advised that she has already spoken with BI colleagues and an invitation has been extended to Craig Kynaston to attend the LMNS Board meeting.

The Committee:
Noted the contents of the report.

13.0 Minute NO QPC-24-07-106 – Healthwatch Shropshire Update

The Committee:-

13.1 Noted that no representative was present at the meeting to provide an update

14.0 Minute No QPC-25-07.107 - Healthwatch Telford & Wrekin Update

14.1 **The Committee:-**
Noted that no representative was present at the meeting to provide an update

15.0 Minute No QPC-25-07-108 - Items for Escalation/Referral to Other Board Committees

15.1 No items were requested to be escalated or referred to other Board Committees.

16.0 Minute No. QPC-25-06.109 Any Other Business (AOB)

16.1 No Other Business was raised.

Date and Time of Next Meeting

The Next meeting is scheduled to be held on 26th September 2024 starting at 2.00pm to 4.00pm via Microsoft Teams.

SIGNED ……. DATE ……

NHS Shropshire Telford and Wrekin
ICS Quality & Performance Committee Meeting

Thursday, 26th September 2024

Via Microsoft Teams

Committee Members Present:

Meredith Vivian	Chair & Non-Executive Director, NHS STW
Vanessa Whatley	CNO NHS STW
Julie Garside	Director of Planning & Performance NHS STW
Mahadeva Ganesh	Interim CMO NHS STW & Medical Director SCHT
Anne Maclachlan	Clinical and Care Director, Shropshire Care Group, MPFT (Part only)
Jill Barker	Non-Executive Director Shropshire Community Health Trust
Rosie Edwards	Non-Executive Director SaTH
Helen Onions	Interim Director of Public Health, Telford & Wrekin Council.
Lisa Rowley	PA to CNO and minute taker

Attendees Representing Committee Members:

Sara Bailey	Deputy Director of Nursing- SaTH (representing Hayley Flavell)
Sara Reeve	Deputy Director of Quality, MPFT (representing Liz Lockett)
Sara Ellis-Anderson	Deputy Director of Nursing (representing Clair Hobbs) Shropshire Community Trust

Presenters in Attendance:

Lorraine Mahachi
Imogen

1.0 Minute No. QPC-24-09.110 - Welcome/Apologies by: Meredith Vivian

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

2.0 Minute No. QPC-24.09.111 Apologies:

Apologies were received from:

Hayley Flavell - SaTH
Sharon Fletcher – NHS STW
Simon Fogell – Healthwatch Telford and Wrekin
Lynn Cawley – Healthwatch Shropshire
Tracey Slater – NHS STW

3.0 QPC-24-09.112 - Members' Declarations of Interests

3.1 No new declarations of interest were noted.

4.0 Minute No. QPC-24-09.113 - Minutes of Meeting held on 25th July 2024

4.1 The minutes of the meeting held on 25th July 2024 were reviewed and accepted as an accurate record of the meeting.

5.0 Minute No. QPC-24-09.114 - Matters Arising and Action Log

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

6.0 Minute No QPC-24-09.115 – Quality &Performance Exception Report:-

The report was taken as read, a discussion with committee members ensued and the following points were highlighted.

Quality – Vanessa Whatley/Sharon Fletcher

6.1 12 hour waits remain high in excess of 2,000 during May have published a report, waits have decreased since April, 2024

6.2 SaTH are carrying out care rounds to identify the number of patients that can avoid the Emergency Department via a faster route such as the UEC improvement programme.

6.3 Quality improvement objectives are underway, progress will be reported from September 2024.

6.4 Category 2 response time has not been met creating clinical risk in the community, resulting in ambulance delays at ED's; a harm review process is in place with the Trust. No immediate harm to patients was identified however, it has been noted that it is not known if there is an impact to patients in the longer-term due to delays in ambulances and ED.

6.5 Following a CQC visit to the Trusts' Emergency Departments in May 2024; CQC published a report rating RSH as requiring improvement and PRH as inadequate. The CQC report reflected the ambulance delays, an action plan will be put in place to address this.

6.6 IPC – *C difficile* continues to be above trajectory; MRSA bacteraemia remains over the expected trajectory which is a challenge for the System, but analysis indicates the management of long term invasive devices. A C diff action plan has been put in place at SaTH which has been developed with the support of NHSE.

Performance – Julie Garside

6.7 Practice visits to 12 practices have been carried that have been chosen based on different data sets and also those practices showing the lowest appointments in 1000 patients together with patient survey results.

6.8 During August 2024 the Patient Services Team received 36 sources of feedback regarding GP Practices particularly regarding access to services i.e., appointments and getting through on the telephone. Within the feedback there were 8 enquiries about care received and 8 compliments. Primary Care feedback is shared with the Primary Care Team on a quarterly basis. Feedback is given to practices during practice visits.

6.9 During August 2024 there was a reduction in front door demand; improvements have also been seen in 4-hour performance, a reduction in 12-hour breaches and the Category 2 response time has been achieving the 30-minute national targe; there has also been an improvement in ambulance offload delays.

6.10 It was noted that there is no longer cause for concern in the number of stranded patients within SaTH following internal improvements being implemented.

6.11 Talking Therapies are exceeding target, there is improvement in relation to waiting times in relation to the 18 week RFT with an 80% compliance in July 2024.

6.12` There were seven 78-day breaches in during July 2024 within the system and 57 as at the end of August, this remains a concern and remains under TIER 1 scrutiny by NHSE.

Following discussion, the Committee:

- Noted the continued collaborative content of the performance and quality integrated report regarding performance of key metrics and quality against national standards and local targets where performance/quality falls short of national standards and locally agreed targets,
- Noted the actions being taken and risks are being appropriately mitigated and provide the necessary assurance.
- Noted that this report continues to evolve to improve the way data and actions are presented to provide assurance to the Committee.
- Provided feedback on the new integrated report to ensure the report meets the needs of the Committee as part of continuous improvement.

7.0 Minute No QPC-24-07.100 - System Risk Register – Sharon Fletcher

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

7.1 Risk SQG1 Children & Young People Mental Health Services – This risk was reviewed in March 2024; this risk is rated as amber with a score of 9. Key

actions remain around the section 31 action plan, CAMHS waiting list and review of governance; Confirmation of the removal of section 31 notice is awaited.

7.2 Risk SQG5 Urgent & Emergency Care – This Risk remains an Extreme Risk with a score of 20. UEC remains in Tier 1 and progress is being monitored with NHSE colleagues. The UEC Board also has oversight of this risk.

7.3 Risk SQG8 Diabetes – This risk remains an extreme Risk with a score of 20. This risk is reviewed by QPC however there are concerns regarding the ability to proceed with the required pathway changes. The Diabetes risk will be discussed further at QPC following the presentation of the report from the risk owner.

7.4 Risk SQG9 Acute Paediatric Pathway – This Risk remains high with a score of 15. The risk has been reviewed; The Paediatric Transformation Programme team at SaTH continue to review and oversee actions. A dashboard is in development to monitor and improve outcomes. CQC have rated the service as Good. The risk remains at 15.

7.5 Risk SQG10 *Clostridioides difficile* - This risk is rated as red with a score of 16. *C diffiicile* cases continue to be higher than trajectory. SaTH, RJAH and SCHT have set their trajectories for 2024/25 the year which will be monitored through IPC operational groups and the system IPC AMR group. The new thresholds are reflective of rising rates as seen nationally. System numbers were 100% over target and SaTH 203% over target. Action plans in place in the Trusts. The risk remains at 16.

7.6 Risk SQG 11 – Adult ADHD Waiting List and risk of harm – This risk is rated as red with a score of 16. The risk remains unchanged due to the lack of progress in reducing the waiting list. The risk remains at 16.

7.7 Risk SQG13 –*13 Shared Care prescribing across Primary Care*

Risk update required. Metrics to support risk in development. Risk has been reviewed with risk score staying the same due to working for plan for the transfer of people with comorbidities and little control over right to choose. Risk unchanged due to lack of progress in reducing waiting list. A task and finish group continues to meet. The risk remains at 16, high risk.

The Committee:

- Considered additional assurance required in relation to the risk register.
- SQG1 - Request for QPC to agree if this risk can be e-escalated from the SQG Risk Register and be managed by the Mental Health and Learning Disability & Autism Group, escalation will continue to be via the System Quality Group meeting.
- Acknowledge that the System risk relating to lack of adequate TB control is considered for development, however actions are progressing, and the new TB service specification and business case are due to go to Commissioning working Group in October 24.

8.0 Minute No QPC-24-07.102 - System Quality Exception - Chairs Report

The paper was taken as read and Vanessa Whatley highlighted the following points:

8.1 SQG had discussed the Channel 4 Dispatches programme aired titled 'Undercover: A&E in Crisis', focussing on Urgent and Emergency Care (UEC) pressures and quality of care aired on Monday 24th June 2024. Undercover footage was filmed in the Emergency Department (ED) at The Royal Shrewsbury Hospital (RSH). It particularly focused on duration of time in the ED, privacy and dignity, infection prevention and control, care provision in the fit to sit area and care delivered in additional spaces (including corridors, and the ambulance offload area). A programme of oversight to the emergency has been put in by SaTH and ICB colleagues. Further information will come back to SQG.

8.2 The Diabetes risk has not been updated for some months due to agreement of the action plan.

8.3 The Diabetes and UEC risks remain scored as extreme.

8.4 STW has decreasing numbers of patients on opioids but remains the highest prescribing ICS, a discussion was held around actions from system partners, and it was agreed all would take back to ensure correct information was given to patients and prescribers were aware of alternatives.

8.5 Topiramate is now also contraindicated in pregnancy and in women of childbearing potential unless the conditions of a Pregnancy Prevention Programme are fulfilled.

8.6 The supply disruption of Creon® capsules (frequently used by gastroenterology) is restricted due to limited availability of active pharmaceutical ingredients and manufacturing constraints to produce the volumes required to meet demand. The system has plans around advising alternatives, but this expected to be an issue for over a year and is being monitored.

8.7 There were 9 child deaths reported in Q1 of 24/25 to CDOP 6 of these children were under 1 year of age, the quarterly child death workshops continue examining the themes and engaging partners in focussed action.

8.8 Healthcare acquired infections remain in line with 23/24. National Objectives were released in August and are considerably higher than previous years which would mean that the system is within trajectory. Trajectories are being set and more information is set to be discussed in a future paper to QPC.

The Committee considered the alerts and disused the Diabetes plan returning to QPC in October and the ongoing challenge in addressing this important area of

healthcare. The risk being updated was requested and Sharon Fletcher agreed to liaise with the risk owner.

Action: Sharon Fletcher to liaise with risk owner to update diabetes risk.

9.0 Emergency Care Quality Governance Update – Vanessa Whatley - Verbal Update – item not presented.

10.0 Minute No QPC-24-07.103 – Deep Dive Primary Care – Nicola Williams

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

10.1 GPs started collective action on the 1st of August 2024 following a national ballot by the BMA in response to widespread opposition to changes to the GP contract for 24/25. The ICB has formed a Task & Finish group to measure, manage and mitigate any risks that this may present to patients.

10.2 Locally GPs are taking limited action and the local group are currently meeting on a weekly basis to assess, manage and mitigate any impacts that this may have. This includes assessment of changes in activity across providers, referrals, and financial impacts. A risk register has been developed and is updated weekly.

The Committee:.

- Noted the update on GP Collective Action across STW and the work of the group to address issues.

11.0 Minute No. QPC-24-07.104 -Safeguarding Annual Report – Paul Cooper/Laura Powell/Elena Lloyd

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

11.1 There have been changes within the Working Together to Safeguard Children Document 2023 with changes to key responsibilities at executive level the new roles are the lead and designated safeguarding partners. This has been put into place in across the ICS.

11.2 Providers are to continue to identify safeguarding concerns and appropriate referral to the Local Authority; The ICB will continue to provide regular assurance to NHSE as part of a standard reporting framework.

11.3 There are 2 Designated Nurses for Safeguarding Children in post who over Shropshire and Telford and Wrekin. Both Designated Nurses for Safeguarding Children within the ICB work closely with Shropshire Safeguarding Community Partnership and the Telford and Wrekin Safeguarding Children Partnership subgroups. Following management of change, changes have been made within the safeguarding team structure resulting in one Designated Nurse taking the lead on Child Death service as

Senior Responsible Officer for Child Death and the other Designated Nurse managing the Special Educational Needs and Disabilities (SEND) team as Senior Responsible Officer for SEND. The Designated Nurses continue to be involved in Multiagency Case File Audits.

11.4 Further progress has been undertaken in relation to the Independent Inquiry into Child Sexual Exploitation (IITCSE) with escalation on a national level.

11.5 A Task and Finish Group was set up to monitor the work being undertaken to complete the recommendations.

11.6 he independent chair of the report to discuss progress made against the recommendations prior to the updated report being published and it was acknowledged that some of the work extended beyond the original recommendations, One of the recommendations related to an awareness of CSE for all staff and the health systems have agreed to adopt the local authority CSE awareness training, co-produced with the consultees.

The Committee:-

- **Noted the contents of the report and changes implemented.**

12.0 Minute No. QPC-24-07.105 – Children in Care Health Initial Health Assessments – Maria Hadley

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

12.1 The process for children in care is that the Local Authority responsible for the care of a child must arrange for them to have a health assessment as required by The Care Planning, Placement and Case Review (England) Regulations 2010. The initial health assessment must be completed by a registered medical practitioner and each Local Authority should ensure that every child in their care has an up-to-date individual health plan, the development of which should be based on the written report of the health assessment. The health plan forms part of the child's overall care plan.

12.2 The Initial Health Assessment (IHA) allows for an assessment of holistic health needs of a child when entering the care system, ensuring a timely review of health needs. The IHA should result in a health plan being available in time for the first statutory review by the Independent Reviewing Officer (IRO) of the child's care plan. That case review should take place within 20 working days from the initial placement. There are a number of areas which the SHA should address areas such as; The child's state of health, including physical, emotional, and mental health, Health history; his/her family health history if known; the effect of the child's health history on his/her development; existing arrangements for the child's health and appropriate dental care needs; vaccinations and immunisation; vision and hearing defects if any.

12.3 A review carried out by the ICB and SCHT identified gaps in information which has led to a review of current process.

12.4 In March 2024; SCHT's SMT following a period of review made the decision to cease accepting requests for IHAs where a full complement of paperwork and/or information was not received which led the Trust to put in place continued monitoring, Local Authority Senior Teams receive weekly updates of outstanding information. Both Local Authorities have adopted the Business administrative support model, dedicated to Initial Health Assessments which is supporting the Social Workers in gathering information.

12.5 Significant progress has been made in order to ensure children receive timely initial health assessment, however, it is not fully resolved and will continue to require Shropshire Community Health Trusts Looked after Children Administrative Team to oversee receipt of information alongside the provision of a weekly return to each Local Authority to ensure monitoring. A weekly report to the LA highlighting any delays along with a training plan has been developed and is driving improvement

The Committee:

- Noted the report presented was for assurance purposes and was pleased to see there was a good response to the quality improvement work to increase the initial health assessments and congratulated all involved.

13.0 Minute NO QPC-24-07-106 – Healthwatch Shropshire Update

13.1 The Committee noted that no representative was present at the meeting to provide an update

14.0 Minute No QPC-25-07.107 - Healthwatch Telford & Wrekin Update

14.1 The Committee Noted that no representative was present at the meeting to provide an update

15.0 Minute No QPC-25-07-108 – Quality Governance Peer Review – Vanessa Whatley

15.1 A Quality Governance Peer Review has been undertaken and the report and action was submitted to the Committee. This has also been to the ICB Board as part of the CEO's paper. This report is welcomed and it is anticipated that it will be completed by end of March 2024.

15.2 The Committee discussed the findings and felt these were enhancements to the governance and welcomed the report and action plan. Alternate month updates were requested.

Action Tracey Slater to report monthly on the progress if the Quality Governance Action Plan.

16.0 Minute No QPC-25-07-108 - MHealth Assertive & Intensive Outreach Report - Deferred to October, 2024 in order to ensure correct governance.

17.0 Minute No QPC-25-07-108 - Items for Escalation/Referral to Other Board Committees

17.1 No items were requested to be escalated or referred to other Board Committees.

18.0 Minute No. QPC-25-06.109 Any Other Business (AOB)

18.1 No Other Business was raised.

Date and Time of Next Meeting

The Next meeting is scheduled to be held on 31st October 2024 starting at 2.00pm to 4.00pm via Microsoft Teams.

SIGNED …… DATE ……

Agenda Item

ICB 27-11.091

Audit & Risk Committee Chairs Reports

Appendix 1 - Enclosure No. 1 Standing Financial Instructions Scheme of Delegation

Appendix 2 - Enclosure No. 1A Appendix 1 Standing Financial Instructions

Appendix 3 - Enclosure No. 1B Appendix 2 Scheme of Delegation

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Meeting Name:	**Audit Committee**
Agenda item no.	**AC-24.11-65**
Meeting Date:	**15 November 2024**
Report title:	**Proposed Update to the ICB's Standing Financial Instructions and Financial Scheme of Delegation**
Report presented by:	**Angus Hughes, Head of Finance**
Report approved by:	**Claire Skidmore, Chief Finance Officer**
Report prepared by:	**Angus Hughes, Head of Finance** **Angela Szabo, Director of Finance**
Meeting report previously presented:	**N/A**

Action Required (please select):									
A=Approval		**R=Ratification**	**x**	**S=Assurance**		**D=Discussion**		**I=Information**	**x**

Executive Summary

This report provides the Audit Committee with an updated version of the ICB's Standing Financial Instructions (SFIs) and Financial Scheme of Delegation (SoD) for review and ratification.

Additions and amendments have been made to the documents to strengthen their content and, in particular for the SoD, to reflect the amended structures and responsibilities post management of change. In making proposals to update the SFIs and SoD, a review of similar documents published by other ICBs was also undertaken in order to identify areas of good practice.

Changes are highlighted in yellow in the updated documents which are included as appendices with this report.

For the SFI's, of particular note are proposed changes to the tendering and procurement thresholds. Specifically, the limit at which quotes are formally required has been reduced from £25,000 to £10,000 and the requirement for a tender process to be pursued has been reduced from £75,000 to £50,000. These changes are in line with our internal triple lock process and with limits used in other ICBs.

Other changes relate to updating role titles, names, references to external bodies or strengthening narrative in existing areas.

The Financial Scheme of Delegation document has been expanded to provide greater clarity of responsibility. It incorporates additional staff banding levels in line with the management of change exercise, and also incorporates the new Specialised Commissioning activity transferred to the ICB. This should make the SoD more resilient and robust for any future changes to staffing structures.

New rows have been added as follows:

- Change of use of budgets
- Requests to raise sales invoices
- Authorisation of credit notes
- External funding bids
- Approval of business cases
- Decommissioning or Disinvestment of existing services
- Procurement Team - Creation of Purchase Orders following requisition approval

- Meds Management - Authorisation of Individual Funding Requests
- Pay Amendments - rebanding
- Salary overpayment agreements
- Redundancy and Severance Pay
- Management Consultancy
- Setting up new, or amending current Supplier details
- GPIT
- New IFRS16 Leases
- Specialised Commissioning Delegation (NHSE Staff) - Authorisation of requisitions (or certification of invoices when no requisition/order was raised)/ Contract Variations

Amendment have been made to the following rows:

- Virements between budgets – ICB Exec directors/VSM/B9 – no limit (new banding added), Band 8C/D £250k (was no limit).
- Banking arrangements - Director of Finance as specified on bank mandate and Deputy Director of Finance/ Head of Finance as specified on bank mandate
- Signing of Healthcare Commissioning Annual Contracts & SLAs and Pooled Budgets – VSM/B9 limit £5m, Head of contracts £2m (new limits)
- Variations to healthcare and non-healthcare contracts - VSM/B9 limit £5m, Head of contracts £2m (new limits)
- Authorisation of monthly block payment for agreed contract value to NHS bodies - Director of Finance (No Limit) – new banding limit added
- Authority to waive tenders or quotations, or to accept a tender or quotation which is not the lowest. – VSM/B9 N/A – new banding limit added, restricted authority remains unchanged
- Authorisation of requisitions (or certification of invoices when no requisition/order was raised)/purchase credit notes – VSM/B9 - £1m – new banding limit added
- Continuing Healthcare - Authorisation of Continuing Healthcare contracts and related weekly cost packages. VSM/B9 £100k (new limit)
- Payroll forms (starters/changes/ leavers & expense claims) – VSM/B9 – N/A – new banding limit added
- Tenancy agreements/ Licenses – VSM/B9 n/a – new banding limit added
- Pharmaceutical, Opthalmic and Dental Primary Care Delegation (NHSE Staff): Authorisation of requisitions (or certification of invoices when no requisition/order was raised)/ Contract Variations" - VSM/B9 £250k – new banding limit added

Recommendation/Action Requested:

The committee is asked to:

- **Review** the proposed changes to the Standing Financial Instructions (SFIs) and Financial Scheme of Delegation (SoD) and
- **Recommend** these for approval by the Integrated Care Board at its meeting on 27th November 2024 for subsequent immediate adoption once approved.

Does the report provide assurance or mitigate any of the strategic threats or significant risks in the System Board Assurance Framework?

No		**Yes**	**x**	**If yes, please detail: Assurance of Delegatory framework within the ICB**

How does this report support the ICB's core aims:

Improve outcomes in population health and healthcare	Delivery of value for money is linked to improved outcome and population health through compliance with Standing Financial Instructions.
Tackle inequalities in outcomes, experience, and access	
Enhance productivity and value for money	Delivering Value for Money through compliance with Standing Financial Instructions and adherence to the Delegation framework.
Help the NHS support broader social economic development	

Conflicts of Interest
None.

Implications	
Engagement with Shropshire, Telford & Wrekin residents, and communities	None
Resource and financial	Strengthening of the Financial governance framework
Quality and safety	None
Sustainability	Delivery of financial governance through the approved delegation framework.
Equality, Diversity and Inclusion	None

Impact Assessments	**Yes**	**No**	**N/A**
Has a Data Protection Impact Assessment been undertaken?			**X**
Has an Equality Impact Assessment been undertaken?			**X**
Has a Quality Impact Assessment been undertaken?			**X**

Appendix 1 Standing Financial Instructions
Appendix 2 Financial Scheme of Delegation

NHS
Shropshire, Telford and Wrekin

Integrated Care System
Shropshire, Telford and Wrekin

Standing Financial Instructions

FINAL 27.11.2024

Contents

1. Purpose and Statutory Framework

1.1.1 In accordance with the Act as amended, NHSE is mandated to publish guidance for Integrated Care Boards (ICB), to which each ICB must have regard, in order to discharge their duties.

1.1.2 The purpose of this governance document is to ensure that the ICB fulfils its statutory duty to carry out its functions effectively, efficiently and economically. The Standing Financial Instructions (SFIs) are part of the ICB's control environment for managing the organisation's financial affairs as they are designed to ensure regularity and propriety of financial transactions.

1.1.3 SFIs define the purpose, responsibilities, legal framework and operating environment of the ICB. They enable sound administration, lessen the risk of irregularities and support commissioning and delivery of effective, efficient and economical services.

1.1.4 The ICB is established under Chapter A3 of Part 2 of the National Health Service Act 2006, as inserted by the Health and Care Act 2022 and has the general function of arranging for the provision of services for the purposes of the health services in England in accordance with the Act.

1.1.5 Each ICB is to be established by order made by NHSE for an area within England, the order establishing an ICB makes provision for the constitution of the ICB.

1.1.6 All members of the ICB (its Board) and all other Officers should be aware of the existence of these documents and be familiar with their detailed provisions. The ICB SFIs will be made available to all Officers on the intranet and internet website for each statutory body.

1.1.7 Should any difficulties arise regarding the interpretation or application of any of these SFIs, the advice of the Accountable Officer or the Chief Finance Officer must be sought before acting.

1.1.8 Failure to comply with the SFIs may result in disciplinary action in accordance with the ICBs applicable disciplinary policy and procedure in operation at that time.

1.1.9 Any changes to the SFIs will require the approval of the ICB's Board.

2. Scope

2.1.1 All officers of the ICB, without exception, are within the scope of the SFIs without limitation. The term officer includes permanent employees, secondees and contract workers.

2.1.2 Within this document, words imparting any gender include any other gender. Words in the singular include the plural and words in the plural include the singular.

2.1.3 Any reference to an enactment is a reference to that enactment as amended.

2.1.4 Unless a contrary intention is evident, or the context requires otherwise, words or expressions contained in this document, will have the same meaning as set out in the applicable Act.

3. Roles and Responsibilities

3.1 Staff

3.1.1 All ICB Officers are severally and collectively, responsible to their respective employer(s) for:

1) abiding by all conditions of any delegated authority;
2) the security of the statutory organisations property and avoiding all forms of loss;
3) ensuring integrity, accuracy, probity and value for money in the use of resources; and
4) conforming to the requirements of these SFIs

3.2 Accountable Officer

3.2.1 The ICB constitution provides for the appointment of the Chief Executive by the ICB chair. The Chief Executive is the Accountable Officer for the ICB and is personally accountable to NHSE for the stewardship of ICBs allocated resources.

3.2.2 The Chief Finance Officer reports directly to the ICB Accountable Officer and is professionally accountable to the NHSE regional finance director

3.2.3 The Accountable Officer will delegate to the Chief Finance Officer the following responsibilities in relation to the ICB:

1) preparation and audit of annual accounts;
2) adherence to the directions from NHSE in relation to accounts preparation;
3) ensuring that the allocated annual revenue and capital resource limits are not exceeded, jointly, with System partners;
4) ensuring that there is an effective financial control framework in place to support accurate financial reporting, safeguard assets and minimise risk of financial loss;
5) meeting statutory requirements relating to taxation;
6) ensuring that there are suitable financial systems in place (see Section 6)
7) meets the financial targets set for it by NHSE;
8) use of incidental powers such as management of ICB assets, entering commercial agreements;
9) the Governance statement and annual accounts & reports are signed;
10) planned budgets are approved by the relevant Board; developing the funding strategy for the ICB to support the board in achieving ICB objectives, including consideration of place-based budgets;
11) making use of benchmarking to make sure that funds are deployed as effectively as possible;

12) executive members (partner members and non-executive members) and other officers are notified of and understand their responsibilities within the SFIs;
13) specific responsibilities and delegation of authority to specific job titles are confirmed;
14) financial leadership and financial performance of the ICB;
15) identification of key financial risks and issues relating to robust financial performance and leadership and working with relevant providers and partners to enable solutions; and
16) supporting a strong culture of public accountability, probity, and governance, ensuring that appropriate and compliant structures, systems, and process are in place to minimise risk.

3.3 Audit Committee

3.3.1 The Board and Accountable Officer should be supported by an Audit Committee, which should provide proactive support to the board in advising on:

1) the management of key risks;
2) the strategic processes for risk;
3) the operation of internal controls;
4) control and governance and the governance statement;
5) the accounting policies, the accounts, and the annual report of the ICB;
6) the process for reviewing of the accounts prior to submission for audit, management's letter of representation to the external auditors; and the planned activity and results of both internal and external audit.

3.4 Breach of SFIs

3.4.1 Failure to comply with these SFIs may result in disciplinary action in accordance with the ICB's applicable disciplinary policy and procedure in operation at that time.

3.4.2 Any act that is considered to be in significant breach of the SFIs should be reported to the Audit Committee for consideration. Where the Audit Committee considers there is evidence of ultra vires transactions, improper acts, or if there are other important matters that the Committee considers should be escalated, the Chair of the Committee should raise the matter at a full meeting of the ICB. Consideration should also be given as to whether the matter should be referred to internal and external audit, the local counter fraud specialist and NHSE.

4. Financial Management

4.1.1 The Chief Finance Officer is responsible for maintaining policies and processes relating to the control, management and use of resources across the ICB.

4.1.2 The Chief Finance Officer will delegate the budgetary control responsibilities to budget holders through a formal documented process.

4.1.3 The Chief Finance Officer will ensure:

1) the promotion of compliance to the SFIs through an assurance certification process;
2) the promotion of long term financial heath for the NHS system (including Integrated Care System (ICS));
3) budget holders are accountable for obtaining the necessary approvals and oversight of all expenditure incurred on the cost centres they are responsible for;
4) the improvement of financial literacy of budget holders with the appropriate level of expertise and systems training;
5) that the budget holders are supported in proportion to the operational risk; and
6) the implementation of financial and resources plans that support the NHS Long term plan objectives.

4.1.4 The Chief Finance Officer and *any senior officer responsible* for finance within the ICB should also promote a culture where budget holders and decision makers consult their finance business partners in key strategic decisions that carry a financial impact.

4.2 Financial planning

4.2.1 NHSE publishes financial planning guidance and resource allocations based on two resource streams: revenue resource limit (split between administration and programme) and capital resource limit. The ICB is notified of annual revenue and capital resource limits annually by NHSE.

4.2.2 The ICB is subject to a statutory requirement not to exceed its notified resource limits.

4.2.3 The Chief Finance Officer has overall responsibility for budgetary activities and is accountable to the ICB for ensuring that the organisation stays within these limits.

4.2.4 The operational responsibilities are delegated to the Chief Finance Officer.

4.2.5 The Chief Finance Officer will:

1) take financial leadership responsibility for ensuring, in conjunction with the ICB's partner NHS trusts and foundation trusts, that resource limits are not exceeded;
2) prepare an annual financial plan for the application of the revenue and capital resources allotted;
3) ensure that the financial plan reflects planned activity in terms of services to be commissioned;
4) submit the annual budget to the ICB for approval showing the total allocations received and their proposed distribution including any sums to be held in reserve;

5) determine arrangements for the delegation of budgets, including to care programmes; to place level; and to provider collaboratives;
6) take responsibility for ensuring that an adequate system for monitoring financial performance is in place to enable the ICB to fulfil its statutory responsibility not to exceed the annual revenue and capital resource limits;
7) provide regular financial reports in the form agreed by the ICB and its Finance Committee.

4.3 Budgetary control and reporting

4.3.1 The Chief Finance Officer will devise and maintain arrangements for budgetary control. The control framework will include:

1) periodic reports to relevant Boards, committees and sub committees, in a form approved by the ICB or the Finance Committee;
2) investigation and explanation of any significant variances from the financial plan, and where necessary, arrangements for corrective action;
3) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;
4) regular and timely budget meetings with budget holders and/or budget managers particularly in relation to budget variances; and
5) arrangements for the authorisation of budget transfers or virements between budget holders.

4.3.2 The Chief Finance Officer is permitted to delegate the management of individual budgets in accordance with the ICB's Scheme of Delegation.

4.3.3 The Chief Finance Officer is responsible for ensuring that any required financial monitoring returns are submitted to NHSE and other monitoring organisations in accordance with statutory and locally agreed timetables.

4.4 Budget virements

4.4.1 Budget virements are permissible within each budget holders approved budget. Pay budgets cannot be increased beyond the funded establishment and virements from non-pay to pay budgets will only be approved on a non-recurrent basis.

4.4.2 The approval limits for budget virements are set out in the Scheme of Delegation.

4.5 Budget holder/manager responsibilities

4.5.1 Budget holders have responsibility delegated to them by the Chief Finance Officer for the management of a budget. Under special circumstances (e.g. long-term absence, holiday cover) a budget holder can delegate authority to another employee, in accordance with these SFIs, to commit expenditure against the budget. This delegation must be in writing and must be notified to the Finance team and must be accepted and noted for audit purposes.

4.5.2 Budget holders may appoint a budget manager for each budget and set out in writing the responsibilities of the budget manager and any other staff who contribute to management of budgets assigned to them, for example staff responsible for confirming receipt of goods or services. The budget holder must confirm to Finance when a budget manager has been appointed.

4.5.3 The Chief Finance Officer is responsible for ensuring that relevant training is available and delivered on an on-going basis to budget holders and budget managers to help them manage their budget successfully and improve financial literacy.

4.5.4 Budget holders must ensure that adequate internal controls are in place to ensure that:

1) all expenditure is lawful and is incurred in accordance with the procedures for procurement and purchasing set out in these SFIs;
2) planned and actual expenditure takes full account of the need to achieve value for money in terms of economy, efficiency and effectiveness;
3) they meet with the designated management accountant regularly to discuss their budgetary position;
4) forecasting of expenditure against budget is robust and where a budget allocation is no longer fully needed or where there is a risk of overspending this is reported to the designated management accountant; and
5) information can be supplied to the Chief Finance Officer as required to enable budgets to be compiled.

4.5.5 In making financial decisions, budget holders are expected to consider not only the impact of the decision on resources for the current year but also any potential resource implications for future years. Budget holders must ensure that non-recurring budgets are not used to finance recurring expenditure.

4.5.6 Payments for liabilities arising as a consequence of a decision taken in an earlier period (even where the decision was taken by a predecessor) still need to be reflected in the appropriate cost centre of the current financial year.

4.5.7 Any likely overspending or reduction of income which cannot be met by budget virement should not be incurred without the prior consent of the Chief Finance Officer. Unauthorised breach of budgetary limits may result in disciplinary action.

5. Income, banking arrangements and debt recovery

5.1 Income

5.1.1 An ICB has power to do anything specified in section 7(2)(a), (b) and (e) to (h) of the Health and Medicines Act 1988 for the purpose of making additional income available for improving the health service.

5.1.2 The Chief Finance Officer is responsible for:

1) ensuring order to cash practices are designed and operated to support efficient, accurate and timely invoicing and receipting of cash. The processes and procedures should be standardised and harmonised across the NHS System by working cooperatively with the Shared Services provider; and
2) ensuring the debt management strategy reflects the debt management objectives of the ICB and the prevailing risks.

5.2 Sponsorship income and gifts

5.2.1 ICB officers have a responsibility to ensure that they are not placed in a position that compromises or appears to compromise their role in undertaking the ICB's public or statutory duties. They should not, nor should they be perceived to, secure valuable gifts and hospitality by virtue of their role in the organisation if this would give the impression that they have been influenced or are deemed to be influencing while acting in an official capacity.

5.2.2 In line with the guidance in Managing Public Money issued by HM Treasury. the ICB is required to disclose in its annual report and accounts, all individual sponsorship and gifts received or given if they exceed the value of £300k.

5.2.3 In accordance with the Declaration of Gifts, Hospitality & Sponsorship – Anti-Bribery Policy, sponsorship or gifts received or given should be recorded in the ICB's gifts and hospitality register, detailing the estimated value and what happened to the sponsorship or gift (ie. whether they were retained, disposed of or accepted).

5.3 Banking

5.3.1 The Chief Finance Officer is responsible for ensuring the ICB complies with any directions issued by the Secretary of State with regards to the use of specified banking facilities for any specified purposes. The ICB must use bank accounts arranged through the Government Banking Service (GBS).

5.3.2 The Chief Finance Officer will ensure that for each account there is an up to date schedule of those persons authorised to release funds from the account and that copies of such schedules are held by the bank and any third parties providing relevant financial services to the ICB.

5.3.3 The Chief Finance Officer will ensure that to action transactions governed by the bank mandates, there must be two approved signatories which are listed on the mandates. One of the signatories, must be either the Chief Finance Officer or his/her designated deputy.

5.3.4 The Chief Finance Officer will ensure that:

1) the ICB holds the minimum number of bank accounts required to run the organisation effectively. These should be raised through the government banking services contract;
2) the ICB has effective cash management policies and procedures in place, and payments made do not exceed the amount credited to an account;
3) the ICB complies with any mandatory requirements or guidance as regards the level of account balances;
4) the ICB meets any mandatory requirement or guidance as regards the level of cash to be used within any specified period.

5.4 Cash management

5.4.1 The Chief Finance Officer is responsible for putting in place arrangements to ensure the effective management of cash held in ICB bank accounts.

5.4.2 The ICB should manage its cash position in accordance with NHSE principles and guidance and should not draw down more cash during the year than the maximum cash drawdown notified to it by NHSE.

5.4.3 The amount of cash drawn down each month should be sufficient for the ICB to make expected payments as they fall due. A monthly cash forecast should be produced for this purpose and reviewed by the Head of Finance or their deputy to inform the requisitioning of cash from NHSE.

5.4.4 Cash requisition forms should be signed and submitted by the Head of Finance or their deputy in line with the monthly timetable issued by NHSE. If the ICB has insufficient cash in-month to meet its payment obligations, an application for a supplementary drawdown of cash should be made in line with the NHSE procedure.

5.4.5 The ICB should not plan to have surplus cash in the bank and closing cash balances each month should be no greater than 1.25% of the monthly drawdown in line with NHSE guidance.

5.5 Debt management

5.5.1 The Chief Finance Officer is responsible for the ICB debt management strategy.

5.5.2 This includes:

1) a debt management strategy that covers end-to-end debt management from debt creation to collection or write-off in accordance with the losses and special payment procedures;

2) ensuring the debt management strategy covers a minimum period of 3 years and must be reviewed and endorsed by the ICB Board every 12 months to ensure relevance and provide assurance;
3) accountability to the ICB Board that debt is being managed effectively;
4) accountabilities and responsibilities are defined with regards to debt management to budget holders; and
5) responsibility to appoint a senior officer responsible for day to day management of debt.

5.5.3 Where debt cannot be recovered it must be written off in accordance with the Debtors Control policy.

6. Financial systems and processes

6.1 Provision of finance systems

6.1.1 The Chief Finance Officer is responsible for ensuring systems and processes are designed and maintained for the recording and verification of finance transactions such as payments and receivables for the ICB.

6.1.2 The systems and processes will ensure, inter alia, that payment for goods and services is made in accordance with the provisions of these SFIs, related procurement guidance and prompt payment practice.

6.1.3 As part of the contractual arrangements for ICBs officers will be granted access where appropriate to the Integrated Single Financial Environment ("ISFE"). This is the required accounting system for use by ICBs. Access is based on single access log on to enable users to perform core accounting functions such as transacting and coding of expenditure/income in fulfilment of their roles.

6.1.4 The Chief Finance Officer will, in relation to financial systems:
1) promote awareness and understanding of financial systems, value for money and commercial issues;
2) ensure that transacting is carried out efficiently in line with current best practice – e.g. e-invoicing
3) ensure that the ICB meets the required financial and governance reporting requirements as a statutory body by the effective use of finance systems;
4) enable the prevention and the detection of inaccuracies and fraud, and the reconstitution of any lost records;
5) ensure that the financial transactions of the authority are recorded as soon as, and as accurately as, reasonably practicable;

6) ensure publication and implementation of all ICB business rules and ensure that the internal finance team is appropriately resourced to deliver all statutory functions of the ICB;
7) ensure that risk is appropriately managed;
8) ensure identification of the duties of officers dealing with financial transactions and division of responsibilities of those officers;
9) ensure the ICB has suitable financial and other software to enable it to comply with these policies and any consolidation requirements of the ICB;
10) ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes; and
11) where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

7. Procurement and purchasing

7.1 Principles

7.1.1 The Chief Finance Officer will take a lead role on behalf of the ICB to ensure that there are appropriate and effective financial, contracting, monitoring and performance arrangements in place to ensure the delivery of effective health services

7.1.2 The ICB must ensure that procurement activity is in accordance with the Public Contracts Regulations 2015 (PCR) for non-healthcare services, and the Healthcare Services (Provider Selection Regime (PSR)) Regulation 2023 for all healthcare services, and associated statutory requirements whilst securing value for money and sustainability.

7.1.3 The ICB must consider, as appropriate, any applicable NHSE guidance that does not conflict with the above.

7.1.4 The ICB must have a Procurement Policy which sets out all of the legislative requirements.

7.1.5 All ICB staff are required to make use of the specialist Procurement team to support and deliver all procurement activity.

7.1.6 All revenue and non-pay expenditure must be approved, in accordance with these SFIs, prior to an agreement being made with a third party that enters a commitment to future expenditure.

7.1.7 All officers must ensure that any conflicts of interest are identified, declared and appropriately mitigated or resolved in accordance with the ICB standards of business conduct policy.

7.1.8 Budget holders are accountable for obtaining the necessary approvals and oversight of all expenditure incurred on the cost centres they are responsible for. This includes obtaining the necessary internal and external approvals which vary based on the type of spend, prior to procuring the goods, services or works.

7.1.9 Undertake any contract variations or extensions in accordance with PCR 2015 (non-healthcare) and PSR (healthcare) and the ICB procurement policy.

7.1.10 Retrospective expenditure approval should not be permitted. Any such retrospective breaches require approval from any committee responsible for approvals before the liability is settled. Such breaches must be reported to the Audit Committee.

7.2 Tendering & Contracting

7.2.1 Quotations: Competitive and Non-Competitive

Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed, £10,000 (this figure to be reviewed periodically). Officers must not divide a proposed contract into smaller contracts to avoid the provisions of these SFIs, the procurement policy and external approval thresholds.

7.2.1.1 Competitive Quotations

1) Competitive quotations must be obtained in line with the limits stated in the ICB's financial scheme of delegation.
2) Quotations should be in writing unless it is impractical to do so in which case they may be obtained by telephone or electronically. Confirmation of telephone or electronic quotations should be obtained in writing without delay, and the reasons why the non-written quotation was obtained should be set out in a permanent record.
3) All quotations should be treated as confidential and should be retained for inspection.
4) The quotations should be evaluated and the one selected should provide the best value for money. If this is not the lowest quotation, then the choice made and the reasons why should be recorded in a permanent record, and pre-approved by the Chief Finance Officer.
5) Where a competitive procurement process is being undertaken, officers must follow the processes and guidance issued by the procurement team. Evaluation criteria must be agreed in advance in collaboration with the procurement team as per the

procurement policy. All queries on procurement must be referred to the procurement team.

7.2.1.2 Non-competitive Quotations

Non-competitive quotations in writing (i.e. from a limited range of providers) may be obtained in the following circumstances:

1) The supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not possible or desirable to obtain competitive quotations;
2) The supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts.

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the ICB and which is not in accordance with SFIs except with the authorisation of the Chief Finance Officer.

7.2.1.3 Approval to commit funds

A business case is required for expenditure on either clinical or non-clinical goods or services where:

1) the procurement is the re-procurement of an existing service but with additional investment;
2) the procurement relates to a new service and new investment is required;
3) the proposed contract is for the provision of consultancy services, in which case the NHSE business case process should be followed;
4) there is a proposal to award a procurement or grant without competition unless this follows an exception defined in the procurement policy; or
5) the contract has a proposed length (including extensions) of ten years or more.

7.2.2 Formal Competitive Tendering

The ICB shall ensure that competitive tenders are invited for:

1) The supply of goods and materials;
2) The rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health (DH)); for special arrangements governing the engagement of management consultants;
3) For the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens).

7.2.2.1 Healthcare Services

Where the ICB elects to invite tenders for the supply of healthcare services, these SFIs shall apply as far as they are applicable to the tendering procedure, and must follow the principles of the PSR. There are no financial threshold restrictions.,

7.2.2.2 Exceptions and Instances where Formal Tendering need not be applied (only applies to non-healthcare services)

Formal tendering procedures need not be applied where:

1) The estimated expenditure or income does not, or is not reasonably expected to exceed £50,000 for the life of the contract. (this figure to be reviewed periodically); or
2) Where the supply is proposed under special arrangements negotiated by the DH in which event the said special arrangements must be complied with.

7.2.2.3 Formal tendering procedures may be waived in the following circumstances:

1) In exceptional circumstances where the Accountable Officer, or Chief Finance Officer decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate ICB record;
2) Where the requirement is covered by an existing contract;
3) Where Crown Commercial Services framework agreements (or alternative framework agreements) are in place;
4) Where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;
5) Where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;
6) Where specialist expertise is required and is available from only one source;
7) When the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;
8) There is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of continuity must outweigh any potential financial advantage to be gained by competitive tendering;
9) For the provision of legal advice and services providing that any legal firm or partnership commissioned by the ICB is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council or England and Wales in relation to the obtaining of Counsel's opinion) and is generally recognised as having sufficient expertise in the area of work for which they are commissioned. The Chief

Finance Officer shall ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work;

The waiving of competitive quotations or tendering procedures must not be used to avoid competition, nor for administrative convenience, nor simply to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided that competitive quotations or tendering is not applicable and may be waived, the fact of the waiver and the reasons, should be documented and recorded in an appropriate ICB record which must receive prior authorisation from the Accountable Officer or Chief Finance Officer. All waivers will be reported to the Audit Committee and will be subject to scrutiny

7.2.3 Fair and Open Competition

The ICB shall ensure that it complies with the Procurement Regulations which are based on the principles of fairness, equal treatment, non-discrimination, and transparency. Tenders will be advertised in line with these principles to ensure fair and open competition.

7.2.4 List of Approved Firms

The Accountable Officer or Chief Finance Officer shall ensure that normally the firms/ individuals invited to tender (and where appropriate, quote) are among those on approved lists. Where, in the opinion of the Chief Finance Officer, it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Accountable Officer.

7.2.5 Contract Variations and Extensions

Items estimated to be below the limits set in these SFIs for which formal tendering procedures are not used, but which subsequently prove to have a value above such limits, shall be reported to the Accountable Officer and must be considered in line with the Public Contract Regulations, Reg 72. Modifications which could be deemed a substantial change are required to be re-tendered.

All extensions and variations to an existing contract must be reviewed in advance of being approved to confirm that they are legally possible; approval to commit funds through an approved business case has been obtained; they represent best value for money, including

financial and non-financial aspects; and they are not being instigated solely to avoid or delay the requirement to conduct procurement.

Extensions to existing contracts can only be approved where:

1) the value of the approved original business case covers the additional cost. If there is no provision in the original business case for the cost of the extension a new business case will be required; and
2) contract performance is satisfactory, and the variation is in line with or complies with procurement regulations. Advice should be sought from the procurement team regarding the extent to which contracts can be amended without the need for a new advertised tender process.

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.

The delegated limits for the approval of contract variations are set out in the Scheme of Delegation.

All extensions and variations must be agreed, documented, signed and countersigned by all parties or executed as a deed where necessary.

7.2.6 Confidentiality of information received

The ICB has policies and procedures in place to meet its information governance, data security and protection obligations and to enable the ICB to fulfil its information governance responsibilities. These policies provide a framework to bring together all of the requirements, standards and best practice that apply to the handling of confidential, business sensitive and personal information and include; Data Protection; Data Quality; Records Management; Access to Information; Freedom of Information and IT/Network Security.

7.2.7 Invitation to Tender

1) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders;
2) In line with Public Contract Regulations, Reg 22, all tenders must be conducted through the eTendering System unless there are exceptional circumstances, (eg: risk of breach of security). The opening and recording of these tenders will be managed by the authorised user and retained on the portal as a fully auditable record.

3) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable. Every tenderer must give a written undertaking not to engage in collusive tendering or other restrictive practice.

7.2.7.1 Receipt of Safe Custody Tenders

Formal competitive tenders are date and time stamped at the point of submission via the eTendering System and cannot be accessed until the closing date has passed. An electronic process for the acceptance/rejection of tenders is undertaken by the Procurement Lead in liaison with the Commissioner.

7.2.7.2 Accessing Tenders

After the stated closure date the Procurement Lead accesses the tenders via the eTendering System. The Procurement Lead must remain impartial throughout the tender process and any issues that may occur, (e.g.: a late tender), must be discussed with the Commissioner and escalated to the identified Senior Responsible Officer (SRO) for decision making.

7.2.7.3 Admissibility

1) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Accountable Officer.
2) Where only one tender is sought and/ or received, the Chief Finance Officer shall be advised and, as far practicable, he/she shall ensure that the price to be paid is fair and reasonable and will ensure value for money for the ICB.
3) Where examination of tenders reveals errors which would affect the tender price, the tenderer is to be given details of the errors and afforded the opportunity of confirming or withdrawing the offer.

7.2.7.4 Late Tenders

1) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Accountable Officer or his/her nominated officer decides that there are clear exceptional circumstances i.e. delayed through no fault of the tenderer. In these circumstances the Procurement Lead and ICB's SRO should escalate the matter to the Accountable Officer prior to releasing the tenders for evaluation.
2) The Accountable Officer or nominated officer shall decide whether such tenders are admissible or whether re- tendering is desirable. Re-tendering may be limited to those tenders reasonably in the field of consideration in the original competition.

3) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration and while re-tenders are being obtained, the tender documents shall be kept securely on the eTendering System and not accessed until a decision has been made.

7.2.7.5 Acceptance of Formal Tenders

1) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender. Information provided by a tenderer under these circumstances shall not be acted upon by the ICB until it has been confirmed in writing by the tenderer.
2) Tenders must be evaluated on the basis of Most Economically Advantages Solution (MEAT) and not awarded solely on the lowest price, (in accordance with PCR15 Regulation 67).
3) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the ICB and which is not in accordance with these SFIs except with the authorisation of the Accountable Officer.
4) The use of these procedures must demonstrate that the award of the contract:
    a. Was not in excess of the going market rate/ price current at the time the contract was awarded;
    b. Achieved the best value for money.
5) All tenders shall be treated as confidential and shall be retained for inspection.

7.2.7.6 Exceptions of Using Approved Contractors

If, in the opinion of the Accountable Officer and the Chief Finance Officer, it is impractical to use a potential contractor from the list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Accountable Officer should be satisfied that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

7.2.7.7 Authorisation of Tenders and Competitive Quotations

Providing all the conditions and circumstances set out in these SFIs have been fully complied with, and the intended expenditures or income falls within the relevant budget, formal authorisation and awarding of a contract may be made within the limits laid down in the ICB's Financial Scheme of Delegation. A list will be maintained of Board members/employees able to authorise invoices and their delegated limits.

Signing and, where appropriate, sealing of contracts and other documents shall be in accordance with the section in the Scheme of Delegation. All signed contracts must be notified to the ICB Contracting team to ensure that details are recorded in the ICB contracts register.

7.2.7.8 Instances where Formal Competitive Tendering and Competitive Quotation is not required

Where competitive tendering or a competitive quotation is not required, the ICB shall use an external procurement service for procurement of all goods and services unless the Accountable Officer or Chief Finance Officer deem it inappropriate, in which case the Chief Finance Officer shall determine an alternative procurement process. The decision to use alternative sources must be documented and reported to the Audit Committee.

7.2.7.9 Compliance Requirements for All Contracts

The Board may only enter into contracts on behalf of the ICB within the statutory powers delegated to it by the Secretary of State and shall comply with:

1) The ICB's Constitution and SFIs;
2) Public Contract Regulations 2015, or Provider Selection Regime Principles and other statutory provisions;
3) Any relevant directions including specific DH guidance, and guidance on the Procurement and Management of Consultants;
4) The NHS Standard Contract Conditions as are applicable;
5) Contracts with Foundation Trusts which must be in a form compliant with appropriate NHS guidance;
6) Where appropriate, contracts which shall be in, or embody, the same terms and conditions of contract as was the bases on which tenders or quotations were invited;
7) Contracts made by the ICB, and where, within all, the Board shall endeavour to obtain best value for money by use of all systems in place. The Accountable Officer shall nominate an officer who shall oversee and manage each contract on behalf of the ICB.
8) Payments should not be made to suppliers in advance of the service/product being delivered. In exceptional circumstances, and where a special case can be made to issue a prepayment, this must be approved in advance by the Accountable Officer and Chief Finance Officer.
9) The contract will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the ICB can jointly manage risk with all interested parties.

7.2.7.10 Adoption of the Tendering Process Conducted by another Organisation

The ICB may, on the express approval of the Accountable Officer or the Chief Finance Officer, adopt the tendering process of another organisation provided that organisation is either:

1) NHSE, ICB, Foundation Trust (FT) or other NHS Trust; or
2) LIFT Company;
3) A partner organisation where the basis of partnership is a Section 75 agreement and provided specifically that:
    a. Such process has not proceeded to contract stage; and
    b. The process would satisfy the ICB's own Constitution and SFIs with regard to procedure and competition; and
    c. The ICB's authorisation limits for acceptance of tenders and letting of contracts are observed.

In all such instances, the Board shall be informed by formal report at its next scheduled meeting.

7.2.8 Use of Purchase Orders

All commitments to suppliers for non-clinical goods, works and services must be made on an official purchase order generated from the finance system. All officers are required to follow this approach, subject to the exceptions outlined below.

The requisitioner, in choosing the item to be supplied, or the service to be performed, should always obtain the best value for money for the ICB. In so doing, the advice of the ICB procurement team shall be sought regarding the choice of an appropriate supplier.

The delegated limits for the approval of purchase requisitions, purchase credit notes, invoices, non-purchase order invoices and payments are set out in the Scheme of Delegation.

All purchase orders must be raised in advance of a commitment being entered and not on receipt of an invoice. An order raised after an invoice is received will be classed as retrospective and is a breach of SFIs.

Purchase orders must be in accordance with agreed contract value and length.

Purchase orders must only be receipted following the delivery of satisfactory goods or services.

The use of non-PO approvals should be limited to the following exceptions:

1) rent and rates payments;
2) utilities suppliers;
3) goods and services only available from one supplier;
4) other exemptions highlighted in the No Purchase Order No Pay policy or authorised by the Chief Finance Officer.

Further advice should be sought from the ICB corporate finance team.

The Chief Finance Officer is responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

8. Care Packages

8.1 Approval of Care Packages

8.1.1 The ICB is responsible for commissioning a number of different types of care packages for people including:

1) Continuing healthcare (CHC) for both adults and children – can be both care home and domiciliary care packages, including provision of equipment;
2) Mental health – these can be in-patient packages or section 117 aftercare packages (jointly funded with a local authority);
3) Learning difficulties – these can be in-patient packages; CHC packages or section 117 aftercare packages (jointly funded with a local authority);
4) Acquired brain injury care packages.

8.1.2 The ICB will employ specialist clinical teams who will be responsible for commissioning, managing and reviewing all care packages. This will include the establishment of appropriate panels to review and approve funding of 'high cost' and 'complex' cases.

8.1.3 The delegated limits for the approval of care packages are set out in the Scheme of Delegation.

8.2 Individual Funding Requests

8.2.1 Individual funding requests (IFRs) on behalf of patients will be considered under the terms of the ICB's IFR policy. The individual funding request process is the means by which the ICB takes into account and prioritises requests for individuals with unusual clinical circumstances, which cannot be accommodated through its other commissioning processes.

9. Staff costs and staff related non pay expenditure

9.1 Chief People Officer

9.1.1 The Chief People Officer (CPO), or the person assuming these responsibilities in the ICB, will lead the development and delivery of the long-term people strategy of the ICB ensuring this reflects and integrates the strategies of all relevant partner organisations within the ICS.

9.1.2 Operationally the CPO will be responsible for:

1) defining and delivering the organisation's overall human resources strategy and objectives; and
2) overseeing delivery of human resource services to ICB employees.

9.1.3 The CPO will ensure that the payroll system has adequate internal controls and suitable arrangements for processing deductions and exceptional payments.

9.1.4 Where a third-party payroll provider is engaged, the CPO shall closely manage this supplier through effective contract management.

9.1.5 The CPO will ensure that the payroll system has adequate internal controls and suitable arrangements for processing deductions and exceptional payments. In addition, they are responsible for ensuring that the contract with any relevant outsourced service provider covers:

1) maintenance of subsidiary records for income tax, national insurance, pensions and other authorised deductions from pay;
2) security and confidentiality of payroll information;
3) separation of duties of preparing records and inputs and verifying outputs and payments;
4) suitable systems for the identification and recording of off-payroll workers;
5) the final determination of pay and allowances;
6) checks to be applied to completed payroll before and after payment;
7) ensuring payment occurs on agreed dates; and
8) arrangements for ensuring compliance with the provisions of the General Data Protection Regulation.

9.1.6 The CPO is responsible for management and governance frameworks that support the ICB employees' life cycle.

9.1.7 Any remuneration, fees and allowances paid to ICB members will be in accordance with decisions taken by the ICB's Remuneration Committee, having received written recommendations from the ICB's CPO.

9.1.8 Decisions regarding remuneration, fees and allowances for employees and individuals providing services to the ICB other than ICB members will be taken by the Remuneration Committee.

9.1.9 All appointments of staff including the engagement of agency workers or contractors, must be done so in line with the detailed scheme of delegation and in line with the ICB's Establishment Control Policy.

9.1.10 Nobody will re-band any posts, either on a permanent or temporary basis, or implement changes to any aspect of employees' remuneration or reimbursement unless they have been specifically authorised to do so under the detailed scheme of delegation and in line with the ICB's Establishment Control Policy.

9.1.11 The remuneration of any and all individuals providing services to the ICB will be via the payroll system unless other arrangements have been explicitly authorised by the Chief Finance Officer.

9.1.12 The Chief Finance Officer has overall responsibility for:

1) specifying timetables for the submission of properly authorised time records and expense claims;
2) payments being made on agreed dates;
3) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;
4) checks to be applied to completed payroll before and after payment.

9.1.13 Budget holders are responsible for submitting properly authorised time records and expense claims in line with the agreed timetables and submitting termination forms immediately upon knowing the effective leaving date of an employee. If an employee or individual providing services to the ICB behaves in any manner suggesting that they have left without notice, the Chief Finance Officer must be informed immediately.

9.2 Contracts of Employment

9.2.1 The Chief People Officer is responsible for ensuring that arrangements are in place for:

1) ensuring that all employees are issued with a contract of employment in a form approved by the Board and which complies with employment legislation;
2) dealing with variations to, or termination of, contracts of employment; and
3) ensuring all contractors, including non-executive directors, clinical leads and advisors and others not formally employed under a 'contract of employment' with the ICB, receive a 'contract or service' that appropriately reflects the agreed terms and conditions of their role.

9.3 Staff Secondments

9.3.1 A business case for any secondment into or out of the ICB, including duration and financial arrangements, must be agreed before any commitment is made. Business cases must demonstrate affordability within existing budgets.

9.3.2 All secondment arrangements must be agreed in writing with the external seconding or receiving organisation, through completion of a formal secondment agreement in a form approved by the Chief People Officer.

9.3.3 On return from a secondment, a member of staff will return to their substantive role unless other arrangements are agreed by HR.

9.4 Salary Advances, Overpayment and Recovery

9.4.1 Salary advances will be considered on a case-by-case basis, particularly for new starters that have missed monthly payroll processing deadlines. Salary advances must be reviewed and approved by the HR team.

9.4.2 If salary overpayments occur, the ICB policy is to pursue repayment.

9.4.3 The Chief Finance Officer will implement a system to ensure the recovery from those leaving the employment of the ICB of any sums due or property belonging to the ICB.

9.5 Off Payroll Arrangements

9.5.1 All ICB staff, whether permanent, fixed term or temporary should be paid via payroll as the default position. The only possible exceptions to this are:

1) temporary staff recruited from agencies, where the worker is on the payroll of the agency and payment is by way of invoices issued by the agency;
2) self-employed temporary contractors, where an IR35 assessment has been completed and the ICB Chief Finance Officer is in agreement that the role is 'outside' IR35 for the purposes of tax and national insurance.

9.5.2 The ICB must comply with HM Treasury rules for off- payroll workers. These require that Board members and/or senior officials with significant financial responsibility in the ICB must be on payroll unless there are exceptional temporary circumstances. Such exceptions require written NHSE Accounting Officer sign-off and cannot last longer than six months.

9.6 Redundancy and Severance Pay

9.6.1 The approval of the ICB Remuneration and Appointments Committee is required for proposed payments falling under any of the following categories:

1) redundancies;
2) payments in lieu of notice;
3) all special severance payments, i.e. non-contractual, novel or contentious payments;
4) financial incentive/retention payments;
5) mutually agreed resignation schemes;
6) voluntary redundancy schemes;
7) where a decision to terminate employment has been overturned; and
8) confidentiality clauses.

9.6.2 Advice should be sought from the Chief People Officer and the Chief Finance Officer, well in advance of the need to undertake any of the above.

9.6.3 Approval will be required by the Chief Executive prior to consideration by the ICB Remuneration Committee.

9.6.4 Proposed non-contractual payments to staff are also likely to require approval from HM Treasury before any proposal is approved by the ICB and communicated to an employee. In all such cases, advice should be sought from the Chief Finance Officer and Chief People Officer.

9.7 Salary Sacrifice Schemes

9.7.1 All salary sacrifices schemes in operation are subject to applicable policies which provide detailed guidance. The HR team will hold details of the schemes currently in operation and make details available to staff via the ICB intranet.

9.7.2 No new salary sacrifice schemes should be introduced without the prior approval of the Chief Finance Officer and the Chief People Officer.

9.8 Business Travel and Expenses

9.8.1 The Chief Finance Officer is responsible for setting out a policy on the circumstances under which the ICB reimburses expenses incurred by staff carrying out business activity, as well as other categories of expense.

9.8.2 Budget holders should ensure they are familiar with such policies and guidance.

10. Non-Pay Expenditure

10.1 Official Orders

10.1.1 Official Orders must:

1) Be consecutively numbered;
2) Use the form provided by SBS;
3) Be in a form approved by the Chief Finance Officer;
4) State the ICB's terms and conditions of trade;
5) Only be issued to, and used by, those duly authorised by the Accountable Officer

10.2 Duties of Officers and Managers

10.2.1 Officers and Managers must ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer and that:

1) All contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Finance Officer in advance of any commitment being made;
2) Contracts above specified thresholds are advertised and awarded in accordance with rules on public procurement;
3) Where consultancy advice is being obtained, the procurement of such advice must be in accordance with DH guidance;

4) No order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or members of staff other than:
   a. Isolated gifts of a modest nature or inexpensive seasonal gifts, such as calendars;
   b. Conventional hospitality, such as lunches in the course of working visits, (reference should always be made to the ICB's Declaration of Gifts, Hospitality and Sponsorship - Anti-Bribery Policy before accepting such items)
   c. No requisition/ order is placed for any items for which there is no budget provision unless authorised by the Chief Finance Officer on behalf of the Accountable Officer;
5) All goods, services, or works are ordered on an official order except works and services executed in accordance with a contract, purchases from petty cash, and goods or services purchased via the ICB's approved corporate credit card scheme, (see Corporate Credit Card policy);
6) Other than for purchases made via the ICB's approved corporate credit card scheme, verbal orders must only be issued in cases of emergency or urgent need, by a member of staff designated by the Accountable Officer, and only in cases of genuine emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";
7) Orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;
8) Goods are not taken on trial or loan in circumstances that could commit the ICB to future uncompetitive purchase or other liability;
9) Changes to the list of officers authorised to certify invoices are notified to the Chief Finance Officer;
10) Purchases from petty cash and/or the ICB's corporate credit card are restricted in value and by type of purchase in accordance with instructions issued by the Chief Finance Officer;
11) Petty cash and corporate credit card records are maintained in a form as determined by the Chief Finance Officer.

10.3 Joint Finance Arrangements with Local Authorities and Voluntary Bodies

10.3.1 Payments to Local Authorities and Voluntary Organisations made under the powers of Sections 256 and 257 of the NHS Act 2006, shall comply with procedures laid down by the Chief Finance Officer which shall be in accordance with these Acts and the 2000 Directions of the Secretary of State.

10.3.2 The Better Care Fund (BCF), is a pooled budget with the local authority which falls under these Acts and the regulations within them. In addition, all payments in respect of the pooled budget shall be in accordance with the ICB's SFIs and the Scheme of Delegation.

11. Annual reporting and Accounts

11.1.1 The Chief Finance Officer will ensure, on behalf of the Accountable Officer and ICB Board, that:

1) the ICB is in a position to produce its required monthly reporting, annual report, and accounts, as required by NHSE and the ICB Finance Committee;
2) the ICBs annual accounts are prepared in accordance with the timetable required by NHSE and approved by the ICB Audit Committee;
3) the annual report and accounts are audited by an auditor appointed by the ICB Audit Committee;
4) the ICB, in each financial year, prepares a report on how it has discharged its functions in the previous financial year;
5) an annual report must, in particular, explain how the ICB has:
    a. discharged its duties in relation to improving quality of services, reducing inequalities, the triple aim and public involvement;
    b. review the extent to which the Board has exercised its functions in accordance with its published 5 year forward plan and capital resource use plan; and
    c. review any steps that the Board has taken to implement any joint local health and wellbeing strategy.

11.1.2 NHSE may give directions to the ICB as to the form and content of an annual report.

11.1.3 The ICB must give a copy of its annual report to NHSE by the date specified by NHSE in a direction and publish the report.

11.2 Internal audit

11.2.1 The Accountable Officer is responsible for ensuring there is appropriate internal audit provision in the ICB. For operational purposes, this responsibility is delegated to the Chief Finance Officer to ensure that:

1) all internal audit services provided under arrangements proposed by the Chief Finance Officer are approved by the Audit Committee, on behalf of the ICB Board;
2) the ICB must have an internal audit charter. The internal audit charter must be prepared in accordance with the Public Sector Internal Audit Standards (PSIAS);
3) the ICB internal audit charter and annual audit plan, must be endorsed by the ICB Accountable Officer, Audit Committee and Board;

4) the Head of Internal Audit must provide an annual opinion on the overall adequacy and effectiveness of the ICB Board's framework of governance, risk management and internal control as they operated during the year, based on a systematic review and evaluation;
5) the Head of Internal Audit should attend Audit Committee meetings and have a right of access to all Audit Committee members, the Chair and Accountable Officer of the ICB.
6) the appropriate and effective financial control arrangements are in place for the ICB and that accepted internal and external audit recommendations are actioned in a timely manner.

11.2.2 The system of selecting the ICBs internal audit service provider will ensure that the ICB has a professional and technically competent internal audit function. The methodology for achieving this will be detailed in the procurement process and service specification for internal audit services. The Audit Committee will be responsible for appointing the internal audit service provider.

11.2.3 The internal audit plan will be determined using a risk based methodology and refer to the ICB's Assurance Framework to enable internal audit to give an annual Head of Internal Audit opinion on internal controls. The Audit Committee is responsible for ensuring a robust and adequately resourced internal audit plan is delivered annually.

11.3 External Audit

11.3.1 The Chief Finance Officer is responsible for:

1) liaising with external audit colleagues to ensure timely delivery of financial statements for audit and publication in accordance with statutory, regulatory requirements;
2) ensuring that the ICB appoints an auditor in accordance with the Local Audit and Accountability Act 2014; in particular, the ICB must appoint a local auditor to audit its accounts for a financial year not later than 31 December in the preceding financial year; the ICB must appoint a local auditor at least once every 5 years; and
3) ensuring that the appropriate and effective financial control arrangements are in place for the ICB and that accepted external audit recommendations are actioned in a timely manner.

11.3.2 The arrangements for selecting the ICB's external audit service provider will ensure that the ICB has a professional and technically competent external audit supplier. The methodology for achieving this will be detailed in the procurement process and service specification for external audit services.

11.3.3 The Audit Committee terms of reference will make provision for it to act in the role of the Auditor Panel, as required by the Local Audit and Accountability Act 2014. The Auditor Panel is responsible for making a recommendation to the ICB regarding the appointment of the external audit service provider.

11.3.4 It is the duty of the Audit Committee to ensure that the external auditor provides a cost effective service. Any problems arising with the service will be discussed and resolved with the provider by the Chief Finance Officer and referred to the Audit Committee by exception.

12. Losses and special payments

12.1.1 Losses and special payments are transactions which the ICB does not approve budgetary provision for in advance, as in the normal course of business, such payment would not be expected to occur.

12.1.2 HM Treasury approval is required if a transaction exceeds the delegated authority, or if transactions will set a precedent, are novel, contentious or could cause repercussions elsewhere in the public sector.

12.1.3 All cases relating to ICB losses and special payments must be submitted to NHSE for approval if the proposed transaction values exceed the delegated limits that are detailed below:

EXPENDITURE TYPE	DELEGATED LIMIT
All losses	Up to £300k
Special Payments including ExtraContractual/ Statutory/ regulatory/ compensation & Ex gratia	Up to £95k
Special severance & Retention payments	£0
Consolatory payments	£500

12.1.4 The Chief Finance Officer will support a strong culture of public accountability, probity, and governance, ensuring that appropriate and compliant structures, systems, and process are in place to minimise risks from losses and special payments.

12.1.5 NHSE has the statutory power to require an ICB to provide NHSE with information. The information is not limited to losses and special payments, must be provided in such form, and at such time or within such period, as NHSE may require.

12.1.6 As part of the new compliance and control procedures, ICBs must submit an annual assurance statement confirming the following:

1) details of all exit packages (including special severance payments) that have been agreed and/or made during the year;

2) that NHSE and HMT[1] approvals have been obtained (in relation to non-contractual pay elements or amounts that exceed the ICB delegated limits), before any offers, whether verbally or in writing, are made; and
3) adherence to the special severance payments guidance as published by NHSE.

12.1.7 The ICB Chief Financial Officer is responsible for ensuring that processes and procedures that facilitate the capturing and reporting of losses and special payments are in place and ensure that a losses and special payments register is maintained.

12.1.8 All losses and special payments must be recorded in the register and reviewed as part of the internal controls process.

12.1.9 All losses and special payments (including special severance payments), must be reported to the ICB Audit Committee.

12.1.10 For detailed operational guidance on losses and special payments, please refer to the ICB Losses and Special Payment policy.

1 This is only applicable to elements of the exit packages that are classified as non contractual

13. Fraud, bribery and corruption (Economic crime)

13.1.1 The ICB is committed to identifying, investigating and preventing economic crime.

13.1.2 The ICB Chief Finance Officer is responsible for ensuring appropriate arrangements are in place to provide adequate counter fraud provision which should include reporting requirements to the Board and Audit Committee, and defined roles and accountabilities for those involved as part of the process of providing assurance to the Board. These arrangements should comply with the NHS Requirements the Government Functional Standard 013 Counter Fraud as issued by NHS Counter Fraud Authority and any guidance issued by NHSE.

13.1.3 In line with NHS Counter Fraud Authority requirements, the Chief Finance Officer will have overall responsibility for the prevention and detection of fraud and corruption. The Chief Finance Officer will make arrangements for the appointment of a Local Counter Fraud Specialist (LCFS) through whom all allegations of fraud and corruption will be investigated.

13.1.4 The LCFS role may be purchased as a service from a suitably qualified service provider. The scope of the LCFS service and the requirement for collaborative working with the NHS Counter Fraud Authority will be outlined in the contract with the nominated service provider. No officer, other than the LCFS shall undertake fraud investigations for the ICB. Where the LCFS role becomes vacant a replacement appointment must be made within 3 months.

13.1.5 The Chief Finance Officer will ensure that the LCFS has appropriate support and access to all necessary facilities, documents and staff (including contractors) in order to carry out their responsibilities effectively.

13.1.6 The LCFS will report to the Chief Finance Officer and will work with the NHS Counter Fraud Authority to ensure the ICB discharges its responsibilities regarding fraud and corruption. The Audit Committee will approve the annual LCFS work plan and receive quarterly updates from the LCFS on work undertaken and the outcome of any investigations. The LCFS will provide a written report at least annually on the Counter fraud work carried out. The Audit Committee will review and approve this report.

13.1.7 If an employee or manager suspects that there has been a potential act of fraud, bribery or corruption against the ICB or the wider NHS, or has seen any suspicious acts or events, they must report the matter to the ICB's Counter Fraud Team (contact details can be found on the ICB's public website and/or intranet) or report the matter to the NHS Fraud and Corruption Reporting Line on 0800 028 4060.

13.1.8 Alternatively, reports can be made through the online reporting tool at NHS Counter Fraud Authority online fraud and corruption reporting tool (cfa.nhs.uk). Further advice on counter fraud issues is available from the Chief Finance Officer or Director of Finance.

13.1.9 Security Management - All members of the ICB and employees (including its contractors), are responsible for the security of the property of the ICB; avoiding loss; exercising economy and efficiency in the use of resources; and conforming with the requirements of the Constitution, Scheme of Delegation and Standing Financial Instructions. In line with their responsibilities, the Audit Committee will monitor and ensure compliance with NHS security management standards. The ICB shall nominate a suitable person to carry out the duties of the Security Management Specialist.

14. Capital Investments & security of assets and Grants

14.1.1 The Chief Finance Officer is responsible for:

1) ensuring that at the commencement of each financial year, the ICB and its partner NHS trusts and NHS foundation trusts prepare a plan setting out their planned capital resource use;
2) ensuring that the ICB and its partner NHS trusts and NHS foundation trusts exercise their functions with a view to ensuring that, in respect of each financial year local capital resource use does not exceed the limit specified in a direction by NHSE;
3) ensuring that there is an effective appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;
4) ensuring that there are processes in place for the management of all stages of capital schemes, that will ensure that schemes are delivered on time and to cost;
5) ensuring that capital investment is not authorised without evidence of availability of resources to finance all revenue consequences; and

6) for every capital expenditure proposal, the Chief Finance Officer is responsible for ensuring there are processes in place to ensure that a business case is produced.

14.1.2 Capital commitments typically cover land, buildings, equipment, capital grants to third parties and IT, including:

1) authority to spend capital or make a capital grant;
2) authority to enter into leasing arrangements.

14.1.3 Advice should be sought from the Chief Finance Officer or nominated officer if there is any doubt as to whether any proposal is a capital commitment requiring formal approval.

14.1.4 For operational purposes, the ICB shall have nominated senior officers accountable for ICB property assets and for managing property.

14.1.5 ICBs shall have a defined and established property governance and management framework, which should:

1) ensure the ICB asset portfolio supports its business objectives; and
2) comply with NHSE policies and directives and with this standard

14.1.6 Disposals of surplus assets should be made in accordance with published guidance and should be supported by a business case which should contain an appraisal of the options and benefits of the disposal in the context of the wider public sector and to secure value for money.

14.2 Asset Register

14.2.1 The ICB shall maintain an asset register recording fixed assets including leased assets under IFRS16.

14.2.2 The Accountable Officer is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer concerning the form of any register, and the method of updating and arranging for a physical check of assets against the asset register, to be conducted once a year.

14.2.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

1) Properly authorised and approved agreements, architects certificates, supplier invoices and other documentary evidence in respect of purchases from third parties;
2) Requisitions and records for own materials and labour including appropriate overheads;
3) Lease agreements in respect of assets held under a finance lease and capitalised.

14.2.4 The Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

14.2.5 The value of each asset shall be indexed to current values in accordance with methods specified in the Government Financial Reporting Manual (FReM).

14.2.6 The value of each asset shall be depreciated using methods and rates as specified in the FReM.

14.2.7 The Chief Finance Officer shall calculate and charge depreciation as specified in the FReM.

14.3 Security of Assets

14.3.1 The overall control of fixed assets is the responsibility of the Accountable Officer. Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Finance Officer. This procedure shall make provision for:

1) Recording managerial responsibility for each asset;
2) Identification of additions and disposals;
3) Identification of all repairs and maintenance expenses;
4) Physical security of assets;
5) Periodic verification of the existence of, condition of, and title to, assets recorded;
6) Identification and reporting of all costs associated with the retention of an asset; reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

14.3.2 Budget holders must ensure that all leavers return IT equipment. ICT must define escalation procedures for any IT equipment that is not returned and stored in the central repository within a set timeframe after leaving date.

14.3.3 Any damage to ICB premises, vehicles and equipment or any loss of equipment or supplies must be reported by officers in accordance with the agreed procedure for reporting losses.

14.4 Grants

14.4.1 The Chief Finance Officer is responsible for providing robust management, governance and assurance to the ICB with regards to the use of specific powers under which it can make capital or revenue grants available to;

1) any of its partner NHS trusts or NHS foundation trusts; and
2) to a voluntary organisation, by way of a grant or loan.

14.4.2 Budget holders must ensure that any capital grant issued is used for its intended purpose and ensure appropriate legal agreements are in place to secure ICB investment if there is a change in use of the asset the grant has been provided for.

14.4.3 Capital grants issued in respect of Primary Care should be issued in accordance with the Primary Care Cost Directions. Primary Care commissioning teams must ensure any capital grant issued is appropriately documented and assessed to enable appropriate management of GP contracts.

14.4.4 All revenue grant applications should be regarded as competed as a default position, unless, there are justifiable reasons why the classification should be amended to non-competed.

15. Legal and insurance

15.1.1 This section applies to any legal cases threatened or instituted by or against the ICB. The ICB should have policies and procedures detailing:

1) engagement of solicitors / legal advisors;
2) approval and signing of documents which will be necessary in legal proceedings; and
3) Officers who can commit or spend ICB revenue resources in relation to settling legal matters.

15.1.2 ICBs are advised not to buy commercial insurance to protect against risk unless it is part of a risk management strategy that is approved by the Accountable Officer.

15. Appendix 1 – Financial Scheme of Delegation

The Financial Scheme of Delegation sets out the levels of financial authority that are delegated to different levels of staff within NHS Shropshire, Telford and Wrekin (NHS STW). Staff may only operate within the authority levels delegated to them and any breaches must be reported immediately to the Chief Finance Officer or Director of Finance. Breaches will also be reported to the Audit Committee.

The Financial Scheme of Delegation is reviewed and amended from time to time. It is the responsibility of the Chief Executive Officer to communicate current policy to staff.

The Financial Scheme of Delegation must be read in conjunction with other relevant financial and other policies of NHS STW, including NHS STW's policies in relation to Conflicts of Interest.

Key:

CEO –	Chief Executive Officer
CFO –	Chief Finance Officer
CMO –	Chief Medical Officer
CNO –	Chief Nurse Officer
CDO -	Chief Delivery Officer
CPO -	Chief People Officer
CSO -	Chief Strategy Officer
VSM -	Very Senior Manager (other Senior Leadership posts)

Notes:

1. An authorised individual may appoint another to formally deputise (e.g. during leave). In that case, the deputy has the authority of the individual that has assigned it. Such appointment must be in writing and clear as to the scope and terms of the assignment.

Delegated matter	Authority									Notes
	Board and chair (if delegated)	Board Sub-Committee	Chief Executive Officer	ICB Executive Directors	VSM Leadership/ Band 9	Band 8C & Band 8D	Band 8A and Band 8B	Band 6 and Band 7	Band 5	
MANAGEMENT ACCOUNTING AND BUSINESS MANAGEMENT										
Virements between budgets	n/a	n/a	No Limit (capital & revenue)	No Limit (capital & revenue)	No Limit (capital & revenue)	Up to £250,000	n/a	n/a	n/a	Must be in accordance with ***Budgetary Control Policy***
Change of use of budgets	n/a	n/a	No Limit	No Limit	No Limit	n/a	n/a	n/a	n/a	Must be supported by approved Business Case
INCOME, BANKING ARRANGEMENTS AND DEBT RECOVERY										
Requests to raise sales invoices	n/a	n/a	No Limit	No Limit	No Limit	Up to £250,000	Up to £100,000	Up to £1,000	n/a	
Authorisation of credit notes	n/a	n/a	No Limit	No Limit	Up to £250,000	n/a	n/a	n/a	n/a	
Banking arrangements	n/a	n/a	As specified on bank mandate	CFO as specified on bank mandate	Director of Finance as specified on bank mandate	Deputy Director of Finance/ Head of Finance as specified on bank mandate	n/a	n/a	n/a	In accordance with mandated Government Banking Service arrangements
CONTRACT MANAGEMENT										
External funding bids	n/a	n/a	No Limit	No Limit	Up to £250,000	n/a	n/a	n/a	n/a	If the bid is in relation to funding for a new service and exceeds £250k per annum then approval of the business case must be sought from the Strategic Commissioning Committee before submitting the bid
Approval of business cases	New Investment: Unlimited	New Investment: Strategic Commissioning Committee - Up to £2.5m	Existing budget: No Limit in conjunction with CFO New Investment: Up to £1m in conjunction with CFO	Existing budget: CFO - No Limit in conjunction with CEO New Investment: CFO - Up to £1m in conjunction with CEO	n/a	n/a	n/a	n/a	n/a	
Decommissioning or Disinvestment of existing services	Above £2.5m	Strategic Commissioning Committee - Up to £2.5m	Up to £1m in conjunction with CFO	Up to £1m in conjunction with CEO	n/a	n/a	n/a	n/a	n/a	All cases to be reviewed by Strategic Commissioning Committee
Signing of Healthcare Commissioning Annual Contracts & SLAs and Pooled Budgets	n/a	n/a	No Limit	No Limit	Up to £5m	Head of Contracts: Up to £2m	n/a	n/a	n/a	If within budget agreed by Board
Variations to healthcare and non-healthcare contracts	n/a	n/a	No Limit	No Limit	Up to £5m	Head of Contracts: Up to £2m	n/a	n/a	n/a	If within budget agreed by Board, and supported by approved Business Case. 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
Authorisation of monthly block payment for - agreed contract value to NHS bodies	n/a	n/a	No Limit	CFO (No Limit)	Director of Finance (No Limit)	Head of Contracts (No Limit)	n/a	n/a	n/a	If within signed annual contract value
PROCUREMENT AND PURCHASING										
Authority to waive tenders or quotations, or to accept a tender or quotation which is not the lowest.	n/a	n/a	No Limit	CFO (No Limit)	n/a	n/a	n/a	n/a	n/a	All instances to be reported to the Audit Committee
Authorisation of requisitions (or certification of invoices when no requisition/order was raised)/purchase credit notes	n/a	n/a	No Limit	No Limit	Up to £1m	Up to £250,000	Up to £100,000	Up to £1,000	n/a	All ICB Staff within existing budget. Purchase orders to be raised for all non-healthcare goods and services
Procurement Team Creation of Purchase Orders following requisition approval	n/a	n/a	n/a	n/a	n/a	Up to £250,000	Up to £250,000	Up to £250,000	Up to £250,000	Applies to Procurement Team
CARE PACKAGES										
Continuing Healthcare - Authorisation of Continuing Healthcare contracts and related weekly cost packages.	n/a	n/a	No Limit	No Limit	Up to £100,000	Up to £5,000	Up to £3000	Up to £1500	n/a	If supported by: - contract/tendering and quotation approval and within budget Limits relate to anticipated total weekly package costs
Meds Management - Authorisation of Individual Funding Requests	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	In accordance with the Individual Funding Request Policy
STAFF COSTS AND STAFF RELATED NON PAY EXPENDITURE										
Pay Amendments - rebanding	n/a	n/a	No Limit	No Limit	n/a	n/a	n/a	n/a	n/a	In conjunction with HR process
Salary overpayment agreements	n/a	n/a	No Limit	No Limit	Up to £5k	n/a	n/a	n/a	n/a	
Redundancy and Severance Pay	n/a	Remuneration Committee - No Limit	No Limit in conjunction with Remuneration Committee	n/a	n/a	n/a	n/a	n/a	n/a	Approval required by CEO in first instance. Also, require NHSE/Treasury approval
Payroll forms (starters/changes/ leavers & expense claims)	n/a	n/a	No Limit	No Limit	No Limit	No Limit	No Limit	No Limit	n/a	In accordance with approval hierarchy in EASY
NON PAY EXPENDITURE (including Triple Lock Process)										
Tenancy agreements/ Licenses	n/a	n/a	No Limit in conjunction with CFO	CFO - No Limit in conjunction with CEO	n/a	n/a	n/a	n/a	n/a	
Management Consultancy	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	NHS England » Consultancy spending approval criteria for providers Must be procured in line with Department of Health guidance
Setting up new, or amending current Supplier details	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Yes	Yes	In accordance with new/amendment to supplier process
LOSSES AND SPECIAL PAYMENTS										
Approve Special Payments	<= £95,000	No	n/a	n/a	n/a	n/a	n/a	n/a	n/a	All cases above £95,000 must be submitted to NHSE for approval
Approve losses, including invoice write-offs	> £50,000 and <= £300,000	n/a	Up to £50,000 (in conjunction with CFO)	CFO Up to £1,000 and up to £50,000 (in conjunction with CEO)	n/a	n/a	n/a	n/a	n/a	All instances to be reported to the Audit Committee. All cases above £300,000 must be submitted to NHSE for approval
Approve Consolatory Payments	<= £500	No	n/a	n/a	n/a	n/a	n/a	n/a	n/a	All cases above £500 must be submitted to NHSE for approval
CAPITAL INVESTMENTS AND SECURITY OF ASSETS AND GRANTS										
GPIT	n/a	n/a	No Limit	CFO: No Limit	n/a	n/a	n/a	n/a	n/a	Within capital budget and within business case approval
New IFRS16 Leases	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Business cases to be reviewed and approved by NHSE Regional team (and nationally if >=£1m)
DELEGATED SERVICES										
Pharmaceutical, Opthalmic and Dental Primary Care Delegation (NHSE Staff): - Authorisation of requisitions (or certification of invoices when no requisition/order was raised)/ Contract Variations	n/a	n/a	No Limit	No Limit	Up to £250,000	Up to £250,000	Up to £100,000	- Band 6: Up to £10,000 - Band 7: Up to £30,000	Up to £5,000	NHSE Staff as part of the delegation of Pharmaceutical, Opthalmic and Dental Primary Care functions
Specialised Commissioning Delegation (NHSE Staff): - Authorisation of requisitions (or certification of invoices when no requisition/order was raised)/ Contract Variations	n/a	n/a	No Limit	No Limit	Up to £250,000	Up to £250,000	Up to £100,000	- Band 6: Up to £10,000 - Band 7: Up to £30,000	Up to £5,000	NHSE Staff as part of the delegation of Specialised Commissioning functions

QUOTATION & TENDERING LIMITS

Value for money should be demonstrated by all staff regardless of the levels of expenditure involved. However, the following limits apply to all expenditure in excess of £10,000 where the Public Contract Regulations 2015 (PCR15) apply:

Value of Expenditure (inclusive of irrecoverable VAT)	Requirement
<£10,000	Informal price testing must be undertaken prior to placing an order
£10,001-£50,000	3 written quotes
>£50,000	Tender

Where the Health Care Services (Provider Selection Regime (PSR)) Regulations 2023 applies, no expenditure threshold applies, PSR should be applied to all Healthcare Services.

Additional points to note for the inclusion of POD/Specialised Commissioning staff:

- The inclusion of lower band staff for the POD/Specialised Commissioning team is minimal risk as they are not material values and the staff are still subject to the same policies which is not a fundamental variation;
- The implication of not agreeing this amendment is that the default would be for all POD/Specialised Commissioning invoices to require sign off by ICB staff. There is no capacity to resource this within the ICB as the existing resource sits with the POD/Specialised Commissio

Agenda Item

ICB 27-11.092

Finance Committee Chair's Reports

Appendix 1 - Minutes of the Finance Committee Section 1 30.07.24

Appendix 2 - Minutes of Previous Meeting Section 2 30.07.24

Appendix 3 - Minutes of the Finance Committee Section 1 26.09.24

Appendix 4 - Minutes of Previous Meeting Section 2 26.09.24

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

NHS Shropshire, Telford, and Wrekin
ICB Finance Committee (Section 1) Meeting
Tuesday 30th July 2024, at 14.00,
Via Microsoft Teams

Present:

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

Attendees:

Kate Owen	Head of PMO NHS STW
Angela Szabo	Director of Finance NHS STW
Sarah Dixon	Improvement Director NHSE
Cynthia Fearon	Corporate PA NHS STW (Note taker).

Apologies:

Gareth Robinson	Directory of Delivery and Transformation NHS STW

1.0 Minute No. SFC-24-07.001 – Introduction and Apologies

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

2.0 Minute No.SFC-24-07.002 – Declarations of Interests

2.1 No declarations of interest were noted.

3.0 Minute No.SFC-24-07.003 – Minutes from the Previous Meeting held on: 27th June 2024

3.1 Agreed as a true and accurate record.

4.0 Minute No. SFC-24-07.004 Matters Arising and Action List from Previous Meetings

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

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

5.0 Minute No. SFC-24-07.005 - BAF and Strategic Risk Register Update

Report received as read.

5.1 AS reported that the risk around the financial plan delivery for 2024/25 has been expanded to cover both capital and revenue. **AS** flagged 2 key capital risks noting these are system risks not ICB risks. Firstly, the 10% reduction in provider operational capital following the change in the national framework. Secondly a shortfall in the funding for the capitalisation of leases under IFRS 16, namely Shropcomm.

AS explained that the narrative on the financial sustainability risk on the SORR controls and assurance, has been updated to match back to the BAF (Board Assurance Framework). These now both include reference to the NHSE grip and control and HFMA financial sustainability checklists.

On the Finance team and PMO team capacity risk, **AS** highlighted the key mitigation following the management of change which includes additional Finance and PMO capacity. Recruitment has now commenced to fill the vacant posts that are in the new structure for the Finance and PMO Teams.

TMcM queried dates that have now passed in other sections of the BAF. **CS** indicated that a broader discussion will be had when the Exec. and NEDs meet next week and updates to the wider BAF will be raised at that meeting.

For future reporting **TMcM** requested that only BAF risk 2 which pertains to the System Finance Committee is reported at the System Finance Committee meeting alongside the relevant financial risks from the SORR.

The ICB Finance Committee:

- reviewed the current system SBAF and SORR entries related to finance.

Will provide onward assurance through the chairs report to the Board for the risks that fall within the Committee's remit from the BAF and the SORR.

6.0 Minute No. SFC-24-07.006 - ICB M3 ICB Finance update

Report received as read.

6.1 At month 3, the ICB is reporting a £13m year to date deficit, which is a £0.2m favourable variance against the year-to-date plan. **AS** reported that the ICB is ahead of plan at month 3 due to efficiencies delivered ahead of plan phasing including pay slippage following the management of change. Delivery of efficiency ahead of plan has offset a cost pressure specifically around Non-Contracted Activity for Mental Health. **AS** explained Mental Health NCA costs are now included in the risk schedule along with associated mitigations.

AS confirmed that Financial Governance is in place for the ICB efficiency programme, delivery is monitored and tracked through the ICB Sustainability Working Group which reports into the System Financial Improvement Programme as well as Section One Finance Committee.

AS highlighted that the ICB are ranked 5/42 for financial performance against the key financial metrics as reported on the NHSE ISFE dashboard. Looking at the actions required to improve performance against the financial metrics further these include:

- the impact of No PO, no pay policy. Letters will be going out to suppliers to confirm an implementation date of the 1st September 2024.
- Reducing the backlog of CHC invoices. An action plan is in place to address outstanding invoice queries regarding package dates, rates and commissioned care across the Finance and the Individual Commissioning teams.

AS set out that the ICB overall run rate was slightly reduced in June 2024 due to continued pay slippage, it was relatively flat for non-pay programme budgets.

AS highlighted, that there has not been significant change in the recurrent underlying position across the first three months of this financial year.

DB requested if we could get on one chart, a bridge for the current underlying position and a bridge of the changes required to reduce the spend to year end. This will flag what key actions need to be taken to address delivery of the in-year forecast deficit and the underlying recurrent run rate.

***Action: AS** to provide one chart from Month 4, a bridge outlining the changes in the recurrent and non-recurrent spend to year end.*

TMcM queried how pay awards are accounted for. **CS** explained that 2.1% is built into the budget already and the difference in the actual pay uplift % and the 2.1% is expected to be received as an allocation in year.

The ICB Finance Committee:

- noted that the ICB is reporting a £13m year-to-date deficit at Month 2 which is a £0.2m favourable position against the year-to-date plan.

7.0 Minute No. SFC-24-07.007 – ICB M3 Efficiency update

Report received as read.

7.1 **KO** highlighted that the ICB target is £35.8m, which is 6.3% of our underlying recurrent expenditure (excluding delegated budgets and running costs).

KO reported that at month 3, the ICB is reporting £7.9m actual efficiency which is a favourable variance against plan of £1.125m. Over performance is due mainly to non-recurrent benefits/funding, rebates and additional running costs savings received/delivered ahead of plan. This has helped the ICB to identify opportunities against the original plan to reduce the unidentified value from £3.1m to £2.4m.

KO explained that the focus has now moved to reducing the risk on the high-risk schemes. The ICB is now reporting £8.2m of high-risk efficiency programmes. This is

being tracked and monitored through weekly meetings with the Chief Delivery Officer, Director of Finance, PMO and project leads. The impact of this is that high risk schemes have been reduced by £2.9m since last month.

KO highlighted that most of the high risk schemed/programmes are profiled for month 7-12.

KO flagged that since this report has been written, plans have been put in place for the unidentified efficiencies through additional pay slippage and additional elective recovery fund income.

DB stated the performance identified in the report as low risk and medium risk shows a good position compared to other organisational reports. **DB** added that the efficiency plan is a challenging but reasonable stretch given the current financial position.

KO mentioned that PWC are currently reviewing the efficiency plan financial governance and efficiency scheme delivery details to ensure that is robust, and that they can deliver against plan. PWC are expected to report a set of recommendations for the ICB to consider to de-risk the current year efficiency programme.

TMcM stated that we are in a far better place than we were a year ago in relation to efficiency plans and delivery to date. **TMcM** thanked **KO** and asked her to pass on his compliments to the rest of the team.

The ICB Finance Committee:

- Noted the current Month 3 efficiency performance of £7.9m year to date which is £1.125m ahead of plan year to date for information and assurance.

8.0 Minute No. SFC-24-07.008 – Deep Dive Report: NHSE Grip and Control Checklist and HFMA Financial Sustainability Self-Assessment and Action Plan

Report received as read.

8.1 **AS** presented the findings of the ICB Deep Dive Report on the NHSE grip and control checklist. This looks at areas such as financial governance, financial management, procurement, estates, financial services in terms of budgetary management, alignment of finance to people systems, and the associated financial controls that we would expect to see in place. The ICB is showing that 70% of the NHSE financial controls as set out in the NHSE grip and control checklist are already in place with actions to address the remaining 30% by the end of September.

The HFMA financial sustainability checklist, goes into more detail to ensure that we have good financial management in place, such as budget control (signing off budgets) and budget training to ICB staff.

AS reported that last year, 23/24, an assessment was done against the HFMA Financial sustainability checklist, therefore a number of actions were completed last year. Current performance against the checklist has been refreshed this year for 24/25 which includes a refresh of the budget holder training. Overall, the ICB have increased the overall assessment rating from 3.71 last year to 4.375 for this year. Improvements were made in relation to the methodology around forecasting, financial planning and budget setting.

AS explained that actions to be completed by September 2024 include full implementation of the 'no PO no pay' process and final sign off through governance of the draft procurement strategy.

PWC are undertaking an external assessment of the ICB's performance against the grip and control checklist and an update will be provided to the September meeting on the outcome of the external assessment.

DB stated, what is important is the speed and organisation's capability to recognise trends and adverse trends within the information and to act accordingly and that the financial impact of the controls on the current run rate should be reported alongside.

AS clarified that this report is for assurance and will also be shared with the Audit Committee.

DB queried whether there were financial controls within the internal audit cycle for this year. **AS** confirmed that this is covered in the financial sustainability value for money external audit and also as a core component for the financial aspects of the internal audit.

The ICB Finance Committee:

- reviewed and noted the deep dive update on grip and control for assurance and noted the action for an update following the external review in September.

Action: *Update following the external review on ICB Grip and Control to be provided to September Finance Committee.*

9.0 Minute No. SFC-24-07.09 – Capital Plan Update

Report received as read.

9.1 **AS** summarised the key documents within the Capital Plan update, including, the STW 24/25 Joint Capital Plan, Capital Strategy including Capital Prioritisation Framework, and the ICS Infrastructure Strategy Capital template.

AS set out that the Joint Capital Plan appendix is as per the financial plan submitted on the 12th June as approved by the ICB Board and will need to be published on the ICB website by the 31st July 2024 to meet NHSE's requirements and deadline.

AS set out the core components of the Capital Strategy and the Capital Prioritisation Framework which is matched to the delivery of the Triple Aim, core ICS aims in line with the Revenue Strategic Decision-Making Framework.

Lastly **AS** set out that all STW organisations had populated the 10-year capital spend template as required by NHSE to inform the comprehensive spending review, prioritised using the Capital Prioritisation Framework. This is based on the business-as-usual operational capital matched to depreciation funding, national capital schemes approved and the impact of IFRS16 (capitalising operational leases) and estimates for digital capital and estates capital matched to the infrastructure strategy.

AS summarised that for the ICB specifically there are no expected IFRS16 impacts planned, ICB Capital was matched to the expected funding for GPIT and Capital grants. In addition capital expenditure is planned for GP digital maturity, One Central Record Platform and GP premises capital works expected to be funded through other funding routes (council, landlord, GP, S106,CIL).

The ICB Finance Committee:

- Approved the system Capital Strategy inclusive of the Capital Prioritisation Framework.
- Approved the publication of the 2024/25 ICS Joint Capital Plan on the ICB/ICS websites and for onward sharing with NHS England and the Health and Wellbeing Boards.
- Approved the ICB element of the 10-Year Capital Expenditure Plan for submission to NHS England by the 31st July 2024.

10.0 **Minute No. SFC-24-07.10 – Financial Improvement Programme External Support**

Report received as read.

10.1 **AS** reported that the ICB has procured some external support for the Financial Improvement Programme (FIP), this is Phase 1 – Investigation and Intervention which will last for four weeks, currently we are in week three. The work will conclude at the end of next week, 9th August.

AS explained that there are three key areas that the scope of the work will cover. The first is Grip and Control i.e., the work currently being undertaken with the NHSE Grip and Control Checklist and HFMA financial sustainability self-assessment as set out in the deep dive. Secondly a review of efficiencies, reviewing the efficiency plan for this financial year and de-risking the current year plan and building a pipeline of opportunities for the future years, to be included within the medium-term financial plan. Thirdly, a review of financial governance and a review of potential options for a system wide PMO.

The ICB Finance Committee:

- Noted that NHS STW has commissioned external support in-year to assist the assessment of the ICB and System Financial Improvement Programme.

11.0 Minute No. SFC-24-07.11 – A.O.B

There were no items noted for this agenda item.

Meeting closed at 14.59pm

Date And Time of Next Meeting

Thursday 26th September 2024, 11.00 via Teams

NHS Shropshire, Telford, and Wrekin
Integrated Care System Finance Committee (Section 2) Meeting
Tuesday 30th July 2024 at 3.15pm
Via Microsoft Teams

Present:

Name:	**Title:**
Trevor J McMillian OBE (Chair)	Non-Executive Director NHS STW
David Bennett	Non-Executive Director NHS STW
Claire Skidmore (part)	Chief Finance Officer NHS STW
Sarah Lloyd	Chief Finance Officer SCHT
Craig MacBeth	Chief Finance Officer RJAH
Richard Peach (for MB)	Group Accountant T & W Council
Sarfraz Nawaz	Non-Executive RJAH
Helen Troalen	Director of Finance SATH
Richard Miner	Non-Executive SATH
Anthony Simms	Director of Finance SCHT

Attendees:

Sarah Dixon	Improvement Director NHSE
Kate Owen	Head of PMO NHS STW
Angela Szabo	Director of Finance NHS STW
Hadi Raza	Consultant – PWC
Cynthia Fearon	Corporate PA NHS STW (Note Taker)

Apologies:

Peter Featherstone	Non-Executive SCHT
Glenn Head	Deputy Chief Finance Officer MPFT
Clair Young	Deputy Director of Finance – Strategy SATH
Michele Brockway	Interim Director Finance & Human Resources T &W Council
Chris Sands	Chief Finance officer MPFT

1.0 Minute No. SFC-24-07.001 Introductions and Apologies

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

2.0 Minute No. SFC-24-07.002 Members' Declarations of Interests: None.

3.0 Minute No.SFC-24.07.003 Minutes of the Previous Meeting held: Thursday 27th June 2024.

3.1 **TMcM** asked if there were any points to be raised on errors or accuracy within minutes of the previous meeting.

HT made reference to 8.1 in the minutes and asked if the sentence could be re-worded to:
"**CY** stated that SATH completely agree with need to include the assumptions as set out within the HTP case within the approach to the Medium-Term Financial Plan and Recovery Plan approach".

There being no other amendments, the minutes were taken as a true and accurate record.

4.0 Minute No. SFC-24.07.004 Matters Arising and Action List from Previous Meeting

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

5.0 Minute No. SFC-24.07.005 – Finance Risk Register/BAF review

Report received as read.

5.1 **AS** described the changes made to strategic risk 2 on the BAF, delivering sustainable services within available resources. **AS** reported that there have been no changes to the level of risk rating. The system controls have been updated to reflect some of the processes that are now in place.

AS highlighted that teams are currently working to the NHSE Grip and Control Checklist and the HFMA Financial Sustainability checklist in each individual organisation within the system.

AS explained that the narrative in the Strategic Operational Risk Register (SORR) has also been updated to match the BAF in terms of the financial sustainability risk.

AS flagged the risk around capital, which has now been added to the delivery of the 24/25 financial plan risk – i.e. this has been split into capital and revenue. From a capital perspective there is a 10% cap on operational capital in year. In addition, there is a shortfall in IFRS 16 funding which is estimated at around £3m. **AS** added that Shropcom have been unable so far to secure funding for their front line digital project, which was planned to take place this year, this has put additional pressure on to this year's capital.

CM stated that RJAH has also got a forecast pressure on the EPR (Electronic Patient Record) system, which needs a mitigation.

SL made reference to capital plans in-year and suggested that the capital risk should be expanded further beyond in-year. As there is a longer-term impact of restricted capital.

CS joined the meeting.

HT highlighted that the consequences and likelihood outlined in the report are the wrong way around. **HT** flagged 25 on the rating being catastrophic. **HT** encouraged that we should have a unified approach on risk ratings as a System.
This discussion will be picked up outside of this meeting.

***Action: AS** to add reference to RJAH EPR risk to the relevant risk schedule and also work with DoFs to consider the scoring applied to the finance risks in order to align with wider system assessment of finance risk as well as scoring for the rest of the BAF/SORR.*

The System Finance Committee:

- Considered the System BAF and SORR and noted further amendments required to reflect the additional risk for RJAH EPR capital expenditure and the impact of restricted capital budgets across financial years.
- The Chairs report will provide assurance to the Board for the risks that fall within the Committee's remit. This is that the principal risks to the ICS of not achieving the strategic and operational priorities have been accurately identified, reviewed and discussed and that mitigating actions are being taken to manage them.

6.0 Minute No. SFC-24-06.006 M3 ICS Finance update

Report received as read.

6.1 **CS** highlighted that as at month 3, the end of quarter one, the System has a year-to-date deficit of £33.7m, £2m adverse to plan. The drivers are mainly due to industrial action £1.4m at SaTH, and RJAH income for veterans and spec comm ERF income, (both are under discussion with NHSE).

CS reported that without these issues the system would be on plan for quarter one.

CS explained that the main focus is to de-risk the efficiency programme and to ensure that risks to financial performance delivery are mitigated.

SN stated that he was concerned about the level of unidentified efficiency savings and the profiling of the plan across the system towards the end of the year.

KO explained that some progress has been made after the circulation of this report, for example, the ICB has a fully identified plan. SATH have also put forward opportunities to meet the £7m unidentified, so this can now be reported as fully identified.

The System Finance Committee noted:

- that the ICS is reporting a year-to-date actual deficit of £33.7m, which is £2m adverse to plan, £1.4m due to the impact of Industrial Action and £0.7m underperformance on Income at RJAH due to the Veterans service (activity beyond block commissioner contracts) and a specialised commissioning ERF baseline error.

- The risks to delivery of the system capital expenditure limit following the 10% cap, shortfall in IFRS16 allocation funding and frontline digital funding.
- That NHS STW has commissioned external support in-year to assist the assessment of the system's Financial Improvement Programme.

7.0 Minute No. SFC-24-07.007 - M3 ICS Efficiency update

Report received as read.

7.1 **KO** reported that the full year planned efficiencies total £89.7m of which 92**%** (£82.6m) are currently identified. The overall target represents 7.14% of the system total underlying recurrent expenditure.

The month 3 total system position is reporting a positive variance of £0.9m year to date against plan.

KO flagged that there has been over performance in delivery ahead of plan phasing mainly attributed to the timing of the receipt of expected non-recurrent benefits. Significant progress has been made to address the unidentified efficiency gap, which totalled £10.2m on the 12th June 2024. Opportunities have been put forward to meet the £10.2m gap across SaTH and the ICB.

KO highlighted that there is still a focus on de-risking the high-risk programmes that are largely profiled to be delivered from month 7 onwards. Each organisation has financial governance in place including the check and challenge meetings. These meetings have helped immensely to reduce the risk.

KO continues to work with PMO teams across the System to consolidate system efficiency reports.

DM stated that as a system we are not reporting on any cross-system programmes**. KO** responded that we have the UEC programme reporting on UEC efficiencies and the System Medicines Value Programme, both have made successful savings to date. **KO** will aim to make that information clearer in future reports.

TMcM noted that we do appear to be ahead of where we were in the previous year in relation to having schemes worked up but that there is still more to be done.

DB noted that the papers do not seem to render well in pdf (some graphs/tables can't be read) and asked for this to be sorted for future report packs.

***Action: CF** to review reports and work with report owners to ensure that they are legible once converted to pdf.*

The System Finance Committee noted:

- that the month 3 Efficiency Plan is £0.9m ahead of plan year-to-date due to the timing of receipt of expected efficiency benefits.

8.0 Minute No. SFC-24-07.008 - Deep Dive Reports: NHSE Grip and Control Checklist and HFMA Financial Sustainability Self-Assessment and Action Plan

Report received as read.

8.1 **AS** presented the system Deep Dive Report on the NHSE grip and control checklist. The checklist outlines a range of controls, that cover financial governance, financial management, procurement, estates, financial services in terms of budgetary management, alignment of finance to people systems, in order to assess whether the financial controls that we would expect to see are in place.

The HFMA financial sustainability checklist, goes into more detail to ensure that we have good financial management in place, such as budget control (eg signing off budgets) and are providing budget holder training.

AS reported that an assessment was done for 23/24 against the HFMA Financial sustainability checklist, many actions were completed last year. The self-assessment was scored, and RAG rated and also audited in 2023/24. The HFMA financial sustainability checklist has been rescored this year for 2024/25 and has shown an improvement in the overall assessment rating across all individual organisations.

SN stated that he would like to see the outcome of the external review into our system grip and control, what PWC's view on this before agreeing the assurance on this paper.

AS stated, that we are expecting clear recommendations on grip and control from PWC for each organisation and for the system. This can be shared at the next meeting.

***Action: AS** to provide a deep dive update report in September following the publication of the PWC Phase 1 report into Grip and Control.*

The System Finance Committee agreed to:

- receive an update following on from the deep dive report in September which includes an external assessment of Grip and Control across all system organisations.

9.0 Minute No. SFC-24-07.009 - Financial Improvement Programme – External Support Scope

9.1 **AS** reported that the ICB, on behalf of the system, have procured external support for the Financial Improvement Programme (FIP). The consultancy firm that is undertaking this work is PWC. The work is over a four-weeks, PWC are currently in week three of the Investigation and Intervention Phase 1. The work will conclude at the end of next week, 9th August.

AS explained that there are three key areas that the scope of the work will cover. The first is Grip and Control i.e., the work currently being undertaken with the NHSE Grip and Control Checklist and HFMA financial sustainability self-assessment as set out in the deep dive. Secondly a review of efficiencies, reviewing the efficiency plan for this

financial year and de-risking the current year plan and building a pipeline of opportunities for the future years, to be included within the medium-term financial plan. Thirdly, a review of financial governance and a review of potential options for a system wide PMO.

The System Finance Committee:

noted that NHS STW has commissioned external support in-year to assist the assessment of the ICS Financial Improvement Programme.

10.0 Minute No. SFC-24.07.10 - Capital Plan Update

10.1 **AS** summarised the key documents within the Capital Plan update, including, the STW 24/25 Joint Capital Plan, Capital Strategy including Capital Prioritisation Framework, and the ICS Infrastructure Strategy Capital template.

AS set out that the Joint Capital Plan appendix is as per the financial plan submitted on the 12th June as approved by the ICB Board and will need to be published on the ICB website by the 31st July 2024 to meet NHSE's requirements and deadline.

AS set out the core components of the Capital Strategy and the Capital Prioritisation Framework which is matched to the delivery of the core ICS aims in line with the Revenue Strategic Decision-Making Framework.

Lastly **AS** set out that all STW organisations had populated the 10-year capital spend template as required by NHSE to inform the comprehensive spending review, with schemes prioritised using the Capital Prioritisation Framework. This is based on the business-as-usual operational capital matched to depreciation funding, national capital schemes approved and the impact of IFRS16 (capitalising operational leases) and includes estimates for digital capital and estates capital matched to the infrastructure strategy inclusive of energy capital investment.

AS noted, that the ICB had included capital spend for 'One Care Record' and GP premises improvements (the latter with other funding sources assumed via the council/S106/CIL). SaTH had included the Hospital Transformation Programme (HTP) and RJAH their Theatre replacement programme.

The System Finance Committee:

- reviewed and approved the system Capital Strategy inclusive of the Capital Prioritisation Framework.
- approved the publication of the 2024/25 ICS Joint Capital Plan on the ICS website and for onward sharing with NHS England and the Health and Wellbeing Boards.
- supported the submission of the 10-Year Capital Expenditure Plan as proposed in the Infrastructure Strategy Capital Template to NHS England by 31st July 2024.

11.0 Minute No. SFC-24.07.11 Any Other Business

11.1 **TMcM** reminded System partners that it had been agreed previously that copies of their Finance Committee (or equivalent) minutes would be shared with this committee for information. All agreed to share chair's summary papers.

There were no further items raised as AOB.

Meeting closed at 15.31pm

Date and Time of Next Meeting

Thursday 26th September 2024, 12,15pm via Teams

NHS Shropshire, Telford, and Wrekin
ICB Finance Committee (Section 1) Meeting
Thursday 26th September 2024, at 11.00,
Via Microsoft Teams

Present:

Name	**Title**
David Bennett (Chair)	Non-Executive NHS STW
Claire Skidmore	Chief Finance Officer NHS STW
Ian Bett	Chief Delivery Officer
Angela Szabo	Director of Finance NHS STW

Attendees:

Kate Owen	Head of PMO NHS STW
Sarah Dixon	Improvement Director NHSE
Cynthia Fearon	Corporate PA NHS STW (Note taker).

Apologies:

Trevor McMillan	Non-Executive NHS STW

1.0 Minute No. SFC-24-09.001 – Introduction and Apologies

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

2.0 Minute No.SFC-24-09.002 – Declarations of Interests

2.1 No declarations of interest were noted.

3.0 Minute No.SFC-24-09.003 – Minutes from the Previous Meeting held on: 30th July 2024

3.1 Agreed as a true and accurate record.

4.0 Minute No. SFC-24-09.004 Matters Arising and Action List from Previous Meetings

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

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

5.0 Minute No. SFC-24-09.005 - ICB M5 ICB Finance and Efficiency update.

Report received as read.

5.1 **AS** reported that at M5 the ICB is reporting a £22.4m year to date actual deficit which is a £0.4m favourable position against the year-to-date plan.

AS highlighted that the ICB is reporting a positive position with its efficiency plans at month 5 year to date of £2.63m ahead of plan. **AS** added that this is namely due to over performance within the CHC review programme and pay vacancies. The level of 'high confidence' schemes has increased by £1m since last month as additional savings opportunities have been put forward to de-risk delivery in-year.

AS noted, unbudgeted expenditure within Mental Health/Acute and Community Non-Contract Activity, and increased Transforming Care Plan package costs.

AS explained from a cost perspective, there are costs included for the elective recovery fund activity and this will be covered by anticipated elective recovery fund income in year.

AS reported on the overall net risk position which has improved from £9.2m to £4.2m in month. The remaining risk mainly relates to inflationary pressures within CHC and other smaller risks arising within Acute and Mental Health.

DB queried whether the efficiency programme was fully mitigated, the total expected forecast and not just the de-risking of high-risk schemes, as detailed within the report, the gross risk was £9.73m.

KO explained that there are currently seven high risk schemes within the CIP programme which total £7.9m (21% of the total target). The majority of those high risk programmes are profiled to deliver from month seven onwards. **KO** added that programme leads have clear action plans, to help mitigate those risks.

DB stated that it would be better to still include in the unmitigated risk section those elements of high risk that are within CIP that we are not confident on delivery.

DB queried the £4.2m net risk position - how much of that can be realistically fully mitigated? **AS** noted, ongoing work to review the risks for example with drugs and devices given what we know about actual costs billed to date. Also, on elective recovery, this is a sizeable risk which currently has a mitigation tied into the overall System discussion to request a national payment variation for SaTH due to data reporting issues. For the ICB, the largest risks are in prescribing and CHC, though current delivery is on plan up to month five. **AS** said that she was expecting that the gross risk would reduce month on month. The risk for High-Cost Drugs is also expected to reduce based on the fact that, a couple of high-cost drugs were not approved for implementation by NICE from month six onwards as originally anticipated.

DB stated we need to be clear on where we are going to identify additional CIP to mitigate efficiency delivery in-year. **IB** responded that the PWC contract for phase 2 of the intervention work has been recently signed. Within the key deliverables, one is contingent on delivery of our efficiency programme. The work programme includes identifying and helping the System to mitigate scheme risk and also look for potential new schemes.

KO stated that within the medicines management CIP, there is a risk with the appliance programme. However, an additional opportunity to mitigate this has been found. Riveroxiban pricing is likely to bring a further £1m of savings, which will offset the majority of the medicine's efficiency programme risk.

CS agreed along with **AS** to take an action to re-look at how the risk is being reported in the Finance and Efficiency update. In particular, to provide more granularity on the risks and actions to either reduce or mitigate them.

Action: Review how risk is being reported, in particular to provide more granularity on the risks and actions to either reduce or mitigate them.

On the Run rate bridge **AS,** highlighted allocations expected of £15.5m for delegated specialised services and elective recovery fund.

AS explained that there is some non-recurrent spend for mental health, community and acute non contracted activity which is expected to come back to plan for the forecast out-turn, through expected ERF allocations, through actions that have been taken to manage to budget and efficiencies.

AS summarised the pay budget position, there have been vacancies from the outcome of management for change year to date, these will reduce as posts are recruited to and there will therefore be a step up in pay costs.

AS set out that in relation to the ERF baseline calculation, the ICB can replicate the national methodology locally and recognises the values quoted. However, there has been a service change with RJAH and SHROP COM which distorts the national baseline which is adjusted locally for MSK. A specific issue around specialised service ERF has been flagged nationally and locally. The system is currently seeking a resolution for RJAH, this is a technical issue. At the moment, we do not have confirmation of this additional expected ERF income, £0.8m.

AS explained the challenges SATH are having with regard to the Data Warehouse, which has now been picked up as a contract matter and has been shared with NHSE through the System Delivery Meeting.

DB stated that he was impressed with the high percentage of recurrent efficiency delivery. He requested that as well as having the spreadsheet scenarios for efficiency as outlined in the report, he'd like to see an assessment on the best case or worse case outcome alongside a most likely forecast outturn for efficiency delivery.

Action: AS/IB/KO to provide a summary on the best case, worse case and most likely expected forecast outturn for efficiency delivery.

DB flagged that we tend to base the financial update on the individual organisational efficiency schemes. Whereas some of the focus should also be on recognising contributions from transformation work, such as System programmes. **IB** stated that we need to separate system transformation programmes into the medium to long term and give clarity to what they are aiming to do. Alongside the appropriate governance being implemented in place to manage the programmes.

Action: AS/IB/KO to provide an update on the system transformation programmes for efficiency delivery alongside the mitigations/pipeline.

DB added that it would also be good to look at productivity in this meeting. **CS** explained that there is a Productivity Oversight Group up and running now which is specifically working through the national data sets that we have access to as well as our local intelligence. **CS** added that this work also informs the work that **KO** is currently doing to identifying efficiency opportunities. **AS** mentioned, that Productivity is planned to be the next Deep Dive topic for the System Finance Committee scheduled for October 2024.

DB suggested it would be interesting to see what capital schemes provider organisations are considering for future years. **CS** mentioned that the ten-year capital plan was brought to the Finance Committee a few months ago. This is still being developed and worked through. **AS** added that we are also hoping to get further national guidance on the three-year capital plan in the next 2 months, with our intention to produce a medium-term Capital Plan for early next year which will be brought back to Finance Committee for review.

DB also queried the STW element of the Midlands distance from target on Specialised Commissioning Allocations, **CS** stated the STW impact was known and although specialised commissioning budgets were delegated with a risk share in place more work needs to be completed to understand the commitments against the allocation. Currently the ICB holds an uncommitted reserve.

The ICB Finance Committee:

- Noted that the ICB is reporting a £22.4m YTD actual deficit which is a £0.4m favourable position against the year-to-date plan. Unmitigated risk is assessed as £4.2m in month 5, which is a further month on month decrease. The team continue to work on de-risking areas where possible and seeking mitigations for if risks were to materialise.
- Noted that the ICB is reporting efficiencies of £2.63m ahead of plan year-to-date and the work ongoing to de-risk efficiency delivery in-year.

6.0 Minute No. SFC-24-09.006 – Deep Dive Forward Plan

Report received as read.

6.1 **AS** highlighted that this was a resharing of the future pipeline for the Deep Dive going forward.

AS noted, that the paper sets out the forward plan for deep dives which will be shared at each meeting to ensure that it remains live and relevant. At the meeting prior to each deep dive, the finance committee will agree the key lines of enquiry that it would like addressed through the next agenda.

The ICB Finance Committee:

- Reviewed and agreed the Deep Dive Pipeline and confirmed the Ophthalmology topic and KLOEs for the October 2024 meeting.

7.0 Minute No. SFC-24-09.007 – Finance Strategy

Report received as read.

7.1 **AS** highlighted that the System Finance strategy is a key document that sets out the System approach to finance, including the financial recovery trajectory as part of the Medium-Term Financial Plan.

AS explained that the Finance Strategy outlines our vision is to deliver sustainable financial balance across our system. Which will enable us to provide a stable financial environment, to enable safe, high-quality care and support continued improvement and investment in healthcare and outcomes.

AS flagged that the System Transformation Programme was a key element that is not currently included in the Finance Strategy, this point was echoed by **DB**. **AS** confirmed that the system transformation programmes and timelines will form the main basis of the Recovery Plan including the delivery of BAU efficiencies.

AS confirmed that all individual system organisations have been asked to review and comment on the draft document and that a revised version will be brought back to Finance Committee for ratification in February 2024.

CS outlined that changes were still required to the document and that as part of the review process we will consider the contractual financial framework and how we describe that we will use finance differently to support the delivery of the System's Strategic Objectives. This is set in the context of delivering the Labour Mission, the recently published Lord Darzi priorities and how we plan to delegate more to place/providers.

The ICB Finance Committee:

- Received and noted this update on the development of the draft Finance Strategy and Supported the need for continued work on the document ahead of finalisation.

8.0 Minute No. SFC-24-09.008 – Medium Term Financial Plan Update

Report received as read.

8.1 **AS** highlighted that this is the first iteration of the MTFP revenue model. Capital and cash MTFP models are to follow. Future versions of the models will be updated in line with any nationally published operational planning guidance as well as our local demand and capacity modelling. They will also be triangulated with our workforce, performance, and activity models.

DB suggested that scenarios need to be built into future reporting, for example if we were going to break even in two-years' time, what would that look like. **AS** explained that scenarios are built within the MTFP report. The value and percentage of efficiency required to break even over two to three years has been modelled. However, we have not done so far, is connect that back to the transformation programmes to form a clear view on the agreed financial recovery plan trajectory. This work will also require a contribution from clinical, operational and workforce colleagues to test the impact on performance and delivery of the financial assumptions.

The ICB Finance Committee:

- Received and noted the first draft base case MTFP financial model and its working assumptions.
- Noted the ongoing work to refine the system wide demand and capacity model with associated workforce and financial impacts to be modelled and that the MTFP will be further iterated on this basis.
- Noted the ongoing work within the Financial Improvement Programme and Productivity Oversight Group required to develop a multi-year efficiency programme.

9.0 Minute No. SFC-24-09.009 – A.O.B

There were no items noted for this agenda item.

Meeting closed at 12.06pm

Date And Time of Next Meeting

Tuesday 29th October 2024, 14.00 via Teams

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

NHS Shropshire, Telford, and Wrekin
Integrated Care System Finance Committee (Section 2) Meeting
Thursday 26th September 2024 at 12.15pm
Via Microsoft Teams

Present:

Name:	**Title:**
David Bennett (chair)	Non-Executive Director NHS STW
Claire Skidmore	Chief Finance Officer NHS STW
Ian Bett	Chief Delivery Officer NHS STW
Angela Szabo	Director of Finance NHS STW
Sarah Lloyd	Chief Finance Officer SCHT
Tim Davis (for MB)	Finance Manager T & W Council
Helen Troalen	Director of Finance SATH
Richard Miner	Non-Executive SATH
Glenn Head (for CS)	Deputy Chief Finance Officer MPFT
Peter Featherstone	Non-Executive SCHT
Victoria Brownrigg (for CM)	Head of Finance RJAH

Attendees:

Sarah Dixon	Improvement Director NHSE
Kate Owen	Head of PMO NHS STW
Cynthia Fearon	Corporate PA NHS STW (Note Taker)

Apologies:

Trevor J McMillian OBE	Non-Executive Director NHS STW
Michele Brockway	Interim Director Finance & Human Resources T&W LA
Chris Sands	Chief Finance officer MPFT
Sarfraz Nawaz	Non-Executive RJAH
Craig MacBeth	Chief Finance Officer RJAH
Ben Jay	Assistant Director of Finance & ICT – Shropshire LA

1.0 Minute No. SFC-24-09.001 Introductions and Apologies

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

2.0 Minute No. SFC-24-09.002 Members' Declarations of Interests:

None were declared.

3.0 Minute No.SFC-24.09.003 Minutes of the Previous Meeting held: Tuesday 30th July 2024.

3.1 **DB** asked if there were any points to be raised on errors or accuracy within

minutes of the previous meeting. These were agreed as an accurate record.

4.0 Minute No. SFC-24.09.004 Matters Arising and Action List from Previous Meeting

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

5.0 Minute No SFC-24-09.005 M5 ICS Finance update including Efficiency.

Report received as read.

5.1 **CS** explained that the finance update and the efficiency update for this month are merged and that we are reviewing the format for future System Finance Committee meetings.

CS highlighted that at month 5, we are now reporting a System deficit of £56m which is £4.7m adverse variance compared to plan. The key drivers for that variance predominantly reside with SATH, namely due to loss of income as a result of industrial action and efficiency delivery behind plan including escalation.

CS stated that we are currently reporting a forecast of a £89m deficit for this financial year 24/25 in line with plan.

CS explained that as system we are paying close attention to run rate patterns and the changes required to deliver the financial plan, currently there is approximately £40m of net risk, that has not been fully mitigated. This includes SaTH income risk due to their data warehouse issues; risk of not receiving income for Endoscopy and a cost risk as a result of HCA rebanding.

CS reported that as a system we are currently ahead with the efficiency plan delivery which is driven by the ICB position. However, there is still a lot to do for the second half of the year. Although, there is a good proportion of recurrent schemes within the programme, we need to reduce the high-risk schemes and provide mitigations for delivery as required.

Regarding workforce, **CS** noted that we are now seeing sustained improvements in reducing agency costs. **CS** flagged that we are though seeing an increase in terms of Bank expenditure. **CS** explained that as the Trusts recruit permanently to posts, that will reduce the reliance on using Agency and Bank staff.

CS highlighted that more information on capital has been put into this report than in previous months. She stated that her intention is to increase the level of information that we are sharing around the risk in the capital programme. Particularly in relation to IFRS 16, where there is a particular cost pressure in SCHT from taking on services from Dudley and NHSE.

CS flagged that for RJAH there is a overspend for the EPR programme. **CS** added that organisations are doing what they can to internally mitigate those risks, but this was also being picked up in the system Capital Prioritisation Oversight Group meeting.

PF queried, whether this committee would benefit from receiving a collated view on projected WTEs and costs between now and the end of the year. **PF** flagged that

there will be key elements that will be driving spend such as winter pressures. **PF** stated that he would like to see the assumptions that have been made by the respective organisations in terms of workforce profile for the winter months. **CS** responded to say that she is sure there is a slide from one of the other committees that outlines that information that could be shared at this committee.

Action: AS to liaise with the workforce leads on changing the presentation of the workforce slide to include current performance and expected forecast for WTE and £ - showing both current run-rate and changes to the expected forecast.

PF also asked about elective recovery fund and suggested we should receive a deep dive report on that. **AS** proposed to the committee that she review the Elective Recovery Fund detail in the existing pack.

Action: AS to review the ERF slides in the current finance pack for Month 6.

DB mentioned that there had been a discussion in Section One of the Finance Committee Meeting regarding reporting and how to present information in a way that tells the story of what the outturn is likely to be. This then helps the committee to then seek assurance from members about actions and commitment to delivery. **DB** asked that a clearer management view on confidence in delivery be presented in future reports alongside the assessment of scenarios.

DB queried the number that is presented in the report regarding workforce reductions for SATH heading into winter (notable from the significant decline in pay costs). **HT** explained that SATH are keeping a close eye on their WTEs and pay bill. **HT** flagged that SATH have some concerns around bank costs. SATH are actively reviewing their payroll costs as they can see good progress with agency costs and recruitment to permanent roles, but bank costs are exceeding plan.

DB noted that there are a lot of good things happening, but the challenge remains significant to deliver against plan. He added that it will only get more significant as we move closer to the financial year end.

Action: SATH, RJAH, SCHT, ICB to prepare to discuss run rate and confidence in delivering the forecast outturn for their organisation at the next scheduled System Finance Committee.

ID mentioned that PWC would like to meet with each Provider organisation to go through and understand their efficiency plan and expected efficiency delivery forecast.

SL stated that she would be happy to support what has been requested. As SCHT, are currently going through their most likely, worst-case, best-case scenarios with their Finance Committee.

DB asked that the profile of System wide transformation programmes be raised at this meeting. He'd like to see tracking of delivery and benefits (for the System as a whole and individual organisations).

SD stated the more assurance NHSE can get about delivery from each organisation and as a System will be much appreciated.

The System Finance Committee:

- Noted that the ICS is reporting a £56.2m actual YTD System deficit v's £51.5m plan, being a £4.6m adverse variance at M5.
- Noted that there is a positive variance against the month 5 YTD efficiency plan of £2.175m, largely due to ICB individual commissioning efficiencies and pay vacancy slippage.
- Noted the year-to-date capital underspend of £12.4m which is anticipated to be recovered by the end of the year and also the risks flagged with regard to scheme slippage and a shortfall in allocation funding for IFRS16 and RJAH EPR frontline digital.

6.0 Minute No. SFC-24-09.006 - Deep Dive Forward Plan

Report received as read.

6.1 **AS** explained that she had previously presented the Deep Dive schedule and that this is a refresh on the plan going forward. **AS** stated, that we will be looking at Productivity at the October meeting. **PF** noted that it would be helpful to look at the shape of the workforce alongside productivity (ie changes from 2019/20).

AS highlighted this paper sets out the forward plan for deep dives which will be shared at each meeting to ensure that it remains live and relevant. **AS** added that at the meeting prior to each deep dive, the finance committee will agree the key lines of enquiry that it would like to be addressed through the next agenda.

PF and **HT** requested if ERF could be included in the Deep Dive Forward Plan.

DB requested that Planned Care and Discharges be considered for a future agenda.

PF suggested that MSK could also be part of the Deep Dive topic on planned care to look specifically at diagnostics and the constraints around it.

Action: AS to review the deep dive schedule with a view to adding ERF, UEC including discharges and Planned Care (incl MSK and diagnostics).

The System Finance Committee noted:

- the Deep Dive Pipeline, confirming the topic of productivity for the October meeting and suggesting areas of interest for future agendas.

7.0 Minute No. SFC-24-09.007 - Finance Strategy

Report received as read.

7.1 **CS** highlighted that the System Finance strategy is a key document

that sets out the System approach to finance, including modelling of the financial recovery trajectory alongside the Medium-Term Financial Plan.

CS noted that the Finance Strategy has an NHS focus and is an NHS facing document. However, **AS** is currently liaising with Local Authority colleagues regarding their financial position with the intention of making reference to their financial position, risks/mitigations and any other critical interdependencies.

CS reported that this is very much a working document and has already received some feedback from provider DoFs.

CS stated that next steps are to get clinical, operational, workforce and finance colleagues together to discuss the forward plan. Exploring scenarios on how things would or could look in the next couple of years and balancing financial restraints with ambition around performance and service transformation.

PF stated that he would like to see collaborative business cases, where we are doing things together. If we keep doing things in silos, we are going to keep coming up with the same issues. We need to tackle things as a partnership, ring fence investments and share the benefits. He noted that we need some guiding principles within the document on how that can be achieved. **CS** explained that we have tools, such as the Strategic Decision-Making Prioritisation Framework which will help with that.

DB stated that the challenge to deliver break even within three years is unrealistic if we continue to work in the way we are doing today. We need to work out how we are going to work differently. We need to look at collective problem solving across the System as opposed to looking at individual Providers.

Action: Each DoF to review the draft Finance Strategy with their respective Finance Committees and feed back to AS ahead of the next scheduled System Finance Committee.

The System Finance Committee noted:

- This update on the development of the Finance Strategy and the request for organisations to provide feedback to support continued work on the document through to finalisation.

8.0 Minute No. SFC-24-09.008 - Medium Term Financial Plan Update

Report received as read.

8.1 **CS** stated that the Medium-Term financial plan (MTFP) also needs to be refreshed along with the Finance Strategy.

CS explained that this is the first iteration of the latest MTFP revenue model. Capital and cash MTFP models are to follow. Future versions of the models will be updated in line with any nationally published operational planning guidance as well as our local demand and capacity modelling. The MTFP will also be triangulated with our workforce, performance, and activity models.

AS highlighted that the System would need to find £98m savings above the 2.2% 'business as usual' efficiency already contained in the model to reach underlying break even in two years which is what NHSE expect from Systems in deficit. From an efficiency perspective, This would mean a total efficiency target of 6.5% per year.

DB stated that it is important to cross reference the work we are doing on the medium-term plan with performance and quality.

Action: Each DoF to review the Medium-Term Financial Plan document with their respective Finance Committees and feed back to AS ahead of the next scheduled System Finance Committee.

The System Finance Committee:

- Noted the first draft base case MTFP financial model and its working assumptions.
- Noted the ongoing work to refine the system wide demand and capacity model with associated workforce and financial impacts to be modelled and that the MTFP will be further iterated on this basis.
- Noted the ongoing work within the Financial Improvement Programme and Productivity Oversight Group required to develop a multi-year efficiency programme.
- Discussed the impacts and consequences of the proposed recovery plan trajectories alongside varying requirements for efficiency delivery in year in order to inform our planning work and in particular, the focus of the Financial Improvement Programme.

9.0 Minute No. SFC-24-09.009 - Any Other Business

9.1 There were no further items raised as AOB.

Meeting closed at 13.24.

Date and Time of Next Meeting

Tuesday 29th October 2024, 15,15pm via Teams

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

NHS Shropshire Telford and Wrekin System Transformation Group

Minutes of Meeting held in on:
Wednesday 30 October 2024 at 09:30am in Meeting Room 2 at Wellington Civic Offices

Present:	
Simon Whitehouse (Chair)	Chief Executive Officer, NHS Shropshire, Telford and Wrekin
Jo Williams	Chief Executive Officer, The Shrewsbury and Telford Hospital NHS Trust
Stacey Keegan	Chief Executive Officer, The Robert Jones and Agnes Hunt Orthopaedic Hospital
Neil Carr	Chief Executive Officer, Midlands Partnership University NHS Foundation Trust
Patricia Davies	Chief Executive Officer, Shropshire Community Health NHS Trust
Claire Skidmore	Chief Finance Officer, NHS Shropshire, Telford and Wrekin
Nigel Lee	Chief Strategy Officer, NHS Shropshire, Telford and Wrekin
In Attendance	
Julie Garside	Director of Planning and Performance, NHS Shropshire, Telford and Wrekin
Gareth Wright	Head of Clinical Operations, Urgent and Emergency Care (UEC) and Emergency Preparedness, Resilience and Response (EPRR), NHS Shropshire, Telford and Wrekin
Bethan Emberton	Business and Programme Manager, NHS Shropshire, Telford and Wrekin
Ash Patel	PricewaterhouseCoopers International Limited (PwC)
Philip Cockayne	PricewaterhouseCoopers International Limited (PwC)
Jayne Knott	Corporate Executive Assistant, NHS Shropshire, Telford and Wrekin
Apologies	
Ian Bett	Chief Delivery Officer, NHS Shropshire Telford and Wrekin
Andy Begley	Chief Executive Officer, Shropshire Council
David Sidaway	Chief Executive Officer, Telford and Wrekin Council

Minute No. STG 30-10-01 Welcome and Apologies

01.1 The Chair opened the meeting of the System Transformation Group and noted the above apologies.

Minute No. STG 30-10-02 Declarations of Interest

02.1 Members had previously declared their interests, which were listed on NHS Shropshire, Telford and Wrekin's Register of Interests and was available to view on the website at:
https://www.shropshiretelfordandwrekin.nhs.uk/about-us/how-we-are-run/polices-procedures-and-governance/conflicts-of-interest/register-of-interest/

Minute No. STG 30-10-03 Minutes and actions of the previous meeting

03.1 The minutes of the meeting held on 25 September 2024 were presented for approval and agreed as accurate.

03.2 All actions were noted as closed.

Resolve: The Group APPROVED the minutes of the meeting held on 25 September 2024.

Minute No. STG 30-10-04 Risks SBAF and SORR

04.1 Claire Skidmore commented that there had been a discussion at finance committee yesterday.

- Proposal for the Finance Committee to review certain elements of strategic risk, which relates to resources.

- Finance Committee endorsed the change in assessment, and this will be in the next iteration that goes to Board. There was also a challenge from one of NHS Shropshire, Telford and Wrekin's Non-Executive Directors around the risk of not delivering sustainable services within available resources.

04.2 Claire also mentioned changes in the Finance Committee.

- NHS Shropshire, Telford and Wrekin's Non-Executive Director Mr Roger Dunshea has now stepped up as Acting Chair as Sir Neil McKay retires at the end of October 2024
- Professor Trevor McMillan will take over as NHS Shropshire, Telford and Wrekin Audit Committee Chair.
- Mr Dave Bennett will Chair NHS Shropshire, Telford and Wrekin Finance Committee as we go through the transition period.

Minute No. STG 30-10-05 Recovery Support Programme (RSP)

Recovery Support Programme (RSP) Meeting Pack.

05.1 A discussion was held, and it was agreed that:

- The slide pack to be submitted to region by tomorrow morning.
- Agreed attendee list to consist of:
  - NHS Shropshire, Telford and Wrekin - Simon Whitehouse, Claire Skidmore, and Vanessa Whatley.
  - Providers - Andrew Morgan, Jo Williams, Ned Hobbs, Patricia Davies, and Stacey Keegan.

05.2 Slide pack discussed, and it was noted that some amendments were required.

05.3 "Dry run" meeting taking place on Friday with Regional colleagues.

System Integrated Improvement Plan

05.4 Julie Garside introduced the paper and highlighted the following key points.

- Documents will be combined to deliver the System Integrated Improvement Plan (SIIP), the delivery of which will allow both NHS Shropshire, Telford and Wrekin, and Shrewsbury and Telford Hospital NHS Trust (SaTH) to move from National Oversight Framework (NOF) 4 to NOF 3 by the end of March 2026.
- The Group is asked to agree the actions noted above and provide the necessary capacity within their respective organisations to get them completed by the end of this week apart from the SaTH finance action which cannot be completed until week commencing 4th November 2024.
- Once the provider Boards have approved their plans, any feedback should be provided to Julie Garside by close of play 15 November 2024 to enable a final consolidated plan to be ready for the Chief Executives to discuss as required at the national Recovery Support Programme meeting on the 20 November 2024 and for it to be submitted to Board for approval on the 27 November 2024.

05.5 Julie Garside mentioned that she would need to do a read across with SaTH undertakings.

Action: Bethan Emberton to update slides with any amendments and submit to NHS England by lunchtime on Thursday 31st October 2024.

Action: Jo Wiliams to share final version Trust undertakings with Julie Garside.

Minute No. STG 30-10-06 Finance Recovery Programme

06.1 Claire Skidmore updated the group with the following key points.

- Priority is to get the medium-term financial recovery plan signed off by all partners, including NHS England for revenue and for capital.
- Financial improvement meetings scheduled in diaries for next week and the following week. Packs will be issued with prepopulated information.

Minute No. STG 30-10-07 Urgent and Emergency Care (UEC)

07.1 Gareth Wright updated the group with the following key points.

Funded Winter schemes

- Mental Health attendance/avoidance
- Respiratory/COPD in primary care
- Discharge support (British Red Cross)
- Communications campaign
- Patient discharge transport
- Volunteer coordination
- Point of care testing for virtual ward
- Enhance escalation and response
- Temporary use of elective beds over the festive period

Extra Winter Mitigations

07.2 High impact, stretch interventions to address current and anticipated pressure are being produced for options appraisal.

- Expand what we have that works.
- Reinstate assessment areas.
- Generate additional capacity.
- Repurpose of space adjacent to the EDs

07.3 It was note that ahead of the delivery group meeting an options appraisal was required to support decision making.

07.4 It was noted that there is winter visit next Thursday 7 November, and a suggestion made the colleagues engage with peers across the region for their feedback following visits.

07.5 It was noted that the Chair of the Board would potentially request an update for November's board on winter preparedness risk and Urgent and Emergency Care actions.

Action: Gareth Wright and Ian Bett to contact Staffordshire and Stoke on Trent, and Hereford and Worcester to enquire if their winter visit had taken place and lessons learnt.

Action: Jo Williams, Gareth Wright and Ian Bett to prepare a paper for Board on 27 November.

Action: Gareth Wright to update winter plan and discuss with the Chair on Friday 1 November.

Minute No. STG 30-10-08 Workforce and Our People Programme

08.1 Stacey Keegan updated the group with the following key points.

- Meeting with PwC in relation to the grip and control of the vacancy panels.
- Concerns around the disestablished posts and have asked PwC for support.
- Good performance against price cap and seeing improvements.
- People collaborative seeing good work coming out of that.
- First revised people committee has taken place.
- Building relationships with colleges in Shropshire.

Minute No. STG 30-10-09 Governance Programme

09.1 The Chair commented that there is work to be done to align this to the improvement plan and making sure that performance against metrics, milestones and evidence is reported on for the next meeting.

Minute No. STG 30-10-10 Leadership Programme

10.1 The Chair pointed out that Kaine Davidson from Midlands Partnership University Foundation Trust (MPUFT) should be contacting system partners to have individual conversations around leadership. It was noted that Dr Lorna Clarson will be the Executive lead for the leadership transition criteria.

Minute No. STG 30-10-11 Elective Care and Diagnostics Programme

11.1 Stacey Keegan noted the following:

Elective

- Long waits with some improvement at SaTH
- Significant risk at The Robert Jones and Agnes Hunt Orthopaedic Hospital (RJAH) with mutual aid.
- Getting It Right First Time (GIRFT) leads, and spinal leads are positive.
- Looking to ask NHS England for support around mutual aid.

Diagnostics

- Deep dive plan for Novembers planned care board.
- Concerns around reporting.
- Community Diagnostic Centre (CDC) 2 – work to try and get to where there is additional funding.
- Referral assessment service, evaluation of options appraisal.
- MSST governance – work underway to look at pathways and where they sit. To be presented at Novembers planned care board. Then update the Group at next meeting.
- Complaints and incidents from all providers to be pulled tother in one place as concerns that these are not being shared across the system.

Minute No. STG 30-10-12 System Programme Management Office (PMO) (PwC)

12.1 PricewaterhouseCoopers International Limited (PwC) presented the paper and highlighted the following key areas.

- The main approach was to do a standardised assessment of each of the six Programme Management Offices (PMOs) across the system.
- Assessed them all against a standardised review criterion.
- The system has approximately 41 whole time equivalents of improvement type resource at its disposal within existing frameworks - 18 that are predominantly within a financial recovery type role, and approximately 23 working in more operational quality improvement roles, predominantly within RJAH PMO team.
- Key observations from the report are:
    - Wide variety of structures in place across the system with no standardised use of technology or templates.
    - Inconsistencies regarding the governance and how different schemes have been approved i.e. stretch opportunities within SaTH.
- PwC propose a single standardised centralised approach to delivering a PMO which will enable the way we effectively take all of the inconsistencies and the different types of reporting that there is across the system.

12.2 Patricia Davies pointed out inaccuracies in the pack (slide 5) around resource available for PMO which included all management accountants in addition to the PMO which is inaccurate.

12.3 It was suggested that one organisation hosts this piece of work and that a final decision would be made at the next meeting following updated proposal from PwC.

Action: PwC to revise draft report/slides and re-present an updated set of decisions and actions to be considered at future meeting for CEO sign off.

Minute No: STG Minute No. STG 30-10-13 – Any Other Business

13.1 It was agreed to add Provider Collaborative Shared Services Programme to next Chief Executive Officers (CEOs) agenda.

The Chair closed the meeting at 12:15pm.

Agenda Item

ICB 27-11.094

System Transformation Group Chair's Report

Appendix 1 - System Transformation Group Minutes -30 10 24

Agenda Item

ICB 27-11.097

Shropshire Integrated Place Partnership Committee

Appendix 1 - ShIPP Committee ToR - Report

SHROPSHIRE INTEGRATED PLACE PARTNERSHIP COMMITTEE(ShIPP)
Report

Meeting Date	**17.10.2024**			
Title of Report	**ShIPP Committee Terms of Reference Final Draft**			
Reporting Officer (Please include email address)	Penny Bason Penny.bason@shropshire.gov.uk			
Which strategic ShIPP priorities does this paper address? Please tick all that apply	Children & Young People	x	Community Capacity & Resilience with the VCSE	x
	Mental Health	x	Local Care and Person-Centred Care (incl. involvement)	x
	Healthy Weight & Physical Activity	x	Supporting Primary Care Networks	x
	Workforce	x	Integration & Better Care Fund	x
	Tackling health inequalities	x		
What inequalities does this paper address? **How has safeguarding been considered?**	All of ShIPP workstreams must support the reduction of inequalities and use data, intelligence and the voice of local people to inform decision making.			
In the development of this work who has been involved?	System Partnership Committee	**ShIPP** **ShIPP Subgroup**		
	Voluntary Sector			
	Other Individuals	**ShIPP membership and associated partners**		

1. Executive Summary

ShIPP is now a formal Committee of Shropshire, Telford & Wrekin Integrated Care Board – a change in role to support agreeing, directing, driving and assuring delivery of community centred health and care integration at place.

Attached, in Appendix A, is the Final Draft Terms of Reference (ToR) for approval.

2. Report Recommendations

1. ShIPP Committee approve the final DRAFT Terms of Reference.

Updated 10.07.23

3. Main Report

The new Shropshire Integrated Place Partnership Committee (ShIPP) has evolved from the Shropshire Integrated Place Partnership that was created in 2022.
ShIPP is now a formal committee of the Shropshire, Telford & Wrekin Integrated Care Board and as such it is accountable to the ICB.
ShIPP aligns strategy with the ICB and continues to align with the Shropshire Health and Wellbeing Board.

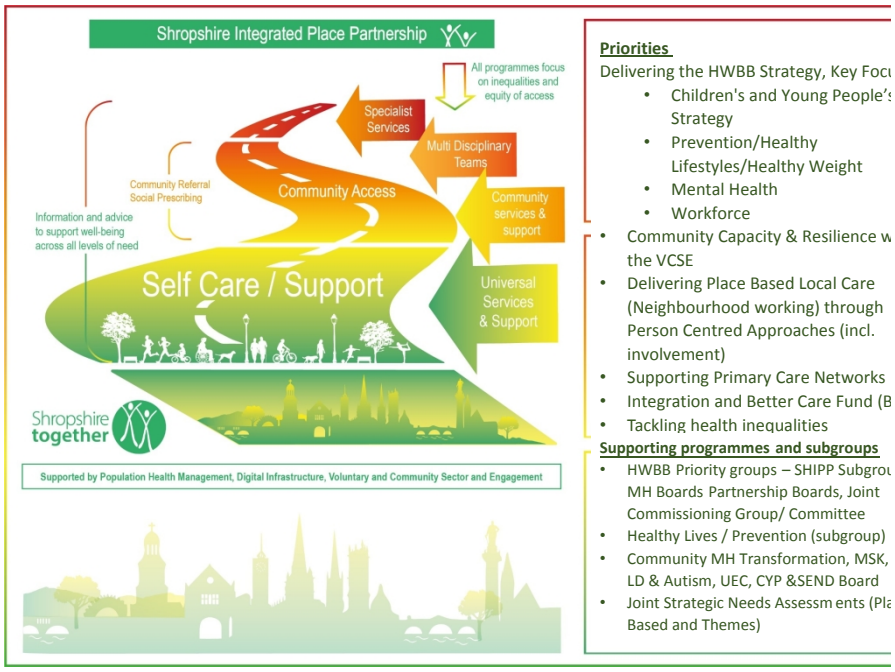
As outlined in the new ToR:

ShIPP is authorised by the ICB Board to:

- Oversee the delivery of key priorities of thematic partnership boards
- Work with the ICB and Health and Wellbeing Board to agree key priorities for community centred health and care in Shropshire
- Create task and finish groups or working groups to develop and deliver action plans to deliver the agreed priorities for community centred health and care in Shropshire
- Assure that locally designed and delivered services deliver the agreed outcomes
- Assure programme activities are delivered within agreed timescales
- Assure requirements for additional activities are highlighted
- Ensure risks are discussed and mitigations sought

Upon agreement of delegation from the ICB these authorisations above will be expanded to include delegated responsibilities as they are agreed.
The priorities of ShIPP are outlined below, and for 24/25 it is not recommended that they change, as they align with the ICB and the HWBB.
As per the September meeting, the Strategic Plan has been updated in line with the ToR.
It is recommended that the ShIPP subgroup continue as a subgroup of the ShIPP Committee to drive forward neighbourhood working.

Priorities
Have remained largely unchanged for 2024/25
And there will be a focus on operational delivery



Updated 10.07.23

The proposed membership of the Committee is outlined in the ToR.

Conclusion:

The Governance of the Place Partnerships as Committees of the ICB will continue to evolve. The updated Terms of Reference is a step toward delegated authority and new ways of working. It is expected that in partnership, the ShIPP membership will discuss and make recommendations for updates and agreement. It is also anticipated that updates to the ToR and the Strategic Plan will occur as a result of our annual workshop in the Spring 2025.

Risk assessment and opportunities appraisal (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)

Risks are routinely highlighted as a result of ShIPP business.

Financial implications (Any financial implications of note)
None as a direct result of this report

Appendices
Appendix A – New ShIPP Terms of Reference

Appendix A

Shropshire Integrated Place Partnership Committee

Terms of Reference

1. Our Vision

HWBB Vision: *For Shropshire people to be the healthiest and most fulfilled in England*

SHIPP vision:

"Working together to ensure people in Shropshire are supported to lead healthy, fulfilling lives."

2. Constitution and Authority

2.1. Shropshire Integrated Place Partnership Committee (ShIPP) has evolved from the Shropshire Integrated Place Partnership that was created in 2022.
2.2. ShIPP is a formal committee of the Shropshire, Telford & Wrekin Integrated Care Board and as such it is accountable to the ICB.
2.3. ShIPP aligns strategy with the ICB and the Shropshire Health and Wellbeing Board.
2.4. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of ShIPP and may only be changed with the approval of ShIPP and its Chair.
2.5. Where appropriate ShIPP will also interface and work with the:
  2.5.1. Joint Health Overview and Scrutiny Committee (and other Shropshire Council Committees as and when appropriate),
  2.5.2. Shropshire Health & Wellbeing Board; and
  2.5.3. Shropshire Safeguarding Children and Adult Boards.
2.6. ShIPP is authorised by the ICB Board to:
  2.6.1. Oversee the delivery of key priorities of thematic partnership boards
  2.6.2. Work with the ICB and Health and Wellbeing Board to agree key priorities for community centred health and care in Shropshire
  2.6.3. Create task and finish groups or working groups to develop and deliver action plans to deliver the agreed priorities for community centred health and care in Shropshire
  2.6.4. Assure that locally designed and delivered services deliver the agreed outcomes
  2.6.5. Assure programme activities are delivered within agreed timescales
  2.6.6. Assure requirements for additional activities are highlighted
  2.6.7. Ensure risks are discussed and mitigations sought

2.7. Upon agreement of delegation from the ICB this section will be expanded to include the delegated responsibilities.

3. ShIPP Principles

Updated 10.07.23

3.1 Work together to develop and deliver the ShIPP Strategic Plan.

3.2 Take a person-centred approach to all that we do; celebrating and responding to the diversity within our population.

3.3 Ensure all programmes involve local people and embed coproduction in all planning.

3.4 Take a Population Health Management approach to all transformation.

3.5 Recognise the importance of system thinking for all ages and families, ensuring that inequalities are addressed from pre-birth.

3.6 Highlight opportunities for system working, at scale, across STW.

3.7 Value and support the community and voluntary sector and consider how the voluntary sector can work alongside statutory services to reduce inequalities.

3.8 Make decisions that shift resources to preventing ill health and wellbeing and that work to reduce inequalities across our communities.

3.9 Use digital resources to remove geographical barriers to place based working.

4. Membership and Attendance

Organisation	Representative	Title/Role
Shropshire Council	Andy Begley	Chief Executive and Chair of ShIPP
	Rachel Robinson	Executive Director of Health and Wellbeing, deputy Paula Mawson, Assistant Director
	Tanya Miles	Executive Director of People (Adults and Children), Deputy Laura Tyler
	Laura Fisher	Head of Housing
Lived Experience Representative	*Representatives to be identified to ensure that programmes of ShIPP and reported to ShIPP have appropriate citizen representation through their development and delivery (through either Patient Participation Group or Making it Real Board and other expert by experience groups); 2 representatives will ensure availability for the meeting*	
Voluntary, Community and Social Enterprise Sector	Julie Mellor	Voluntary and Community Sector Assembly Representative
Healthwatch	Lynn Cawley	Chief Executive
NHS Shropshire, Telford & Wrekin	Claire Parker	Director of Strategy and Development, deputy Emma Pyrah, Head of System Development
	Gemma Smith	Director of Strategic Commissioning
	Lorna Clarson	Chief Medical Officer
	Sharon Fletcher	Deputy Director Quality
	Deborah Shepherd	GP Partner Member

Updated 10.07.23

5 Primary Care Networks (PCNs) - expectation that 2 reps to attend and provide PCN input	Jess Harvey	Clinical Director SE Primary Care Network
	Simon Jones / Nick VonHirschberg	Clinical Director North Primary Care Network
	Charlotte Hart	Clinical Director Shrewsbury Primary Care Network
	Deborah Shepherd	Clinical Director SW Primary Care Network
	Daniela Puiu/Katy Lewis	Clinical Director Shropshire Rural PCN
Shrewsbury and Telford Hospital NHS Trust	Carla Bickley	Associate Director of Strategy & Partnership
	Dr Jenni Rowlands	Deputy Medical Director (or appropriate clinical lead)
Shropshire Community Health NHS Trust	Patricia Davies	Chief Executive, deputy Steve Ellis Chief Operating Officer
Midlands Partnership Foundation NHS Trust	Cathy Riley	Managing Director Shropshire, Telford & Wrekin Care Group, deputy Paul Bowers
Robert Jones and Agnes Hunt Orthopaedic Hospital	Mike Carr	Deputy Chief Executive and Chief Operating Officer, deputy Geraldine Vaughn, programme support for MSK

Officers in Attendance

Organisation	Representative	Title
Shropshire Council	Penny Bason	Head of Joint Partnerships
	Louisa Jones	Business Support
TBA	TBA	System Finance Lead
ICB	Strategy Team with Rachael Jones	System Strategy and Communication and Engagement link
ICB	Emma Pyrah	Head of System Development, Deputy Fiona Smith

Other members may be co-opted by the Partnership as required. System partners may attend the group as needed or by request.

5. Role of Members

5.1 Chair

5.1.1 The Chief Executive of Shropshire Council will Chair the Board.

5.1.2 The Executive Director of Health and Wellbeing, Shropshire Council will deputise

5.2 Role and behaviours of members

5.2.1 As a collective ShIPP members will ensure that the principles of ShIPP and its purpose are championed throughout the Integrated Care System and in their own organisations.

5.2.2 ShIPP members will work collaboratively on all aspects of work including:

- Seeking to release resource to contribute to the development and delivery of plans to deliver key ShIPP priorities;
- Across our statutory duties to achieve best outcomes for local children, young people and adults;
- Looking at all opportunities to pool resources to improve outcomes for local people;
- Sharing information, experience and resources to identify solutions, eliminate duplication of effort, mitigate risk and reduce cost;
- Developing the workforce in line with the ShIPP priorities and person centred approaches;
- Sharing intelligence to achieve the ShIPP priorities;
- Monitoring progress using high level metrics to understand system improvement;
- Using the Joint Strategic Needs Assessments and data to drive decision making.

5.1.2 Ensure that all that we do in terms of development adopts a person-centred, preventative, strengths and community asset-based approach to transformation and delivery.

5.1.3 Learn from people of all ages who experience our services and best practice of partner organisations, and/or other areas, and seek to develop as a partnership to achieve the full potential of the relationship.

5.1.4 Resolve issues of difference positively and professionally, throughout the meetings and through subgroups.

5.1.5 Utilise the agreed branding when presenting about the integration work (internally and externally).

5.1.6 During online meetings members should have their cameras on to promote and foster good communication and engagement.

6 Meeting Quoracy and Decisions

6.1 Meetings

6.1.2 The Group will meet on a bi-monthly basis and arrangements for meetings will be made in accordance with the ICB's Standing Orders.

6.1.3 Additional meetings may take place as required.

6.1.4 The Board or Chair may ask ShIPP to convene further meetings to discuss particular issues as and when needed.

6.1.5 ShIPP may meet virtually or face to face. If ShIPP meet virtually the meeting will be recorded. Members will be asked to have their camera on. Members will also be asked to use the chat function appropriately, including not having separate conversations.

6.2 Quorum

6.2.2 For a meeting to be quorate there must be at least four members of different organisations present.

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

6.2.4 If the quorum has not been reached, then the meeting either may be postponed until the meeting can be quorate or the meeting may proceed if those attending agree, but no decisions may be taken.

6.2.5 Decisions deemed by the Chair to be 'urgent' can be taken outside of the meeting via email communication, and with the agreement of a quorate number of members. Where this happens, the decision made in this way must be reported to the next meeting to ensure it is captured in the minutes.

6.3 Decision Making and Voting

6.3.2 Decisions will be taken in accordance with the ICB's Standing Orders. ShIPP will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

6.3.3 Only members of ShIPP may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

6.3.4 Where there is a split vote, with no clear majority, the Chair of ShIPP will hold the casting vote or propose a way forward.

7 Reporting

7.1 The Chair of ShIPP is the conduit for reporting to and receiving updates and requests from the ICB Board and the Health and Wellbeing Board (and other Boards as required).

7.2 The Chair's report of ShIPP will be shared with the ICB Board to provide updates on activity and risks.

8 Conflicts of Interest

8.1 ShIPP will maintain a standing register, as per any other corporate decision-making body. In advance of any meeting of ShIPP, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals.

8.2 At the beginning of each meeting of ShIPP, members and attendees will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declaration will be formally recorded in the minutes for the meeting. Members must ensure that they continue to comply with relevant organisational policies / guidance.

9 Review

In view of the rapidly evolving nature of our health and social care system, these Terms of Reference will be reviewed in six months ().

Updated 10.07.23

Version control

Version	Date	Author	Comments
DRAFT 1.0	13.09.2024	P. Bason	Review and re-write of TOR
DRAFT 1.1	16.09.2024	P. Bason	Update following first DRAFT review with Chair
DRAFT 1.2	1.10.2024	P. Bason	Update following ShIPP and ShIPP Subgroup, second DRAFT
DRAFT 1.3	15.10.2024	P. Bason	Update following second draft comments.

Agenda Item

ICB 27-11.098

Telford and Wrekin Integrated Place Partnership Committee Chair's Report

Appendix 1 - TWIPP 07.11.2024 – Agenda

Appendix 2 - TW Integrated Place Partnership Committee - TOR - FINAL Oct 24

Appendix 3 - TWIPP priority pack - November 2024

Integrated Care System
Shropshire, Telford and Wrekin

AGENDA

Meeting Title	Telford & Wrekin Integrated Place Partnership (TWIPP)	**Date**	07.11.2024
Chair	David Sidaway	**Time**	14:30 – 16:00
Minute/Action Taker	Sarah Downes	**Venue/ Location**	Wellington Civic, Room 1.

A=Approval R=Ratification S=Assurance D=Discussion I=Information

Ref	Agenda Item	Presenter	Purpose	Paper	Time
TWI07/10 /24 – 01	Welcome, Introduction and Apologies	Chair	N/A	N/A	1 min
TWI07/10 /24 – 02	Declarations of Interest	Chair	N/A	N/A	2 mins
Priority Focus: Healthy Ageing					
TWI07/10 /24 – 03	**What's the current position and what's happening now?** a) STW Healthy Ageing (Frailty) Strategy b) STW Acute Frailty programme c) Implementing the Ageing Well Strategy and Ageing Well Partnership d) Community falls prevention approach	Anna Morris, NHS STW Alison Massey, NHS STW Leeona Marsh, TWC Rachel Threadgold / Louise Mills, TWC	D	Presentations to be shared after the meeting	30 mins
TWI07/10 /24 – 04	**Discussion opportunity for members looking at:** a) Where are the gaps in what we've heard? b) What and where are the opportunities?	Sarah Downes	D	N/A	30 mins

	c) What are the priority actions that TWIPP should focus on? *(Group discussions with feedback)*				
TWI07/10 /24 - 05	**Plenary** *(inc if this approach worked)*	Chair / Vice-Chair	A	N/A	15 mins
Other business					
TWI07/10 /24 – 06	GP Out of Hours Procurement Update	Gemma Smith	I	Verbal	2 mins
TWI07/10 /24 – 07	Topic for the next meeting	Chair	D	Verbal	5 mins
TWI07/10 /24 – 08	Areas of risk identified and escalation needs	Chair	S	N/A	2 mins
TWI07/10 /24 – 09	Any Other Business	All	I	Verbal	3 mins
For information					
TWI07/10 /24 – 10	Minutes from last meeting 12.09.2024	N/A	I	Attached	N/A
Next Meeting Details					
9 January 2025, 1.30-3pm at Wellington Civic, Room 1					

Telford & Wrekin Integrated Place Partnership

(Committee of Shropshire, Telford and Wrekin Integrated Care Board)

Terms of Reference

1. Constitution and Authority

1.1. Telford and Wrekin Integrated Place Partnership Committee (TWIPP) has evolved from the Telford & Wrekin Integrated Place Partnership that was created in 2019.

1.2. TWIPP is a formal committee of the Shropshire, Telford & Wrekin Integrated Care Board (ICB) and as such it will deliver delegated ICB functions when formalised.

1.3. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of TWIPP and may only be changed with the approval of TWIPP and its Chair.

1.4. Where appropriate TWIPP will also interface and work with the:

1.4.1. Joint Health Overview and Scrutiny Committee (and other Telford & Wrekin Council Scrutiny Committees as and when appropriate),

1.4.2. Telford and Wrekin Health & Wellbeing Board;

1.4.3. Shropshire, Telford & Wrekin Integrated Care Board committees and groups, including but not limited to the Quality and Performance Committee and Population Health; and

1.4.4. Telford & Wrekin Safeguarding Children and Adult Boards.

1.5. **Authority**

TWIPP is authorised by the ICB Board to:

- Oversee the delivery of key priorities of thematic partnership boards
- Agree key priorities for community centred health and care in Telford and Wrekin
- Create task and finish groups or working groups to develop and deliver action plans to deliver the agreed priorities for community centred health and care in Telford and Wrekin

Upon agreement of delegation from the ICB this section will be expanded to include the delegated responsibilities.

2. Our Vision

"Working together for children, young people and adults in Telford and Wrekin to enable them to enjoy healthier, happier and more fulfilling lives"

3. Purpose

3.1. The purpose of the Telford and Wrekin Integrated Place Partnership Committee (TWIPP) is to agree and drive the delivery of proactive, preventative, high quality community centred health and care integration at place.

3.2. Using population health intelligence and feedback from local residents, TWIPP will have a key focus upon reducing health inequalities, improving place-based proactive prevention and delivering seamless, accessible, safe, high quality community centred health and care services for all Telford and Wrekin residents.

3.3. TWIPP will understand how effectively the improvements in quality and safety within Telford and Wrekin are being driven forward. This is aligned to the quality statements set out by the Health and Care Act in 2022 and outlined in the CQC Integrated Care System Assessment process.

Upon agreement of delegation from the ICB this section will be expanded to include the delegated responsibilities.

4. TWIPP Principles and Responsibilities

4.1. TWIPP has an agreed set of principles to help it achieve its priorities. These align with principles of the Integrated Care Strategy, as well as from all member organisations and are adapted from the Local Government Association's Six Principles to achieve integrated care[1].

4.1.1. **A person-centred approach** - All partners plan and deliver care and support with individuals and, where they wish, with their families, to achieve the best health and wellbeing outcomes. Co-production is a core principle, ensuring that the people who use services are at the centre of design and delivery of services. Ensuring that seldom heard groups and those experiencing inequalities are also included.

4.1.2. **A proactive preventative, assets-based population health approach** that maximises health and wellbeing, independence, and self-care in or as close to people's homes as possible in order to reduce their need for health and care services. This will improve health and wellbeing for all, including addressing inequalities and the wider determinants of health. Using engagement with people and communities to find out if change is working.

4.1.3. **Collaborative local leadership with a shared vision, culture and values** to support transformation. All TWIPP members / partners are respected and valued and discussions are open and honest. They contribute and support the development and delivery of plans to deliver TWIPP priorities and support the contributions of other members / partners. All members communicate regularly within their own organisations and networks to promote the work and priorities of TWIPP.

4.1.4. **Subsidiarity** – the Board and TWIPP are committed to making decisions at the most local level, as close as possible to the communities that they affect. Accountability mechanisms will build on existing structures. Governance structures are open, transparent and locally accountable.

4.1.5. **Building on what already works and learning from others** - where areas are working effectively, learn from them, build on them and scale up. TWIPP is enabled to develop

[1] https://www.local.gov.uk/six-principles-achieve-integrated-care

neighbourhood level approaches according to what is appropriate for them, rather than adhering to a rigid national or system blueprint. Empower organisations to be innovative, collaborative and maximise digital opportunities.

4.1.6. **Achieving best value and sustainability** – All members and partners work together to ensure that the delivery of priorities represents the best value, including, of securing the best possible health and wellbeing outcomes using safe and high-quality services, while ensuring the sustainable use of resources.

5. TWIPP Outcomes

TWIPP's current priorities are:

1. Supporting General Practice by working together to reduce and manage demand for GP services/appointments
2. Improving all-age mental health provision (prevention, early intervention and specialist services)
3. Preventing, reducing and delaying frailty (with a focus on healthy ageing)

The outcomes TWIPP will achieve will be defined by each priorities area within their Programme Initiation Documents.

In addition to its priority areas, TWIPP will:

- Work with the system to devolve decision making and resources to place and neighbourhood where appropriate;
- Act in an oversight capacity for the Better Care Fund Board, the Ageing Well Partnership, the Mental Health Partnership, Learning Disability Partnership, Autism Partnership and Children, Young People and Families Board. This will include at least annual updates to TWIPP along with providing where needed an escalation route.

6. Role of Members

6.1. As a collective TWIPP members will ensure that the principles of TWIPP and its purpose is championed throughout the Integrated Care System and in their own organisations.

6.2. TWIPP members will:

6.2.1. Ensure that all that we do in terms of development adopts a person-centred, preventative, strengths and community asset-based approach to transformation and delivery.

6.2.2. Work collaboratively on all aspects of work including:

- Seeking to release resource to contribute to the development and delivery of plans to deliver key TWIPP priorities;
- Across our statutory duties to achieve best outcomes for local children, young people and adults;
- Looking at all opportunities to pool resources to improve outcomes for local people
- Sharing information, experience and resources to identify solutions, eliminate duplication of effort, mitigate risk and reduce cost
- Developing the workforce; and
- Sharing intelligence to achieve the TWIPP priorities.

6.2.3. Learn from people of all ages who experience our services and best practice of partner organisations, and/or other areas, and seek to develop as a partnership to achieve the full potential of the relationship.

6.2.4. Resolve issues of difference positively and professionally.

6.2.5. Utilise the agreed branding when presenting about the integration work (internally and externally).

7. Membership and Attendance

7.1. Attendees

Organisation	Representative	Title/Role
Telford & Wrekin Council	David Sidaway	Chief Executive and Chair of TWIPP
	Cllr Paul Watling	Lead Cabinet Member for Adult Social Care and Health Systems and Telford and Wrekin Resident's Champion
	Cllr Shirley Reynolds	Lead Cabinet Member for Children, Young People, Education, Employment & Skills
	Jo Britton	Executive Director of Children and Families (Statutory DCS)
	Fliss Mercer	Executive Director for Adult Social Care, Housing and Customer Services
	Simon Froud	Director of Adult Social Care (Statutory DASS)
	Helen Onions	Director of Health and Wellbeing (Statutory DPH)
Lived Experience Representative	*Representatives to be identified (potentially through Making it Real Board and other expert by experience groups)*	
Voluntary, Community and Social Enterprise Sector	Louise Cross and Richard Nuttall	Co-Chairs of Chief Officer Group
Healthwatch	Simon Fogell	Chief Executive
NHS Shropshire, Telford & Wrekin	Claire Parker	Director of Strategy and Development
	Gemma Smith	Director of Strategic Commissioning
	Lorna Clarson	Chief Medical Officer *(also responsible for Primary Care in ICB)*
Primary Care Networks (PCNs)	Dr Ian Chan	TELDOC PCN Clinical Director
	Dr Derrick Ebenezer	Wrekin PCN CD
	Dr Stefan Waldendorf	Newport/Central PCN CD
	Dr Nitin Gureja	South East Telford PCN CD
Shrewsbury and Telford Hospital NHS Trust	Carla Bickley	Associate Director of Strategy & Partnership
Shropshire Community Health NHS Trust	Steve Ellis	Deputy Director of Operational Service Development
Midlands Partnership Foundation NHS Trust	Cathy Riley	Managing Director Shropshire, Telford & Wrekin Care Group
Robert Jones and Agnes Hunt Orthopaedic Hospital	Mike Carr	Deputy Chief Executive and Chief Operating Officer
Shropshire Partners in Care	David Crosby	Chief Officer

7.1.1. Only members of TWIPP have the right to attend Committee meetings, but the Chair or Vice Chair may invite relevant staff to the meeting as necessary in accordance with the business of TWIPP.

7.1.2. The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of matters.

7.1.3. Members are expected to attend 75% of meetings held each calendar year.

7.2. **Chair and Vice Chair**

7.2.1. The Group will be chaired by the Chief Executive of Telford & Wrekin Council.

7.2.2. In the event of the Chair being unable to attend, the Executive Director of Adult Social Care, Housing and Customer Services at Telford & Wrekin Council will chair the meeting as the Vice Chair.

7.2.3. In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number to Chair the meeting.

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

8. Meeting Quoracy and Decisions

8.1. **Meetings**

8.1.1. The Group will meet on a bi-monthly basis and arrangements for meetings will be made in accordance with the ICB's Standing Orders.

8.1.2. Additional meetings may take place as required.

8.1.3. The Board or Chair may ask TWIPP to convene further meetings to discuss particular issues as and when needed.

8.1.4. TWIPP may meet virtually or face to face. If TWIPP meet virtually the meeting will be recorded.

8.2. **Quorum**

8.2.1. For a meeting to be quorate there must be at least three members of different organisations present.

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8.3. **Decision Making and Voting**

8.3.1. Decisions will be taken in accordance with the ICB's Standing Orders. TWIPP will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

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9. Reporting

9.1. The Chair of TWIPP is the conduit for reporting to and receiving updates and requests from the Board.

9.2. The Chair's report of TWIPP will be shared with Board to provide updates on activity and risks.

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10.2. At the beginning of each meeting of TWIPP, members and attendees will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declaration will be formally recorded in the minutes for the meeting. Members must ensure that they continue to comply with relevant organisational policies / guidance.

10.3. The Chair of TWIPP will determine how declared interests should be managed, which is likely to involve one the following actions:

10.3.1. Requiring the individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to TWIPP decision-making arrangements.

10.3.2. Allowing the individual to participate in the discussion, but not the decision-making process.

10.3.3. Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to TWIPP decision-making arrangements.

11. Meeting Support

11.1. The meeting will be supported by Assurance & Integration Programme Manager and Telford and Wrekin Place Lead.

11.2. The meeting will be serviced by a Secretariate or a member's PA and will operate using the following principles:

11.2.1. Agenda items will be sought from the members of The Group 14 days prior to the meeting.

11.2.2. The Chair will agree the final agenda.

11.2.3. Papers will be circulated 5 working days before each meeting.

11.2.4. Additional items for the agenda will be taken by exception with the knowledge and agreement of the Chair in advance of the meeting commencing.

11.2.5. The minutes of each meeting will be circulated within 10 working days of the meeting being held and will be ratified at the following meeting.

11.2.6. All correspondence will be through TWintegratedplacepartnership@telford.gov.uk

11.3. A chair's report will be created from the minutes.

Version control

Version	Date	Author	Comments
DRAFT 0.1	19.08.2024	S. Downes	Review and re-write of TOR
DRAFT 0.2	23.08.2024	S Downes	Amended following comments from FM
DRAFT 0.3	30.08.2024	S Downes	Amended following comments from JB and system meeting parameters
FINAL DRAFT	26.09.2024	S Downes	Amended following feedback from TWIPP members (see minutes for more detail). Sent to Vice Chair for final check before finalising as per agreement at TWIPP on 12/09/2024.
FINAL	03.10.2024	S Downes	Finalised following agreement from Vice-chair

Telford & Wrekin Integrated Place Partnership (TWIPP)

Priority Pack

Sarah Downes, Telford & Wrekin Place Lead
Sarah.downes@telford.gov.uk

Priority areas for 2024-2026

1. **Supporting General Practice** by working together to reduce and manage demand for GP services/appointments

2. **Improving all-age mental health services and support** (prevention, early intervention and specialist services)

3. **Healthy Ageing - preventing, reducing and delaying frailty**

Sources of evidence:

- JSNA
- STW Big Conversation 2023
- NHS GP Experience Survey
- Healthwatch Telford and Wrekin GP Access Report
- Telford & Wrekin Council's Resident's Survey 2023
- Health & Wellbeing Strategy Consultation 2023
- Annual Public Health Report 2024
- Other strategy development consultations
- Experts by Experience/ group feedback
- Elected Members feedback from conversations with constituents
- Scrutiny, Health and Wellbeing Board and Integrated Care Board discussions
- NHS England

Priority area 1: Supporting General Practice

What is the evidence telling us?

- Demand on GP services is high - 9% increase in appointments in General Practice since pre-pandemic (ICB, Dec 2023 report). Not all appropriate demand.
- Inequality of access and quality across Telford and Wrekin. From the 2023 GP Patient Satisfaction Survey, results varied from 5% of people find it easy to get through to someone on the phone to 80%. Similarly, those reporting good experiences of GP practices varied from 42% to 91% across the practices.
- Impact on people – feedback from residents through various evidence routes (see previous slide) not only highlights how important it is to them but the impact of not being able to access good quality sustainable general practice is significant.
- Impacting on acute services – if people think they cannot get a GP appointment, they go elsewhere such as to A&E. In STW, we have some of the most stretched A&E departments in the country, impacting on waiting times and ambulance delays. (ICB, Dec 2023 report)
- People want joined up, high quality, accessible health services
- Significant opportunities for health and care integration across place to support improvements. Including but not limited to:
  - Integrated Neighbourhood Teams based on a proactive care model
  - Community Prevention approaches (e.g. Live Well Hubs)
  - Prevention and early intervention services
  - More care closer to home
  - Supporting residents to understand what services are available and how to access them in their community

"Once you manage to get into the surgery, the treatment/care is excellent"

"Saturday & late evening phone appointments have also been very helpful"

"Waiting times must be reduced"

"Had to go 30hours in A&E with pneumonia because I … can't get to speak to a dr"

Priority area 2: All age mental health services and support

What is the evidence telling us?

- Premature morbidity in adults with severe mental illness is worse in TW than England average. The suicide rate in the borough for 2019-21 (11.4 per 100,000) was similar to the England average (10.4) but was the highest rate recorded for the borough since 2012-14.
- The rate of pupil suspensions at secondary school is higher than the national average (T&W rate of 26.2 compared to England rate of 14.0) (source DfE LAIT Tool 2021/22)
- Residents are reporting, through various routes mentioned in slide 3, a poor experience (pre-specialist service active involvement)
- Impact of Adverse Childhood Experiences and the impact of the pandemic on mental health is significant.
- Concerns raised around:
  - Accessibility
  - Waiting lists and availability of appointments
  - Support before reaching crisis point not available
  - Providing more services locally
  - Lack of awareness of how to manage own mental health
- Significant opportunities for health and care integration across place to support improvements. Including but not limited to:
  - Mental health prevention and early intervention services for all ages
  - More support/care closer to home
  - Role of VCSE
  - Supporting residents to understand what services are available and how to access them in their community

"Early help is needed"

"It should be easy to access mental health services"

"Lockdown causing isolation and now the cost-of-living crisis and other global events together clearly affecting their mental health and emotional wellbeing and their motivation and hopes for the future"

"There is more support that I am looking for but it is hard to find and I don't drive or use buses..."

Potential priority area 3: Healthy Ageing (Frailty)

What is the evidence telling us?

- Frailty is generally characterised by issues like reduced muscle strength and fatigue. Around 10% of people aged over 65 live with frailty. This figure rises to between 25% and a 50% for those aged over 85. Frailty (rather than age) is an effective way of identifying people who may be at greater risk of future hospitalisation, care home admission or death.
- TW Population of 65+ increased 35.7% since the previous census (this was the largest increase in the West Midlands and one of the largest in England). 14.9% of those 65+ reported they had bad or very bad health.
- 30% of people aged 65 and over will fall at least once a year. For those aged 80 and over it is 50%. They are the number 1 reason older people are taken to A&E.
- People want to stay as independent as long as they can and to be able to remain living in their own home.
- Concerns raised around:
  - Access to primary care services for health checks and mental health support
  - Access to support groups locally
  - Access to health screen and vaccinations locally
  - Support to age well
  - Risk of loneliness and isolation
  - Lack of joined up health and care
- Significant opportunities for health and care integration across place to support improvements. Including but not limited to:
  - Multi-disciplinary approaches using risk stratification and population health management approach to target those most at risk
  - Role of VCSE
  - Falls pilots and pathways

Community-centred approaches - prevention and reducing demand on care and support services

Strengthening communities

- Use of data and insight
- Place based projects (health inequalities and prevention)
- Live Well Hubs

Volunteer & peer roles

- Health Champions
- Feed the Birds (loneliness & isolation)
- Cancer Champions
- Blood Pressure Champions

Collaborations & partnerships

- TWIPP
- Ageing Well Strategy
- All-age Carers Strategy
- Mental Health Strategy
- Excess weight prevention
- Physical Activity

Connecting people to community resources & practical help

- Making Every Contact Count training / staff health & wellbeing
- Social Prescribing
- Healthy Lifestyles Services (Independent Living Centre & in the community
- Calm Cafes
- Falls Prevention 'Moving On' classes
- CVS
- Age Concern
- Low level support for people leaving hospital

Example: Development of local 24/7 supported accommodation

- No provision locally for people with mental health needs resulting in out of area placements
- Multi-agency work to develop local option (including commissioners, housing, a local developer, operational health and care teams)
- Rehab teams involved in the local delivery of care and support
- Multi-agency approach to prioritising placements whilst ensuring compatibility and reducing risk

- **Impact for residents:**
  - ✓ Moving back to telford, closer to family, friends and support network
  - ✓ Have their own front door
  - ✓ Develop daily living skills and increasing independence in their own home

- **Additional community support;**
  - ✓ Re-location of a Calm Café to the same locality to enable residents to access this preventative support and access other community services
  - ✓ Connections to the Donnington Energize project which will provide residents opportunities to increase their levels of physical activity to secure wider health benefits

Acura Living - White Cottage Apartments (youtube.com)

Example: Community Preventing Falls through Exercise

- Public health funding to support the delivery of weekly ‘Moving on’ sessions in the community

- Mary joined the Falls Prevention class following an unsuccessful knee operation. Mary’s walking has now improved, and she regularly attends the local Moving On session. She can now walk 2-3 miles at once; she volunteers and leads local walks close to where she lives.

“I feel good about the classes, they keep me going and allow me to do the things I do”

For further information on TWIPP please contact: Sarah Downes, sarah.downes@telford.gov.uk